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Submitted electronically via www.regulations.gov

September 11, 2025

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Payment Sched Re: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program (CMS-1832-P)

Dear Administrator Oz:

The AAMC welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year 2026 Physician Fee Schedule and Quality Payment Program proposed rule published July 16, 2025 (90 *Fed. Reg.* 32352).

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, clinical care, biomedical research, and community collaborations. Its members are all 160 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 Canadian medical schools accredited by the Committee on Accreditation of Canadian Medical Schools; nearly 500 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 210,000 full-time faculty members, 99,000 medical students, 162,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Through the Alliance of Academic Health Centers International, AAMC membership reaches more than 60 international academic health centers throughout five regional offices across the globe. Learn more at aamc.org.

Through their mission of providing the highest quality patient care, teaching physicians who work at academic health systems provide care in what are among the largest physician group practices in the country, often described as "faculty practice plans," because many of these physicians teach and supervise medical residents and medical students as part of their daily work. Teaching physicians are vital resources to their local and regional communities, providing significant primary care services and other critical services, including a large percentage of tertiary, quaternary, and specialty referral care in the community. They are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Care is often multidisciplinary and team based. These practices are frequently organized under a single tax identification number (TIN) that includes many specialties and subspecialties. These practices support the educational development of residents who will become tomorrow's practicing physicians.

The following summary reflects the AAMC's key recommendations on CMS' proposals regarding physician payment updates, telehealth payment policy, Medicare Shared Savings Program (SSP) accountable care organizations (ACOs), requests for information (RFIs), and the QPP in the Calendar Year (CY) 2026 Physician Fee Schedule Proposed Rule:

PHYSICIAN FEE SCHEDULE (pp. 3-26)

- ***Payment Updates:*** Given the critical importance of patient access to health care services and the ongoing challenges faced by physicians, the AAMC encourages CMS to support stakeholders' efforts to have Congress pass legislation that would provide an annual inflation-based payment update based on the Medicare Economic Index (MEI).
- ***Valuing Physician Services***: CMS should not arbitrarily modify valuations of physician services based on one-size-fits-all adjustments or site-of-service and instead work with stakeholders on alternative policy options to achieve the agency's goals to appropriately pay for services while improving patients' access to care.
- ***Telehealth:*** Extend the COVID-19 telehealth flexibilities where CMS has the authority to do so and encourage CMS to work with Congress to make permanent, or at a minimum to provide a two-year extension, of the remaining COVID-19 telehealth flexibilities.
- ***Virtual Supervision:*** Allow teaching physicians to bill for services involving residents with virtual presence during the key and critical portion of the service in all teaching settings when the service is furnished virtually and finalize policy to permanently allow virtual supervision of clinical staff for services provided incident-to a physician's professional service, diagnostic tests and cardiac, pulmonary, and intensive cardiac rehabilitation services.
- ***G2211 Add-on Code:*** Allow G2211 to be reported in conjunction with home and residence-based E/M services.
- ***Advanced Primary Care Management (APCM) Services:*** Create three new APCM add-on G-codes for mental health services and define APCM services as preventive care no longer subject to coinsurance requirements.
- ***Digital Mental Health Treatment (DMHT):*** Expand payment for DMHT to include attention deficit hyperactivity disorder.

DISCRETIONARY PROVISIONS (pp. 26-36)

- ***Medicare Prescription Drug Inflation Rebate Program:*** Simplify proposals to identify 340B units for exclusion from Part D inflationary rebates and establish strict guardrails for a claims repository model.

- ***Ambulatory Specialty Model (ASM):*** Improve model design to ensure model supports specialty engagement in value-based care delivery, including by making participation voluntary, allowing group practice participation and reporting, and better aligning model components to Merit-based Incentive Payment System (MIPS) scoring and financial risk.
- ***Medicare Shared Savings Program ACOs:*** Improve quality reporting by better aligning patients eligible for Medicare CQM reporting with patients assignable to the ACO, consider methods to distinguish providers delivering primary care to ensure ACO assignment meaningfully reflects primary care relationships with ACO professionals, and modify extreme and uncontrollable circumstances (EUC) policies in line with the QPP, including recognition of cyberattacks as an EUC.

QUALITY PAYMENT PROGRAM (QPP) (pp. 36-53)

- ***Improving the QPP***: Considering the ongoing operational challenges with the QPP, work with stakeholders to identify longer term policy solutions that would drive improvements in health care quality, improve access for all beneficiaries, and reduce burden for clinicians.
- ***Traditional MIPS:*** Maintain the overall performance threshold at 75 points for the foreseeable future to provide stability for clinicians as they adjust to significant programmatic changes and ensure policies for reporting and scoring quality, cost, improvement activities, and interoperability support meaningful measurement for clinicians and care delivery enhancements for patients.
- ***MIPS Value-based Pathways (MVPs):*** Retain MVP reporting as a voluntary MIPS reporting option and retain traditional MIPS as the agency works to develop the comprehensive, meaningful measures needed to advance MVP adoption and ensure that rules for subgroup reporting allow practices who opt to report MVPs can best represent the clinical context of care delivered within their practice**.**
- ***Advanced APMs:*** Perform qualified participant (QP) determinations at both the APM entity level and the individual clinician level and amend the definition of an attribution-eligible beneficiary to include any covered professional service when making QP determinations.

PHYSICIAN FEE SCHEDULE [II]

PAYMENT UPDATE TO THE PHYSICIAN FEE SCHEDULE CONVERSION FACTOR FOR 2026

CMS Should Work with Congress to Increase the Medicare Payment Update

CMS sets forth the dollar conversion factor that would be used to update the payment rates. For 2026, under law, CMS must set two separate conversion factors (CFs) that tie to a clinician's participation in the Quality Payment Program (QPP). Clinicians who are qualified participants (QPs) in advanced alternative payment models (based on performance in the QPP) receive a 0.75 percent update from the CY 2025 CF, as well as a budget neutrality adjustment (BN) of 0.55 percent, and a 2.5 percent increase recently adopted by Congress for CY 2026. This results in a proposed QP CF of $33.5875 for CY 2026. Clinicians who are not QPs receive a 0.25 percent update to the CY 2025 CF, the 0.55 percent BN adjustment, and the onetime 2.5 percent increase. This results in a proposed non-QP CF of $33.4209 for CY 2026. (p. 32801)

Physician payments have failed to keep pace with rising inflation and practice costs. AMA analysis found that from 2001-2025, physicians are paid 33 percent less today, when adjusted for inflation. [1] The AAMC remains deeply concerned about the lack of inflationary adjustments to physician reimbursement, especially at this time when teaching physicians and other health care professionals are still managing rising practice costs while also recovering from historic workforce shortages. Simply put, failing to adjust the existing formula to address inflation makes delivering care an unsustainable challenge that will reduce access to care.

This year, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress increase the 2026 Medicare physician payment rate with an inflation-based payment update based on the Medicare Economic Index (MEI) minus 1 percentage point.[2] The Commission's recommendation to improve the stability of Medicare physician payment recognizes that it is critically necessary to ensure patient access to care is not further hindered by faulty payment policy. In the 2025 Medicare Trustees Report, the trustees also expressed concern with the failure of Medicare payments to keep pace with "underlying economic conditions," and warned that "the availability, particularly with respect to physician services, and quality of health care received by Medicare beneficiaries will, under current law, fall over time compared to that received by those with private health insurance."[3] MedPAC also found that Medicare patient access to physicians is already strained and more than one in ten patients reports difficulty finding a new specialist physician each year.[4] According to the AAMC's projections, by 2036 the country could experience a shortfall of up to 86,000 physicians.[5] These shortages may be exacerbated if physicians face cuts in payment.

We are concerned that future reductions to the fee schedule valuations of services by physicians combined with workforce shortages could result in even greater access problems for patients. A cut in physician payment is likely to trigger further retirement or a reduction in physician services during a time when physicians are needed the most in their communities. **Given these unprecedented challenges and the critical importance of patient access to health care services, we encourage CMS to support stakeholders' efforts urging Congress to pass legislation that would provide an annual inflation-based payment update beyond CY 2026.** This would help to ensure that physicians and other health care providers can continue to provide high quality care to their patients by giving them crucial short-term financial stability and allowing time for long-term payment reform.

Looking ahead, we believe that there are ongoing structural problems with the Medicare Physician Fee Schedule (PFS) that must be addressed. Medicare provider payments have been constrained for many years by the budget neutral system, which has led to arbitrary reductions in reimbursement. **At a minimum, we recommend that budget neutrality policies be revised to**

[1] AMA, Medicare physician pay has plummeted since 2001. Find out why.(Apr. 21, 2025).
[2] MedPAC, Report to Congress: Medicare Payment Policy, Chapter 4 (Mar. 2025).
[3] 2025 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Jun. 2025)
[4] *Supra*, note 2, finding 11 percent of Medicare beneficiaries reports difficulty finding a new specialist each year, nearly 8 million patients, in comparison to commercially insured patients.
[5] AAMC, The Complexities of Physician Supply and Demand: Projections From 2021 to 2036 (Mar. 2024).

ensure that utilization estimates are accurate, that certain categories of services (e.g., newly covered Medicare services, health professions added, new technology, etc.) are exempt from future budget neutrality adjustments, and the $20 million threshold that triggers budget neutrality is raised to at least $53 million. We welcome an opportunity to work collaboratively with CMS, Congress, and other stakeholders to address these long-term challenges in the future.

Prospectively Correct Budget Neutrality Adjustment to Ensure CY 2024 Overestimates of G2211 Utilization Causing $1B Cuts to Physician Payment in 2024 and 2025 Do Not Continue in 2026

In 2024, Medicare began paying for HCPCS code G2211, which is reported with an office visit when there is a longitudinal relationship between the physician and patient. CMS is required to adjust the Medicare CF annually to maintain budget neutrality. In previous rule-making, CMS overestimated the use of G2211, projecting that 38 percent of all outpatient and office E/M visits reported in 2024 would be billed with this code and grow to 50 percent in 2025.[6] Recent analysis conducted by the AMA found that only 10.5 percent of outpatient and office E/M visits included the G2211 add-on code in the first three quarters of 2024.[7] Through the AAMC's work with the Clinical Practice Solutions Center we also find utilization of G2211 was and remains lower than CMS projections.[8] According to the AMA's analysis, the budget-neutrality adjustment in the 2024 final rule resulted in a 2.18 percent cut to the 2024 conversion factor, but the actual 2024 claims data suggest this should have been only a 0.79 percent cut.[9] The AMA notes that if CMS does not correct this overestimate, PFS payment will continue to suffer an annual underpayment of $1 billion.[10] **Therefore, we urge CMS to revisit its utilization assumptions for G2211, using actual CY 2024 claims data, and make a prospective budget neutrality adjustment to the 2026 conversion factor to ensure the overestimate does not continue to compound cuts to physician payment.**

DETERMINATION OF PRACTICE EXPENSE (PE) RVUS

CMS Should Not Arbitrarily Update Practice Expense Based on Site of Service

CMS proposes reducing the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to nonfacility RVUs for each service valued in the facility setting under the PFS beginning in CY 2026. CMS believes that allocating the same amount of indirect PE per work RVU for services furnished in the facility setting as the nonfacility setting no longer is supported by physician practice trends. (p. 32373). This policy change would result in a decrease in the total PFS payment in the facility setting of minus seven percent and an increase in nonfacility-based payments of four percent, and many specialties would receive even more

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[6] CY 2024 Physician Fee Schedule, 88 FR 78818 at 78971 (Nov. 16, 2023).
[7] Andis Robeznieks, Overestimate tripled budget-neutrality Medicare physician pay cut, AMA (May 30, 2025).
[8] Analysis of data derived from the Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient.
[9] *Supra*, note 6.
[10] *Id*

substantial cuts. (p. 32805) **The AAMC believes this policy is arbitrary and will lead to significant volatility in the valuation of services that could interrupt access to physician care.** The AAMC strongly urges CMS to reconsider its proposal as it does not accurately reflect resource costs incurred by practices in the facility setting and the impacts on physicians and other health care professionals would be unsustainable.

Such a policy fails to consider practice costs for physicians who provide care in facility settings, many of whom continue to maintain office-based practice settings. When private practice physicians provide services in the facility setting, their practice still incurs administrative costs that are only paid for via the professional claim. For example, their physician practice still must handle coding and billing, scheduling, and employ administrative staff and clinical staff that support the clinical services performed in the facility. Shifting all indirect payments to the facility fee would leave these independent practices uncompensated and create a financially unsustainable model for these physicians. CMS' proposal could have the opposite effect than desired and push those clinicians to either no longer maintain that office-based practice due to inability to cover the costs, or alternatively reduce their services in the facility setting, limiting patient access to care. **In lieu of implementing the proposed policy on indirect practice expenses, the AAMC urges CMS to work with stakeholders to consider alternative policies, tailored based on accurate data, to ensure that actual resource costs are considered and that the practice expenses of physicians are appropriately valued.**

CMS highlights challenges with applying this policy as proposed, noting it could greatly reduce payment for services delivered via global service packages where included services may be furnished across facility and nonfacility settings, like maternity services with the MMM global period. (p. 32374) There are over 4,000 global service packages that bundle post-operative office visits in the surgical global period, where the office visits are often performed in a physician office while the surgery itself must be performed in a facility setting. Analysis of separately reported 99213 office visits suggests less than ten percent are furnished in the on-campus hospital outpatient setting, and that 90 percent of 99213 visits are in the non-facility setting. CMS' proposal negatively impacts the entire surgical global facility PE RVU without accounting for this factor.

Similarly, nursing facilities rely on physicians to care for patients. Nursing Facility visits are reported with CPT® Codes 99304-99316, which describe services provided to patients classified as receiving nursing facility (non-facility) or skilled nursing facility (facility) services. Often, these patients could be in the same room/bed and change from skilled to non-skilled overnight. The physician work, direct and indirect practice expense costs and professional liability costs are the same for the physician practice, regardless of the patient assignment for the facility. Currently, the 2025 physician payment rates are appropriately identical, regardless of the patient's status of skilled or non-skilled nursing facility assignment. Under the proposal, the physician visit practice expense payment for 99309 (subsequent nursing facility care, high complexity) would be 35 percent less for the skilled nursing facility visit. Most physicians who see patients in the nursing facility have offices and their indirect costs do not vary based on how

the patient is classified at the nursing facility. Implementing this policy could reduce access to physician care in nursing facilities.
As demonstrated, the application of the indirect practice expense methodology should be reconsidered. **CMS should accomplish its goal to better support office-based physicians with alternative proposals that are fair to all physicians and do not risk reducing patients access to care.**

VALUATION OF SPECIFIC CODES

CMS Should Not Adopt an Arbitrary, One-Size-Fits-All Efficiency Adjustment Policy to Re-Value Clinician Effort

CMS proposes to establish an across-the-board -2.5 percent efficiency adjustment to work RVUs, as well as corresponding updates to the intra-service portion of physician time inputs for non-time-based services (7,267 physician services). CMS believes this would account for changes in practitioner experience, operational workflows, and new technologies that allow services to be delivered more efficiently. (p. 32401) The 2.5 percent cut is derived from the cumulative MEI productivity adjustments from CY 2022 through CY 2026, with the adjustment to be finalized based on the final CY 2026 MEI. (p. 32402) CMS would not apply the efficiency adjustment to time-based codes, including but not limited to E/M visits, care management services, behavioral health services, services on the CMS telehealth list, and maternity codes with a global period of MMM. The adjustment impacts most specialties by reducing their payment by one percent. CMS would then compound the impacts of the adjustment with additional reductions every three years. (p. 32403)

While the AAMC understands CMS' desire to ensure that efficiencies that have accrued by practitioners for some services are reflected in the values, **we disagree with the notion that efficiencies are gained equally across all non-time-based services and thus can be adjusted with a one-size-fits-all adjustment as proposed.** For example, CMS proposes to apply the same efficiency adjustment to all impacted codes, including codes adopted in the PFS for CY 2025. This suggests CMS believes a service only recognized in Medicare since January has achieved the same efficiencies as a service that has been furnished to beneficiaries for decades. CMS itself notes that research finds efficiencies have been gained more in minor procedures and radiology services than in major inpatient procedures. (p. 32402) CMS ignores this and states it believes that the broad application of an efficiency adjustment will somehow improve accuracy of all services, rather than those with demonstrated, observed efficiencies. That is, rather than applying an efficiency adjustment that is varied in its applicability based on actual efficiencies in delivering medical care, CMS believes it can use a rough proxy (productivity) as an estimate of efficiency and by applying across all non-time-based services generally meet some modicum of accuracy in the value of services under the PFS.

Instead, the AAMC encourages CMS to consider working with stakeholders to develop a data-informed methodology that would allow it to evaluate service specific efficiencies. We encourage CMS to focus such efforts on a subset of high-volume services that have been recognized in the PFS for a minimum of at least fifteen years and ensure that newly added services are not erroneously devalued before broad adoption into clinical practice. Additionally, the AAMC continues to believe that the RUC survey process and use of clinical vignettes remains critically relevant data to inform valuing the intensity of physician work. **CMS should continue to support the use of surveys to ensure the clinical expertise of practice physicians and other health care professionals is respected and utilized in establishing work RVUs.** With a focused approach to evaluating a sub-set of services, CMS could then apply an efficiency adjustment that is data-informed and tailored to those certain services that have demonstrated efficiencies not currently captured through existing valuations.

CMS Should Adopt Proposed New Codes for Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) to Address Barriers to Furnishing These Services

RPM (CPT® codes 99453, 99454, 99091, 99457, and 99458) involves the collection and analysis of patient physiological data that is used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. It allows patients to be monitored remotely while in their home, and for providers to track a patient's physiological parameters (e.g., weight, blood pressure, glucose) and implement changes to treatment as appropriate. Physicians and practitioners may provide RPM services for patients with acute and chronic conditions. RTM (CPT® codes 98975, 98976, 98977, 98980, and 98981) involves utilizing devices to monitor a patient's health or their response to treatment using non-physiological data. This practice includes collecting data related to musculoskeletal and respiratory medication or therapy responses. CMS proposes adopting payment for two new codes for RPM, 99XX4 for 2-15 days per 30-day period of monitoring and 99XX5 for the first 10 minutes of real-time communication with patients or caregivers. (p. 32436) Similarly, CMS proposes adopting payment for four new RTM codes 2-15 days per 30-day period of monitoring for respiratory system, musculoskeletal system monitoring, and cognitive behavioral therapy 98XX4, 98XX5, and 98XX6 as well as 98XX7 for the first 10 minutes of real-time communication with patients or caregivers. (p. 32437)

The AAMC commends CMS for recognizing the new RPM codes and RTM codes that describe less than 16 days of data transmission and less than 20 minutes of interactive communication per 30-day period. One of the barriers to the use of RPM and RTM services is the requirement that monitoring must occur during at least 16 days of a 30-day period for providers to bill for the initial set-up and continued monitoring. The 16-day requirement prevents providers from using these codes when clinical indications are that the patient would require less than 16 days of monitoring. For example, patients with pneumonia or COPD exacerbation can be sent home on oxygen therapy, requiring oxygen saturation (O2sat) monitoring. Often, pneumonia or COPD exacerbation improves within less than 16 days. Similarly, a patient wearing a heart monitor to track palpitation symptoms might only need data collection during symptomatic periods, which could be less than 16 days. And if a health care practitioner intends to change heart medications for heart rhythm, the patient would require monitoring for less than 16 days. Similarly, during the remote monitoring period, practitioners are often able to provide complete and accurate, medically necessary information in less than 20 minutes. **Therefore, the AAMC strongly**

supports the proposal to create new codes to remove barriers and allow for greater utilization of remote monitoring services when medically appropriate.

For 99XX5 and 98XX7 CMS proposes not to accept the recommended valuations for wRVUs. For 99XX5, the RUC recommended .39 for wRVUs and CMS proposes 0.31. For 98XX7, the RUC recommended .66 for wRVUs and CMS proposes .31. **Given the value of the time spent coordinating and delivering care, the expenses associated with configuring systems to capture necessary documentation, and the clinician time spent documenting time each calendar month, we recommend that CMS recognize a greater valuation of the work for these services by accepting the RUC-recommended wRVUs**.

PAYMENT FOR MEDICARE TELEHEALTH SERVICES UNDER SECTION 1834(M) OF THE ACT

Congressional Telehealth Waivers and Flexibilities

CMS Should Work with Congress to Permanently Implement Telehealth COVID-19 Policies

The AAMC commends CMS for the telehealth waivers, flexibilities, and regulatory changes established in response to the COVID-19 PHE that have facilitated the widespread use of telehealth and other communication technology-based services and have improved access to health care. These waivers and flexibilities have increased patient access to care and allowed for a more efficient use of in-person resources. Despite this success, without Congressional action, many of the key telehealth waivers and flexibilities will expire September 30, 2025. Expiration of these flexibilities and waivers would reduce access to care, particularly impacting patients in rural and other underserved areas. **We urge CMS to work with Congress to make telehealth flexibilities permanent, or at a minimum to provide a two-year extension of them.**

Eliminate the Geographic Location and Originating Site Restrictions

During the COVID-19 PHE, CMS paid for telehealth services furnished by physicians and other health care practitioners to patients located in any geographic location and at any site, including the patient's home.[11] Payment for these telehealth services was then extended until September 31, 2025.[12] This has allowed patients to remain in their homes, reducing their exposure to infectious diseases, and reducing the risk that they expose another patient or their physician and other health care professionals. It has also expanded access to care for patients who find travel to an in-person appointment challenging, which may be particularly important to patients with disabilities or chronic conditions which need regular monitoring. It also helps facilitate care to individuals who, because of their job, caregiving responsibilities, transportation issues, or other limitations, find it difficult to attend an in-person visit. **The AAMC acknowledges that the geographic location and originating site restrictions are mandated by statute;**[13] **therefore,**

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[11] Policy and Regulatory Provisions in Response to the COVID-19 Public Health Emergency, 85 FR 19230 at 19232 (Apr. 6, 2020).
[12] Consolidated Appropriations Act, 2025; Pub. L. 119-4, § 2207, 139 Stat. 43 (Mar. 2025).
[13] 42 U.S.C §1834(m)

we urge CMS to work with Congress and other stakeholders to permanently eliminate the geographic and patient location restrictions to allow telehealth services in all locations, including the home.

Expand The Definition of Eligible Telehealth Providers

Addressing workforce shortages will require a multipronged approach, including innovation in care delivery, greater use of technology, increased Medicare support for Graduate Medical Education, and improved, efficient use of all health professionals on the care team. During the PHE, CMS extended eligible telehealth providers to include physical therapists (PTs), occupational therapists (OTs), speech language pathologists (SLPs), and audiologists.[14] This expanded definition of eligible telehealth practitioners was then extended until September 30, 2025.[15] These practitioners have proven that they are able to furnish high-quality care via telehealth effectively, safely, and efficiently to patients. Expanding the definition of eligible providers has resulted in increased access to care, making it obtainable to those who might not otherwise be able to receive it. Patients have come to rely on being able to obtain these services virtually. If PTs, OTs, SLPs, or audiologists are no longer able to furnish telehealth services to patients beyond September 30, 2025, it will result in lapses in care that may negatively impact patient health. **The AAMC acknowledges that the definition of eligible telehealth providers is mandated by statute; [16] therefore, the AAMC recommends that CMS work with Congress and other stakeholders to permanently expand the definition of eligible telehealth providers to include PTs, OTs, SLPs, and audiologists.**

Eliminate the In-Person Visit Requirement for Mental Health Telehealth Services

AAMC commends CMS for providing permanent coverage and payment of telehealth for mental health services. In previous rulemaking, CMS permanently removed geographic restrictions and permitted the home to be an originating site for telehealth services furnished for the treatment of mental health disorders.[17] According to data from the Health Resources and Services Administration (HRSA), as of September 11, 2025, approximately 127 million people currently reside in Mental Health Professional Shortage Areas (HPSAs), and there is a shortage of 6,419 practitioners.[18] The removal of Medicare's geographic and originating site requirements for behavioral telehealth services has significantly increased access to care. According to data from faculty practices participating in the Clinical Practice Solutions Center (CPSC), the use of telehealth for mental health services remained a significant portion of mental health services in 2023, following the end of the COVID-19 PHE.[19] Behavioral health practitioners continue to use telehealth modalities to provide telehealth services at consistently high levels.

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[14] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (Updated Nov. 13, 2022).
[15] *Supra*, note 12.
[16] CY 2023 Physician Fee Schedule, 87 FR 70187 (Nov. 18, 2022).
[17] CY 2022 Physician Fee Schedule, 86 FR 64996 at 65058 (Nov. 19, 2021).
[18] Health Resources & Services Administration, Health Workforce Shortage Areas (as of Sep. 10, 2025).
[19] *Supra*, note 8.

The AAMC believes that the in-person requirements will act as a significant barrier to care for mental health services. Continuity of care is crucial for mental health services, and this in-person visit requirement may result in a lapse of care and ultimately negatively affect clinical outcomes for patients. Mental health services are the only type of service provided by telehealth that would require an in-person visit at a specific interval, which is arbitrary and discriminatory against this particular type of service. Furthermore, the in-person requirement will increase wait times for those in need of an in-person visit due to workforce shortages. It also adds an additional burden of commuting to see the provider. This burden will disproportionally affect those in underserved communities, rural areas, and anyone who does not have reliable transportation.

The AAMC acknowledges that the statute mandates an initial in-person visit prior to the mental health telehealth visit, as well as a subsequent in-person visit at an interval determined by the Secretary of HHS.[20] Through previous rulemaking, CMS has established that subsequent in-person visits must occur at 12-month intervals. **The AAMC recommends that CMS work with Congress and other stakeholders to permanently remove the in-person visit requirements for mental health telehealth services.**

While we are concerned that the in-person visit requirements may interfere with continuity of care, the AAMC supports CMS' establishment of an exception to the 12-month in-person visit requirement when the burden to the patient outweighs the potential benefit, to help mitigate the potential for unnecessary and dangerous interruptions in care.[21]

CY 2026 Physician Fee Schedule Telehealth Proposals

CMS Should Modify the Review Process of and Add Certain Services to the Medicare Telehealth Services List

CMS has taken steps to streamline telehealth by creating both a permanent and provisional category, replacing Categories 1, 2, and 3, of the Medicare Telehealth Services List.[22] Under this approach, new services could be added to the provisional list when public comments express support for possible clinical benefit, without the evidence necessary to support clinical benefit for addition to the permanent list. Upon review, after the implementation of the provisional category, CMS states that the provisional category further complicated the process of updating the telehealth list. To remedy this, CMS proposes removing the provisional category and simplifying the prescribed steps to add services to the telehealth list permanently. (p. 32387) CMS states that practitioners, with their in-depth knowledge of their patients' clinical needs, are best positioned to exercise their professional judgment to determine whether providing a service via telehealth is safe, effective, and appropriate for specific instances of care.

As proposed, CMS will review a service to determine if it is separately payable under the PFS, subject to statutory requirements under section 1834(m), and can be furnished through audio-

[20] 42 CFR § 410.78(b)(4)(iv)(D).
[21] *Supra*, note 17 at 65059.
[22] CY 2025 Physician Fee Schedule, 89 FR 97710 at 97747 (December 9, 2024).

video technology. If CMS determines these three requirements are satisfied, the service will be added to the telehealth list on a permanent basis. After reviewing the provisional list, CMS has determined that all services on the list meet the above requirements and, if this policy is finalized, will be recategorized to permanent services on the telehealth list. CMS also proposes to add Multiple-Family Group Psychotherapy (90849), Group Behavioral Counseling for Obesity (G0473), Infectious Disease Add-On (G0545), and Auditory Osseointegrated Sound Processor (92622 and 92623) to the Medicare telehealth list. (p. 32390)

The AAMC strongly supports the proposal to maintain a permanent streamlined Medicare Telehealth Services List as an efficient and predictable way for practitioners to provide telehealth services. Additionally, the AAMC supports adding Multiple-Family Group Psychotherapy, Group Behavioral Counseling for Obesity, Infectious Disease Add-On, and Auditory Osseointegrated Sound Processor to the List for CY 2026.

CMS Should Remove Frequency Limitations for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services Furnished via Telehealth

Before the COVID-19 PHE, telehealth services were restricted to once every 30 days for subsequent inpatient visits, once every 14 days for subsequent nursing facility visits, and once per day for critical care consultation services. CMS temporarily suspended these limitations during the COVID-19 PHE.[23] CMS then extended the temporary suspension of frequency limitations through the end of CY 2025.[24] CMS now proposes to permanently remove these frequency limitations. (p. 32393)

The AAMC strongly supports the proposal to extend the removal of these frequency limitations permanently to support continuity of care. We believe that providers are best situated to determine when subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services furnished via telehealth are medically necessary.

CMS Should Permanently Allow Practitioners Furnishing Telehealth Services from Home to Use an Enrolled Practice Location with a Valid Reassignment Relationship

During the COVID-19 PHE, CMS allowed practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from the location where they had been enrolled. CMS then extended this flexibility until the end of CY 2025 stating that given the shift in practice patterns toward models of care that include the practitioner's home as the distant site, it would be appropriate to continue this flexibility as they consider various proposals that may better protect the safety and privacy of practitioners. [25]

However, CMS did not address extension of this flexibility in the current rulemaking, therefore it is set to expire at the end of CY 2025. If this policy lapses, practitioners will no longer be able to

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[23] *Supra*, note 11 at 19241.
[24] *Supra*, note 22 at 97761.
[25] *Id.* at 97762.

use their practice location instead of their home address in enrollment when providing telehealth services. **The AAMC strongly recommends that CMS permit practitioners to use their enrolled practice location instead of their home address when providing telehealth services from their home permanently.** Requiring reporting of a practitioner's home addresses for enrollment is likely to discourage practitioners from providing telehealth services from their home, limiting patients' access to care. As CMS previously noted, practitioners have expressed privacy and safety concerns associated with enrolling their home address. They fear the unintended consequences of their personal information becoming available to the public, especially if it is displayed on Medicare websites that include physician lookup features, such as *Care Compare*. There has been an increased trend towards violence against physicians and other health care professionals in recent years.[26] The inclusion of a physician's home address poses a potential threat for a physician and their family.

In addition to privacy and safety concerns, this requirement poses operational challenges and creates an undue administrative burden to update and change provider addresses. Updating the 855B forms or PECOS to include the home addresses of the many practitioners that are employed by large multispecialty practices would be challenging, particularly as practitioners join and leave the group practice or move to new homes. This policy complicates the Medicare Administrative Contractor (MAC) assignment if a provider's home is located in a different MAC jurisdiction than the practitioner's physical office location. In such cases, the group practice would be required to enroll with multiple MACs to ensure practitioners receive payment at the payment amount for services based on where they are located when performing telehealth services. This policy does not consider that where the practitioner is permitted to furnish telehealth services (i.e., their home) may differ from where the patient is located and from the location in which the practitioner generally practices.

Practices rely on hybrid models of care that enable shifting from in person appointments to telehealth if needed to maintain continuity of care. For example, during weather events such as a snowstorm, hurricane, or flood, practitioners can switch appointments from in-person to telehealth when appropriate. Specialists who generally provide in-person care are also able to switch to a telehealth service with short notice in response to an emergency situation. This is a crucial flexibility given the shortage of specialists, particularly in rural areas, to improve access to care. Additionally, practitioners who can provide telehealth services while registered through their practice location can offer extended evening and weekday appointments from different locations and are not forced to forgo treating patients, allowing patients with urgent clinical needs outside of business hours to receive care. Removing this requirement would make it more feasible for practitioners to provide safe and effective telehealth services and expand access to medically necessary care by ultimately increasing the availability of practitioners.

Provider enrollment requirements are designed to protect the Medicare Trust Fund by ensuring the accuracy of payments and that providers meet the appropriate qualifications and requirements for participation in the Medicare program. We believe that if there is a valid reassignment

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[26] O'Brien, et al, The growing burden of workplace violence against healthcare workers: trends in prevalence, risk factors, consequences, and prevention – a narrative review, eClinical Medicine (Jun. 2024).

relationship between the remote practitioner and a Medicare-enrolled practice with a physical office location where care is delivered to patients, safeguards are in place. The benefits of providing telehealth to patients far outweigh any compelling reason to require enrollment of home addresses.

Given privacy, safety, operational challenges, and opportunities for expanded access to care, if a practitioner is enrolled in Medicare and reassigns payment to a physical office location where he or she practices, CMS should not require that practitioner to enroll other addresses, such as their home, where they provide telehealth services.

Permanently Allow Direct Supervision of Clinical Staff Through Virtual Supervision

Direct supervision is required for various types of services, including most incident-to services and many diagnostic tests. Generally, direct supervision requires the supervising practitioner to be immediately available within the office suite. During the COVID-19 PHE, CMS adopted a policy on an interim basis that direct supervision for services billed "incident to" a physician service could be met through virtual supervision.[27] CMS extended this policy defining direct supervision to permit the presence and "immediate availability" of the supervising practitioner using audio-video technology through CY 2025.[28] CMS also finalized a policy to permanently allow audio-video direct supervision requirements for services furnished incident to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision for which the underlying HCPCS code has been assigned a PC/TC indicator of '5' and lower level E/M services described by CPT code 99211.[29]

CMS proposes to permanently allow direct supervision requirements for certain services to be met through audio-video technology, including all services provided incident to a physician's professional service, diagnostic tests, Cardiac (CR), Pulmonary (PR), and Intensive Cardiac Rehabilitation (ICR) services unless the service has a global surgery indicator of 010 or 090, indicating a 10- or 90-day postoperative period, respectively (p. 32395).

The AAMC strongly supports the proposal to permanently define direct supervision to permit the presence and "immediate availability" of the supervising practitioner using audio-video technology for services incident to a physician's professional service, diagnostic tests and cardiac, pulmonary, and intensive cardiac rehabilitation services. Virtual supervision in these instances enables expanded access to health care services while reducing risk of exposure to infectious diseases. Our members have found virtual supervision of clinical staff to be safe and effective, and report that it has improved access to care.

[27] *Supra*, note 11 at 19246.
[28] *Supra*, note 22 at 97764.
[29] *Id.*

Allow Virtual Supervision of Residents for 3-Way Telehealth Services

During the COVID-19 PHE, CMS allowed the supervisory requirement for teaching physicians "to be present for the key portion of the service through real-time audio-video technology" (herein referred to as virtual supervision) both for services when the resident and patient are together in person and for telehealth services in all residency training locations.[30] In previous rulemaking, CMS finalized a policy to permanently allow virtual supervision of residents in training sites located in non-Metropolitan Statistical Areas (non-MSAs) for both in-person and telehealth services, and stated that this policy would improve access to care in these underserved areas. [31] CMS extended the COVID-19 flexibility to allow virtual supervision of residents furnishing telehealth services in MSAs through CY 2025 but did not extend the flexibility that allowed virtual supervision of in-person services provided within an MSA.[32] CMS proposes to no longer allow virtual supervision of residents providing telehealth service in MSAs. (p. 32396). If finalized as proposed, teaching physicians in MSAs would be required to maintain physical presence during the key and critical portions of all resident-furnished services provided, including for telehealth services.

The AAMC strongly recommends that CMS permanently allow virtual supervision of residents for telehealth services in all residency training locations. At a minimum, CMS should allow virtual supervision of residents for telehealth services in underserved areas, as well as in non-MSAs.

Residents have been virtually supervised safely and effectively when providing telehealth services since the COVID-19 PHE. The teaching physician is present virtually during key and critical portions of the service through interactive audio-video real time communications technology, and both the attending physician and resident have access to the electronic health record. Teaching physicians render personal and identifiable physician services and exercise full personal control over the management of the care for which payment is sought. CMS requires that the documentation in the patient's medical record clearly reflects how and when the teaching physician was present during the key and critical portion of the service, along with a notation describing the specific portions of the service for which the teaching physician was virtually present. After the visit, if medically necessary, the teaching physician continues to engage with the patient through phone calls, messages, video updates, study reviews, and collaboration with other providers.

The use of telehealth has been of great benefit for patients. It maintains and expands access to safe and effective care, particularly for patients in rural and other underserved areas. It improves access to care for those who need to care for dependents, face transportation issues, are unable to take time off work, or otherwise find it difficult to attend an in-person visit to receive care. Furthermore, physicians can effectively use telehealth to monitor the care of patients with chronic conditions, such as diabetes and heart conditions, reducing their risk of hospital

[30] *Supra,* note 11 at 19259.
[31] CY 2021 Physician Fee Schedule, 85 FR 84472 at 84582 (Dec. 28, 2020).
[32] *Supra*, note 22 at 97765.

admissions. Telehealth also protects patients from exposure to infectious diseases, such as the seasonal flu. Allowing residents to provide these telehealth services while being supervised virtually further expands access and promotes training opportunities.

As part of their training, it is essential for residents to have experience with providing telehealth services before they enter the physician workforce, as they will most likely be providing telehealth services to their patients independently in the future. Virtual supervision of residents allows the teaching physician and residents to provide telehealth services safely and effectively from different locations. They interact with the patient virtually, receiving real-time information from the patient simultaneously. This enables the supervising physician to take an active role in patient evaluation and treatment. Video platforms allow the residents and teaching physicians to communicate seamlessly by sending real-time private messages to each other and/or by meeting virtually face-to-face in a private breakout room separated from the patient**.** From the patient's vantage point, the only difference between virtual supervision and in-person supervision during a service provided via telehealth is one provider video feed instead of two feeds on the screen**.** As a result, the teaching physician and resident do not need to be in the same room. The need and demand for these services is expected to increase as remote digital tools for at-home health monitoring continue to expand, and as the population continues to age, resulting in transportation and mobility challenges.

While we appreciate that CMS finalized a policy to increase access by allowing virtual supervision of residents for telehealth services in non-MSAs, it is important to recognize that significant workforce shortages are also impacting access to care in MSAs. According to data from the HRSA, 127 million people currently reside in Mental Health HPSAs, and there are 6,419 fewer practitioners than are needed.[33] Approximately 31.2 percent of Mental Health HPSAs are located in non-rural areas and 6.3 percent are in partially non-rural areas.[34] Currently, 86 million people reside in a Primary Care Shortage Area, and there are 14,618 fewer primary care practitioners than are needed.[35] Additionally, a March 2024 report from the AAMC predicts a shortage of up to 86,000 physicians by 2036.[36]

These shortages have a real impact on access to care for all patients. Specialties such as Psychiatry and Behavioral Health, Family Medicine, Internal Medicine, Primary Care, Endocrinology, Dermatology, Nephrology, Allergy/Immunology, Radiology, Cardiology, Infectious Diseases, and more have provided high-quality oversight through virtual supervision of telehealth to help ensure access to care. For Pediatrics, fellows have played a vital role in treating patients while being supervised virtually, especially in areas with limited access to care. While utilizing virtual supervision policies, teaching physicians has more time to educate residents and provide comprehensive patient care, ultimately improving patient outcomes. For example, allowing teaching physicians to supervise residents virtually increases the availability of the teaching physician, including extended weekday and weekend hours to address patient

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[33] *Supra*, note 18.
[34] *Id.*
[35] *Id*.
[36] *Supra*, note 5.

needs. They can continue to supervise residents even when experiencing periods of quarantine or mild illness. Additionally, this policy helps residency programs access a broader pool of experienced teaching physicians and specialists. It also helps prevent provider burnout by reducing travel time and allowing providers to practice more efficiently.
Guardrails exist through the Accreditation Council for Graduate Medical Education (ACGME) and other accrediting organizations that have established standards and systems to ensure patient safety and oversight of residents under virtual supervision. ACGME sets forth extensive program requirements, including requirements related to supervision.[37] ACGME recognizes that direct supervision occurs when either the supervising physician is physically present with the resident during the key portions of the patient interaction or when the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology.[38] The program must also demonstrate that the appropriate level of supervision is in place for all residents and is based on each resident's level of training and ability guided by milestones, as well as patient complexity and acuity.[39] The faculty must assess the knowledge and skills of each resident and delegate to the resident the appropriate level of patient care authority and responsibility, and each resident must also know the limits of their scope of authority. Teaching physicians are ultimately responsible for determining the level of supervision required and for any adverse events that occur. ACGME, other accrediting organizations, and the medical education community work hard to monitor, report, and address any issues related to workload, patient safety, medical error, resident well-being and burnout, professionalism, and resident learning and outcomes.[40] And while we greatly appreciate CMS' proposal to expand virtual supervision for clinical staff, we believe that due to the extensive education and training that residents receive, residents can be effectively supervised virtually as well.

Below are statements from member organizations outlining the importance of continuing the currently allowed virtual supervision flexibility for telehealth encounters:

> <u>Neurology</u>
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> *Telemedicine is a very important part of our training program. Notably, telemedicine is an expected and increasingly essential part of both acute and outpatient stroke management. Therefore, we train our fellows to be adept in both acute and outpatient stroke management using telemedicine. At this point, approximately 50-60% of their outpatient experience is telemedicine.*
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> *Because of the requirements of the vascular neurology program, the vascular neurology fellows are expected to staff with a licensed faculty member when geographically separated. Notably, at least one vascular neurology fellow is on call and is usually in the hospital; at least one vascular neurology off-call and is usually on an elective rotation*

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[37] ACGME Common Program Requirements
[38] *Id.*
[39] *Id.*
[40] *Id.*

with another service. This means that it is organizationally difficult and educationally detrimental for the fellows to be in the same place.

Further, and because of the academic and travel demands of the faculty, it would be limiting and currently organizationally impossible to expect faculty to be in the same place as the fellows. Notably, the faculty that staff clinic are often in a separate campus or are traveling. As such, requiring faculty to be in the same place would drastically limit the number of faculty available, would limit clinic time, and would curtail teaching.

Geriatric Psychiatry

I sometimes have a clinic where all the patients (or all but one) have virtual visits. We do synchronous supervision usually through a combination of speaking on the phone or using Zoom with the patient in the waiting room. We also always review the history and plan together with the patient on video.

Pediatric Hematology Oncology

I strongly believe this flexibility is beneficial both to direct patient care and fellow training. For context, our pediatric hematology/immune-hematology clinic provides ~60-65% of our patient visits via telehealth. The following case studies serve as examples of how virtual supervision of virtual visits is helpful to our patients and trainee education: (1) For our immuno-hematology patients that are often seen by many specialties, having the ability for attendings to staff fellows that are at different locations has been hugely beneficial - as it allows for flexibility in the appointment time for patients, permits continuity of care longitudinally with the fellows and facilitates training in rare diseases for fellows. Of note, we have strong relationships with all the fellows as we also staff them in person over the course of the year. (2) During afterhours/weekends, we often have patient calls/critical labs that can prompt an ad-hoc virtual visit. Virtual supervision allows for the fellow and attending to jump on an ad-hoc virtual visit (nearly always from different locations) to provide immediate care to patients. These visits are crucial for triaging immediate issues and often help prevent ED visits and mitigate issues for patients efficiently. (3) We have also had the scenario where the anticipated fellow or attending is ill and a different fellow/attending steps in last minute to help maintain the patient visits scheduled. Or, more frequently, one of the fellows/attendings are not well enough to be in person (since we care for immuno-compromised patients, we VERY strongly encourage providers who are not feeling well to work from home or take a sick day as needed). For those who are feeling well enough to work from home, having the fellow and attending work from separate locations is hugely beneficial in maintaining the previously scheduled visits. If we couldn't continue visits with virtual supervision, the patient visits would otherwise need to be cancelled.

Requiring that the teaching physician be physically present for the key and critical part of telehealth services is an inefficient use of resources which ultimately limits access to care, decreases training opportunities for residents, and does not improve the quality of care or patient experience. Virtual supervision of resident telehealth services has been permitted for almost five years, and during that time practice patterns have evolved to leverage real-time audio-video technology to meet supervision requirements, increase patient access and streamline care. It is imperative that the Agency does not regress to an outdated policy that is less effective and stunts overall care. **Therefore, we urge CMS to support an effective, innovative care solution by allowing virtual supervision of residents in all residency training locations for those telehealth services that may be furnished safely and effectively**.

Address Barriers to Uptake & Sustainability of Interprofessional Consults

CMS adopted payment for six interprofessional consultations (CPT codes 99446, 99447, 99448, 99449, 99451, and 99452) that are billed by practitioners who can independently bill Medicare for E/M visits. [41] CMS also adopted payment for six mental health interprofessional consultations codes (HCPCS codes G0546, G0547, G0548, G0549, G0550, and G0551) that are billed by specialists statutorily restricted to Medicare payment for mental health services (i.e., clinical psychologists, clinical social workers, marriage and family therapists, or mental health counselors) because these practitioners cannot independently bill Medicare for E/M visits.[42] These mental health interprofessional consultation HCPCS codes are cross-walked and mirror the original interprofessional consultation CPT codes.

The AAMC has partnered with over 55 adult and pediatric health systems through Project CORE (Coordinating Optimal Referral Experiences) to implement interprofessional consults ("eConsults") and continues to engage new health systems and other health care organizations, including payers, interested in implementing and scaling this high value service. In the CORE model, eConsults are an asynchronous exchange in the electronic health record (EHR) that are typically initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The goals of the program include increasing timely access to specialty input and reducing unnecessary specialty referrals while maintaining continuity of care for patients with their PCP. Patients benefit from more timely access to the specialist's guidance and payers benefit from a less costly service by avoiding the new patient visit with a specialist, not to mention likely downstream costs, when eConsults take the place of a referral. The AAMC believes that investing in these technologies will extend the capacity of the existing behavioral health workforce and promote access to care in historically underserved communities. The AAMC continues to develop resources for health systems to aid in the adoption and evaluation of both synchronous and asynchronous telehealth modalities.

Instructions for CPT code 99452 clarifies that it should be reported by the treating physician/ QHP for 16-30 minutes in a service day preparing the referral and/or communicating with the consultant. The corresponding mental health HCPCS G0551 code is cross walked to CPT code 99452. The time for these codes should include all the activities associated with the

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[41] CY 2019 Physician Fee Schedule 83 FR 59452 at 59489 (Nov. 23, 2019).
[42] *Supra*, note 22 at 97929.

interprofessional exchange between the treating provider and consulting physician, including follow-up on the consultant's recommendations, which often crosses multiple dates of service. **To achieve this change, the AAMC recommends that CMS should develop a new G code to replace 99452 and amend G0551 to reflect this description modification**. As part of the CMMI Making Care Primary model, which included implementation of eConsults, a new code was developed to address this issue and could serve as a model for a new G code.

This new code and amendment would help to expand the use of these valuable services in the future and ensure from a program integrity standpoint that patients and payers are realizing the intended value of this service. Interprofessional consultation is only valuable to providers, patients, and payers when the treating provider poses a question, the specialist consultant provides recommendations and a contingency plan, and the plan is implemented and communicated back to the patient by the treating provider.

EVALUATION AND MANAGEMENT (E/M) VISITS

Allow Providers to Bill the Complexity Add-on Code for Home and Residence-based E/M Visits

In 2021 CMS created an add-on code G2211 that could be reported in conjunction with outpatient/office E/M visits to account for resources related to medical care that serves as the continuing focal point for all needed health care services and/or medical care services that are a part of ongoing care related to a patient's single, serious, or complex condition. However, the Consolidated Appropriations Act 2021(CAA) imposed a moratorium on Medicare payment for G2211 until January 1, 2024.[43] Effective January 1, 2024, CMS finalized payment for this code, incorporating several refinements to the policies based on feedback received from stakeholders in 2021.[44] CMS is now proposing to extend this policy to allow HCPCS code G2211 to be billed as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350). (p.32496)

The AAMC strongly supports the proposal to expand the use of G2211 to be reported alongside home and residence-based E/Ms. As CMS notes, home visits occur at least monthly, and patients that suffer from serious illness may receive weekly visits. These visits involve developing and following through on a longitudinal care plan with proactive contacts to address patients' health care needs. G2211 appropriately recognizes the resource costs involved in building trust in these long-term practitioner-patient relationships.

ENHANCED CARE MANAGEMENT

Integrate Behavioral Health into Advanced Primary Care Management (APCM) Services

Last year, CMS established three new HCPCS codes (G0556, G0557, and G0558) for Advanced Primary Care Management (APCM) services to describe and pay for a set of care management

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[43] Consolidated Appropriations Act, 2021; Pub. L. 116-260 (Dec. 2020).
[44] *Supra*, note 6.

services and communications technology-based services (CTBS) furnished when the practitioner is the continuing focal point for all needed health care services and is responsible for all primary care services.[45] In doing so, CMS recognizes the broader range of services and simplifies billing requirements relative to existing care management and CTBS codes for practices able to meet the requirements for delivering advanced primary care.

CMS now proposes to create three new behavioral health add-on G-codes for APCMs including for the initial psychiatric collaborative care management, in the first calendar month (GPCM1), subsequent psychiatric collaborative care management (GPCM2), and care management services for behavioral health conditions (GPCM3). (p. 32501) CMS proposes to crosswalk the add-on codes to existing Behavioral Health Integration and Collaborative Care Model codes but would remove the time-based requirements to reduce the burden associated with time-based documentation. CMS proposes to allow auxiliary personnel to furnish these services under the general supervision of the billing practitioner.

The AAMC strongly supports the creation of three new APCM add-on G-codes for mental health services. Mental health and physical health are closely connected; individuals with chronic medical conditions tend to also struggle with mental health issues.[46] Patients experiencing complex health issues often find limited support for mental health care, further exacerbating mental health and other chronic conditions. The AAMC commends CMS for its efforts to promote whole-person care by ensuring that mental health can be addressed through the APCM add-on codes. Furthermore, we support the removal of the time-component as it minimizes the documentation burden, allowing clinicians to efficiently provide these services across the patient populations.

RFI: APCM and Prevention

CMS seeks comments on APCM cost-sharing requirements, particularly whether the inclusion of preventive services should change existing coinsurance requirements. (p.32502) CMS also requests feedback on any other changes that should be considered for APCM services. (p.32502)

Eliminate Coinsurance Requirements

As finalized, APCM codes require 20% coinsurance to be collected from the patient because they are currently characterized as non-preventive services billed under Medicare Part B. Under the Affordable Care Act, most health plans, including Medicare, must cover a set of preventive services at no cost to the patient.[47] Services provided through the APCM bundle are analogous to existing covered preventive services, promoting proactive, personalized care and early detection of diseases, and should be considered as such. Specifically, a personalized prevention plan includes a health risk assessment to identify chronic diseases, injury risks, modifiable risk factors, and urgent health needs, which as CMS notes, is substantively similar to the service

[45] *Supra*, note 22 at 98012.
[46] Mental Health America. *Co-occurring: Mental Health and Chronic Illness.* Accessed Sept 2025, summarizes specific chronic illness impacted by mental health conditions.
[47] Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (Mar. 2010).

element of APCM that requires an overall systematic needs assessment addressing both medical and psychosocial needs. (p. 32502) The personalized prevention plan also includes improving self-management or community-based lifestyle interventions, which CMS notes, is substantively similar to the self-management oversight requirements for APCM services. (p. 32502). While we acknowledge that some of the services provided through the APCM bundle are not considered preventive services when independently billed, the totality of the services provided is substantially aligned. **Therefore, AAMC recommends that CMS consider APCM services as preventive care and remove the coinsurance requirement.**

However, if CMS does not believe that it is appropriate to define the APCM bundle as a preventive service given the current composition of services, we recommend that CMS add the Annual Wellness Visit (AWV) to the bundle. As an independently billed service, the AWV is considered a preventive service and incorporating it into the bundle would further support a finding that the APCM bundle is a preventive service. If CMS disagrees that adding AWV to the APCM bundle would classify the bundle as a preventive service, we recommend that CMS use its waiver authority to test whether an exception to coinsurance requirements improves access to APCM services.

It is necessary to remove the coinsurance requirements to avoid unintentionally limiting the usage of these codes. The elements associated with billing APCM billing are not required to be furnished during any given calendar month for which the service is billed, but any APCM services would be described in the medical record, and, as appropriate, their relationship to the clinical problem they are intended to resolve and the treatment plan. A coinsurance bill could cause the patient to believe a billing error has occurred. Furthermore, patients may refuse to consent to receive bundled APMC services altogether, knowing that they could get billed for coinsurance. As such, the AAMC reiterates the recommendation to define APMC services as preventive services, removing the coinsurance requirements.

Ensure That Practice-level Capabilities Appropriately Align to Best Support Practice Uptake of the APCM Codes to Best Serve Medicare Patients

The AAMC appreciates the thorough cataloguing of practice-level capabilities for delivering advanced primary care, and we agree that high-level primary care requires certain investments in redesigning care delivery and enhanced opportunities for patient-centered care communications and coordination. However, we are concerned that the extent to which CMS will require such practice-level capabilities for billing these new codes may significantly limit their use, similar to the Chronic Care Management (CCM), Principal Care Management (PCM), and Transitional Care Management (TCM) codes.[48] Some AAMC members have expressed interest in the APCM codes but are limited by the upfront investment to implement the robust practice-level capabilities in order to bill these codes. And those that might be further along in that care re-

[48] Senate Committee on Finance, Bolstering Chronic Care through Physician's Payment: Current Challenges and Policy Options in Medicare Part B, p. 19 (May 17, 2024), citing evidence that only 4 percent of eligible Medicare beneficiaries are enrolled in CCM services and that quantification and billing requirements are responsible for the low uptake of the CCM code.

design are concerned with the documentation burden to ensure that their practice-level capabilities are fully represented in the medical record to support billing for the APCM codes. **CMS should consider modifications to the practice-level capability requirements in response to stakeholder feedback to ensure APCM services are best set up for success in serving Medicare patients and their families.** This could include allowing practices to attest to meeting all capabilities through participation in accountable care organizations (ACOs), NCQA Patient-Centered Medical Home recognition,[49] or state Medicaid Advanced Medical Home status rather than trying to document capabilities for each patient in the medical record.[50]

Conduct Greater Research to Determine Appropriate Values for the APCM Codes

CMS cross-walked each level APCM code to an existing CPT code or codes, or, in the case of GPCM3, as a relative increase from GPCM2.[51] Altogether, CMS approximates a national payment rate ranging from $15 per month to $110 per month for the CY 2025 payment.[52] The AAMC is concerned that the update cross-walking and valuation does not fully reflect the full resources and infrastructure necessary to furnish these services, given the service elements and requisite practice-level capabilities. For example, the GPCM1 code is cross walked to CPT 99490, which for non-complex CCM services vary in national payment from $55.88 to $77.99 per month. Similarly, the GPCM2 code includes a cross-walk to CPT codes 99490, 99439, 99487, and 99489, which vary in national payment from $42.23 to $165.63 per month in 2025.[53] It is unclear why a practice would choose to make such investments in APCM services when they could instead focus on existing CCM services with significantly more remuneration and less upfront investment in infrastructure and service re-design. This is to say nothing of the PFS billing the practice would elect to forgo under APCM services for CTBS codes when providing comprehensive care management and enhanced communication opportunities to patients. **Altogether, we are concerned that the potentially significant undervaluation for these codes will significantly limit their use and reduce the availability of advanced primary care delivery for Medicare patients. We recommend that CMS conduct further research into the resources necessary to deliver advanced primary care to determine appropriate values for the APCM codes.**

POLICIES TO IMPROVE CARE FOR CHRONIC ILLNESS AND BEHAVIORAL HEALTH NEEDS

The AAMC supports CMS' efforts to promote access to behavioral health services and is committed to advancing policies that enable academic health systems to deliver high-quality behavioral health care to their patients. The nation is experiencing a mental health and substance use disorder crisis. Ensuring meaningful access to mental health and substance use disorder treatment is essential to addressing this crisis.[54]

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[49] *See*, NCQA, Patient-Centered Medical Home (PCMH) Recognition.
[50] *See*, for example, North Carolina Medicaid, Advanced Medical Home.
[51] *Supra*, note 22 at 97902.
[52] *Id.*
[53] CMS PFS Look up Tool.
[54] Thomas D'AUnno and Charles J Neighbors, Innovation in the Delivery of Behavioral Health Services (May 2024)

Finalize Payment for Digital Mental Health Treatment (DMHT) Devices to Include ADHD

Last year CMS adopted payment for services utilizing Digital Mental Health Treatment (DMHT) devices for behavioral health by establishing three new HCPCS codes, including initial supply of the device, education and onboarding (G0552), first 20 minutes (G0553), and each additional 20 minutes of monthly treatment management (G0554).[55] CMS now proposes to expand payment for DMHT to include devices for the treatment of attention deficit hyperactivity disorder (ADHD).(p. 32504).

The AAMC strongly supports CMS' proposal to expand payment for DMHT to include attention deficit hyperactivity disorder (ADHD). According to the CDC, 15.5 million adults in the U.S. currently have ADHD, and more than half of adults with ADHD were diagnosed in adulthood.[56] One-third of adults are not receiving any type of ADHD treatment.[57] There are now a growing number of evidence-based ADHD-specific digital therapies that clinicians can use to optimize treatment plans.[58] We commend CMS for providing payment for these services to encourage investments in and facilitate the use of DMHT.

RFI: Payment Policy for Software as a Service (SaaS):

CMS seeks feedback on the use of software-based technologies with new functionalities, Software as a Service (SaaS), including those utilizing artificial intelligence (AI). (p. 32507) Before 2022, CMS considered most computer software and associated analysis and licensing fees to be indirect costs of practice expense tied to costs for associated hardware that is considered medical equipment. CMS made intermediate, service-specific policies to allow for PFS payment of SaaS and AI applications in certain circumstances (i.e., Fractional Flow Reserve Computed Tomography [Heartflow])

The AAMC supports technical innovation to improve health care and supplement physician work. CMS should consider payment policies that reward explainability and transparency and require monitoring and auditing of the use of any innovative technologies. It is also important that CMS consider related risks, including data privacy, security, bias and possibilities of medical inaccuracies. For example, CMS could consider payment only for FDA-approved SaaS.

RFI: Prevention and Management of Chronic Disease

CMS is soliciting feedback to understand how to enhance support management for prevention and management of chronic diseases. (p. 32507) Chronic disease management is a critical focus of academic health systems, and they are trying many different approaches to this complex issue. One area that needs more focus and attention is the importance of coordinated care models across specialties that focus on whole person care and include integrating mental and behavioral

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[55] *Supra*, note 22 97926.
[56] Centers for Disease Control and Prevention. ADHD in adults: An Overview. (Oct 2024).
[57] *Id*.
[58] Baweja, R., et al., From Consensus Statement to Pills to Pixels: New Innovations in Attention-Deficit/ Hyperactivity Disorder Care. *Journal of Child and Adolescent Psychopharmacology*, *34*(4), 167–182. (May 2024), a literature review including digital therapeutics and neurostimulation devices for ADHD.

health care with medical/physical health care. Such models of care focus on reducing the stigma associated with seeking mental health/behavioral health care, addressing the bi-directional relationship between mental health conditions and chronic diseases, and utilizing team-based approaches in providing whole-person care and could improve chronic disease health outcomes.

CMS should continue to support integrated behavioral health models of care by including support for interprofessional consultations, expanding value-based contracts that align incentives with the goals of whole-person care, and proving reimbursement for additional team members including community health workers (CHWs), peer coaches, and master level therapists. The AAMC commends CMS for gathering this information because we believe that managing chronic illnesses and treating problems related to aging effectively reduces cost and supports a healthier population when compared to treating acute conditions alone.

Community Health Integration (CHI) and Principal Illness Navigation (PIN) for Behavioral Health

Previously, CMS established payment for the provision of CHI services (G0019 and G0022***)*** to address upstream drivers of health that present a barrier to patient care as identified during an initiating visit.[59] CMS also established payment for the provision of PIN service (G0023, G0024, G0140, and G0146) to help Medicare patients diagnosed with high-risk conditions (e.g., chronic obstructive pulmonary disease, congestive heart failure, dementia, cancer, severe mental illness, substance use disorder, etc.) identify and connect with appropriate clinical and support services.[60] PIN services are designed in parallel to CHI services, but focused on patients with a serious, high-risk illness who may not have health-related social needs.

CHI and PIN services are furnished monthly, and provided by certified or trained auxiliary personnel, including community health workers, under the general supervision of the billing practitioner as "incident to" the professional services. To bill for CHI or PIN services, there must be an initiating CHI or PIN visit with the billing practitioner. CMS now proposes to expand the initiating visits services for CHI to include and Psychiatric Diagnostic Evaluation (CPT code 90791) and Health Behavior Assessment and Intervention (HBAI) services (CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168) so that the specialties limited by statute to services for the diagnosis and treatment of mental health conditions (i.e., CSW, MFT, and MHCs) can bill for CHI services personally performed for diagnosis and treatment of mental illness (p. 32510)

AAMC strongly supports permitting Psychiatric Diagnostic Evaluation and HBAI services to count as initiating visits so that mental health providers can independently perform and bill for CHI services. Whole-person care is critical for treating mental health conditions, and mental health providers are uniquely situated to address upstream drivers of health. Mental health providers, including CSWs, MFTs, and MHCs, are permitted to bill independently under the PFS when providing treatment for mental health conditions. Both Psychiatric Diagnostic Evaluation and HBAI services are mental health services in which a provider is likely to discover

[59] *Supra*, note 6 at 78931.
[60] *Id*. at 78937.

upstream drivers of health that are impacting mental health treatment plans and mental health providers are trained to assist patients in addressing these needs.

STRATEGIES FOR IMPROVING GLOBAL SURGERY PAYMENT ACCURACY

Ensure Payments to Surgeons Best Reflect Time and Resources Involved with Furnishing Procedures

CMS seeks feedback on potential future policies to address Medicare payment to surgeons as a share of a global procedure's valuation when billed with modifier -54 to denote the provider does not intend to provide post-operative care. Current "procedure shares" are based on assumptions and clustered at certain values (roughly 79-81 percent of the total package valuation for more than half of all procedures with 90-day global periods and 90 percent for most 10-day global period procedures). CMS seeks feedback on three alternatives to the status quo assumed procedure shares for valuing the surgeon's portion of the global package when only furnishing the procedure. (p. 32523) The agency's second alternative approach would use post-operative visit counts from claims-based reporting to reflect real-world, observed patterns of post-operative care to determine procedure shares of the package. Such an approach would provide transparency for routine updates to procedure shares over time should CMS observe trends in the number of post-operative visits for a given package. The other two approaches discussed would likely inflate the level of post-operative visits based on long held assumptions and result in reduced payment to surgeons via reduced procedure shares of the global service valuation. Claims analysis suggests that 85 percent of procedures would have a higher procedure share if CMS employed a claims-based approach to assess work dedicated to post-operative care. (p. 32524) **CMS should ensure that any future policies to amend the procedure shares of global surgery packages accurately and appropriately reflect the time and resources involved with furnishing surgical procedures.**

DISCRETIONARY PROVISIONS [III]

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

Simplify Proposals to Identify 340B Units for Exclusion from Part D Inflationary Rebates, Establish Strict Guardrails for a Claims Repository Model

The Inflation Reduction Act of 2022 (IRA) requires drug manufacturers to provide rebates to Medicare on Part B and Part D drugs for instances where prices increase faster than the rate of inflation. For Part B drugs, the determination of whether a drug's price increased faster than inflation is made on a quarterly basis, while this determination is made over a 12-month period for Part D drugs. The IRA also requires that units of drugs subject to a manufacturer discount through the 340B Drug Pricing Program be excluded from inflationary rebate calculations. The requirement to exclude 340B drug units went into effect for Part B drugs in 2023 and goes into effect for Part D drugs in 2026. The comments below reflect the AAMC's response to CMS' proposals to identify 340B units to remove from Part D inflationary rebates.

Proposed Prescriber-Pharmacy and Beneficiary-Pharmacy Methodologies

CMS is proposing two new claims-based methodologies to identify 340B units to remove from Part D inflationary rebates. The first, referred to as the Prescriber-Pharmacy methodology, would identify prescription drug events (PDEs) as 340B by matching the affiliation of the National Provider Identifier (NPI) of the prescriber for the PDE with a 340B covered entity or contract pharmacy. For covered entities, CMS would match the list of NPIs pulled from the PDEs submitted in a month with Medicare inpatient, outpatient, and professional claims to identify Medicare Provider Numbers (MPNs). Those MPNs identified would then be compared to the 340B Office of Pharmacy Affairs Information System (OPAIS) database. A prescriber NPI affiliated with an MPN listed on the OPAIS database as 340B covered entity would be considered a 340B-affiliated prescriber. Meanwhile for contract pharmacies, CMS would utilize the 340B OPAIS database to identify registered contract pharmacies that have agreements with covered entities. Those identified would then be matched with NPIs by using the name and address fields reported to the Nation Council for Prescription Drug Programs (p. 32640).
CMS outlines several limitations with this proposed methodology including the 340B OPAIS database not containing all covered entities and some covered entities not having MPNs. (p. 32640). Specifically related to identifying contract pharmacies, CMS acknowledges they may need additional methods to verify names and addresses, including conducting a manual review of any matching algorithm utilized to identify and correct errors. This would create additional burden for the agency. The AAMC has concerns with the limitations raised by CMS and believes that the data matching described in this methodology is likely to result in an overestimation of the amount of 340B units. Further, the AAMC is supportive of the least burdensome approach to identifying 340B units in Part D claims. Utilizing complex algorithms or methods of matching incomplete data creates additional burden and a need for greater oversight to ensure accuracy.

The second methodology, referred to as the Beneficiary-Pharmacy methodology, is similar to the Prescriber-Pharmacy methodology, but would instead identify PDEs as possibly 340B by using PDE records associated with a contract pharmacy of a 340B covered entity and matching them with beneficiaries who receive care from a 340B covered entity affiliated with that pharmacy. This method would create beneficiary-pharmacy pairs to identify PDEs as possibly 340B. CMS would do this by using the same method as the Prescriber-Pharmacy methodology to link covered entities NPIs and MNPs with pharmacy NPIs. This list of pharmacy NPIs would then be combined with a file containing beneficiaries associated with a PDE and the MPNs of the provider where those beneficiaries received care. The combined file of these two lists would link beneficiaries to contract pharmacies in order to identify PDEs as 340B related. (P. 32641). This approach would have the same limitations as the Prescriber-Pharmacy methodology but would have an additional layer of complexity due to the beneficiary matching.

CMS acknowledges that that under both of these methodologies the determination of potential 340B-eligibility of a PDE record does not necessarily mean that the covered entity is able to replenish drug units at the 340B price. Meaning these units would not be acquired at the 340B rate which could result in overestimation of 340B units. An overestimation of the 340B units would mean that CMS would receive fewer rebates back to the Medicare program for drugs with prices that increase faster than the rate of inflation. This undermines the intent of the inflationary rebates and diminishes the impact of such a policy. In order for inflationary rebates to be impactful, it is important that CMS identify an accurate methodology to remove 340B units from the Part D inflationary rebate calculations. Overall, both of these methodologies are overly complex, leave room for assumptions, and could lead to the overestimation of 340B units**. We urge the agency not to finalize the proposal for the Prescriber-Pharmacy or Beneficiary-Pharmacy Methodology and encourage CMS to work with stakeholders to identify ways to refine its methodologies to better capture Part D 340B drug units without adding undue burden or implementing new reporting mechanisms**.

Further, CMS outlines limitations of this methodology on 340B-eligible Aids Drug Assistance Programs (ADAPs) that collect rebates to receive 340B discounts instead of receiving those discounts at the time of purchase from a contract pharmacy registered in the 340B OPAIS database. (p. 32640). CMS is proposing to utilize these two methodologies at the same time the Health Resources and Services Administration (HRSA) announced a voluntary pilot program for a 340B rebate model for certain drugs beginning in 2026.[61] This creates additional questions and uncertainty around how the PDEs may be identified as 340B under these methodologies for drugs subject to these pilot rebate models. CMS should evaluate the effects the voluntary 340B pilot rebate program will have on a claims-based methodology to identify 340B units to remove from Part D inflationary rebates prior to implementing such a methodology.

Alternative Estimation Methodology

In last year's rulemaking, CMS proposed a methodology for excluding 340B drug units from Part D drugs in calculating inflationary rebates by using an estimation methodology.[62] Under this proposal, CMS would have estimated the number of 340B units that should be excluded from the inflationary rebate in an applicable period by applying an estimation percentage to the number of drugs expected to receive an inflationary rebate. The estimation percentage would be calculated at the national drug code (NDC) level and based on the number of 340B drug units for an NDC in the applicable period divided by the total number of drug units sold for the same NDC. However, this proposal was not finalized, and CMS stated in this year's proposed rule that they would no longer be pursuing this methodology at this time but may consider it in future rulemaking. (p. 32641). The AAMC has previously been supportive of this proposal and believes the estimation methodology is a better option than the Prescriber-Pharmacy or Beneficiary-Pharmacy methodology as it is more streamlined.[63] To that end, we urge CMS to re-consider implementing the estimation methodology in future rulemaking.

[61] 90 FR 36163 (Aug. 1, 2025).
[62] 89 FR 61596 (Jul. 31, 2024).
[63] AAMC, Comments on the CY 2025 Physician Fee Schedule Proposed Rule (Sep. 2024).

Voluntary Medicare Part D Claims Data 340B Repository

Lastly, building on the agency's CY 2025 Request for Information (RFI),[64] CMS is proposing to establish a voluntary 340B claims data repository. CMS intends to propose a policy to utilize the claims repository to identify 340B units at the claim-level to prevent duplicate discounts in the inflationary rebates in future applicable periods. The proposed claims-data repository would allow covered entities to retroactively submit data to CMS or to a CMS contractor on a quarterly basis**,** with data due three months after the end of a quarter. Only 340B claims covered under Medicare Part D during the reporting timeframe would be reported in the repository. CMS is proposing participation be voluntary but is also actively evaluating whether to make participation mandatory. (p. 32641). The AAMC previously shared comments in response to CMS' RFI, suggesting that an independent claims repository *could* be a viable and accurate option to identify 340B drug units.[65]

However, included in our response were several concerns we encourage the agency to address prior to implementing. These concerns included assurances the repository would be independent and free from conflicts of interest, protection for submitted data as well as other sensitive or proprietary information, limited use only for identification of 340B units for exclusion from Part D inflationary rebates, streamlined reporting, and ample time for covered entities to submit claims. **While CMS has addressed some of these concerns within their proposal, the AAMC believes additional guardrails are still needed to ensure the data collected is accurate, streamlined, and protected from other parties or used at a later date for alternative purposes.** The agency must thoroughly vet any third-party contractor that may be utilized to implement the proposed repository to ensure there are no conflicts of interest. Additionally, some covered entities may need more time than others to set up systems to report data. CMS should be flexible with the initial implementation timeline to allow for covered entities to work out any roadblocks in their efforts to submit accurate and complete data. We urge CMS to further evaluate the safeguards and assurances stakeholders need prior to requiring submission to the Medicare Part D 340B Claims Data Repository. The agency should work with stakeholders to ensure the implementation of a claims data repository is accurate and effective, while simultaneously minimizing burden or potential future harm on providers and all parties involved.

AMBULATORY SPECIALTY MODEL (ASM)

CMS seeks feedback on a proposed new Ambulatory Specialty Model (ASM) that would begin in 2027. (p. 32558) In this new model, CMS proposes to leverage components of the MIPS Value Pathways (MVP) framework for a mandatory physician payment model to increase specialist engagement in value-based care, focusing on two cohort conditions: heart failure and low-back pain.

The AAMC shares CMS' commitment to value-based care. The AAMC has long supported academic health systems participating in CMS models, including accountable care models and

[64] *Supra*, note 64 at 61971.
[65] *Supra*, note 55.

episode-based models. We are pleased that CMS is invested in improving the quality and value of care, and we appreciate the opportunity to offer feedback on the proposed new ASM.

Model Participation

Make Participation Voluntary

CMS proposes mandatory participation within the two cohort conditions (heart failure and low-back pain) with model participation tied to practice in a selected geographic regions and meeting episode cost-based measurement thresholds. (p. 32562). Many specialty physician practices do not have the resources and are not in a financial position to support the necessary investments and take on the financial risk to participate in a mandatory model. We recommend that CMS make the model voluntary for all participants and make other suggested modifications to the model included in these comments to incentivize participation in the model rather than remaining in MIPS. We strongly believe that practices will elect to participate in this model if they believe it will support the delivery of high-quality patient care and is not overly administratively burdensome.

Allow a Group Practice Participation Option in Addition to Individual Participation in the ASM

CMS proposes that model participation be at the individual level, based on individual tax identification number (TIN) and national provider identifier (NPI) combinations. (p. 32565) The AAMC supports CMS' efforts to better align primary and specialty care to increase care coordination and improve outcomes. Improving the transition from primary to specialty care and back is vital to ensuring that patients' experience of care is seamless. Often, this integration occurs in the context of and because of a health system. Indeed, when looking at MIPS reporting, few clinicians report individually, in part because it does not appropriately recognize team-based care and because it is incredibly burdensome.[66] Additionally, CMS has a policy goal of transitioning MIPS reporting to MVPs (or the APM Entity-based reporting through the APM Performance Pathway) and proposes policies "that would enable *groups* to self-identify their specialty composition and submit MVP data that appropriately reflects the broad range of services provided by the clinicians within the group." (p. 32698, emphasis added)

By only allowing participation at the individual clinician level in ASM, CMS artificially silos participants and does not set participants up for future success in subgroup reporting of MVPs following the end of the ASM. Instead, CMS should begin with the TIN/NPI level to identify participants who meet the model's participation criteria and then allow those NPIs within the same TIN to participate as a group practice. Allowing practices to coordinate participation in the model across impacted clinicians will reduce model reporting burden and better allow the model to support health system-based improvements to seamless care coordination between specialists

[66] CMS, 2023 QPP Results at a Glance, showing that nearly 70 percent of MIPS eligible clinicians participated through their group practice, and fewer than 10 percent of MIPS eligible clinicians participate as individuals.

and primary care. Forcing clinicians within a group practice to participate as individuals is antithetical to team-based care design necessary for success in value-based care.

Allow Clinicians Who Meet Qualifying Participant (QPs) Thresholds in Advanced Alternative Payments Models an Option to Participate in ASM Instead of Mandatory Participation

The AAMC strongly believe that clinicians who meet QP thresholds for their participation in advanced APMs (AAPMs) demonstrate sufficient specialist engagement in value-based care, and as such should have the option to participate in the ASM instead of being mandated to participate. Additionally, we recommend that CMS consider AAPM participation as a factor in geographic area selection, similar to its use of prior bundled payment model participation in selection regions for the Transforming Episode Accountability Model (TEAM).[67] This could help ensure that specialists who have already committed to participating in value-based care delivery are not overexposed to financial risk while ensuring that there are not driving double payments of savings (for example, contributing to shared savings in an ACO and achieving bonus payments through the ASM).

CMS Should Consider Methods to Recognize Non-Physician Practitioners Delivering Specialty Care for Engagement in Specialty Care Models

CMS notes that non-physician practitioners (NPPs) will not be able to participate in the ASM, as they do not have the necessary specialty designations in the provider enrollment system. (p. 32563). The AAMC believes this highlights a challenge with the inability to recognize specialty care delivered by NPPs, as NPPs increasingly specialize.[68] We encourage CMS to consider methods to better distinguish NPPs providing specialty care to beneficiaries to ensure that the agency can meaningfully engage NPPs in specialty care model design.

Model Payment Adjustments

CMS Should Reduce the ASM Redistribution Percentage to No More Than 5 Percent

CMS proposes the use of an incentive pool to redistribute funds from participants based on performance in the program, like the Hospital Value-Based Purchasing Program (VBP). Unlike the VBP, which is budget neutral (i.e., all money withheld from hospitals is redistributed), CMS proposes a 15 percent ASM redistribution percentage as a withhold for CMS savings. **The AAMC strongly encourages CMS to reduce the ASM redistribution percentage to a maximum of 5 percent to improve model financial incentives for ASM participants**. CMS could supplement savings to the Trust Fund via savings achieved through improved performance on the episode-based cost measures utilized in the model in comparison to those clinicians scored

[67] 89 FR 68986 at 69682 (Aug. 28, 2024), noting TEAM policy to stratify CBSA selection by a CBSA's past exposure to CMS' bundled payment models.
[68] Michelle Andrews, The Lure of Specialty Medicine Pulls Nurse Practitioners From Primary Care, KFF Health News (May 17, 2024), noting that increasingly nurse practitioners and physician assistants are joining cardiology, dermatology, and other specialty practices.

on the measures in MIPS. CMS notes that a key evaluation question is observing a reduction in Medicare expenditures in absolute terms. (p. 32626) This result could support a finding of cost savings sufficient for CMMI's policy goals.

ASM Risk Levels Should Align with MIPS Maximum Risk

CMS proposes to establish increasing financial risk for participants in the model over five years, starting with a 9 percent ASM Risk Level and increasing to 12 percent in the final performance year. The ASM Risk Level is used to calculate the ASM incentives for each ASM condition cohort, and is the maximum upside or downside risk to which an ASM participant would be subject to during an ASM payment year. CMS notes that the initial 9 percent risk level aligns with MIPS, but that increasing risk beginning in the third performance year "would provide an incentive for increased accountability." (p. 32609) **The AAMC strongly disagrees and believes that risk levels in a model designed off MIPS Value Pathways should not exceed the risk level in MVPs.** CMS notes that 9 percent is the applicable risk for MIPS payment adjustments in CY 2024, but fails to note that is the statutory maximum risk *indefinitely* in the program, and would only increase with Congressional intervention.[69] Additionally, because risk within ASM is concentrated within each ASM condition cohort, there is a greater likelihood of being subject to the highest negative payment adjustment relative to performance within the much bigger, threshold-based, risk pool of MIPS. This could lead to increased accountability as CMS posits, but could also lead to reduced access to care for Medicare patients suffering from low-back pain and heart failure as some ASM participants look to reduce exposure to payment penalties. Finally, clinicians participating in ASM will likely transition back to MVPs upon completion of the model and should have a steady risk level to support long term financial planning for that transition.

Model Performance Assessment

Quality Measure Set Should Remain Constant for the Duration of the Model Test

CMS states it does not intend to add or remove quality metrics from either ASM condition cohort's measure set for the ASM test period. (p. 32583) The AAMC strongly recommends against using untested quality metrics in mandatory models. We also recommend keeping a consistent set of quality metrics for supporting continuity and evaluating the model.

Performance on Improvement Activities and Promoting Interoperability Should Contribute Positively to an ASM Participant's Final Score

CMS proposes that Quality and Cost will each contribute 50 percent to an ASM participant's final score and that performance on Improvement Activities and Promoting Interoperability can only decrease a participant's final score. (p. 32598) This differs significantly from scoring in MIPS, where clinicians receive 15 percent of their total score from performance on Improvement

[69] Medicare Access and CHIP Reauthorization Act of 2015, PL. 114-10 (Apr. 16, 2015), stating that the defined applicable percent "for 2022, and subsequent years, 9 percent" and codified at 42 CFR § 414.1405(c).

Activities and 25 percent from Promoting Interoperability.[70] The AAMC believes that clinicians should have the opportunity to earn points towards their ASM final score based on their performance across all four performance categories, similar to their scoring under MIPS and MVPs. Demoting Improvement Activities and Promoting Interoperability to negative only categories, meaning that sufficient performance can only at best have zero impact on a participant's final score, sends a message to clinicians that they are not meaningful performance categories.

Make the First Model Year a Reporting Only Year to Allow Clinicians Opportunity to Understand Performance Measurement and Assessment in the Model

Beginning the model in 2027 is unlikely to be sufficient time for clinicians and groups to build out the necessary internal electronic health record reporting systems, clinician education, workflows, and alignment required for success in the model. To address this, CMS should implement PY 1 as a reporting-only year with no incentives or penalties to allow clinicians to build a baseline understanding of the model.

Small Practice Scoring Adjustment Should be Contingent on Adopting a Group Practice Participation Option

CMS proposes to allow ASM participants, proposed as individual clinicians, to be eligible for a small practice scoring adjustment to their final score if their practice consists of 15 or fewer clinicians. (p. 32603) Because the model is proposed as an individual clinician model, every participant is performing as a solo practitioner relative to reporting burden, performance management, and financial impact. However, we recommend that CMS allow group practices to participate in the model, so if CMS finalizes a group practice participation option, we believe a small practice scoring adjustment could be appropriate.

Waivers of Medicare Program Requirements

Exempt ASM Participants from MIPS by Classifying the Model as an Advanced APM

CMS proposes to waive ASM participants from participation in MIPS for any ASM performance year/ASM payment year in which they meet ASM participant eligibility criteria. (p. 32616) **The AAMC supports this exemption but encourages CMS to apply the MIPS exemption based on classifying the model as an advanced APM rather than through its waiver authority.** We believe this model would meet the requirements of an advanced APM through sufficient financial risk, assessment of quality performance, and requiring the use of certified electronic health record technology. This would mean that ASM participants who meet QP thresholds are not only exempt from MIPS, but also will receive the higher update to the PFS conversion factor in the relevant payment year.

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[70] 42 CFR §§ 414.1355(b) and 414.1375(a).

Provide Telehealth Flexibilities for ASM Participants

CMS proposes to waive the geographic site requirements of 1834(m)(4)(C)(i)(I) through (III) of the Act that limit Medicare payment for telehealth services, similar to waivers in TEAM and the Comprehensive Joint Replacement model and waive the originating site requirements of sections 1834(m)(4)(C)(ii)(I) through (VIII) to allow telehealth to be furnished in the ASM beneficiary's home or place of residence during the ASM episode. (pp. 32617-8) CMS proposes one deviation from TEAM and CJR – to allow ASM participants to bill established G-codes rather than model-specific sets of HCPCS G-codes to describe telehealth E/M services furnished to model beneficiaries in their homes. CMS believes establishing ASM-specific G-codes could be duplicative of existing G-codes and be burdensome for model participants. (p. 32618) The AAMC supports these proposals and appreciates CMS' consideration of potential burden and proposal to use existing codes on the Medicare telehealth list that may be furnished in the patient's home.

MEDICARE SHARED SAVINGS PROGRAM (SSP)

Quality Reporting

Revise the Definition of a Beneficiary Eligible for Medicare CQM Reporting

CMS proposes to revise the definition of a "Beneficiary Eligible for Medicare CQMs," which is a reporting collection type ACOs may use to report quality data for purposes of quality assessment in the SSP. Specifically, CMS seeks to better support ACOs in reporting Medicare CQMs by creating greater overlap with the list of patients assignable to the ACO. (p. 32675) **The AAMC agrees this modification would reduce burden and confusion for ACOs reporting Medicare CQMs and supports this proposal.**

Require CMS-Approved Survey Vendors to Administer the CAHPS for MIPS Survey Online Beginning with 2027 Surveys

CMS proposes to require CMS-approved CAHPS for MIPS survey vendors to offer the survey to patients via a web-based protocol in addition to phone and mail-based modalities. This proposal is in response to a prior request for information in last year's rulemaking cycle that found that stakeholders were largely supportive of such a change. If finalized, vendors would need to include the web survey mode costs as part of their publicly reported overall costs for administering the survey. (p. 32682) **The AAMC supports including web-based survey modalities to improve patient response rates.**

Beneficiary Assignment

Amend the Definition of "Primary Care Services" to Recognize Care Furnished Under Newly Proposed Codes.

CMS proposes to add three newly proposed services (GPCM1, GPCM2, and GPCM3) to the definition of primary care services it uses to identify primary care delivered on behalf of ACO professionals for beneficiary assignment and reflect changes that align with proposed changes to codes in the Medicare Physician Fee Schedule for CY 2026. (p. 32671) These additional services reflect services that are provided in conjunction with Advanced Primary Care Management services currently included in the definition. **The AAMC supports these proposed additions to the definition of primary care services, effective with PY 2026 ACO claims-based beneficiary assignment.**

Consider Methods to Distinguish NPPs Delivering Primary Care to Ensure ACO Assignment Meaningfully Reflects Primary Care Relationships with ACO Professionals

CMS has previously finalized a change to the assignment methodology to incorporate patients who receive the primary care services from non-physician ACO professionals when determining whether an ACO is responsible for a patient's care.[71] The AAMC strongly supports CMS efforts to develop policies that expand Medicare patient's access to accountable care. We also strongly agree that ACO assignment policy should recognize the valuable role that NPPs play in our health care system and primary care delivery. However, we are concerned that the current policy assigns beneficiaries who received specialized point-in-time care from ACO professionals during the assignment period but otherwise do not have long standing primary care relationships with the ACO. This is in part due to CMS' inability to differentiate between NPPs practicing primary care compared to those practicing specialty care as NPPs. When they enroll in Medicare, NPPs cannot report a specialty designation. Thus, beneficiaries that receive care from NPPs who are practicing as specialists may be assigned to an ACO, even if that beneficiary no longer has a primary care relationship with ACO professionals by the applicable performance period. Since finalizing this policy, we have heard from members considering ending their participation in the Program due to challenges specialty-focused care driving patient assignment. **We urge CMS to consider methods to better distinguish NPPs in primary care settings to ensure that assignment based on care delivered by NPP ACO professionals meaningfully reflects primary care relationships with the ACO.**

[71] 42 CFR § 425.20, specifically the definition of an Assignable Beneficiary, as amended in the CY 2024 PFS rulemaking cycle.

<u>Extreme and Uncontrollable Circumstances (EUC) Policies</u>

Modify Quality and Financial EUC Policies to Apply Where the ACO or APM Entity That is Affected by an EUC Due to a Cyberattack as Determined by the Quality Payment Program (QPP)

CMS proposes to revise the Program's EUC policies to determine quality and financial performance effective for performance year 2025 to recognize EUCs due to cyberattacks. (p. 32686) CMS notes the challenges ACOs could face in circumstances where a cyberattack interferes with the electronic health record systems, impacting the ACO's data quality and ability to meet the program's reporting requirements, and should not be held to a quality performance standard based on an inaccurate assessment of their patient's utilization of services. Thus, CMS proposes providing relief to the ACO by mitigating shared losses for the affected performance year as it does under the QPP. **The AAMC commends CMS for recognizing the challenges health care entities face regarding cyberattacks, including malware/ransomware, and how such challenges can be compounded when held to downside financial risk in an ACO.** We support finalizing this policy as proposed.

<u>QUALITY PAYMENT PROGRAM [IV]</u>

The AAMC appreciates the agency's efforts to continue to develop the Quality Payment Program (QPP) policies that more effectively reward high-quality care of patients and increase opportunities for Advanced APM participation. While we support the goals of the program to deliver high-value care for Medicare patients, we believe that significant refinements to the program are needed. **We encourage CMS to work with key stakeholders to identify longer-term policy solutions that would improve quality, access, patient outcomes, and reduce burden.** Our comments on the proposals in the rule related to the QPP follow.

MIPS VALUE-BASED PATHWAYS (MVPS)

Do Not Sunset Traditional MIPS Until Significant Conceptual and Operational Challenges with MVPs are Adequately Addressed

CMS established a new MIPS participation framework, referred to as MIPS Value Pathways (MVPs), in the CY 2020 rulemaking cycle.[72] CMS eligible clinicians have been able to meet MIPS reporting requirements through the MVPs since 2023. The Agency has indicated its goal to move away from Traditional MIPS and to have MVPs become the only method available to participate in MIPS in future years, potentially by 2029.

It is important for CMS to understand the unique challenges posed by the QPP for large multi-specialty practices such as those typically found in academic health systems. Physicians at AAMC member institutions are organized into large multi-specialty groups known

[72] CY 2020 Physician Fee Schedule, 84 FR 62568, at 62949 (Nov. 15, 2019).

as faculty practice plans, which often have a single TIN. Recent data shows that the practice plans range in size from a low of 315 individual NPIs to a high of 5,692 with a mean of 1,857 and a median of 1,479.[73] On average, these practices have over 137 adult and pediatric specialties and subspecialties, such as burn surgery, gastroenterology, and pediatric endocrinology, to name a few.[74] In some cases, faculty practice plans are highly integrated and make decisions about quality and care coordination as a single entity. In other instances, such decision-making occurs at the departmental or specialty level. Given the size of these practices and the numerous specialties that report under one TIN, we believe MVPs should remain optional for participating in MIPS.

With the large number of distinct specialties reporting under one TIN, it will be very challenging to identify MVPs that will be meaningful for the myriad specialties and subspecialties in the practice and encompass the scope of conditions treated in academic health systems. Mandatory reporting will require significant administrative capacity to identify appropriate MVPs, map out applicable subgroups, and track and report metrics across each MVP. An additional challenge for faculty practice plans will be tracking physicians who join and leave the practice throughout the course of the year, including transitions from residency to practice around July 1 each year. These shifts in practice add complexity for identifying which physicians should be included in a particular subgroup during a calendar-year based performance period. CMS must address these administrative challenges for large multispecialty practices before mandating MVP reporting.

Therefore, we urge CMS to continue to make MVP reporting voluntary for the foreseeable future. We have significant concerns with plans to sunset the traditional MIPS reporting option in future years, making MVPs, APM Performance Pathway, or qualified participation in Advanced APMs the only mechanisms for participating in the QPP. There are several conceptual challenges with the MVP program, and sufficient time will be needed to address them before sunsetting traditional MIPS. First, there must be enough clinically relevant measures available to create MVPs that are meaningful to the over one million eligible clinicians that participate in the MIPS path of the QPP. Given the numerous physician specialties and subspecialties, it will be difficult to create enough MVPs, especially within the next four years. Development of and refinement of existing MVPs to support required reporting will require significant input from physicians. **Practices should be given the opportunity to assess the advantages and disadvantages and select whichever option is most meaningful and least burdensome for participating in the QPP under MIPS.**

Ensure Comprehensive, Meaningful MVPs are Available to All Specialties and Sub-specialties

CMS proposes to adopt six new MVPs: Diagnostic Radiology, Interventional Radiology, Neuropsychology, Pathology, Podiatry, and Vascular Surgery. The AAMC supports the Agency's efforts to develop sufficient MVPs to meaningfully engage all specialties and sub-specialties, but we do not believe the portfolio of MVPs will meet that mark in the near future. Not all existing MVPs fully capture the clinical care delivered within the specialty and across

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[73] *Supra*, note 8.
[74] *Id.*

sub-specialties. For example, the Advancing Cancer Care MVP is predominantly focused on medical oncology and would not be meaningful for radiation oncologists, despite the name. Similarly, the Complete Ophthalmologic Care MVP has been improved upon, but the lone cost measure focuses on cataract care, leaving out specialists whose practice is entirely sub-specialized within retinal or glaucoma care. This says nothing of the challenges with MVPs for non-patient facing specialties, like radiology and pathology, who provide clinically significant services in a manner that is challenging to meaningfully measure under the MVPs framework. **CMS should retain traditional MIPS as a reporting option and invest in developing the comprehensive, meaningful measures needed to advance MVP adoption.**

Practices Must Have the Flexibility to Compose Subgroups for Reporting MVPs Based on Clinical Practice and Team-Based Care Patterns

Faculty practices are large multispecialty practices with a median of 1,574 clinicians, including physicians and non-physician eligible clinicians.[75] The care provided is team-based, often with collaboration across specialties. Non-physician practitioners (NPPs) are critical to care design within academic health systems and may rotate across specialties within the performance period to best serve patients. Claims-based subgroup composition restrictions might inadvertently limit full representation of team-based care and frustrate health system efforts to meaningfully report on the value of care delivered within their practices. While most MVPs are designed around a specialty, a few are designed around a condition that can cross specialties and be more appropriate for some specialists than the specialty-specific MVP. A couple of examples of such instances are the Advancing Care for Heart Disease MVP (cardiology, internal medicine, family medicine, as well as nephrology) and Advancing Rheumatology Patient Care MVP (internal medicine, family medicine, in addition to rheumatologists). **Given these dynamics, we strongly believe that rules for subgroup composition should be flexible to ensure practices can best report MVPs in ways that make sense for the clinical context of care delivered within their practice and that best represent team-based care delivery.** Requirements for the size of a given subgroup or limitations determined by the information available in claims data will likely hinder practice reporting administration without meaningful benefits to the agency when assessing performance.

RFI: Core Elements for MVPs

CMS seeks comments on a Core Elements policy that is being considered for CY 2027. Under this policy, MVP participants would be required to select one quality measure from a subset of quality measures in each MVP, referred to as "Core Elements." CMS' goal is to further emphasize and increase reporting on select quality measures to allow for more direct comparison between clinician performance data to better assess the care provided to patients. Measures selected as Core Elements are intended to reflect the care that is essential to each specialty. (p. 32701) CMS may consider Core Elements from the Adult Universal Foundation quality

[75] *Id*.

measures or the MVP's Advancing Health and Wellness quality measures subcategory, when possible.

The AAMC supports CMS' concept of creating a framework that would allow for comparative performance assessments within MVPs. However, as described, it is unclear whether this policy would support this aim. CMS refers to potentially identifying multiple measures within an MVP as Core Elements that could be selected to meet the single Core Element reporting requirement, which means there could be variation of measures within the MVP, reducing potential for performance comparisons. (p. 32702). We ask that CMS provide additional details to clarify how the Core Elements policy would be used to promote comparative data, and whether it might be more efficient to select a single meaningful measure to report within a specific MVP. For example, CMS could select one meaningful measure for the Advancing Cancer Care MVP, which all clinicians and subgroups participating in the MVP would be required to report. Additionally, a Core Element policy may improve comparisons within specialty by broadly reflecting care for condition/specialty, but is likely to exclude meaningful measure engagement from sub-specialists who are less likely to provide care that would be measured by the comprehensive Core Element measures. We ask CMS to address how a Core Element policy would meaningfully engage sub-specialists within subgroups in MVP performance comparisons.

RFI: Medicare Procedural Codes to Direct MVP Specialty Reporting

CMS seeks comments on a potential policy to utilize Medicare procedural codes to further facilitate more MVP specialty reporting. (p. 32702) Currently, MVP participants may select any MVP to report. (p. 32702) CMS is considering requiring clinicians to report a specific MVP based on the procedural codes that they bill as well potentially requiring specialists to report specific measures within an MVP. (p. 32702)

The AAMC strongly urges CMS not to move forward with any proposals to use procedural codes for MVP reporting assignments that limit opportunities to select MVPs that align with team-based care in a given practice. As discussed above, while most MVPs are designed around a specialty, a few are designed around a condition that can cross specialties and be more appropriate for some specialists than the specialty-specific MVP. A couple of examples of such instances are the Advancing Care for Heart Disease MVP (cardiology, internal medicine, family medicine, as well as nephrology) and Advancing Rheumatology Patient Care MVP (internal medicine, family medicine, in addition to rheumatologists). MVPs composition restrictions based on procedural codes billed might inadvertently limit full representation of team-based care and frustrate health system efforts to meaningfully report on the value of care delivered within their practices. For example, NPPs are critical to care design within academic health systems; however, in many cases NPPs bill for services under a physician or another billing practitioner. In these cases, when an NPP is not the billing practitioner, CMS will not have any information on their specialty-care practice and will not be able to meaningfully include them in appropriate MVPs.

Given these dynamics, we strongly believe that rules for MVP composition should be flexible to ensure practices can best report MVPs in ways that make sense for the clinical context of care delivered within their practice and that best represent team-based care delivery. Requirements for clinicians to report a specific MVP based on the procedural codes that they bill will likely hinder practice reporting administration without meaningful benefits to the agency when assessing performance.

RFI: Well-being and Nutrition Measures

New Well-being and Nutrition Measures Should be Valid, Reliable, and Meaningfully Represent Care Provided by Clinicians

The AAMC supports the agency in its efforts to improve well-being and nutrition in part through its quality measurement programs. We recognize the important role nutrition plays in the health and well-being of Americans. In general, we believe that new quality metrics should be endorsed by a Consensus-Based Entity as valid and reliable for the measured entity (i.e., valid and reliable for analysis of performance of acute and chronic conditions when considered for use in clinician measurement programs). In the case of new measures for well-being and nutrition, we believe that the metrics must be meaningfully connected to the delivery of high-quality care. Some measure concepts, while critically important to improving population health, may not be valid and reliable for clinician-level quality measurement and instead be better used in health plan or public health department quality measurement and improvement.[76]

Consider Measures that Encourage Providers to Gain Insights on Upstream Drivers of Health

Much of what influences an individual's overall health and well-being is outside the health care delivery system. Nonmedical upstream drivers of health, such as safe environments, access to nutritious food, and physical activity, greatly impact well-being. We recommend CMS consider measures for health care providers to drive improvements in well-being that encourage providers to gain greater insights into the nonmedical factors that are influencing their patients' and community's health.

ALTERNATIVE PAYMENT MODEL (APM) PERFORMANCE PATHWAY (APP)

CMS established the APM Performance Pathway (APP) for MIPS reporting and scoring for clinicians in MIPS APMs in the CY 2021 rulemaking. Clinicians in MIPS APM Entities may participate in MIPS using any available MIPS reporting pathway, including the APP, Traditional MIPS, and MVPs. Last year, CMS finalized the new APP Plus quality measure set based on the agency's Universal Foundation adult measure set. APM Entities other than Shared Savings

[76] For example, "Overall well-being – OHM-01" is a broad, global outcome measure as part HHS' Healthy People 2030 vision, but is intended for assessing well-being at the population-level and "Well-Child Visits in the First 15 Months of Life" is a well-being measure of care delivered in the ambulatory care setting that analyzes health plans and integrated delivery systems

Program ACOs have the choice to report the APP core quality measure set or the APP Plus quality measure set. For the APP core measure set, CMS proposes a substantial update to the Depression Screening and Follow-up Plan measure, mirroring updates proposed to the measure in the MIPS Quality Performance Category. (p. 33141) CMS also proposes substantial updates for the Breast Cancer Screening measure (p. 33162), the newly added Colorectal Cancer Screening measure (p. 33162), and the MIPS Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measure (p. 33155) for performance year 2026, mirroring updates to the measures as proposed for the MIPS Quality Performance Category. **The AAMC supports updates to these measures.**

RFI: Toward Digital Quality Measurement (dQMs) in CMS Quality Programs

CMS is seeking comments on the anticipated policy to the use of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) in electronic clinical quality measure (eCQM) reporting. CMS also requires feedback on the approach to eCQM reporting using FHIR in CMS Quality Programs (p. 32710- p.32715)

The AAMC supports a long-term goal of implementing a digital and interoperable quality measurement enterprise. Such an enterprise has great promise to improve patient outcomes and experience while also lessening quality measurement burdens for both health systems and the federal government. We also support the use of Fast Healthcare Interoperability Resources (FHIR), as this standard is internationally supported and easier to implement and more fluid than many other available frameworks. However, prior to adopting FHIR-based dQMs, we recommend CMS prioritize the adoption of data modernization guidance to ensure public and private infrastructure are well-equipped to support this shift in interoperable data reporting pathways necessary for successful FHIR-based reporting.

Each Measure Under Consideration for Transition to FHIR-based Measurement Should be Evaluated for Potential Benefits and Security Risks and Costs Prior to Proposing the Transition for Use in CMS Programs

The AAMC supports CMS dQM initiative's initiative to adopt self-contained measure specifications and code packages that can be transmitted electronically via interoperable systems. Though dQMs may be helpful for some quality measures to better assess public health and outcomes data, transitioning to dQMs for *all measures* may not warrant the risk and burden. Given that dQMs require additional considerations for compliance due to the specificity of information, we request the creation of regulatory frameworks to protect patient safety and privacy. **In choosing which quality measures to move to dQMs, CMS should formally evaluate the potential difference in performance and benefit that could be achieved and weigh it against the security risk and cost. If the impact of conversion to a dQM does not outweigh the burden for a given quality measure, we believe that conversion to FHIR-eCQMs may be sufficient.**

Publicly Share Information on Progress to Re-specify eCQMs to FHIR-based Measurement, Including Testing and Feasibility

CMS discusses efforts it is taking to convert current eCQMs to FHIR-based eCQMs using Quality Improvement-Core (QI-Core) Implementation Guides. This includes efforts undertaken through HL7 Connectathons and integrated systems testing. (p. 32712) The AAMC asks CMS to publicly share more on this effort, including information on real-world testing and feasibility of the FHIR-based eCQMs. We are concerned that only the most sophisticated health systems can engage with FHIR testing activities and may not be able to provide a comprehensive or representative sample of issues providers might face with implementing FHIR-based measurement. During the conversion from QRDA to FHIR, we underscore the importance of data validation to mitigate data gaps and inconsistencies, given that the outputs using QRDA and FHIR can differ even when using the same quality measure definition. Additionally, FHIR-based specifications for eCQMs should go through the measure endorsement process by a Consensus-Based Entity prior to their proposed adoption in CMS programs to ensure the measures, as re-specified, are valid, reliable, and feasible to report.

Ensure a Sufficient Timeline, Greater than 24 Months, for Transition to FHIR-based eCQM Reporting

Specific to timing, CMS asks whether a minimum of 24 months from the effective adoption of FHIR-based eCQM reporting option through ONC Health IT Certification Program criteria is sufficient time for provider implementation. Similarly, CMS asks if a two-year reporting options window is sufficient prior to mandating eCQMs be reported using FHIR-based methods. (p. 32713) The AAMC believes a longer timeframe will be necessary to support successful transition to FHIR-based eCQM reporting. Changes to ONC Health IT Certification Program criteria often take time to realize on the ground within the EHR and challenges with implementation are only compounded when these changes are needed to meet reporting requirements tied to Medicare funding. For example, CMS initially revised the specifications for the hospital-wide measures in the Inpatient Quality Reporting program to become hybrid EHR-based measures, without any direct tie to a CEHRT criteria change, with a two-year voluntary reporting period before transitioning to mandatory status. That voluntary reporting period had to be extended due to the challenges faced by those hospitals able to invest in voluntary reporting, and in the FY 2026 Inpatient Prospective Payment System rulemaking, CMS finalized policies to further reduce thresholds for reporting EHR-based data to ensure hospitals will be able to successfully report.[77] Based on this experience, we urge CMS to consider implementation and reporting requirement transitions greater than 24 months to ensure all providers, including individual clinicians and small physician practices, have sufficient time to successfully report FHIR-based measurement. We also advocate for flexibility in allowing health systems to choose whether or not to use the FHIR server for data extraction and calculations during this transition period.

[77] 90 FR 36536, 37025 (Aug. 4, 2025).

TRADITIONAL MIPS

Maintain MIPS Performance Threshold for the Foreseeable Future to Provide Stability for Clinicians

CMS establishes a performance threshold score that eligible clinicians must meet to avoid a negative payment adjustment. CMS proposes maintaining the MIPS performance threshold at 75 points for performance year 2028 through 2030. (p. 32698) **The AAMC supports maintaining the 75-point performance threshold beyond 2030 to provide stability for providers as they adjust to scoring the Cost performance category and reporting MVPs.** Additionally, we urge CMS to support any efforts in Congress that would allow CMS to have more flexibility to set MIPS performance thresholds based on current circumstances rather than a preset formula.

RFI: Future MIPS Performance Thresholds

CMS seeks feedback on potential changes to the performance threshold. CMS is considering the possibility of a single year or a multiple year update. CMS is also considering increasing the performance threshold based on data from a prior period which would provide larger positive MIPS payment adjustments for MIPS eligible clinicians with MIPS final scores higher than the threshold.

As discussed above, the AAMC recommends that CMS maintain the performance threshold at 75 points for the foreseeable future. However, for future policy considerations, we recommend that CMS consider threshold updates based on observed performance trends from previous years. This process should be flexible and allow for both increases and decreases to the performance threshold based on the identified trends. Any changes to the performance threshold should only occur after several years of data has been observed to ensure that trends are consistent and should be announced at least a year in advance to give practices time to adjust processes, if needed, to meet thresholds requirements. We urge CMS to avoid making any abrupt or significant changes to the threshold that might frustrate participation in MIPS.

MIPS Performance Category: Quality

Allow Measures Impacted by Limited Measure Choice to be Eligible for Full Points

For a topped-out measure, performance is considered so high and unvarying that meaningful distinctions and improvements in performance can no longer be made. If a measure has been identified as topped out for three consecutive years after being originally identified through the benchmarks, the measure may then be proposed for removal. CMS acknowledges that this is a problem for certain specialties facing both limited measure choice and limited scoring opportunities. To address this, CMS previously finalized a policy allowing measures impacted by limited measure choice to remain eligible for the full 10 points. This year, CMS has identified 19 topped-out measures that would be eligible to receive 1 to 10 points, if finalized, due to limited choice.

The AAMC commends CMS for identifying this issue, and we strongly support this proposal to address topped-out measures impacted by limited measure choice. Topped-out measures often remain clinically meaningful even with consistently high performance, especially for specialties with limited available measures. Specialties with limited measure sets should not be arbitrarily penalized in program scoring for maintaining high performance.

Amending Quality Performance Scoring Methodology

CMS proposes to modify the methodology for scoring the administrative claims-based measures beginning with the CY 2025 performance period/ CY 2027 payment year so that it would be based on standard deviation, median, and an achievement point value that is derived from the performance threshold. (p. 32760) **The AAMC supports the methodology changes so that performance rates near the 50th percentile measure do not receive a disproportionately low score.**

Provide Timely Benchmarks for Quality Metrics

CMS publishes data during the performance period setting benchmarks for quality measures, including information when a quality measure does not have a benchmark. The AAMC urges CMS to provide more timely benchmarks ideally in advance of the performance period or at least no later than the first quarter of the performance period for all active measures. And, if unable to set a benchmark for a given measure at such time, provide bonus points for providers who submit measures that lack benchmarks to encourage submission of the measure to be able to develop a future benchmark.

MIPS Performance Category: Cost

Create a Two-Year Informational-Only Feedback Period

CMS proposes implementing a two-year information-only performance feedback period on new cost measures. (p. 32720) New cost measures would be scored, but the score would not contribute to the final score during this period. (p. 32720) This policy would not apply to any existing cost measures finalized prior to the CY 2026 performance year/ 2028 payment year or cost measures modified after 2026 performance period/2028 payment year. (p. 32721) Cost measures within an informational-only feedback period can be included in an MVP if they are clinically relevant. (p. 32721) And CMS would not publicly report scores during the two-year information-only period. (p. 32721)

The AAMC strongly supports the creation of a two-year informational-only feedback period on new cost measures. As CMS notes, this period would allow for more timely and detailed performance feedback, which can be used to improve cost performance score. Currently, eligible clinicians do not receive feedback on cost measurement until partially through the second performance period in which the measure is in use (p. 32720). This delay prohibited eligible clinicians from making adjustments based on prior performance before the next performance period begins. The AAMC commends CMS for recognizing and addressing this issue by implementing the two-year informational period.

Modify the Total Per Capita Cost Measure to Better Reflect Care Delivered by NPPs Furnishing Specialty Care Excluded from Measurement

CMS proposes substantive changes to the Total Per Capita Cost (TPCC) measure by updating attribution rules and candidate events including removal of clinicians and their candidate events from attribution if the clinician is an NPP (e.g., NP, PA, or CCNS) and the other practitioners in their TIN are excluded by specialty criteria. CMS also proposes to require the second service used for a candidate event to be relevant and provided within 90 days of the first candidate event by a clinician within the same TIN, and both services must be provided by a clinician not excluded by specialty, ensuring a stronger ongoing care relationship. Currently, the measure does not exclude advanced care practitioners from attribution based on specialty. Therefore, NPPs that provide specialty care are evaluated on cost, even when physicians' care is excluded based on specialty designation

The AAMC supports this proposal to address attribution issues that arise for the TPCC measure because NPP specialty and subspecialty are not available as part of the Medicare Part B claims. We also support CMS' proposal to require the second service to be relevant and provided within 90 days of the first and be provided by a non-excluded specialty to promote a stronger ongoing relationship.

We strongly recommend that CMS consider addressing the lack of NPP specialty and subspecialty designations throughout the Medicare program. In general, we believe that CMS should distinguish NPPs in primary care settings and specialty settings to ensure that NPP care delivery is accurately reflected in Medicare program data and to ensure new care delivery payment models are able to meaningfully reflect NPP care delivery for patients.

Attribution for Cost Measures Should be Transparent and Accurately Reflect Patient and Clinician Relationships

It is critical that when measuring costs, there is an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that patients often receive care from multiple clinicians across several facilities and teams within a single practice or facility. The attribution method to establish care relationships and measure costs of care must be clear and transparent to clinicians. We suggest that better data sources and analytic techniques should be explored in the future to support more accurate attribution of these episodes.

Remove Costs of Preventive Services from Cost Measures

The AAMC recommends that CMS remove the cost of all Medicare-covered preventive services from cost measures to remove potential disincentives to furnish high-value care.

Potential savings from preventive services are unlikely to be realized during the performance period in which they are provided, setting up a potential penalty for clinicians seeking to expand the availability of such services. Previously, CMS noted its intention to expand coverage and access to preventive services, and the agency should ensure its pay-for-performance methodologies do not frustrate those policy aims.

All Cost Measures Should Account for Clinical Complexity and Upstream Drivers of Health

The AAMC recommends that all cost measures used in the MIPS program be appropriately adjusted to account for clinical complexity and upstream drivers of health. The episode cost measures are risk-adjusted based on variables such as age and comorbidities by using Hierarchical Condition Categories (HCC) data and other clinical characteristics. While the TPCC measure and the Medicare Spending Per Beneficiary (MSPB) measures are risk-adjusted to recognize demographic factors, such as age, or certain clinical conditions, these measures are not adjusted for other upstream drivers of health. In addition to differences in patient clinical complexity, upstream drivers of health can drive differences in average episode costs. Without accurately accounting for clinical complexity and social risk factors, the cost measure scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their performance will not be equitably reflected in MIPS scoring. The AAMC has long supported policies aimed at best using data to improve outcomes, in part by identifying the clinical and social factors influencing health. To this end we have supported the use of ICD-10 diagnostic codes, including Z-codes for upstream drivers of health, to best capture clinical and social context that can in turn inform appropriate risk adjustment models that will help transform our health care system away from fee-for-service payment towards paying for value. CMS has enacted policies to encourage providers to screen patients for upstream drivers of health and to utilize the information collected to inform patient-centered treatment plans and to connect patients with community-based resources, where appropriate. **We continue to urge CMS to adopt policies, including cost measurement methodologies, that incorporate ICD-10 codes inclusive of Z-codes to improve payment accuracy and reduce health disparities.** The use of Z codes will enable more robust risk adjustment, while also reducing burden on providers who are already familiar with capturing clinical factors through ICD-10 coding.

MIPS Performance Category: Promoting Interoperability

Reconsider Inclusion of the Security Risk Analysis Measure

A covered entity under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) must conduct a self-assessment of potential risks and vulnerabilities to the confidentiality, integrity, and availability of electronic protected health information (ePHI) and implement security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level[78]. The Security Risk Analysis measure currently only requires an attestation on whether the HIPAA covered entity has conducted and reviewed a security risk analysis. CMS

[78] 45 CFR part 160 and subparts A and C of part 164.

proposes modifying the Security Risk Analysis measure to require a second attestation for implementing security measures sufficient to reduce risks and vulnerabilities. (p. 32727) The AAMC strongly supports policies that promote cybersecurity best practices, but we question whether this measure does so, given that it is based directly on the HIPAA requirements implemented in the HIPAA Security Rule already imposed on covered entities. We urge CMS to remove this measure from the program as an opportunity to reduce burden of reporting and refocus PI Program measurement to drive improved interoperability and data sharing.

Update SAFER Guide Measure

The Safety Assurance Factors for EHR Resilience Guides (SAFER) measure was adopted 2022 performance year and requires clinicians to attest "yes" or "no" to whether they have conducted an annual assessment using the High Priority Practices Safer Guide at any point during the performance year. In performance year 2025, CMS finalized policy to require clinicians to attest "yes" for their response to count for completion of the measure, and a "no" response will result in a score of zero for the PI performance category. CMS proposes updating the SAFER Guide measure so that clinicians must use the 2025 version of the High Priority Practices SAFER Guides. **The AAMC supports CMS proposal requiring usage of the 2025 SAFER guidelines, which ASTP has updated and streamlined to focus on the highest risk, most commonly occurring issues that can be addressed through technology or practice changes to build system resilience.**

Adopt Optional Public Health Reporting Using TEFCA Measure

CMS proposes adopting the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) measure as an optional bonus measure under the Public Health and Clinical Data Exchange objective. The TEFCA framework supports nationwide health information exchange by connecting health information networks (HINs) across the country (p. 32715). The measure requires participation in the TEFCA framework as well as attesting to the transmission of electronic health information. **The AAMC supports adoption of the optional measure to promote public health reporting and effective data exchange.**

Adopt a Measure Suppression Policy

CMS propose to adopt a measure suppression policy to permit CMS to exclude a PI measure from scoring or the determination of a meaningful EHR user. This would allow CMS additional flexibility to determine whether a measure should be used to calculate scores or determine whether MIPS eligible clinicians meet the definition of a meaningful EHR. Specifically, this would address the impacts of uncontrollable changes that arise outside of rulemaking for a given performance period or EHR reporting period. (p.32732). As proposed, the measure must still be reported. **The AAMC strongly recommends that CMS finalize the measure suppression policy to account for unforeseen, uncontrollable events that might impact PI scoring.**

Suppress the Electronic Case Reporting Measure

CMS proposes to exclude the Electronic Case Reporting (eCR) measure from scoring for CY 2025 performance period/2027 MIPS payment year due to the CDC's temporary pause on onboarding health care organizations that produce and receive electronic case reporting data. Currently, there are eight measures under the Promoting Interoperability performance category Public Health and Clinical Data Exchange objective, including the required measure eCR (p. 32734) The eCR measure requires eligible clinicians to demonstrate active engagement to public health agencies from EHRs to public health agencies in order to promote fast, accurate response to public health events (p. 32726) Due to the CDC's temporary pause, it may not be possible to satisfy the eCR requirements by the end of the CY 2025 performance period. **Therefore, the AAMC strongly recommends that CMS finalize its policy to exclude the eCR measure from scoring for CY 2025 performance period/2027 MIPS payment year.**

RFI: Regarding the Query of Prescription Drug Monitoring Program (PDMP) Measure

> *Changing the Query of PDMP Measure from an Attestation-Based Measure to a Performance Based Measure in the Future in Line with ONC Adoption of Certification Criterion to Better Support PDMP Interoperability*

CMS is seeking information on whether to change the Query of PDMP measure to a performance-based measure to further promote the utilization of PDMPs and support appropriate prescribing practices. (p. 32747) The AAMC supports improved interoperability measure concepts to improve patient care and ensure legitimate prescribing of controlled substances. One barrier to a performance-based Query of PDMP measure is ensuring all CEHRT products adopt and use the "PDMP Databases – Query, receive, validate, parse, and filter" certification criterion proposed (but not yet finalized) by ONC.[79] If finalized by ONC as a certification criterion, we believe this will greatly improve providers' ability to report a performance-based PDMP query measure. However, we note that it would likely be several years before all certified EHRs would be ready to deploy the criterion and then require a period of transition for clinicians to adapt to performance-based measures. Additionally, there is ongoing work to establish a national PDMP to more effectively support data collection and analysis towards the Drug Enforcement Administration's anti-diversion efforts for controlled substances. CMS should consider the government's timeframe for implementing a national PDMP,[80] and align it with the implementation timeframe before changing the Query of PDMP measure to a performance-based measure.

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[79] 89 FR 63498, at 63547 (Aug. 5, 2024)
[80] 90 FR 6541, at 6543 (Jan. 17, 2025), describing a proposed nationwide PDMP check that would be delayed in effective for three years, based on development of such a nationwide PDMP capability.

Evaluate Future Modification of the Query of PDMP Measure to Include All Schedule II Drugs in Line with State PDMP Capabilities and Broader Policy Goals of Adopting a Nationwide PDMP

CMS is seeking information on whether to revise the measure to include all Schedule II Drugs, rather than only focusing on Schedule II opioids. (p. 32750) The AAMC supports further investigation of an expanded PDMP measure. As CMS notes, most states (but not all) collect data on Schedules II, III, and IV drugs that are prescribed. (p. 32751) Providers in states that do not collect expanded data across all drug Schedules will likely need more time to develop capacity and readiness for expanded PDMP checks once supported in their state. CMS should ensure all states are able to collect data on all Schedule II drugs before expanding the measure in the PI Program. As previously noted, there is ongoing work to establish a national PDMP.[81] CMS should consider the government's timeframe for implementing a national PDMP, and whether that timeframe might be best aligned with a modification of the Query of PDMP measure to include all Schedule II drugs. That extra time to implement could align with the time necessary to evaluate the potential unintended consequences of measure expansion, including creating barriers for patients appropriately prescribed Schedule II non-opioid drugs, such as central nervous stimulants to treat ADHD.

RFI: Performance-Based Measures

The AAMC strongly supports efforts to modernize public health through advancing data science capabilities. Improving public health interoperability is key not only for the health of individual patients but also for the wellbeing of entire communities. The ability to exchange public health data efficiently between hospitals, health systems, and state/local public health entities is vital for addressing large-scale health challenges, such as pandemics, vaccination programs, and tracking public health trends. Improved public health data and data sharing directly influences the collective health and safety of communities and the nation. We urge CMS and ASTP/ONC to continue to collaborate with the Centers for Disease Prevention and Control (CDC) on efforts to improve public health interoperability, including efforts to understand limitations with underfunded state and local public health departments and their underlying public health technology infrastructure to ensure that our public health agencies have the capabilities needed to work with providers to improve public health interoperability through updated health IT module certification requirements. These standards and public health agency capabilities are critically important steps that must be successfully taken prior to holding providers accountable for performance-based measures on exchanging clinical data with public health agencies as part of the PI Performance Category.

Rather than transitioning all measures in the Public Health and Clinical Data Exchange Objective to performance-based measures, we recommend that CMS focus on one or two measures as test cases, potentially the antimicrobial use and resistance (AUR) Surveillance Reporting measure. Current infectious disease public health reporting measures for AUR are largely focused on

[81] *Id.*

surveillance, tracking the rates of prioritized infections, antimicrobial use, and antimicrobial resistance in hospitals. While this information is relevant, these measures often do not drive meaningful change in the quality-of-care that patients with infections receive. We suggest the development of a new performance-based quality measure that catalyzes improvement in antimicrobial stewardship efforts.

The data modernization efforts at the CDC, including the Data Modernization Initiative (DMI) and Public Health Data Strategy (PDHS), are critical to reducing AMR. While the PDHS lays out important strategic steps, DMI serves as the vehicle for innovation and improvement in data collection. Since 2019, some progress has been made to accelerate modernization through federal policies, data standards, and system interoperability. CDC modernization efforts must continue to be prioritized in tandem with measure restructuring to lower administrative and provider burden. These efforts will allow for the development of report cards for providers to benchmark progress against national averages, driving improved care.

RFI: Data Quality

ASTP/ONC has worked diligently in the last several years to improve interoperability through the implementation of (and updates to) the United States Core Data for Interoperability (USCDI) standards. **The AAMC supports policies to improve the widespread adoption of updates to the USCDI, and we recommend that CMS and the ASTP/ONC commit resources to addressing semantic differences across health systems when implementing data standards under the updates to the USCDI.** Data standardization is critical for interoperability, and we believe that the USCDI is a key to such standardization. However, we have heard from members that data standardization alone has not yet moved the needle for improving interoperability of health information to improve care delivery due to semantic differences by health systems when implementing data standards. As an example, the AAMC leads Project CORE: Coordinating Optimal Referral Experiences through implementation of electronic consultations through tools built into the EHR. Our experience working with member academic health systems through Project CORE has highlighted significant interoperability issues across systems, even in cases where they are operating within the same platform or using the same EHR tools developed by the same EHR vendor. For example, a call at one institution for the value of a white blood count lab may return the value but using the same vendor platform (or a FHIR application programming interface) to call at another institution might not result in a returned value due to semantic inconsistency. Currently, there are no feedback loops to address such inconsistencies in the implementation of normative standards across the nation. ASTP/ONC could support broader semantic standardization through the development of national and regional user groups that provide feedback loops on semantic differences, helping to serve as a mechanism for truly normalizing national data standards into clinical practice. Additionally, ASTP/ONC support for broader adoption and implementation of standard ontologies with quality assurance processes (i.e., LOINC, RxNorm, SNOMED, etc.) may help improve semantic differences between health systems.

ADVANCED ALTERNATIVE PAYMENT MODELS (AAPMs)

If an eligible clinician participates in an Advanced APM and is a qualifying APM participant (QP) or a partial qualifying APM participant (partial QP), the MIPS reporting requirements and payment adjustment do not apply to that clinician. For payment years 2019-2024 (performance years 2017-2022), QPs received a 5 percent APM incentive payment, for the 2025 payment year (2023 performance year), QPs received a 3.5 percent APM incentive payment, and for the 2026 payment year (2024 performance year), QPs received a 1.88 percent APM incentive payment. Beginning with payment year 2027 (performance year 2025), there is no further statutory authority for an APM Incentive Payment. However, for payment year 2026 (performance year 2024) and beyond, clinicians in AAPMs have the opportunity for a 0.75% update to the CF, while those not in AAPMs would receive a 0.25% update.

We are deeply concerned that the expiration of the AAPM incentive payment will have a chilling effect on participation in APMs. We urge CMS to include in its legislative agenda support for the continuation of the AAPM bonus. If Congress does not act to extend the bonus, we urge CMS to take administrative actions within its authority that would mitigate the effects of the expired bonus. This could include changes to benchmarking, increasing shared savings opportunities, reducing the administrative burden, allowing more flexibility, and allowing longer transitions for APMs to downside risk.

Add a QP Determination at the Individual-level for All Advanced APM Participants

As stated above, CMS has set forth thresholds that must be met for clinicians participating in Advanced APMs to become APM Qualifying Participants (QPs) to receive payment incentives. In order to receive a QP determination under an Advanced APM, an eligible clinician must appear on the APM Entity Participation List on one of the official snapshot dates on March 31, June 30, or August 31. (p. 32769) If a clinician is not listed on a snapshot, they do not receive a QP determination for that APM Entity, and CMS will not make an individual determination. (p. 32769) However, if a clinician is listed under multiple APM Entities but does not achieve QP status at the entity level, CMS will make individual QP determinations. (p. 32769)
Under current policy, an eligible clinician who is fully engaged with an Advanced APM may still be unable to earn QP status which may ultimately discourage Advanced APM participation. CMS notes that clinicians in condition-specific or episode-of-care focused models are most disadvantaged when the APM entity fails to achieve QP status. To remedy this CMS proposes adding an individual-level QP determination for all Advanced APM participants to increase flexibility. Specifically, CMS would calculate a threshold score for each NPI based on all covered professional services furnished across all Tax Identification Numbers (TINs) to which the eligible clinician has reassigned their billing rights. **The AAMC strongly recommends that CMS finalize the proposal to make two determinations of whether the QP thresholds are met by calculating thresholds at both the APM entity level and the individual level to encourage Advanced APM participation. If either QP determination exceeds the relevant threshold, the eligible clinician should be considered a QP.**

Amend the Definition of an Attribution Eligible Beneficiary for Purposes of Assessing QP Thresholds

Current policy limited attribution-eligible to those patients who had at least one E/M service furnished by an eligible clinician participating in an APM Entity during the QP Performance Period. In CY 2025, CMS proposed to amend the definition of an attribution-eligible beneficiary at § 414.1305 for purposes of making QP determinations.[82] CMS did not finalize the policy and is now once again proposing to amend the definition. Specifically, CMS proposes to revise the definition to any covered professional service to more accurately reflect eligible clinicians' actual participation in Advanced APMs (p. 32772)

The AAMC strongly recommends that CMS finalize the proposed policy to define an attribution-eligible beneficiary as any covered professional service to more accurately reflect eligible clinicians' actual participation in Advanced APMs. We agree that this would be better aligned with the QP determination methodology with the universe of services to which the QPP applies, rather than the subset of E/M services. As noted by CMS, E/M services tend to be furnished at a higher proportion by primary care practitioners than specialists for the same patient, and by narrowly measuring patients through E/M services, CMS might have inadvertently encouraged APM Entities to reconsider the inclusion of specialists in APM participation.

Encourage Congress to Enact Retroactive legislation to Freeze QP Thresholds or Grant Authority to Set Thresholds at a Level That Would Encourage Participation in APMs

To be classified as a qualifying participant (QP) or partial QP in an AAPM, providers must meet or exceed thresholds based on patients seen or payment received for services provided through AAPMs. Congress established these thresholds in the Medicare Access and CHIP Reauthorization Act of 2015, setting a higher threshold in order to be considered a QP.[83] Increased thresholds would have made it much more difficult for an eligible clinician to be considered a QP and to receive the 5% bonus payment in 2023. Congress recognized this problem and addressed it in the Consolidated Appropriations Act, 2022 which froze the thresholds for payment years 2023 and 2024 at the 2021 and 2022 payment year levels. The Consolidated Appropriations Act, 2023[84] froze the thresholds for an additional year through payment year 2025, and again through the Consolidated Appropriations Act, 2024, through payment year 2026.[85]

Without action from Congress, thresholds automatically increased on January 1, 2025, with QP status now requiring at least 75% of their revenue in the Medicare FFS program received through a Medicare APM, or 50% of their Medicare FFS patients would need to receive services through

[82] *Supra*, note 22 98346.
[83] *See* Section 1848(q)(1)(C)(ii)(I) of the Social Security Act, as amended by The Medicare Access and CHIP Reauthorization Act of 2015 (Pub. L. 114-10).
[84] Consolidated Appropriations Act, 2023; Pub. L. 117-328 (Dec. 2022).
[85] Consolidated Appropriations Act, 2024; Pub. L. 118-122 (Mar. 2024).

the APM. We are deeply concerned that this increase will discourage Advanced APM participation, thereby limiting beneficiary access to high-quality and high value care. It is very difficult for APMs to increase the volume of payments received through the APM or amount of Medicare FFS patients who receive services through the APM, due to intentional attribution design within the models. For example, episodic models attribute patients based on a triggering procedure, and ACOs attribute patients specifically based on receipt of primary care services. **We urge CMS to encourage Congress to decrease QP thresholds, or, at a minimum, give CMS the authority to set thresholds in the future at a level that will incentivize participation in advanced alternative payment models.**

CONCLUSION

The AAMC appreciate your consideration of the above comments. We would be happy to work with you on any of the issues discussed above or other topics that involve the academic medicine community. Please contact my colleagues Gayle Lee (galee@aamc.org), Phoebe Ramsey (pramsey@aamc.org), and Ki Rosenstein (krosenstein@aamc.org) with any questions about these comments.

Sincerely,

Jonathan Jaffery, MD, MS, MMM
Chief Health Care Officer
AAMC

Cc: David Skorton, MD, AAMC President and CEO