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Advancing Health in America

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September 14, 2026

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

Submitted Electronically

RE: CMS–1848–P Medicare and Medicaid Programs; CY 2027 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 healthcare organizations; our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare 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) 2027.

The AHA applauds CMS for proposing significant changes that would strengthen the Medicare Shared Savings Program (MSSP) and expand participation in accountable care. We believe that these policies would sustain and grow the program, reduce administrative burden and promote innovation in care delivery. Specifically, we appreciate the agency's proposals to establish guardrails for the Accountable Care Prospective Trend (ACPT), increase the BASIC track Level E sharing rate and prior savings adjustment scaling factor, and enhance beneficiary engagement through cost-sharing reductions. These and other proposed changes would help to mitigate the benchmark ratchet effect, which has penalized providers for their past success, as well as incentivize new participation in accountable care organizations (ACOs). We look forward to continued collaboration with CMS as it seeks to increase the number of Medicare beneficiaries in alternative payment models (APMs).

We remain concerned, however, about the overall inadequacy of Medicare physician payments and the potential impact on access to and quality of care. **We oppose the proposed reduction in the conversion factors for CY 2027.** Hospitals and their associated physicians are currently facing substantial 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 a more adequate physician payment update in 2027 and going forward.**

We also are concerned that CMS has not provided sufficient information for interested parties to be able to evaluate the effects of its proposed changes to the indirect practice expense (PE) methodology. **Given the potentially significant impact on payment, we urge CMS not to finalize these proposals until it has published a more detailed impact analysis to ensure stakeholders have a meaningful opportunity for comment. We also remain strongly opposed to the indirect PE site-of-service differential for facility and non-facility settings, and we urge the agency to repeal this policy.**

In addition, we commend CMS for proposing to allow more flexibility for teaching physicians to be virtually present for services involving residents. **However, we urge the agency not to finalize its proposed changes to remote monitoring services, which would result in immediate and significant disruption for Medicare beneficiaries and limit access to care.**

Finally, while we appreciate CMS' commitment to reducing inappropriate duplication in payment under the PFS, **we oppose its proposal to reduce payment by 50% when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) visit is furnished on the same day as a global procedure.** At a time when the Administration has prioritized improving efficiency and care coordination in fee-for-service (FFS) Medicare, this proposal would result in more fragmented care and reduced access for patients.

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 Robyn Tessin, AHA director of physician payment policy, at rtessin@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy

Enclosure

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CONVERSION FACTOR UPDATE

As required by law, CMS proposes to implement two separate conversion factors: one for qualifying alternative payment model participants (QPs) and one for non-QPs. The QP conversion factor would be reduced by 1.19% and the non-QP conversion factor by 1.68% in CY 2027 as compared to CY 2026. The proposed conversion factors reflect statutory updates of 0.75% and 0.25%, respectively, as well as an increase of 0.53% that CMS states is necessary to account for proposed changes in the work relative value units (RVUs). However, they are offset by the fact that the one-year statutory conversion factor increase of 2.50% included in last year's budget reconciliation act (Pub. L. No. 119-21) for CY 2026 will no longer be in effect for CY 2027.

The AHA opposes the proposed reduction in the conversion factors for CY 2027. Physician payments continue to be inadequate. In fact, they are lower than they were a full 26 years ago. Specifically, the proposed conversion factors of $33.17 and $32.84 are 13% and 14% 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 paid under the PFS. Appropriately accounting for recent and future trends in inflationary pressures and cost increases is essential to ensure that Medicare payments for professional services more accurately reflect the cost of providing care.

Indeed, the 2026 Medicare Trustees Report acknowledged the inadequacy of Medicare physician payments and the potential impact on access to care. It states that the current physician payment system "raises important long-range concerns that will almost certainly need to be addressed by future legislation. The law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases. ... Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."[2] Similarly, in its June 2026 Report to Congress, the Medicare Payment Advisory Commission recommended increasing PFS payment rates "[t]o bring FFS Medicare's overall payment levels closer in line with providers' costs."[3]

Moreover, because many other payers tie their payment rates to the Medicare PFS, providers' losses under Medicare are compounded by losses from other payers.

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[1] https://www.ama-assn.org/system/files/2026-medicare-updates-inflation-chart.pdf
[2] https://www.cms.gov/oact/tr/2026
[3] https://www.medpac.gov/wp-content/uploads/2026/06/Jun26_Ch1_MedPAC_Report_To_Congress_SEC_v3.pdf

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. For example, the current national staffing emergency could jeopardize patients' and communities' access to high-quality care. Indeed, physician shortages are projected to exceed 86,000 by 2036.[4] We also have seen how increased administrative burden contributes to physician burnout and to clinicians leaving the field. And this is occurring while the aging beneficiary population has increased demand for 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.

PRACTICE EXPENSE METHODOLOGY

Modifications to Indirect Practice Expense Methodology

CMS proposes several modifications to its indirect PE methodology. Under the current methodology, indirect PE is allocated based on the greater of the work RVUs or clinical labor portion of the direct PE RVUs, with the exception of services with technical, professional and global components, which are allocated based on the sum of both. CMS states that it believes it would be more accurate to use the same allocation methodology for all PFS services. Therefore, the agency proposes to allocate indirect PE using the sum of the work RVUs and clinical labor RVUs for all services, except for codes with 010- and 090-day global periods.

CMS also proposes to phase out the indirect practice cost index (IPCI) over a two-year period. The agency states that reliance on the IPCI effectively favors outdated aggregate specialty-level survey data over code-level inputs and allocators. To mitigate potential volatility from removing the IPCI, CMS proposes a PE stabilization adjustment that would cap any annual change in a code's PE RVUs at +/-5%. The cap would not apply to codes that are new, revised, revalued or formerly contractor priced and newly nationally priced.

The AHA is concerned that CMS has not provided sufficient information for interested parties to be able to evaluate the effects of these complex and interrelated proposed changes. It is clear that there would be significant redistributive effects across specialties, resulting in a downward impact on payments for many physicians. For example, CMS' specialty impacts by practitioner table indicates that 54% of dermatologists and 23% of otolaryngologists would see a decrease of more than 10% in their total RVUs.[5] Similarly, 34% of otolaryngologists, 30% of orthopedic surgeons and 23% of dermatologists would experience a cut of more than 5%.

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[4] https://www.aamc.org/media/75236/download?attachment
[5] https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1848-p

However, given their interconnected nature, it is not clear how each individual proposed change would affect particular physician specialties, services and codes. In addition, it is not feasible for stakeholders to make this assessment themselves based on the high-level aggregate impact analyses that the agency has published. **Given this, we urge CMS not to finalize these proposals until it has published a detailed impact analysis for each individual proposed change to the indirect PE methodology. Greater transparency is needed to ensure stakeholders have a meaningful opportunity for comment.**

Additionally, CMS has not offered any policy rationale for its proposed exclusion of 010- and 090-day global period codes from its policy that would use the sum of the work RVUs and clinical labor RVUs as an indirect PE allocator. As support for this proposal, CMS cites a RAND Corporation report finding that the existing methodology inadvertently advantages certain services for which the sum is currently used as an allocator because summing these RVU components results in a larger indirect allocator than using the greater of either. However, upon review of the report, we note that 010- and 090-day global period codes were included, not excluded, in RAND's analysis.[6] CMS does not explain or even mention this discrepancy between its proposed policy and the RAND report's methodology. Yet, excluding the 010- and 090-day global period codes would mean that these services would continue to be undervalued relative to other codes that would benefit from the larger summed allocator. **We urge CMS not to finalize what would amount to an arbitrary payment cut for the physicians who bill these global services codes.**

Indirect Practice Expense Site-of-Service Differential

In last year's rule, CMS finalized its proposed indirect PE site-of-service differential for services furnished in facility and non-facility settings. Under this policy, the agency reduces the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs. CMS states that implementation of this policy has resulted in an unintended differential for physician visits in nursing facility settings based solely on whether the beneficiary's stay is covered under Medicare Part A or B. Therefore, the agency proposes to equalize the rate for nursing facility visits by setting the facility PE RVU equal to the non-facility PE RVU for certain Current Procedural Terminology (CPT) codes.

The AHA supports this proposal to equalize the non-facility and facility PE RVUs for nursing facility visits. Nursing facility visits are classified as either non-facility or skilled facility services. However, a patient could be changed from non-skilled to skilled care overnight and still be in the same bed and the same room. We agree that a physician's indirect PE would not vary based on how the visit is classified.

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[6] https://www.rand.org/pubs/research_reports/RRA4720-2.html#document-details

In addition, CMS requests comments on whether the indirect PE site-of-service differential for facility/non-facility settings that it finalized last year is still appropriate, or whether it should consider other approaches, particularly for physicians employed by hospitals and other facilities. **The AHA continues to oppose the indirect PE site-of-service differential and urges CMS to repeal it. We remain deeply concerned about its significant downward impact on payments to many physicians.** Specifically, CMS estimated that physician payments in the facility setting would decrease by 7% in CY 2026, with an even greater impact on certain specialties. For example, the agency indicated that 39% of hematology/oncology physicians would see a cut of more than 10% in their total RVUs.[7] Similarly, 83% of critical care, 73% of infectious disease and 57% of general surgery practitioners would experience a decrease of over 5%.

In addition, we remain concerned that this indirect PE site-of-service differential has created inappropriate incentives. For example, it has created 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 authorization and other complex billing and utilization management policies.[8] 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. An AHA analysis of LevinPro HC data between 2019 and 2024 reveals that commercial insurers and corporate entities like Amazon continue to lead physician practice acquisitions, with a particular emphasis on acquiring higher-margin, scalable specialties in densely populated markets rather than lower-margin specialties.[9] CMS' significant reduction in Medicare payment rates for certain physicians has only hastened physician practices' move toward these non-traditional providers.

Finally, we emphasize that even aside from impacts, CMS' methodology should, as a principle, ensure that indirect PE is fully accounted for in PFS payments for all physicians, including those who are solely facility-based. 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. Office space separate and apart from the hospital or facility is often required for the practice's administrative and clinical staff. Moreover, the practice incurs other

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[7] https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notices/cms-1832-f
[8] https://www.aha.org/fact-sheets/2023-06-07-fact-sheet-examining-real-factors-driving-physician-practice-acquisition
[9] https://www.aha.org/infographics/2025-10-21-whos-really-driving-physician-acquisitions

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. For example, for global surgery codes, 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 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 restore the work allocator to 100% for facility PE RVUs, as it was before CY 2026. 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. The agency should rely on evidence-based approaches to ensure indirect PE is accurately reflected in PFS rate setting for facility and non-facility settings, rather than apply an arbitrarily selected 50% reduction as under current policy. Further consideration of these issues is needed before the agency applies other policy changes to the PE methodology, particularly with this magnitude of impact on specialists.

MEDICARE ECONOMIC INDEX COST SHARES

The Medicare Economic Index (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 PE. 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 2027, 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.

OFFICE/OUTPATIENT EVALUATION AND MANAGEMENT VISITS

E/M Visit Complexity Add-On Code

The O/O E/M visit complexity add-on code (Healthcare Common Procedure Coding System [HCPCS] code G2211) is intended to recognize the ongoing, longitudinal relationship that a practitioner furnishing the visit has with the patient. CMS states that it has come to believe that the resource costs of furnishing longitudinal care would be more accurately valued as a modifier to the base E/M code instead of an add-on code. Therefore, it proposes to replace HCPCS code G2211 with a modifier, which it states would increase payment for all levels of the base E/M code by 16%. Additionally, CMS proposes a similar modifier for practitioners participating in an ACO under MSSP, the ACO Primary Care Flex Model or the Long-term Enhanced ACO Design (LEAD) Model, which it states would increase payment of the associated E/M visit by 32%.

The AHA supports these proposals. Percentage-based modifiers would better reflect the differences in physician work across E/M levels; they also would address CMS' stated concern that as a flat-rate increase, the current add-on code disproportionately augments lower-level intensity base codes. We encourage the agency to provide outreach and education to coding and billing professionals to ensure they will be aware of these changes.

In addition, we appreciate CMS' recognition of the longitudinal care management provided by clinicians participating in ACOs and believe the proposed modifier would incentivize clinicians to join and remain in ACOs. We support the agency allowing ACO participants to bill the modifier for services furnished to all Medicare beneficiaries they treat, not only those who are assigned to the ACO. The care delivery infrastructure developed by ACO participants can benefit Medicare patients regardless of their assignment status.

We also encourage CMS to expand its payment policies for E/M visit complexity to include additional longitudinal providers of care, such as critical access and other small, rural hospitals, rural health clinics (RHCs), and federally qualified health centers (FQHCs). Clinicians who practice in these settings often serve as the continuing focal point of care for rural and underserved Medicare populations. Additionally, long-term care and nursing facility settings should be included. Although CMS extended the complexity add-on code to home and residence E/M visits in last year's final rule, it did not apply to the nursing facility E/M code family. Expanding the policy to nursing and other long-term care settings would promote parity and reflect the inherent complexity of caring for frail, high-needs Medicare beneficiaries.

Overlap Between Standalone E/M Visits and Global Periods

CMS states its belief that there is likely overlap and duplication of payment between the E/M services included in a global surgical package and any additional E/M services billed under modifier -25 as significant and separately identifiable from the procedure. The agency asserts that there are efficiencies when the same physician (or a physician in the same group practice) provides an E/M service for the same patient in conjunction with a procedure with a global period. To address this potential overvaluation, CMS proposes to reduce payment when a separately identifiable O/O E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10- or 90-day global procedure. The highest paid service (either surgical or E/M visit) would be paid at 100% and all other services furnished on the same day would be paid at 50%.

The AHA opposes this proposal. While we appreciate CMS' commitment to reducing inappropriate duplication in payment under the PFS, the proposed 50% payment reduction is overly broad and arbitrary. Moreover, at a time when the Administration has prioritized improving efficiency and care coordination in FFS Medicare, this proposal would result in more fragmented care and reduced access for patients. Specifically, the agency makes this proposal based solely on its belief that overlap and duplication "likely" occur when an E/M service is furnished on the same day as a global procedure. It did not provide any analysis or empirical evidence of actual duplication, let alone the magnitude of duplication. Payment reductions of this scope should be based on clear and statistically significant evidence of overlap in identified services, not on a speculative assumption that overlap is likely.

In addition, any duplication between E/M services and global procedure codes should have been already identified and corrected through CMS' potentially misvalued code initiative required by section 1848(c)(2)(K) of the Social Security Act. Indeed, the agency has repeatedly reviewed and revalued specific codes through this initiative. Consequently, the physician work and PE resources that are currently assigned to the global service codes should reflect only the resources involved in furnishing those services. If finalized, the proposed policy would effectively reduce payment again, resulting in a double-counting of assumed overlap.

Even if CMS' belief is supported by evidence and there is in fact overlap in the resources reflected in E/M services and global procedure bundles, the proposed payment reduction is an overly broad policy solution. Under the proposal, CMS would apply the 50% payment cut any time a separately identifiable O/O E/M visit is furnished on the same day as a global procedure, regardless of how recently a particular global code has been reviewed and revalued. This is problematic because, at a minimum, codes that have been reviewed recently should already reflect any elimination of duplication in resources. In fact, CMS has not explained why the proposal should be applied uniformly to all global procedure codes. That is, rather than analyzing

the wide variety and individual characteristics of these codes, the agency would use the blunt tool of an across-the-board reduction. Indeed, in the CY 2017 PFS rulemaking, CMS recognized that a code-level analysis is the appropriate pathway when it undertook a review of potentially misvalued global codes typically billed with an E/M service under modifier -25.[10] **As such, the agency should follow past precedent and address any actual overlap on a code-specific basis through its potentially misvalued code initiative, rather than through a uniform, payment-level reduction.**

Additionally, the proposed 50% reduction is arbitrary and disproportionate to any alleged duplication that it targets. CMS has not explained why it selected 50% other than by way of analogy to its multiple procedure payment reduction (MPPR) policy for surgical services. This policy reduces payment by 50% for the second and subsequent surgical procedures furnished to the same patient on the same day to account for overlap in PE and pre- and post-surgical physician work. However, it is not appropriate to compare the shared resources between two or more procedural services with a separately identifiable E/M service and a procedure. Procedural services may include related visits and share substantial resource costs, whereas a separate E/M service and a procedure are distinct services with limited overlap. As such, CMS' proposal to apply the same 50% reduction in this context does not accurately reflect the resources involved in furnishing these different types of services.

Moreover, for other services paid under the PFS, the agency has established MPPR policies that are targeted to the specific type of resource for which there is overlap. For example, the MPPR policy for advanced imaging services applies a 50% reduction to the technical component of the second and subsequent services and only a 5% reduction to the professional component. For diagnostic cardiovascular and ophthalmology services, the MPPR is 25% and 20%, respectively, and it is applied only to the technical component of the services. **In contrast, in proposing to apply a 50% reduction to the full value of all lower-paid same-day services, CMS departs from this narrowly tailored approach without any justification.** Due to this discrepancy, the agency should undertake a code-level analysis to identify any specific resource categories in which there may be overlap before it reduces payment for services.

Physicians should be fully compensated for all services furnished on the same day, whether they are E/M visits or global procedures. **In many cases, addressing multiple clinical needs during the same encounter is not only clinically appropriate but also less burdensome for patients.** For example, dermatologists routinely perform skin examinations and, when warranted, conduct biopsies or other minor procedures on the same day after they have evaluated the patient's needs. Similarly, otolaryngologists may have to evaluate a patient before proceeding with a scheduled procedure in one ear to determine whether treatment is also necessary for the other ear. Scheduling these services on different days would result in delayed care and impose unnecessary

[10] 81 FR 80204.

inconvenience on patients. **Indeed, the impact on access to care would be particularly pronounced for patients in rural communities who must travel long distances for return visits, as well as those in other underserved areas experiencing workforce shortages and limited specialist availability.** For many of these individuals, obtaining a return appointment may take months, resulting in avoidable delays in diagnosis and treatment. Given these significant unintended consequences for care coordination, efficiency and patient access, we strongly urge CMS not to finalize this proposal.

Finally, although the agency notes that the proposed policy would apply only to O/O E/M visits, it seeks comment on whether the policy should also apply to other E/M visits, such as inpatient E/M visits. **The AHA strongly opposes any expansion of the policy to inpatient and other E/M services**. In general, the codes for these services do not include direct PE costs, and the physician work associated with a procedure performed on the same day would occur at a different time and reflect separate clinical activities. Given the lack of any significant overlap between inpatient E/M visits and same-day procedures, we urge CMS not to apply the proposed payment reduction to inpatient or other settings of care.

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' current policies that extend or make permanent several telehealth flexibilities. However, we cannot emphasize enough the need to permanently lift additional statutory and regulatory restrictions.**

The telehealth flexibilities granted because of the COVID-19 public health emergency (PHE) resulted in significant benefits to patient care. These flexibilities are needed now, more than ever, to ensure patients' continued access to high-quality care. The growth 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 healthcare 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 Dec. 31, 2027. 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 FQHCs and RHCs, 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 follow.

Medicare Telehealth Services List

CMS proposes to add the following services to the Medicare Telehealth Services List for CY 2027: advance care planning (ACP) services performed by clinical staff, group-based medical sessions, treatment of speech and other disorders for the pediatric population, and E/M visits for the diagnosis and treatment of vaccine adverse effects. **We support CMS' proposal.** Adding these services to the Medicare Telehealth Services List would expand access and provide options for patients to receive care. As technology and consumer preferences have evolved, more care can safely be delivered via telehealth.

Remote Monitoring

In response to recent reports from the Department of Health and Human Services (HHS) Office of Inspector General (OIG), CMS proposes several changes to remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) services paid under the PFS.[11] The agency currently requires that RPM services be furnished only to an established patient; in this rule, it proposes to expand this established patient requirement to RTM services. CMS also proposes that practitioners billing for RPM or

[11] https://oig.hhs.gov/reports/all/2025/billing-for-remote-patient-monitoring/, https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/

RTM services must furnish a separately reportable initiating visit in association with the onset of these services, and that the services must be initiated by the billing practitioner during a face-to-face (in-person or telehealth) visit.

In addition, CMS states that currently, RPM or RTM services may be outsourced to third-party companies that provide services via telephone and online contact only, using staff who have little to no established relationship with the beneficiary or interaction with the billing practitioner. Based on the OIG reports finding concerns with third-party outsourcing of these services, the agency proposes to allow payment for RPM and RTM services only when they are performed by clinical staff employed by the billing practitioner and not by a contractor. Finally, CMS proposes to reduce the valuation of these services because it believes the associated device costs may be overvalued and to eliminate PE inputs for certain codes. The agency also seeks comments on bundling the RPM and RTM codes to reduce administrative burden.

The AHA opposes these proposed policy changes for RPM and RTM services and urges CMS not to finalize them. Changes of this magnitude beginning only months from now would result in immediate and significant disruption for Medicare beneficiaries who rely on these services to manage chronic conditions, prevent avoidable complications and maintain consistent engagement with their care teams. **At a time when the Administration is making historic investments to expand technology-enabled care and address chronic disease, these proposals run counter to those efforts.** Indeed, many states are using Rural Health Transformation Program (RHTP) funds to make substantial investments in health information technology as a strategy to improve access to care, strengthen care coordination and support chronic disease management in rural communities. Initiatives to scale up telehealth capabilities and remote monitoring have been a priority across state plans under the RHTP. These proposals would hinder states' efforts to support technology-enabled models of care that enable rural providers to intervene earlier when health conditions worsen and better manage limited clinical workforce resources.

First, the AHA disagrees that RPM and RTM services should be limited to established patients. RPM and RTM have been critical tools in safely discharging patients with chronic conditions from the hospital, transitioning patients to better self-manage conditions and reducing readmissions. During the COVID-19 PHE, 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 prior to discharge), which provided critical support in the immediate timeframe after discharge. Requiring an established patient relationship for RPM and RTM services would create a barrier to patients having access to services in a timely manner.

Additionally, the proposal to require a separately reportable visit in association with the onset of RPM and RTM services would be duplicative and increase burden for providers and patients. For example, oftentimes patients with acute or chronic conditions will begin remote monitoring services in connection with an inpatient

hospital stay. Remote monitoring that will commence after an inpatient stay is typically established as part of the discharge workflow so that monitoring can begin promptly when the patient returns home. As such, it would be unnecessary and duplicative to require the patient to return in person or via telehealth for a separately reportable visit. Indeed, such a policy undermines the goals of more efficient and better coordinated care that CMS has prioritized under the Comprehensive Care for Joint Replacement Model and through other value-based care initiatives. Additionally, requiring a separate visit to initiate remote monitoring would be particularly burdensome for patients in rural areas who face long travel times and limited telehealth access, as well as further strain the already scarce staffing and other resources of rural providers.

Further, while we recognize there may be unscrupulous third-party organizations that seek to exploit these services as described in the OIG's reports, prohibiting the use of contractors entirely would be overly broad and significantly disrupt providers' legitimate business models. **Many providers, including independent, rural and safety-net hospitals, simply do not have the staffing capacity or other resources necessary to provide these services to patients without the use of contractors.** For many hospitals and health systems, it is a strategic business decision to rely on outside parties with specific expertise in certain areas, such as technology support; device set-up, maintenance and retrieval; and patient education on the use of specialized equipment. If providers cannot use contractors to support these services, many will be forced to scale back patient enrollment in remote monitoring or discontinue the services altogether. The impact would be especially severe for rural and safety-net hospitals, which often serve populations experiencing significant barriers to care, including long travel distances, provider workforce shortages and limited specialty access. For many of these providers, the administrative and operational burdens associated with the proposed restrictions would leave few viable alternatives other than reducing participation in remote monitoring programs or ending them entirely, thereby diminishing access to care for some of Medicare's most vulnerable beneficiaries.

Indeed, CMS itself has recognized that technology vendors can play a critical role in Medicare beneficiaries' care. Under its Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model, it states that more than 150 organizations have been accepted to participate, most of which have not previously served Medicare beneficiaries. These organizations will bring technology-supported care options to help beneficiaries manage their chronic conditions, including remote monitoring as described in the ACCESS request for applications.[12] Yet under CMS' proposals in this rule, for purposes of remote monitoring services billed under the PFS, providers would be prohibited from contracting with these ACCESS participants. **It is arbitrary and overly broad for CMS to propose a blanket ban on the use of contractors for remote monitoring services billed under the PFS while simultaneously allowing these**

[12] https://www.cms.gov/priorities/innovation/access-model-accepted-applicants

organizations to enroll in Medicare Part B and provide the same services to beneficiaries under ACCESS.

Additionally, the proposed requirement that the clinical staff performing remote monitoring services must be directly employed by the billing practitioner or their practice is overly restrictive and does not reflect how healthcare providers are commonly structured. As an example, for academic medical centers, it is typical for the billing physician to be employed by the faculty practice plan while the nursing or other clinical staff who perform the remote monitoring services are employees of the hospital. Similarly for health systems and other large organizations, the billing practitioner and clinical staff may be employed by separate legal entities or business units within the larger organization. As a result, CMS' proposal could result in hospitals and health systems no longer being able to provide remote monitoring services simply due to their organizational structures.

Finally, the AMA/Specialty Society RVS Update Committee (RUC) stated that it has moved up its review of the existing RPM and RTM CPT codes to January 2027 as a result of CMS' proposed reductions in their valuation. **Accordingly, we recommend that CMS delay making any changes to the valuation of these codes until after the RUC has completed its review.**

We urge CMS not to finalize these proposed changes to remote monitoring services and instead work with stakeholders on a balanced approach that protects patients, preserves clinically integrated care and strengthens program integrity protections. Program integrity concerns should be addressed through proportionate, evidence-based guardrails rather than broad restrictions on beneficiary access to care. In contrast, CMS' proposals far exceed the OIG's recommendations, which include implementing methods to better identify and monitor companies that bill for remote monitoring services, rather than a complete prohibition on the use of contractors.

Teaching Physicians With Virtual Presence

Current policy allows teaching physicians to have a virtual presence during Medicare telehealth services in all teaching settings, but only in clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident and patient in different locations. In this rule, however, CMS proposes to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. **We support this proposal.** For many hospitals and health systems, teaching physicians may be geographically dispersed or balancing supervisory functions with care delivery and administrative tasks. The proposed flexibility would enable improved patient access and maximize limited teaching physician capacity given prevalent staffing shortages, as well as provide real-world telehealth experience for residents.

ADVANCE CARE PLANNING SERVICES

CMS proposes to establish two new HCPCS codes to describe ACP services furnished by clinical staff under the direct supervision of the billing practitioner. The agency further proposes that existing ACP CPT codes 99497 and 99498 would be used only for time personally spent by the billing practitioner. CMS states these proposals would more accurately distinguish and value the work performed by billing practitioners from that of their clinical staff. **The AHA supports these proposals as they underscore the growing recognition of ACP as a long-term, team-based service.** The coding changes would support more consistent integration of these conversations into ongoing patient care while maintaining involvement by the treating physician or other qualified healthcare professionals when appropriate.

SHARED MEDICAL APPOINTMENTS

Recognizing the importance of healthcare delivery approaches that enable multidisciplinary support, foster beneficiary engagement, and encourage sustainable lifestyle and behavioral changes, CMS proposes to create coding and valuation specifically for shared medical appointments (SMAs). SMAs are voluntary group-based sessions where multiple patients with a common condition receive medical care together. The AHA appreciates that CMS acknowledges the benefits of SMAs, and we agree that this innovative approach to care should be appropriately reimbursed; however, we are concerned that the coding and valuation proposed does not adequately account for the value of these services and if implemented would undermine their use. **In addition to our specific recommendations below, we suggest that CMS work with SMA subject matter experts to refine the proposal prior to adopting the code.**

Our primary concern is that CMS conceptualizes SMAs and their application more narrowly than how they are actually used. CMS proposes to establish coding and payment for SMAs provided for medical conditions that are modifiable with lifestyle change, “including diet, physical activity, and self-management.” This definition would limit the clinical scope for which SMAs are used in a way that will exclude many successful use cases of the practice. Our members have successfully deployed SMAs to benefit patients with multiple needs and many various conditions that are not solely addressed with lifestyle changes, such as ADHD, pregnancy, depression, pain management, osteoporosis, food allergies and cancer survivorship; implementing the code as proposed would result in the disbanding of active SMAs that do not meet the criterion of being “lifestyle-based.”

In addition, CMS proposes that SMAs be limited to beneficiaries who have an existing clinical relationship with the practitioner, as defined as having received a professional service from the billing physician or other qualified health professional or another physician or other qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months.

This provision dilutes the very purpose of SMAs in that they are intended to foster interdisciplinary collaboration, referrals and team-based care. Clinicians can successfully engage through SMAs with new patients, patients with new conditions, first-time visits and additional areas where patient needs are addressed outside of the immediate department.

The proposed descriptor is also inconsistent with how SMAs are conducted. First, CMS proposes to establish SMAs as a 60-minute session (although the agency notes that "SMA sessions generally last 60 to 120 minutes"); our members generally hold 90-minute SMA sessions. Next, CMS notes that, while SMA sessions generally "may include up to 25 patients," they propose to limit use of the code to appointments with up to 10 beneficiaries per session. We agree that CMS should set maximum time and patient limits in order to guard against fraudulent use of this important service; however, the proposed constraints inappropriately impose a one-size-fits-all structure. One of the benefits of SMAs is that they are flexible to meet the specific needs of their patient constituents; the number of patients that are suitable for an SMA will depend on the complexity of their conditions and the components of the appointment. We recommend that CMS work with subject matter experts to determine whether it is appropriate to set a cap on the number of beneficiaries in an SMA for billing purposes based upon the complexity of services provided; **at minimum, though, CMS should allow SMAs to include up to 15 beneficiaries per session.**

In a similar vein, CMS proposes to incorporate the work RVUs, work time and direct PE inputs associated with a Level 3 O/O visit for an established patient. However, our members find that historically their SMAs have inputs associated with an average visit between Levels 3 and 4. While some SMAs are less resource intensive, others involve a higher level of complexity and professional management; assigning the same G-code to all SMAs unilaterally would eliminate the ability for a clinician to identify those higher intensity services by billing under CPT codes.

We raise these concerns because SMAs offer significant value for patients as well as efficiencies for the entire healthcare system; not only are these services associated with improved patient outcomes such as reduced hospital readmissions, but also because a large proportion of them are virtual, providers can reduce costs while still maintaining access to care for larger volumes of patients. Implementing billing with the proposed limitations (continuity, attendance, duration and medical scope) and decreased reimbursement would result in fewer SMA offerings. We agree with several of the aspects of CMS' proposal, including the limitation on billing additional services and the incorporation of components in the code descriptors related to both medical care and education and group counseling; indeed, to guard against inappropriate use of SMAs, billing requirements should include standard, evidence-based components such as defined staffing. However, we encourage CMS to consider additional refinements to its proposal as suggested above prior to finalizing the adoption of coding and payment for SMAs.

MATERNITY CARE SERVICES

CMS proposes creating HCPCS Level II G-codes (HCPCS G-codes) that would maintain the existing global maternity care reporting structure in lieu of adopting the revised CPT maternity care services code set effective Jan. 1, 2027. **We oppose the creation of separate HCPCS G-codes for Medicare payment purposes and urge CMS to adopt the CPT code set as developed through the CPT Editorial Panel and RUC processes.**

The revised CPT maternity care code set reflects significant changes in contemporary obstetrical practice and was developed to better represent the distinct phases of maternity care, including antepartum care, labor management, delivery services and postpartum care. CMS notes that these revisions were undertaken to reflect changes in practice patterns and contemporary clinical guidelines. The CPT framework enables reporting of the actual services provided throughout the maternity episode rather than relying on a bundled global coding structure.

The AHA is concerned that creation of a parallel HCPCS G-code structure for Medicare payment purposes would introduce substantial administrative complexity and confusion for physicians, hospitals, health systems, payers, vendors, researchers and other stakeholders. Maintaining two coding systems to describe the same maternity care services would require providers to navigate different reporting methodologies depending on the payer, increasing operational burden, coding complexity, education needs and the potential for billing errors. Such duplication would be particularly challenging during and after implementation of the new CPT framework, as organizations would be required to maintain workflows, edits, training, analytics and reporting systems for both coding structures simultaneously.

In addition, adoption of HCPCS G-codes for Medicare payment purposes would undermine one of the primary objectives of the CPT revisions: the ability to capture services across the full maternity care continuum in a consistent and transparent manner. The revised CPT code set separately identifies each phase of maternity care, permitting a more complete understanding of the services furnished and the resources required across each phase of care. By contrast, the proposed HCPCS G-codes would largely preserve the historical global reporting methodology and continue to aggregate multiple components of care into single codes. As a result, stakeholders would lose important clinical and operational information about the timing, intensity and nature of services furnished during pregnancy and childbirth. [13]

The AHA also is concerned that use of separate HCPCS G-codes would significantly limit the ability to compare maternity care utilization, outcomes, quality measures and resource use across payers and care settings. The healthcare industry is preparing for

[13] https://www.ama-assn.org/practice-management/cpt/cpt-2027-maternity-care-services-code-changes

nationwide implementation of the revised CPT framework beginning Jan. 1, 2027. CMS develops HCPCS Level II codes to identify products, supplies and services not included in the standard CPT (Level I) code set and to support Medicare payment policy. However, HCPCS Level II codes also can be used by Medicaid and other health insurance programs. As a result, creation of separate maternity care HCPCS Level II G-codes could encourage broader adoption by state Medicaid agencies and other payers, thereby increasing variation in maternity care reporting across the healthcare system and further fragmenting maternity care data.[14] Rather than promoting consistency, the existence of both CPT and HCPCS maternity coding structures could result in fragmented adoption patterns, further complicating data aggregation, benchmarking, longitudinal analyses, quality assessment, health services research and population health surveillance activities. Consistent use of a single national coding framework is essential to ensuring that maternity care services can be evaluated, compared and measured across care settings, payer types and patient populations.

Moreover, the detailed CPT framework creates opportunities for more sophisticated evaluation of maternal health outcomes, quality measurement, healthcare research and future policy development. Separate reporting of maternity care services provides valuable information regarding care patterns, care transitions, service intensity, resource utilization, risk adjustment and maternal health interventions throughout the pregnancy journey. The ability to distinguish services furnished during each phase of care is foundational to ongoing efforts to improve maternal morbidity and mortality outcomes and better understand factors affecting maternal health.[15] By contrast, the proposed HCPCS G-codes would obscure these distinctions and limit the granularity of data available for quality improvement, performance measurement, research and policy development.

National attention continues to focus on disparities in maternal morbidity, mortality, access to care and pregnancy outcomes across geographic, socioeconomic and demographic populations.[16] Detailed reporting across the maternity care continuum may help support analyses of care patterns and outcomes among different patient populations. The proposed HCPCS G-codes would largely preserve an aggregated reporting structure and reduce the level of clinical detail available for these activities.

The revised CPT code structure is also more reflective of contemporary team-based maternity care delivery. Today's maternity care frequently involves multiple clinicians, practice settings and levels of care across the antepartum, labor, delivery and postpartum periods. The new CPT codes were specifically designed to support reporting of services furnished across these distinct phases, recognizing that care is

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[14] https://www.cms.gov/medicare/coding-billing/healthcare-common-procedure-system
[15] https://www.cms.gov/maternal-health
[16] https://www.cms.gov/priorities/innovation/innovation-models/tmah

often delivered by different practitioners and organizations. Retaining maternity care HCPCS G-codes would fail to align coding policy with modern clinical practice and would perpetuate limitations associated with a coding structure developed decades ago.

For these reasons, **the AHA urges CMS not to create separate HCPCS G-codes that maintain the legacy maternity care global reporting structure and instead to adopt and implement the revised CPT maternity care services code set beginning Jan. 1, 2027.** Adoption of the CPT framework will better support accurate reporting, enhance data transparency, facilitate quality measurement and maternal health research, reduce administrative complexity, improve data comparability and promote consistency across the healthcare system.

SOFTWARE AS A MEDICAL SERVICE LABORATORY ANALYSES

In general, the AHA appreciates CMS' efforts to modernize Medicare payment policies for emerging technology-enabled services and supports the agency's goal of developing a consistent framework for software-enabled technologies across Medicare payment systems. In the rule, CMS proposes several changes to software as a medical service (SaMS) for laboratory services. Specifically, the agency proposes to change terminology from Software as a Service (SaaS) to SaMS, and to migrate payment for SaMS for laboratory tests from the Clinical Laboratory Fee Schedule (CLFS) to contractor pricing. **The AHA requests further clarification on the proposed changes in terminology to SaMS and how the agency will distinguish standalone services from hybrid ones. We also recommend that the agency further evaluate impacts of migrating from CLFS to contractor pricing before finalizing.**

Request Clarification on Proposed Changes to Terminology

CMS proposes to change terminology for SaaS to SaMS. The agency asserts that in fields other than healthcare, SaaS terminology is used for general cloud-based computing service models, which can generate confusion. As we noted in our comments on the CY 2027 hospital outpatient prospective payment system (PPS) proposed rule, we urge CMS to further clarify the proposed transition from SaaS to SaMS.[17] Specifically, we encourage CMS to clarify whether the transition to SaMS is intended solely as a naming convention or whether it reflects broader distinctions regarding the scope, classification, valuation or payment treatment of these technologies.

We also encourage CMS to provide additional guidance regarding how it intends to distinguish standalone SaMS technologies from hybrid services that combine laboratory testing, digital pathology, imaging, artificial intelligence and clinical decision support

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[17] https://www.aha.org/system/files/media/file/2026/08/aha-comments-on-the-cms-hospital-outpatient-pps-and-asc-payment-system-proposed-rule-cy-2027-letter-8-28-2026.pdf

functions. This guidance should use transparent criteria for identifying services that qualify as SaMS laboratory analyses and provide stakeholders opportunities to review and comment on future reclassification proposals. Clearer guidance would promote predictability for providers, technology developers and beneficiaries as innovative diagnostic technologies continue to emerge.

Recommend Further Evaluation of Proposed CLFS Migration Before Finalization

CMS also proposes to remove certain currently payable services from the CLFS and instead make them payable under the PFS through contractor pricing. Specifically, the agency proposes to migrate payment for 10 HCPCS codes from the CLFS to contractor-based pricing.

We urge CMS to evaluate the impacts to patient access, provider adoption and payment predictability stemming from this significant policy change before finalizing. We appreciate CMS' interest in establishing a consistent payment framework for technologies that the agency believes function primarily as algorithmic analyses rather than laboratory tests. However, as healthcare technologies increasingly integrate laboratory analyses and advanced computational methods, it may become more difficult to distinguish standalone SaMS services from hybrid diagnostic services that continue to rely on laboratory resources and expertise. We encourage CMS to provide additional guidance regarding the factors it will use to identify services that should be considered SaMS laboratory analyses and to offer stakeholders opportunities to review and comment on any proposed reclassification of additional services.

The proposed SaMS laboratory services include several advanced oncology and genomic-related analyses that play increasingly important roles in precision medicine and individualized treatment planning. Therefore, CMS should ensure that any transition in payment methodology does not inadvertently create barriers to beneficiary access or discourage continued innovation in these areas. We encourage CMS to monitor utilization and access trends closely as the market for these technologies continues to evolve.

In addition, **the AHA urges CMS to ensure that future payment methodologies appropriately reflect the full range of resources necessary to implement, maintain, validate and secure these technologies.** As we have previously commented, hospitals and other providers incur significant costs related to technology infrastructure, interoperability, clinician oversight, algorithm validation, workforce training and cybersecurity, all of which support the safe and effective use of software-enabled clinical tools.[18] In addition, we encourage CMS to recognize that these technologies often supplement, rather than replace, clinical expertise and therefore require ongoing

[18] https://www.aha.org/system/files/media/file/2025/09/AHA-Comments-to-CMS-on-CY-2026-Physician-Fee-Schedule-Proposed-Rule.pdf

clinician review, validation and oversight to ensure appropriate application in patient care settings. Also, the budget-neutral aspect of payment increases has meant that increases in certain services have resulted in cuts in others. While we support "rightsizing" payment for technology-enabled services, doing so should not come at the expense of other services.

RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS

RHCs and FQHCs are paid an "all-inclusive rate" (AIR) and a prospective payment system (PPS) amount, respectively. These payment rates are designed to reflect the cost of all services and supplies that an RHC or FQHC furnishes to a patient in a single day. RHCs and FQHCs are also paid outside of the AIR and PPS for non-face-to-face care management work involved in coordinating care. To that end, Section 5114 of the Deficit Reduction Act of 2005 provided for the coverage and payment of diabetes self-management training (DSMT) and medical nutrition therapy (MNT) services as standalone billable visits under the FQHC benefit, but did not make similar changes for coverage and payment when furnished in RHCs. As such, CMS proposes to recognize DSMT and MNT services as qualified preventive services that are covered and paid as standalone billable visits under the RHC benefit as well. **We support this proposal.**

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM 340B DATA REPOSITORY

The AHA supports CMS' goal of improving the administration of the Medicare Part D Inflation Rebate Program and continues to support the Medicare Part D 340B Claims Data Repository. In fact, the AHA has long supported development of the repository because a direct, independent reporting mechanism has the potential to provide a more accurate and transparent method of identifying 340B-acquired Part D drugs than CMS' current claims-based matching methodology.

It is, however, important to fairly acknowledge the costs this repository will impose. That does not mean that the AHA opposes a repository like that which is proposed here; it is simply important to appreciate the burdens it carries so that CMS can account for them in its policymaking and the particular implementation timeline for this policy.

As drafted, this proposal significantly understates the operational complexity associated with compliance. While CMS characterizes the requirement as the submission of a limited number of data elements, hospitals will need to establish entirely new reporting feeds and data governance processes to identify, collect, validate, reconcile and transmit accurate claims-level information across a wide range of pharmacy dispensing arrangements. Many hospitals rely on multiple third-party administrators, contract pharmacies, split-billing software vendors and pharmacy information systems that were not designed to support this reporting requirement. Implementing these capabilities will require extensive coordination among pharmacy, revenue cycle, information technology, compliance, legal and finance staff, as well as potentially costly modifications to vendor

contracts and data systems. Given that CMS intends to require reporting across in-house pharmacies, contract pharmacy arrangements and replenishment models, hospitals will need substantial lead time after the repository becomes operational to ensure data accuracy and reporting consistency.

Relatedly, the agency has substantially underestimated the burden associated with this proposal. CMS estimates that its proposal would require approximately 462,000 annual burden hours at a cost of $52.4 million across all 340B covered entities. While these estimates are substantial, they understate the full cost. Notably, the agency's estimates do not reflect the significant one-time implementation costs hospitals will incur to build reporting infrastructure, establish new data interfaces, validate information across multiple dispensing channels, train staff, update policies and procedures, modify vendor agreements, and create ongoing auditing and monitoring functions. Nor do the estimates adequately account for the complexity of collecting and reconciling data across contract pharmacy networks and third-party administrators. For many hospitals — particularly rural, safety-net and other resource-constrained providers — the actual costs and administrative burden will be considerably higher than CMS' projections.

We are particularly concerned that the proposed enforcement framework is disproportionate to implementation challenges hospitals will face and the nature of the information being collected. CMS proposes to tie compliance with repository reporting requirements to Medicare enrollment requirements and indicates that failure to comply could result in revocation of Medicare billing privileges. Such a penalty is extraordinarily severe when compared to the purpose of the repository, which is to collect information that may help CMS evaluate alternatives to its existing methodology for identifying 340B units in the Medicare Part D inflation rebate program. Reporting errors, delays or data discrepancies may arise from implementation challenges, vendor limitations, data matching issues or other operational factors that are often outside a hospital's direct control. For example, given the Health Resources and Services Administration's (HRSA's) recent notice of the 340B Rebate Program beginning Jan. 1, 2027, and applying to Medicare Part D drugs negotiated under initial price applicability year 2026 and 2027, hospitals may not be able to reconcile Part D drug units for which a 340B rebate was incorrectly delayed or denied.[19] This could create additional complexity and unintended reporting error. It is therefore inappropriate to expose hospitals to potential Medicare enrollment consequences for a newly established reporting system that has not yet been fully implemented, tested at scale or demonstrated to function reliably. At a minimum, CMS should provide a lengthy transition period following repository implementation and adopt a good-faith compliance framework focused on education and correction rather than punitive enforcement.

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[19] https://www.federalregister.gov/documents/2026/08/03/2026-15633/notice-regarding-340b-rebate-model-pilot-program

All in all, the AHA supports the concept of a data repository and is eager to work with CMS to ensure its success. To do that, we believe a phased-in approach will be most successful. Given the repository will go live for the first time in fall 2026, we believe that any changes for CY 2027 would be premature, preventing the agency and the regulated community from learning from the initial rollout. Rather, CMS should propose changes like this in the future. That would allow CMS to assess data quality, identify operational challenges, refine technical specifications and work collaboratively with stakeholders to improve reporting processes. This is particularly important as HHS appears to be simultaneously pursuing its 340B Rebate Program, which the agency acknowledges will overlap in certain essential ways with this repository.[20] In general, we believe this repository is the superior way to address any perceived 340B program integrity concerns. This potential only can be realized if hospitals are given adequate time to develop reliable reporting processes. Such an approach would advance CMS' policy objectives while minimizing unnecessary burden, reducing compliance risk and ensuring that any future mandatory reporting program is supported by realistic implementation timelines, accurate burden estimates and an enforcement structure that is proportionate to the nature of the information being collected.

MEDICARE SHARED SAVINGS PROGRAM

Financial Methodology

Rebalance Financial Incentives Across Risk Tracks. CMS makes two proposals that it states are intended to rebalance financial incentives across the MSSP risk tracks and encourage ACOs to select a track based on their capacity to reduce spending rather than on the differences in financial advantages embedded in track design. First, the agency proposes to increase the sharing rate of the BASIC track Level E from 50% to 60%. CMS expresses concern that participation in the BASIC track Level E may continue to decline and that some ACOs may be transitioning to the ENHANCED track due to its higher sharing rate of 75% before they are ready for its increased demands. **The AHA supports the proposed increase in the BASIC track Level E sharing rate.** We agree that reducing the sharing rate gap between these tracks would support the retention of ACOs in the BASIC track Level E, allowing them to gain more experience with managing downside risk before moving to the ENHANCED track.

Second, CMS proposes to reduce the maximum weight used in calculating the positive regional adjustment for lower-spending ACOs under the ENHANCED track from 50% to 35%. The agency states that this change would more appropriately balance rewarding regional efficiencies at the start of an ACO's agreement period with improvement

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[20] See Medicare Part D Claims Data 340B Repository FAQs. "The 340B repository is part of a comprehensive effort involving a larger scope of drugs than the pilot to assess use of the 340B repository to exclude 340B units from Part D inflation rebate calculations. We have designed the 340B repository to minimize burden on covered entities to the extent possible, and we will coordinate with HRSA to reduce covered entities' data reporting burden, where feasible."

relative to its own historical performance over time. The weights used for ACOs that are higher-spending relative to their region and for BASIC track ACOs that are lower-spending would remain unchanged. **We oppose this proposal because it effectively would penalize ACOs that are more efficient than their region and further exacerbate the benchmark ratchet effect that the regional adjustment was designed to mitigate.** Indeed, CMS stated that the regional adjustment is intended to make an ACO's benchmark "more independent of its historical expenditures and more reflective of FFS spending in its region."[21] Reducing the weight of this adjustment for efficient ACOs would undermine its purpose by intensifying the benchmark ratchet effect that the adjustment was created to help alleviate in the first place.

When CMS first established the regional adjustment, the agency stated that it expected it would improve incentives for ACOs to invest in effective care management.[22] Many ACOs have responded accordingly and made significant investments in care coordination and population health management to become more efficient than their region. **Yet instead of rewarding these ACOs for their efforts, the proposal effectively would penalize them for achieving the efficiency gains and success in care redesign that CMS was attempting to incentivize through the regional adjustment. It also runs counter to other CMS proposals that are designed to combat the ratchet effect.**

The proposal also relies heavily on CMS' descriptive observations instead of statistical analysis. For example, based on its comparison of ACOs' performance in the ENHANCED track and BASIC track Level E, the agency expresses concern that the scale of positive regional adjustments to the benchmark is partly driving performance rather than genuine efficiency gains. Yet, it offers only observational data in support of this assertion. It does not provide any analysis demonstrating statistically significant evidence of this effect. Without stronger evidence, the agency has not justified changing this longstanding policy that has been essential to ensuring ACOs' success and retention in the program.

Finally, this proposal would create an inappropriate divergence between MSSP and the LEAD Model. Specifically, CMS incorporated a 50% weight for the positive regional adjustment in LEAD based on its experience with the policy in MSSP. Consequently, reducing the adjustment's weight in MSSP may encourage more efficient ACOs to consider participating in LEAD instead, contrary to CMS' goal of retaining ACOs in MSSP over the long term.

Increase the Prior Savings Adjustment Scaling Factor. CMS proposes to increase the prior savings adjustment's scaling factor from 50% to 75%. The agency states that it believes this change is warranted because the current methodology may not provide

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[21] 81 FR 37951.
[22] 81 FR 37951.

sufficiently strong or consistent incentives for ACOs to generate and sustain savings or continue participation in MSSP when they are compared against benchmarks that include their own previous success in reducing spending. **We support this proposal and agree it would provide additional relief from the rebasing of benchmarks and further incentivize ACOs to remain in MSSP and achieve savings over the long term.**

Risk Adjust the 5% Cap on Upward Adjustments to the Benchmark. Each of the three upward adjustments (regional, prior savings and population adjustments) to the benchmark that an ACO could be eligible for is capped at 5% of the national per-capita Medicare FFS expenditures for the assignable beneficiary population. CMS states that ACOs serving medically complex patient populations have expressed concern that the current 5% cap is applied as a flat percentage without accounting for the severity and case mix of each ACO's assigned beneficiary population. As such, the agency proposes to risk adjust the 5% cap for each adjustment using the ACO's weighted average CMS–Hierarchical Condition Category risk score for each Medicare enrollment type (end-stage renal disease, disabled, aged/dual eligible and aged/non-dual eligible).

The AHA supports the proposal to risk adjust the cap as it would encourage more ACOs to enroll and manage patients of higher acuity and cost who stand to benefit most from coordinated care. We agree that risk adjustment would better align benchmark adjustments with clinical complexity and encourage organizations engaged in providing high-needs care to participate in MSSP. We also recommend that CMS tailor the risk adjustment policy to ensure it does not adversely affect ACOs that serve populations with lower-than-average risk scores. Specifically, the cap should not be adjusted downward if an ACO's beneficiary population risk is lower than the national assignable population average. ACOs should not be penalized for factors largely outside of their control, such as caring for less clinically complex patients with below-average risk profiles.

However, it is worth noting that although we support appropriate risk adjustment of the cap, a 5% cap limits an ACO's ability to realize the full value of efficiencies it achieves through participation in MSSP. As part of care redesign efforts, many ACOs perform non-billable services involving care coordination, health IT, patient outreach and other population health initiatives. This contributes to a widening disconnect between an ACO's benchmark that reflects historical spending and the resources necessary to sustain improvements in the quality and cost of care furnished to beneficiaries. **As such, to more adequately support the non-billable work of ACOs and incentivize additional providers to participate in MSSP, we recommend increasing the cap from 5% to at least 7%.** This would include the upward adjustments to the benchmark under current policy (regional, prior savings and population adjustments) as well as the proposed growth adjustment discussed below, if finalized. Additionally, because many ACOs that are long-term participants in MSSP may be more likely to reach the cap, we suggest that CMS consider a tiered cap approach that would reflect different lengths of participation. Specifically, a tiered cap structure could involve increasing allowable

benchmark adjustments based on the length of an ACO's participation in MSSP. Such a policy would recognize the investments in care redesign made by long-standing ACOs and help to mitigate the benchmark ratchet effect that particularly affects them.

Growth Adjustment to the Benchmark to Incentivize New Participation. CMS proposes a growth adjustment to the benchmark that the agency states is intended to reward ACOs for recruiting providers and beneficiaries who are inexperienced with value-based care. CMS proposes to calculate the growth adjustment as the product of an ACO's new growth share of assigned beneficiaries and an incentive factor of 5% of the ACO's per-capita benchmark. The agency further proposes that the growth adjustment would be added to the highest of the regional, prior savings and population adjustments, and the resulting amount would be subject to the proposed risk adjusted 5% cap.

We support the proposed growth adjustment because it is intended to assist ACOs in expanding their beneficiary populations while offsetting the associated investment costs. However, we are concerned that its effect would be limited as many ACOs would not benefit from this adjustment if the cap remains set at 5%. Many long-standing ACOs with years of participation in MSSP are already reaching the cap, and unless CMS raises it, the proposed growth adjustment may not achieve its intended effect. Additionally, we recommend removing the proposed requirement that newly assigned beneficiaries must be specific to new ACO professionals. Removing this requirement would better incentivize ACOs to actively expand their beneficiary population by rewarding growth above what is typically observed.

Modify the ACPT Component of the Benchmark. CMS proposes several refinements to the ACPT. Specifically, it proposes to establish a guardrail to be applied at reconciliation for a given performance year (PY) such that the ACPT could not be more than 1% below or 1.5 % above the observed national growth rate. CMS further proposes to apply the lower-bound guardrail of 1% retroactively for MSSP agreement periods beginning on or after Jan. 1, 2024, and before Jan. 1, 2027. CMS predicts that if finalized, this policy would delay PY 2025 reconciliation until November 2026. Finally, the agency proposes to calculate and release the ACPT in the summer preceding a given PY rather than setting the ACPT values at the beginning of an ACO's five-year MSSP agreement period as under current policy.

The AHA supports the proposal to establish guardrails for the ACPT as it would improve stability and predictability for ACOs while helping to shield them from the financial consequences of unexpected spending growth. We appreciate the asymmetrical design of the guardrails that would allow ACOs to share in more savings than losses as well as the retroactive application of the lower-bound guardrail to address instances where the ACPT is lower than observed national growth and could reduce or eliminate shared savings for ACOs. Additionally, calculating and providing the ACPT closer and specific to a PY would create consistency among ACOs regardless of their agreement period start date and may help to improve the accuracy of the ACPT. Regarding the expected delay in PY 2025 reconciliation, we request that CMS issue a

provisional reconciliation as soon as possible to support the continued operations of ACOs that depend on shared savings payments.

Advance Investment Payments

CMS proposes that, rather than using a risk factors-based score to set quarterly advance investment payment (AIP) amounts for eligible ACOs as is done now, it would include a rural criterion and use a flat, $45-per-beneficiary payment. Qualifying beneficiaries would reside in a county with rural census status and be dually eligible for Medicare and Medicaid; for beneficiaries who do not meet these criteria, the ACO would receive a quarterly payment of $25 (capped at 10,000 beneficiaries).

We reiterate our opposition to CMS' current policy that limits eligibility for AIPs to only physician-led or low-revenue ACOs. Hospitals and health systems are critical stakeholders in the journey to value, yet this policy has hampered their ability to participate in MSSP. The agency has based this policy on the faulty assumption that low-revenue (physician-led) ACOs perform better than high-revenue (hospital-led) ACOs. **However, research shows there is no significant difference in performance between high- and low-revenue ACOs.[23] Furthermore, high-revenue ACOs often have more clinically complex, higher-cost patients attributed to them.** In addition, limiting eligibility for AIPs to only low-revenue ACOs inappropriately penalizes high-revenue ACOs, many of which are actually small organizations that critically need these resources for infrastructure investment to successfully participate in MSSP. For example, analysis suggests that critical access hospitals, FQHCs and RHCs are predominantly classified as high-revenue and therefore ineligible for AIPs. **We urge CMS to remove the problematic high- and low-revenue distinctions that inappropriately preclude certain ACOs from obtaining necessary resources for infrastructure investment to successfully participate in MSSP.**

Quality Performance Standard and Reporting

CMS proposes a number of changes to the quality reporting requirements for MSSP ACOs that are intended to ease the transition into digital quality measure (dQM) reporting; these proposals also address concerns raised previously regarding the logistical challenges of participating in the program. **The AHA supports these proposed changes, as they take into account the complexity of reporting performance data at an ACO level when that organization may comprise multiple specialties and provide care for a broad population.** Meeting MSSP's aggressive data completeness threshold should entail not only ACOs submitting statistically sufficient amounts of data, but also evaluating the value of care using relevant indicators of performance; these proposals would help achieve both of those aims.

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[23] https://premierinc.com/newsroom/blog/pinc-ai-analysis-hospital-led-acos-perform-as-well-as-physician-led-models

Extending Availability of Merit-based Incentive Payment System Clinical Quality Measures Collection Type. Current MSSP policy permits ACOs to use Merit-based Incentive Payment System (MIPS) clinical quality measures (CQMs) as a collection type when reporting the APM Performance Pathway (APP) Plus measure set through PY 2026. CMS adopted this approach to provide ACOs with time to prepare for the transition to electronic CQMs (eCQMs). In light of concerns raised by ACOs related to the resources needed to both sustain MIPS CQM reporting and prepare for the transition to eCQMs, CMS proposes to further extend the availability of the MIPS CQM collection type for PY 2027 and subsequent years. **The AHA supports this proposal, as it would allow ACOs more time to transition resources strategically towards dQM reporting rather than merely converting data to fit new collection types.**

Similarly, CMS proposes to score all measures of the Medicare CQM collection type using flat benchmarks based on current ACO performance rather than historical benchmarks based on prior performance. CMS asserts that this change, combined with extending the availability of the MIPS CQM collection type, would allow more ACOs to meet the minimum quality performance standard to qualify for the maximum available shared savings (and, for ENHANCED track ACOs, avoid maximum shared losses). **The AHA supports this proposal, as it will protect ACOs with high-quality performance on individual measures from being penalized due to comparisons to their own best past performance. It will also support participation by newer ACOs that do not yet report eCQMs.**

Allowing Exclusion of Participant Taxpayer Identification Numbers from Measure Data Submission. CMS proposes that an ACO may exclude one or more participant Taxpayer Identification Numbers (TINs) from its measure data when submitting for individual measures in the case of unforeseen circumstances or lack of supportive certified electronic health record (EHR) technology (CEHRT) from the subspecialty participant TIN. As a guardrail to ensure appropriate use of the TIN exclusion policy, CMS proposes that ACOs must still report on participant TINs representing at least 95% of its assigned beneficiaries before measure specifications are applied — meaning, ACOs would still have to meet that requirement when excluding TINs.

The AHA supports this proposal; however, to maximize its potential benefit, we urge CMS to incorporate greater flexibility in meeting the assigned beneficiary requirement.

As CMS correctly acknowledges in the proposed rule, ACOs may struggle to obtain data from individual practices for multiple reasons, including sudden practice closures or the use of subspecialty EHRs. Medicare CQMs are often specified for populations served by general acute care hospitals, so individual practices and their EHRs may not collect specific data elements in ways that ACOs can feasibly aggregate for the purposes of MSSP. This can make it impossible to meet CMS reporting requirements, such as the 75% data completion threshold required for quality measures.

CMS' proposed TIN exclusion policy gives permission to ACOs to purposely leave out data they would otherwise be unable to obtain. However, to make a meaningful difference for many ACOs, this exclusion would have to be coupled with greater flexibility in meeting the percentage of assigned beneficiaries requirement. For example, an ACO that cannot identify which of its participants are specialty-only and what share of its assigned beneficiaries these participants represent would have no way of knowing whether it still meets CMS' proposed 95% of assigned beneficiaries threshold. Thus, we recommend that CMS allow proportional reductions to the assigned beneficiary percentage after TIN exclusions are applied.

CMS notes that it plans to provide a new aggregate preview report comprising "the data necessary" to determine how many beneficiaries would be represented by all the TINs that the ACO plans to report on to help inform the decision of whether to exclude individual TINs. We urge CMS to provide detailed reports by TIN to assist in the beneficiary and participant inventory process necessary to support the agency's proposal.

Revising the Definition of "Beneficiary Eligible for Medicare CQMs." In previous rulemaking, CMS revised the definition of a patient whose data is used to calculate ACO CQM performance to include patients with at least one primary care service from an ACO professional who is a primary care physician, a certain specialty designation, or a physician assistant, nurse practitioner, or clinical nurse specialist. However, ACOs raised concerns that CMS' definition of beneficiaries eligible for inclusion in calculating measure performance was misaligned with the definition of beneficiaries actually assigned to (that is, served by) the ACO. Therefore, beginning in PY 2027, CMS proposes to revise the definition of beneficiaries eligible for Medicare CQMs to align with that of beneficiaries assigned to the ACO.

The AHA appreciates the concept of CMS' proposal. However, to ensure a level playing field across ACOs, we **urge CMS to investigate whether this provision would disadvantage ACOs that prospectively assign beneficiaries and ensure this would not inadvertently prevent these ACOs from meeting the 95% voluntarily aligned beneficiaries requirement.**

CEHRT Use Requirements

CMS proposes to modify "Certified Electronic Health Record Technology" or CEHRT use requirements for MSSP. Specifically, CMS proposes to sunset the current Shared Savings Program CEHRT use requirement that ACOs report all MIPS Promoting Interoperability measures and activities, and ACOs instead would be required to perform at least one of three allowable activities:

- Completely report at least one of the five ACO-reported measures in the APP Plus quality measure set through the eCQMs collection type or the proposed Medicare eCQMs collection type via CEHRT.
- Attest to the ACO's use of Fast Healthcare Interoperability Resource (FHIR) capabilities to support reporting of at least one of the five ACO-reported measures in the APP Plus quality measure set using CEHRT.
- Select and attest to one of the proposed Shared Savings Program CEHRT use metrics, which are based on a subset of MIPS Promoting Interoperability performance category measures, and which may be updated annually if there are changes. For CY 2027, CMS proposes three attestation measures for this option including ACO electronic prescribing, ACO health information exchange (HIE) bi-directional exchange and ACO provider-to-patient exchange.

In general, we support CMS' proposed approach to CEHRT use requirements in MSSP. The availability of multiple options to meet requirements and the use of attestation-based measures provide flexibility for ACOs and reduces some of the administrative burden associated with reporting the full inventory of MIPS promoting interoperability measures.

The agency also seeks feedback on electronic prior authorization measures for ACOs that participate in the Shared Savings Program. Specifically, the agency seeks feedback on whether it should require the use of specific FHIR-enabled Health IT Modules within CEHRT to complete at least one prior authorization request and determination for either medical items/services or prescription drugs as options to meet Shared Savings Program CEHRT use requirements beginning in CY 2028. **The AHA encourages alignment of Electronic Prior Authorization measures across CMS programs and urges CMS to continue voluntary reporting measures through CY 2028 or later in order to allow for adequate time for configuration, testing and training.**

Beneficiary Assignment

CMS makes several proposals to further its goal of expanding the population of Medicare FFS beneficiaries in MSSP ACOs. First, the agency proposes to exclude from assignment calculations any primary care services billed through a non-ACO TIN by an ACO physician or other practitioner who is used in assignment. In addition, it proposes to expand the criteria for assignment eligibility to permit assignment of a beneficiary with at least one month of Part A and Part B enrollment during the assignment window and no Medicare group health plan enrollment during that same month.

We support these proposals in concept because they would increase beneficiary assignment to ACOs. However, we recommend that CMS, before finalizing, further analyze the impacts of these changes and implement guardrails to mitigate any unintended consequences. The agency states that a small number of ACOs would be disproportionately affected by these changes and that the beneficiaries that would be added tend to be higher cost and higher risk. In addition, beneficiaries

often transition out of Medicare Advantage in order to elect the Medicare hospice benefit, which could lead to unusual enrollment patterns for ACOs that include hospice. Further, the MSSP risk adjustment model was not designed to project these types of enrollment changes mid-year, which could result in newly-added beneficiaries not being captured in risk adjustment.

Finally, CMS proposes to revise the definition of primary care services used for assignment by adding additional specific codes to its existing list of primary care services codes. **We support this proposal.**

Beneficiary Notification

CMS proposes that the standardized written notice to beneficiaries must be furnished by May 30 of the PY (unless CMS specifies a later date), rather than prior to or at the first primary care service visit with an ACO participant as currently required. CMS also proposes to eliminate the requirement to provide follow-up communication to the beneficiary no later than 180 days from when the standardized written notice was provided. **We support these proposed policy changes that would reduce administrative burden and implementation challenges for ACOs associated with the current timeframes for beneficiary notifications.**

Beneficiary Engagement

Part B Cost-Sharing Support. CMS proposes to allow ACOs to enter into Medicare Part B cost-sharing support agreements with their provider participants to reduce or eliminate cost sharing for categories of items and services and eligible beneficiaries identified by an ACO. To offer cost-sharing support, an ACO would have to apply to CMS for approval. The agency states that the Anti-Kickback Statute safe harbor for CMS-sponsored model arrangements and patient incentives would be available to protect remuneration exchanged under Part B cost-sharing support arrangements between ACOs and ACO participants.

The AHA supports these proposals and applauds CMS for expanding the range of tools available to ACOs to engage beneficiaries in their care. Patients may skip or delay necessary care due to higher out-of-pocket costs, resulting in worse health outcomes. We agree that offering Part B cost-sharing support would allow ACOs to remove cost barriers for beneficiaries to receive items and services that would positively impact their health. As Part B cost-sharing support has been a commonly used beneficiary engagement incentive in the ACO Realizing Equity, Access and Community Health Model, CMS should allow it to be used in MSSP.

Discontinuation of Prepaid Shared Savings. CMS proposes to eliminate as of Jan. 1, 2028, the prepaid shared savings option, which allows ACOs with a history of earning shared savings to receive an advance on expected savings for a PY. The agency cites low uptake as its reason, with only four ACOs participating in this option in 2026. **We**

oppose this proposal. Ending the prepaid shared savings option when it has been available to ACOs for only one year would be premature and deny additional ACOs the chance to participate. **Rather than discontinuing the policy, we recommend that CMS consider making changes that would reduce the barriers to participation previously identified by commenters, such as restrictions on the use of funds and amount of documentation required.** Adopting less burdensome guardrails would enable more ACOs to access prepaid shared savings and make the upfront investments in infrastructure and care redesign necessary to continue to achieve savings for the program.

QUALITY PAYMENT PROGRAM

Mandated by the Medicare Access and CHIP Reauthorization Act of 2015, the Quality Payment Program (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 MIPS Value Pathways (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 to officially sunset traditional MIPS such that, beginning with the CY 2029 performance period, eligible clinicians participating in MIPS and not reporting through the APM Performance Pathway would be required to report the measures and activities in a selected MVP. While the AHA recognizes the benefits of the MVP framework for evaluating quality of care provided within specialty practice, **we do not support CMS' proposal to remove the MIPS reporting option beginning CY 2029.**

In theory, MVPs offer the opportunity to assess specific and relevant aspects of performance through measures that connect quality, cost and improvement activities within clinical focus areas, rather than through disparate and potentially extraneous measures in siloed performance categories under traditional MIPS. However, this theory assumes that MVPs as currently constructed using existing quality measures provide adequate and meaningful evaluations of the myriad subspecialties represented by over 500,000 MIPS-eligible clinicians. To date, participation in MVPs has been low: In 2024, only 16.6% of eligible clinicians registered for MVP reporting and only 2.2 % received a final score in this reporting pathway.[24] This mismatch suggests significant barriers to MVP participation, which CMS would only have a few years to address before the program becomes mandatory under its proposal.

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[24] https://d2g5m5leph8kam.cloudfront.net/s3fs/s3fs-public/2026-05/2024-qpp-participation-results-at-a-glance.pdf?VersionId=yQGh5j15BoP.LpM8TxKuiS_ITlrpS9IQ

CMS estimates that the proposed inventory of 30 available MVPs would result in "coverage of approximately 98 percent of specialties for MIPS eligible clinicians based upon self-reported specialty designations data and MVP topic." Importantly, this statement indicates that the quality measures included in the portfolio of various MVPs correspond to 98% of the *specialties and topics* on CMS' list; it does not mean that 98% of *clinicians* currently or will have a relevant MVP for which they will be able to meet reporting requirements and receive a final score, or that the measures within these MVPs are valid and reliable or glean meaningful information about performance.

Indeed, a 2025 letter from 32 major medical specialty societies and associations noted that "there are too few relevant MVP quality measures for many acute and chronic conditions, … As a result, physicians are forced to use less clinically meaningful measures, reducing the opportunity for quality improvement. Currently, MVPs include mismatches between cost, quality and population health measures that fail to assess the value of care."[25] In its proposal, CMS notes that it is developing additional MVPs, but if CMS were to finalize its proposal, clinicians would have just two performance years to identify an MVP most relevant to their specialty, build workflows to collect the required data (even if that data informed measures with questionable relevance to their work) and establish reporting processes. This timeline is untenable, considering that CMS would need to develop and propose new MVPs in subsequent PFS updates.

The AHA continues to believe that MVPs have the potential to coalesce meaningful evaluations of quality for certain specialties, but forcing clinicians into a small number of categories for assessment will not achieve this goal. Further, applying the MVP reporting framework to TINs that represent multiple subspecialties (or even, in the future, ACOs) would result in significant administrative complexity without producing useful evaluations of quality and value. Because of these disadvantages, **we urge CMS to retain the MIPS as a reporting option while continuing to encourage voluntary MVP participation through development of additional MVPs and refinement of existing categories.**

Core Measure Designation

CMS proposes to develop a "curated set" of core quality measures for each MVP by selecting at least three MIPS measures already assigned to that MVP that reflect the care central to the subspecialties within it. If finalized, MIPS eligible clinicians and MVP participants would be required to report the minimum number of measures, including at least one core measure. If a participant does not have an applicable core measure for which they can meet the numerator and denominator criteria for the applicable performance period, CMS would establish a core measure self-attestation process (that is, the clinician would attest in good faith that there was not a core measure available to them and would not be subject to penalty), and clinicians could then choose to report

[25] https://www.hospitalmedicine.org/letters/shm-joins-cross-specialty-letter-to-cms-on-mvps/

any other applicable measure.

Parallel to our recommendations above regarding the proposal to officially sunset the MIPS program, **the AHA urges CMS to further test the concept of core measures before mandating their use to determine whether the measures proposed to receive this designation truly reflect the most relevant aspects of care within each MVP.** We agree with CMS' rationale behind replacing the current "high priority" measure designation with a more specific categorization that would result in more consistent comparisons within specialties or topics; however, as noted above, we remain concerned that the current MVPs and the measures within would not sufficiently address all clinicians who would be required to select and report them. For example, the proposed new Hospitalist MVP would include three process measures: two core measures related to treatment of heart failure and one related to ACP. It is not clear how CMS determined that these three measures are the most central to the practice of hospital medicine, or whether their use would result in meaningful differentiation in performance across hospitalists. Rather than mandating the use of specific measures, we recommend that CMS deploy the core measure designation first on a voluntary basis and engage in further analysis to determine — based upon quantitative and qualitative investigation — whether its proposed core measures are substantively tied to differences in quality.

CMS proposes to establish a self-attestation process to account for instances where a participant does not have an applicable core measure for which they can meet the numerator and denominator criteria for the applicable performance period. In addition, CMS clarifies that, if finalized, small practices would be exempt from the core measure reporting requirements. We appreciate that CMS recognizes the potential limitations of its core measure designation, namely that it will likely be a challenge for participants to meet minimum volume standards for measure reliability for at least some of these measures. In addition to delaying the implementation of the core measure designation pending additional analysis, **we encourage CMS to develop adequate guidance on the self-attestation and exemption process associated with core measure reporting.** Specifically, we urge CMS to clearly define "other applicable measures" and provide assurances to participants that they would not be penalized by appropriately attesting that there was no core measure available to them.

Promoting Interoperability

Health IT Certification Program Proposed Updates. The agency proposes to update the definition of "CEHRT" to align with Office of the National Coordinator (ONC) Health IT Certification Program proposed updates relevant to the MIPS Promoting Interoperability performance category. The changes would align with ONC's proposed changes from the "Health Data, Technology, and Interoperability: ONC Deregulatory Actions to Unleash Prosperity" or HTI-5 proposed rule. CMS proposes to change the definition starting with the CY 2027 performance period/2029 MIPS payment year.

The AHA recognizes CMS' desire to align its definition of certified EHR technology with the most recent version of its HTI rules. At the same time, the HTI-5 rule has not yet been finalized, and we have urged CMS to make several modifications to the HTI-5 proposals that we reiterate here.[26] We appreciate CMS and ONC's focus on ensuring modernized certification criteria that remove undue regulatory barriers. However, we have recommended that ONC retain current HTI criteria around privacy, security transitions of care and decision support interventions because the risks of their removal outweigh potential benefits.

We also continue to urge CMS and ONC to work in a coordinated fashion to ensure providers have sufficient time to implement changes affecting EHR certification criteria. In HTI-5, ONC proposed that all 41 removals or modifications to certification criteria be effective either as of the date of the final rule or no later than Jan. 1, 2027. Similarly, in the PFS proposed rule, CMS proposes that changes to the Certified EHR definition be effective for the CY 2027 performance period for the Promoting Interoperability Program. This timeline does not provide sufficient runway for workflow redesign, testing and implementation. At a minimum, we recommend that both CMS and ONC should provide 24 months for transitioning certification criteria after updates are made to both certification criteria and corresponding CMS programs through final rules.

Finally, we oppose the removal of certification requirements for automated numerator recording and measure calculation, since providers depend on this functionality to support reporting of promoting interoperability measures such as "Provide Patients Electronic Access" measure. As part of the proposed rule, CMS proposes to remove "family health history," "patient health information capture," "automated numerator recording," "automated measure calculation" and "clinical quality measures—filter" from the base definition of CEHRT. Automated numerator recording and measure calculation in baseline certification requirements ensures that certified technologies have the functionality needed for providers to report on mandatory measures. We are concerned that removing this functionality could shift the risk, cost and administrative burden of reporting Promoting Interoperability measures to providers. Developers may impose additional fees for these features since they would be considered "add-on" services. Instead of saving costs and reducing burden, the costs and burden would shift to end users. Therefore, we recommend that CMS retain these requirements in the definition of CEHRT. If CMS were to finalize this proposal, we would urge the agency to also remove the corresponding mandatory reporting requirements for providers.

Proposal to Remove ONC Direct Review and ONC-ACB Surveillance Attestations. CMS proposes to remove the ONC Direct Review and ONC-Authorized Certification Bodies (ACB) Surveillance attestations starting with the CY 2026 performance period/2028

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[26] https://www.aha.org/lettercomment/2026-02-27-aha-comments-astponc-health-care-technology-interoperability-proposed-rule

MIPS payment year. **We concur that this would reduce burden on MIPS providers and support the removal of these attestations.** We also agree that surveillance activities remain important and as such would urge the agency to encourage voluntary cooperation with ONC and ONC-ACB.

Proposal to Remove Security Risk Analysis Measure. The agency proposes to remove the security risk analysis measure beginning with the CY 2027 performance period/2029 MIPS payment year. **We agree that this can reduce administrative burden, since providers are already bound by other privacy and security statutes and regulations (e.g., HIPAA).** Removal of this measure can also help address concerns raised on the integration of SAFER guides with this measure, as SAFER guide assessment is resource-intensive and can divert resources away from other direct service, cybersecurity and interoperability objectives. We would encourage CMS to ensure alignment with the hospital promoting interoperability program by similarly removing security risk analysis measures in inpatient PPS rulemaking.

Proposed Electronic Authorization Measure for Prescription Drugs. The agency proposes to add a required Electronic Prior Authorization for Prescription Drugs attestation measure under the HIE objective beginning with the CY 2028 performance period/2030 MIPS payment year. The new measure description would be “For at least one prescription drug ordered by the MIPS eligible clinician during the performance period for which prior authorization is required, the prior authorization is requested electronically using CEHRT.” We appreciate that CMS has separated prescription drug measure proposals, and see the potential of electronic prior authorization processes for prescription drugs to reduce administrative burden. However, we are concerned that the proposed addition of a required measure for prescription drugs would not provide sufficient runway for testing, training and configuration. With electronic prior authorization workflows, the ability to implement is predicated on technological readiness of multiple stakeholders including payers, EHR vendors and clearinghouses. As such we urge the agency to begin with an optional bonus measure and delay mandatory reporting to future years.

Proposed Changes to Electronic Prior Authorization Measure. Finally, CMS proposes to update the previously adopted Electronic Prior Authorization (ePA) measure. In general, hospitals and health systems see significant potential in electronic prior authorization to reduce administrative burden. However, workflows are dependent on integrations between providers, EHRs, payers and clearinghouses. Timelines must be aligned with stakeholder readiness across these groups. Therefore, we have the following detailed feedback on the ePA measure proposals.

CMS proposes, for the CY 2027 performance period, to change the measure from being required to optional. **We strongly support CMS’ approach to making the ePA measure optional and eligible for bonus points. We encourage the agency to continue this through CY 2028 and delay mandatory reporting until CY 2029 or later to allow for adequate time for configuration, testing, training and maturation**

of new end-to-end workflows across providers, payers, EHR developers and clearinghouses. We also appreciate that CMS has retained the measure structure as an attestation measure.

Also, for the CY 2027 performance period/2029 payment period, CMS proposes to update the measure description to the following: "For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the prior authorization is requested electronically through a Prior Authorization API using CEHRT." **We oppose the proposed modifications to the measure definition that would change from "using data from CEHRT" to "using CEHRT."** MIPS providers, including hospitals and health systems, may use different EHR platforms, revenue cycle systems, payer portals and clearinghouses in ePA processes. The proposed modifications to the definition could unintentionally limit the types of tools that could be used for prior authorization workflows and impose undue burden on hospitals. We urge CMS to retain the current language of "using data from CEHRT."

Finally, CMS proposes to modify the measure for the CY 2028 performance period/2030 payment year to include a complete set of actions necessary to support prior authorization: "For at least one medical item or service (excluding drugs) ordered by the MIPS eligible clinician during the performance period, the MIPS eligible clinician uses CEHRT to electronically request and receive coverage requirements, request and populate prior authorization documentation using templates and rules, submit the prior authorization request, and receive the payer response through a provider Prior Authorization API." Providers are dependent upon payers and EHR vendors to operationalize the full set of prior authorization actions. As a result, provider performance on the measure is dependent on factors outside of the provider's control. Additionally, there is considerable variability in the readiness of payers and EHRs to support the required workflow, and without an adequate on ramp, providers may be in a position where they would be responsible for a measure that is outside their direct influence. This also would create variability in measure definitions across programs, which is something the agency has sought to minimize. **Therefore, we encourage CMS to continue optional reporting using the current definition through CY 2028.**

Digital Quality Measure Request for Information. The agency also issues a request for information (RFI) on digital quality measurement in MIPS, specifically the use of FHIR-based quality reporting. As we have previously commented, 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.[27] 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

[27] https://www.aha.org/lettercomment/2025-06-16-aha-comments-cms-and-astponc-request-information-re-health-technology-ecosystem

staggeringly complex task. As CMS and ONC continue their digital quality measurement 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 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, 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.

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, hospitals 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 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.

AMBULATORY SPECIALTY MODEL

CMS proposes several changes to the Ambulatory Specialty Model (ASM), a mandatory model designed to improve quality and reduce costs by measuring the performance of certain specialists who frequently treat low back pain or heart failure. These updates are intended to address outstanding policy questions and concerns raised following the establishment of ASM in previous rulemaking. **The AHA appreciates the clarification and supports the proposals below in that they would streamline certain requirements and reduce some administrative burden; however, we continue to have concerns regarding ASM's financial model, attribution methodology and quality performance standards, and will once again 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.**

Rural Scoring Adjustment

In response to concerns that ASM participants in rural areas may face structural challenges that affect their ability to perform, CMS proposes to include a rural scoring adjustment in the calculation of an ASM participant's final score. Using the same definition of "rural area" as used for MIPS, CMS would add five points to the final score for participants who otherwise meet program requirements. Participants in rural areas would also remain eligible for the model's small practice or solo practitioner scoring adjustment and the complex patient scoring adjustment. **The AHA supports this provision and appreciates that CMS acknowledges the unique pressures faced by providers in rural areas.**

Participation

CMS proposes clarifications and updates to previously established TIN change exceptions to recognize additional scenarios where a clinician may be excepted from the model's requirements, including when a participant TIN changes before the start of the performance year; in this case, the participant would have to notify CMS in writing no later than 60 days after the start of the applicable performance year. In addition, CMS proposes that a participant who changes their TIN during the performance year must provide written notice of the change to CMS within 30 days of stopping reassignment to the original TIN. **The AHA supports this provision but encourages CMS to consider additional flexibilities in notification timelines for participants who change TINs.**

CMS also proposes updates to its policy regarding exceptions for heart failure-related specialty type redesignations to provide relief from participation for participants who officially redesignate their primary specialty type through an approved Medicare enrollment application to a limited set of specialty types and provide sufficient documentation. **While we appreciate this additional flexibility, we encourage CMS to broaden the exception beyond a single ASM performance year**; certain heart failure specialty types provide highly specialized or procedure-focused services that are outside of the scope of ASM (i.e., broader management of cardiovascular disease). If those specialties are redesignated to one of the limited set of specialty types that exempts them from model requirements in one year, they should remain exempted as long as they retain that designation and board certification in that specialty.

Voluntary Submission of Patient-Reported Outcomes Data

CMS is considering future adoption of patient-reported outcomes-based performance measures (PRO-PMs) in ASM. To support the development, testing and potential future inclusion of these measures in the model, CMS proposes to establish a voluntary data submission opportunity and associated scoring incentive. **We support CMS' approach to testing the feasibility of the use of PRO-PMs in the model that combines**

voluntary submission for an indefinite period coupled with a scoring incentive. We urge CMS to offer flexibility to participants who voluntarily submit data and to not withhold the scoring incentive based on strict data completeness thresholds.

REQUEST FOR INFORMATION: DUPLICATE LABORATORY TESTING, IMAGING, AND RESULT SHARING AND INTEROPERABILITY

In the proposed rule, CMS issues an RFI to gather input from stakeholders to inform potential actions aimed at addressing interoperability barriers for imaging and lab testing. We agree that timely access to secure, high-resolution images is often a critical component of diagnosis and early intervention and can improve outcomes and reduce costs. However, the seamless transfer of images has historically been hampered by siloes generated from proprietary systems, inconsistent formats and the lack of exchange frameworks. The AHA previously commented to ONC on barriers and opportunities for imaging interoperability.[28] We invite CMS to review our full comments and reiterate several key themes here.

In general, we support the evolution of standards as technology advances and urge the agency to develop reasonable glidepaths and timelines to support this transition. We agree that establishing standards and certification criteria for imaging interoperability could support the more-timely exchange of imaging data. The lack of certification criteria has led to vendor variability in adherence to industry standards for storing, retrieving, printing, processing and displaying medical images. It has also increased costs since features that do adhere to international standards, like Digital Imaging and Communications in Medicine (DICOM), may be considered "add-on" functionality and be subject to surcharges for providers. However, the adoption of standards must be set on realistic timelines to allow time for testing, training and workflow redesign.

We also would encourage the agency to host listening sessions with ONC to capture feedback on current imaging workflows and functional requirements across radiology and specialty areas. The successful adoption of new imaging data exchange standards would require understanding the variations in file formats, file sizes and workflows across multiple clinical areas. We would especially encourage agencies to include in listening sessions hospital and health system IT leaders and representatives from clinical specialties that rely heavily on diagnostic imaging. These include emergency medicine, cardiology, oncology, orthopedics, neurology, obstetrics and gynecology, and anesthesiology.

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[28] https://www.aha.org/lettercomment/2026-03-16-aha-responds-astponc-rfi-diagnostic-imaging-interoperability

REQUEST FOR INFORMATION: REDESIGNING PRIMARY CARE TO MAKE AMERICA HEALTHY AGAIN

In the proposed rule, CMS also issues an RFI on redesigning primary care. Below we offer our feedback on considerations for technology-enabled services.

The AHA recognizes the pivotal role that health technology plays in primary care delivery today and its potential to transform the patient and provider experience in the future. Hospitals and health systems are using technology to strengthen patient engagement, care coordination and chronic disease management. Technologies like AI, wearables and remote monitoring tools support patients in adopting healthy lifestyle choices and preventive behaviors. This in turn can support earlier intervention and identification of risks before they become more acute or chronic conditions.

As CMS considers approaches to reimbursement for technology-enabled services, we recommend the agency:

- Adopt reimbursement frameworks that account for unique costs associated with developing, deploying, validating and maintaining technologies in digital health workflows.
- Ensure that "rightsizing" of payment for technology-enabled services does not come at the expense of other services.

Cost Factors for Technology-enabled Services

The implementation of new technologies and standards often requires significant financial investment and workflow changes for healthcare providers. Ensuring appropriate reimbursement can support wider adoption of these tools and ultimately support improved access to services. **While we have appreciated CMS' efforts to update reimbursement for new technologies, historical payment within PFS has not fully accounted for the costs of these services. We recommend CMS consider additional cost factors to support more adequate reimbursement for technology-enabled services since the costs associated with developing, deploying and maintaining technology like AI extend beyond licensing costs. The addition of new factors to reimbursement methodology for technology-enabled services should not come at the expense of other services.** There are specific factors that CMS should consider when setting payment rates for certain technology-enabled services, since the costs associated with developing, deploying and maintaining tools like AI extend beyond the software. As we have previously commented, examples of cost factors that should be considered include:[29]

[29] https://www.aha.org/system/files/media/file/2025/09/AHA-Comments-to-CMS-on-CY-2026-Physician-Fee-Schedule-Proposed-Rule.pdf

- 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 (or SaMS) tools require stakeholders to engage in routine maintenance and post-deployment testing to ensure ongoing integrity of tools. Maintenance may include technology vendors, developers and providers.
- Cybersecurity insurance. While the expansion of technology-enabled services holds tremendous promise, there are also potential risks from a cybersecurity perspective. According to U.S. government reporting, the most significant cyber threats targeting U.S. critical infrastructure, including healthcare, originate from noncooperative foreign jurisdictions.[30,31,32,33] Cross-border hacking incidents, which result in the theft of protected health information (PHI) and ransomware attacks targeting healthcare, have increased dramatically, rising nearly tenfold since 2020. Most PHI data breaches reported to the HHS Office for Civil Rights were the result of hacking incidents targeting non-hospital healthcare providers, including third-party service and software providers. The rise in frequency and severity of cyberattacks accompanying the expansion of tools has driven increased 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 must also be considered.
- Software and storage fees. These costs also include software licenses, as well as costs for data storage. AI offerings generally rely on large data sets, which also require servers. We encourage CMS to consider the costs for maintaining this underlying data infrastructure.

Rightsizing Payment for Technology-Enabled Services Should Not Come at the Expense of Other Services

The AHA appreciates CMS' continued interest in updating reimbursement for technology-related services. In general, reimbursement for physician payment has been woefully inadequate, and the budget-neutral aspect of payment increases has meant that increases in certain services has resulted in payment reductions in others. Given the significant financial pressures that providers and hospitals already face, CMS should

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[30] https://www.dni.gov/files/ODNI/documents/assessments/ATA-2025-Unclassified-Report.pdf
[31] https://www.ic3.gov/AnnualReport/Reports/2024_IC3Report.pdf
[32] https://usun.usmission.gov/remarks-at-a-un-security-council-briefing-on-ransomware-attacks-against-hospitals-and-other-healthcare-facilities-and-services/
[33] https://www.cisa.gov/topics/cyber-threats-and-advisories/nation-state-cyber-actors

not increase payment for technology-enabled care at the expense of other in-person services. This may unintentionally disincentivize adoption.