AMA
AMERICAN MEDICAL ASSOCIATION

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The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1848-P. Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the physician and medical student members of the American Medical Association (AMA), I appreciate the opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2027 Notice of Proposed Rulemaking (Proposed Rule) on the revisions to Medicare payment policies under the Medicare Physician Payment Schedule (PFS) and Quality Payment Program (QPP), published in the Federal Register on July 16, 2026.

EXECUTIVE SUMMARY

The PFS is the only major Medicare payment system not subject to an automatic, inflation-based annual update. The cumulative effect of that omission is substantial. Between 2001 and 2026, Medicare physician pay increased only 10 percent while the cost of operating a medical practice increased 63 percent. Adjusted for those practice cost increases, Medicare physician pay declined 33 percent over that period. Medicare hospital payment systems, by contrast, were updated by over 80 percent during the same years. Congress has provided temporary relief in five of the last six years, but each of those adjustments has expired on its own terms. With the expiration of the most recent 2.5 percent update at the end of CY 2026, physicians will once again see a net reduction to their Medicare payments for CY 2027, unless Congress intervenes—even as CMS' own projections show the Medicare Economic Index rising by 2.5 percent.

Physician practices that have absorbed a quarter century of erosion simply cannot weather additional cuts. Yet this rule advances several significant redistributive changes at once, and their combined effect falls hardest on the practices least able to absorb it. Small, independent, and rural practices operate on the thinnest margins, and for some, these changes would mean being paid less than it costs to deliver care, which could accelerate the consolidation and loss of access that CMS itself says it wants to prevent. The AMA shares CMS' goal of sustaining independent practice, but that goal cannot be reconciled with finalizing these policies without first understanding whom they harm.

That concern runs through many of the most consequential proposals in this rule. Repeatedly, CMS advances significant, redistributive changes without providing either the evidence needed to justify them or the disaggregated impact estimates needed to appropriately evaluate them. The practice expense methodology is the clearest example: CMS proposes four major, interrelated changes but publishes only aggregate specialty-level impact estimates, leaving physicians unable to see how any single proposal affects their own specialty or codes. This includes changes that are not supported by, and in some cases run contrary to, the analyses CMS itself commissioned, and CMS declined to use the updated Physician Practice Information Survey data the AMA provided in January 2025, precisely the kind of current data its own prior research recommended. **Before finalizing changes of this magnitude, we urge CMS to pause, collect the necessary data, publish the underlying analyses including specialty-level impact estimates, and continue to engage with the physician community.**

We are particularly concerned about the following proposals:

- **Payment reduction for services furnished with a separately identifiable E/M visit (modifier -25).** CMS proposes to reduce payment by 50 percent when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) service reported with modifier -25 is furnished on the same day as a procedure with a 000-, 010-, or 090-day global period. CMS proposed a similar policy in 2019 and withdrew it after stakeholders raised serious concerns; this version would apply to even more procedures. CMS offers no evidence that duplication exists or of its magnitude, and its request for comment on alternative percentages suggests the 50 percent figure is not derived from data. Such overlaps in value have already been removed for the services typically furnished together through the misvalued code initiative and the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) valuation process, which expressly excludes work associated with a separately identifiable E/M service. Any residual overlap sits largely in pre-service time, yet CMS would cut the entire lower-valued service, including work, practice expense, and professional liability. We are also concerned about the magnifying effects of CMS finalizing such a policy, that once established, would be extended to other services and adopted by private payers. **CMS should not finalize this flawed policy and should instead address any genuine overlaps in valuation on a code-specific basis.**

- **Changes to the practice expense (PE) methodology.** CMS proposes four distinct and interrelated changes to the PE methodology but has not published the per-proposal, specialty-level impact analysis needed to evaluate any of them, and they come on top of the CY 2026 facility reductions, which cut facility-based payment by seven percent overall and considerably more for some specialties and physicians. **Given their redistributive effect and the absence of supporting analyses, CMS should defer these proposals until specialty-level impact estimates are published for each, and phase in any resulting change over multiple years.**

- **Cuts and new restrictions on remote monitoring services.** Citing a lack of data on the typical device used and recommendations made by the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG), CMS proposes to reduce practice expense relative value units (RVUs) for remote monitoring services and to eliminate all direct practice costs for the treatment management codes, producing substantial 2027 payment reductions, often at the 19 percent statutory limit. In addition, its proposal to bundle 19 remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) codes into four new G-codes would sharply reduce coding specificity and, because the cap does not apply to new codes, impose full payment cuts all at once in 2027. In direct response to CMS' concerns over lack of data, the RUC has moved its review of the RPM and RTM codes up to January 2027. **The AMA strongly urges CMS to pause the proposed reductions and establishment of G-codes while this data**

is gathered. CMS also proposes a new initiating visit requirement and restricting these services to only being delivered by practice-employed staff, which could significantly reduce the availability of remote monitoring services. **CMS should not impose any new regulatory burdens on physicians associated with the requirement for a separately reportable initiating visit and should not finalize its proposal to restrict the provision of these services to staff employed by the practice**.

- **Ambulatory Specialty Model (ASM).** The AMA supports the concept of a specialty model that focuses accountability on the services participating physicians deliver, and we appreciate that several proposed refinements respond to our previous recommendations. However, CMS did not adopt several fundamental changes we identified as necessary including raising the redistribution percentage from 85 to 100 percent, setting performance thresholds prospectively so physicians know what success requires, and reducing the maximum risk level in the first two years from nine percent to two percent. As proposed, ASM would still exclude most physicians who manage these patients while mandating participation by specialists who may see such a patient once, rely on an untested measure that penalizes physicians for services they did not order or deliver, and reduce payments for small practices that are unable to submit patient-reported outcome data. **The AMA is concerned that ASM implementation in 2027 under the current or proposed rules would have serious negative consequences for Medicare patients and physicians.**

- **Mandatory transition to MIPS Value Pathways.** The AMA strongly opposes sunsetting traditional Merit-based Incentive Payment System (MIPS) and requiring MIPS Value Pathways (MVPs) reporting beginning in 2030. MVPs have been built around physician specialties and broad categories of health problems rather than the specific conditions a given clinician treats, so they yield inaccurate comparisons across subspecialties. Additionally, significant measure gaps remain, some specialties have no applicable MVP, and CMS has not explained what becomes of existing MIPS measures that do not appear in any MVP. **CMS should incentivize MVP reporting rather than mandate it, and close these critical gaps, before it considers proceeding with mandatory MVPs.**

- **Restriction of Alternative Payment Model (APM) incentives to APM-participating taxpayer identification numbers (TINs).** CMS proposes to apply APM Incentive Payments and the differing conversion factor update for qualifying APM participants only to claims associated with NPI/TIN combinations that include Advanced APM-participating TINs. We believe this change would exceed CMS' authority under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), add unnecessary complexity and confusion, and diminish future incentives to join APMs, particularly for specialty, small, rural, and independent practices that CMS is working to recruit into APMs. Accordingly, **we urge CMS not to finalize this proposal.**

- **Annual inflation-based payment update.** We urge the Administration to bring Medicare physician payment updates more in line with rising practice costs by supporting congressional action to enact a permanent, inflation-based update tied to the Medicare Economic Index, including through the Patients First Act (H.R. 9693).

We thank CMS for their attention to these critical issues and offer more detailed comments on these and other proposals in the comments that follow.

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I. UPDATES TO PAYMENT PROVISIONS

A. CY 2027 Medicare Conversion Factors

The AMA appreciates that CMS proposes to implement the statutory updates required under section 1848(d) of the Social Security Act, as amended by MACRA, together with a positive 0.53 percent budget neutrality adjustment reflecting proposed changes in work RVUs. We are deeply concerned, however, that these positive updates are more than offset by the expiration of the one-year 2.5 percent update that Congress provided for 2026. As a result, under current law, physicians would face a net Medicare payment cut in 2027. CMS proposes a qualifying APM conversion factor of $33.17, a decrease of 1.19 percent from 2026, and a nonqualifying APM conversion factor of $32.84, a decrease of 1.68 percent from 2026. In short, physicians are facing yet another year in which Medicare payment goes down while practice costs continue to climb.

Physicians continue to strongly advocate to Congress for permanent updates to the conversion factor that account for the growth in physician practice costs. The recurring pattern of temporary, expiring patches underscores why a one-year fix is no substitute for a durable, inflation-based update. Despite temporary updates in five of the last six years, Medicare physician payment has continued to erode as economic pressures on physician practices, including rising costs of rent, wages, supplies, and administrative burdens, have intensified. Between 2001 and 2026, Medicare physician pay increased only 10 percent, or 0.4 percent per year on average, even though the cost of operating a medical practice increased 63 percent, or 2.0 percent per year on average. When adjusted for inflation in practice costs, the picture is even more stark: Medicare physician pay declined 33 percent from 2001 to 2026, or 1.6 percent per year on average. In contrast, hospitals have received far more robust payment updates over the same period. Medicare hospital updates totaled approximately 85 percent, or 2.5 percent per year on average, with inpatient services increasing by 87 percent and outpatient services by 84 percent. CMS projects that the Medicare Economic Index (MEI) will increase by 2.5 percent for 2027, yet statutory updates for physician payment fall far short of that benchmark, widening the gap between payment and the cost of delivering care.

Inadequate physician payment has real-world consequences, accelerating the trend toward consolidation of independent physician practices and worsening seniors' access to care. These pressures are not borne equally. Small, independent, and rural practices, which operate on the thinnest margins and lack the scale to absorb administrative and input-cost increases, are least able to withstand another year of declining payment, and specialties with higher practice expenses are disproportionately exposed, as fixed statutory updates fail to track their rising costs. The bifurcated conversion factor further magnifies these disparities: physicians unable to participate in qualifying APMs, often because no suitable model exists for their specialty or practice setting, absorb a steeper reduction than their qualifying participant (QP) counterparts, compounding the payment differential over time.

To protect Medicare for the next generation, we urge the Administration to support congressional action to enact permanent, inflation-based updates for physician payments tied to the MEI. We specifically support the Patients First Act (H.R. 9693), which would establish an annual MEI-based update, reform budget neutrality, replace the Merit-based Incentive Payment System, improve APM incentives, and create a new primary care payment pilot outside of budget neutrality. The need for this reform is reinforced by independent expert bodies. In its 2026 report, the Medicare Payment Advisory Commission (MedPAC) recommended increasing payment rates for physician services to bring fee-for-service (FFS) Medicare payment levels closer in line with providers' costs. The 2026 Medicare Trustees Report likewise warned that the current MACRA structure raises long-range concerns that will almost certainly need to be addressed through future legislation. The Trustees cautioned that physician payment updates do not account for or vary with underlying economic conditions and are not expected to keep pace with increases in physician practice costs. Absent changes to the delivery system or payment updates

through subsequent legislation, the Trustees expect beneficiary access to Medicare-participating physicians to become a significant issue in the long term.

B. Determination of Practice Expense (PE) Relative Value Units

The AMA supports a Resource-Based Relative Value Scale (RBRVS) grounded in accurate, current data that reflect the resources actually incurred to furnish services, including differences across settings and practice arrangements. Resource-based relativity has been a foundational principle of the PFS since its inception. Consistent with that principle, the AMA has welcomed and supported CMS' recent efforts to update key practice expense inputs including clinical labor, supply, and equipment pricing.

We are concerned, however, that several practice expense and related proposals over the past two rulemaking cycles move in the opposite direction of a resource based, data driven approach. These proposals replace specific data inputs with broad, round-number methodological adjustments whose empirical basis is not established in the rulemaking. In several instances, these adjustments also diverge from the analyses CMS itself commissioned. For example, the multi-phase RAND practice expense studies recommended developing improved and recurring data sources rather than eliminating data-driven components of the methodology. Similarly, the RAND analysis underlying the proposed indirect allocator proposal modeled a policy that did not include the 010- and 090-day global exclusion CMS now proposes. Moreover, updated Physician Practice Information (PPI) Survey data, collected by the AMA through a multi-year effort and provided to CMS in January 2025, offer current, specialty-level practice-cost information of the type that several of these proposals assert is lacking.

Changes of this significance should be grounded in robust empirical evidence. We therefore urge CMS to rely on the best available data before making fundamental changes to the PE methodology, and we support the RUC's willingness to work with CMS to that end.

Proposed Modifications to the PE Formula

Recommendations:

- CMS should postpone implementation of these practice expense proposals until a future rulemaking cycle in which a granular specialty impact analysis may be published for each distinct proposed change in the practice expense methodology.
- CMS should work with the AMA to consider how the 2024 PPI data could be used in the future to reflect changes in physician practice cost and physician hours worked.
- CMS should implement the proposal to continue to use the 2006-based MEI cost shares for CY 2027 until the 2024 PPI data can be considered.

The AMA appreciates that CMS published the Practice Expense (PE) Relative Value Unit (RVU) Algorithm on the CMS website. The PE formula is complex, and changes can have significant redistributive effects across services and specialties. Therefore, full transparency is required to ensure that stakeholders have all relevant information available to meaningfully comment on proposed methodological changes. We encourage CMS to consider providing additional supporting materials, including utilization crosswalk files between the current and previous years, restoration of key utilization file fields (such as undiscounted allowed services and PE, PLI, and work discounted allowed services, complete modifier column), documentation of any scalar adjustments applied to indirect scaling adjustments or other steps throughout the rate-setting process, identification of codes with professional and technical components that do not use TC or PC/26 modifiers, and identification of any codes whose RVUs are assigned outside the standard rate-setting process.

For CY 2027, CMS is proposing four major changes that impact the indirect PE methodology as follows:

(1) Utilization: Utilization is a significant driver in the PE methodology, both in developing the pools of available PE RVUs and in determining the specialty mix of a particular CPT code. Utilization has historically been adjusted to account for modifiers, payment rules (such as the multiple procedure payment reduction), and geographic mix. For 2027, CMS proposes a new approach to account for these items by calculating the ratio of allowed charges to the national PFS payment amount for each claim line. CMS would also use this approach to adjust time within the PE methodology.

CMS states that these proposed changes have "a very minimal impact on the resulting PE RVUs." However, CMS does not publish a separate impact analysis demonstrating how this proposal impacts individual codes or specialties. CMS does publish a utilization file online that shares the newly discounted utilization. Within this file, and within the allowed charges included in the published specialty impact table, these data indicate significant utilization changes for pathology, independent laboratories, and physical/occupational therapy. However, it is not evident how these dramatic changes in utilization impact these specialties and others within the PE methodology.

(2) Indirect PE Allocation: Expand the allocation of indirect PE to utilize the sum of both work RVUs and clinical labor (rather than the greater of the two) for all services except 010- and 090-day global period codes.

A report related to this modification is available from RAND. However, RAND does not exclude the 010- and 090-day global period codes from the proposal. CMS does not provide a rationale in the Proposed Rule for adding the exclusion of the 010- and 090-day global period codes.

Additionally, the RAND analysis does not reflect the current state of the methodology or other changes proposed for CY 2027. RAND modeled this change against a CY 2025 baseline. It therefore does not account for the CY 2026 policy reducing the facility-based indirect allocation to 50 percent of the work RVU, nor for the other proposals in this rule that interact with indirect PE allocation, most significantly, the proposed removal of the indirect practice cost index (IPCI). Because these policies operate on the same indirect PE RVUs, their effects cannot be assessed in isolation, and the specialty-level impacts shown in the RAND report do not represent what would result under the combined set of policies CMS now proposes. The AMA therefore cannot evaluate the full impact of this proposal on code-level accuracy or specialty-level payment. The AMA urges CMS to publish an impact analysis that reflects the proposal as actually proposed, including the global period exclusion and the CY 2026 facility-based indirect allocation change, and that accounts for its interaction with the other practice expense changes proposed for CY 2027.

(3) Indirect Practice Cost Index (IPCI): Remove the IPCI from the calculation of the PE RVUs over a two-year transition period.

The IPCI was implemented to ensure that all indirect costs measured at the specialty level in the PPI Survey are appropriately reflected in the PE methodology. CMS argues that improvement in code level direct expense data and allocation methodologies allow for the elimination of the IPCIs over two years. CMS also expresses concern about the use of the dated PPI Survey information; however, the PPI PE/Hour data and proportion of direct to indirect costs remain a component of the PE methodology. Code and specialty level impacts are not available for this specific proposed change to the PE methodology.

(4) Stabilization Factor: Initiate a PE stabilization factor for PE RVUs for CPT codes that are not new, revised or revalued to ensure that the PE RVU does not change by more than five percent relative to the previous year. Concerned that removal of the IPCI may cause disruption year-to-year for codes that should otherwise be

stable, CMS introduces the stabilization factor to counterbalance the proposed removal of the IPCI. CMS explains that the existing limit on how much a stable code may be decreased in total RVUs will remain at 19 percent and will be employed after this stabilization factor.

The AMA appreciates that CMS, subsequent to publication of the Proposed Rule on July 15, made available on July 21 both the list of codes subject to the 5 percent stabilization adjustment for CY 2027 and the fully transitioned PE RVUs those codes would eventually reach. This information meaningfully improves transparency and allows stakeholders to see not only which codes are constrained in CY 2027 but the full magnitude of the reductions being spread over time. The AMA appreciates CMS's responsiveness in providing this information.

In general, the AMA is supportive of transitions and methods to stabilize the RVUs from year-to-year to protect physicians and other clinicians from large reductions that may destabilize their practices. To the extent practicable, this stability should apply to all services.

The AMA is concerned, however, about the specific proposals discussed in this rulemaking process as CMS has not provided sufficient information for stakeholders to evaluate the effects of these four complex and interrelated proposals. CMS has historically published impact analysis for each significant proposed modification to the practice expense methodology. As these proposals are all intertwined, it is not possible for most individuals to understand how each individual proposal impacts their specific codes or specialty based on aggregate tables alone. Further, important elements of CMS' rationale are also missing, such as the decision to exclude 010- and 090-day global period codes from the expansion of the sum of work plus clinical labor as an indirect allocator. **CMS should postpone implementation of these practice expense proposals until a future rulemaking cycle in which granular specialty impact analysis may be published for each distinct proposed change in the practice expense methodology.**

The AMA also encourages CMS to re-examine the results of the recent Physician Practice Information (PPI) Survey. The AMA's PPI survey was a multi-year effort to collect updated physician practice data for potential use in the RBRVS. These data were collected at the specialty level and shared with CMS in January 2025. The PPI data represent the most recent data on physician practice costs and hours. In the CY 2026 Proposed Rule, CMS stated that "we intend to work with interested parties, including the AMA to understand whether and how such data should be used in PFS rate setting in future rulemaking." At that time, the AMA recommended that CMS should delay implementation of any modifications to the indirect practice expense methodology until the 2024 PPI data are implemented. While the AMA supports CMS' efforts to simplify the complex PE formula, we continue to believe that **CMS should work with the AMA to consider how the 2024 PPI data could be used in the future to reflect changes in physician practice cost and physician hours worked. The AMA also supports the CMS proposal to continue to use the 2006-based MEI cost shares for CY 2027 and until 2024 PPI data may be considered.**

Updates to Practice Expense Methodology – Site of Service Payment Differential

Recommendations:

- CMS should repeal its 2026 implementation of the 50 percent work adjustment to the indirect practice expense methodology effective January 1, 2027.
- CMS should implement the proposal to modify the PE RVUs for nursing facility visits, CPT codes 99304-99316, to restore equalized payment between skilled and non-skilled nursing facility PE RVUs effective January 1, 2027.

- CMS should work with the AMA to better understand the 2024 PPI data and how these data could be used within the PE methodology.
- CMS should utilize data-driven approaches to address CMS' concern regarding potential duplication of indirect expense payment between the PFS and hospital payment systems. CMS should work closely with stakeholders to ensure that independently practicing physicians are not unintentionally harmed.

Effective January 1, 2026, CMS implemented a significant refinement to the PE methodology, allocating half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting (e.g., hospital, ambulatory surgical center) compared to those allocated to services furnished in the non-facility setting. This policy resulted in a seven percent cut to facility-based payment, while non-facility-based payment to physicians increased by four percent. Many specialties were subject to even more substantial cuts in the facility setting, with facility-based ophthalmologists receiving a 13 percent cut, facility-based otolaryngologists receiving a 12 percent cut, and facility-based gastroenterologists facing a 10 percent cut. In this CY 2027 Proposed Rule, CMS states that it remains open to additional data and feedback, including consideration of additional refinements to the methodology. We support the CMS decision to consider additional information and potentially reconsider its current approach. However, until a more data-driven approach is developed, we urge CMS to repeal the current change to the indirect practice cost methodology. **Specifically, CMS should repeal its 2026 implementation of the 50 percent work adjustment to the indirect practice expense methodology effective January 1, 2027.**

Unintended Consequences of CMS Indirect Practice Expense Methodology 2026 Change

The AMA previously shared with CMS examples of impacts to individual services and patient care, many of which may have been unintended by CMS in formulating this proposal. We again share clinical examples where the broad-based adjustment produces payments that do not reflect actual practice costs. These examples illustrate the need for a more targeted approach than the broad-based work adjustment in the indirect practice expense methodology.

- All Surgical Global Codes with Bundled Post-operative Office Visits: Over 4,220 CPT codes have post-operative office visits bundled into their surgical global period. These visits are often performed in a physician office (non-facility) even though the surgery itself was performed in the facility setting. As a comparator, only 6 percent of separately reported 99213 office visits are provided in the on-campus hospital outpatient setting; 90 percent of these 99213 visits are in the non-facility setting. This nuance for surgical global codes would not be apparent in the claims data, a circumstance that is not considered in CMS' CY 2026 PE methodology change. CMS' CY 2026 policy negatively impacts the entire surgical global facility PE RVU without accounting for this factor. For example, the highest volume 090 code is cataract surgery with intraocular lens implantation (CPT code 66984) which was performed 81 percent of the time in the ASC setting for Medicare. However, ophthalmologists perform the medically necessary follow-up office visits in their offices. Moreover, ophthalmologists are maintaining offices that are open and staffed while they are performing surgery at the ASC or HOPD.

- Direct Costs in Facility RVUs: CMS notes that, "[i]n the facility setting, the payment rate includes physician work RVUs, and the indirect practice expense is allocated based on the physician work RVU. The direct costs in the facility setting are paid under a different payment system than the PFS, such as the Outpatient Prospective Payment System (OPPS). Indirect costs allocated to services furnished in the facility setting are meant to reflect the typical costs associated with practice expenses in that setting of care." However, we are concerned that this description does not fully reflect how the RBRVS is structured. CMS also includes direct PE inputs (e.g., clinical staff, supplies, and/or equipment) in the facility RVUs for 5,410 CPT codes. These direct costs for facility services correlate with indirect costs incurred by the physician

practice. As a result, a broad reduction in indirect PE may not accurately reflect the resources physicians, both facility-based and office-based, incur while providing services in the facility setting.

- Nursing Facility E/M Visits: Nursing Facility visits are reported with CPT Codes 99304-99316, which describe services provided to patients classified as receiving either nursing facility (non-facility) or skilled 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. In other words, a patient's classification may change without any meaningful change in the physician service or the resources incurred by the practice. The 2025 physician payment rates were appropriately identical. Take, for example, the national physician payment rate for CPT code 99309 Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded, the payment was $104.16 in 2025, regardless of the patient's status of skilled or non-skilled nursing facility assignment. However, in 2026, the physician visit practice expense payment for CPT code 99309 is 35 percent less for the skilled nursing facility visit. Most physicians who see patients in the nursing facility maintain offices, and their indirect costs would not vary based on how the patient is classified at the nursing facility.

The AMA is encouraged and supports CMS' proposal to correct this RUC-identified anomaly for CY 2027 by equalizing the non-facility and facility PE RVUs for nursing facility visits. Specifically, **CMS should implement the proposal to modify the PE RVUs for nursing facility visits, CPT codes 99304-99316, to restore equalized payment between skilled and non-skilled nursing facility PE RVUs effective January 1, 2027.** We agree with CMS that "[t]his particular situation illuminates ongoing concerns regarding the site of service differential." (*Vol. 91, No. 135 FR 43860).*

The AMA Physician Practice Information (PPI) Survey

The AMA recognizes the broader concern regarding the site of service payment differential between the non-facility and facility settings. This creates inherent unfairness to office-based physicians trying to compete with higher-paid sites of service, such as the hospital outpatient setting. However, the main driver of this differential has been the lack of inflationary updates to physician payment, in contrast to facility payment schedules where an annual inflationary update applies. We also know that cost reporting by hospitals is inconsistent and unreliable. For instance, for packaged services, hospitals often do not report supplies on their cost reports. In other instances, they use a flawed methodology, such as square footage allocation rather than actual costs.

The catalyst for the AMA launching the 2024 PPI survey was the AMA House of Delegates approved policy, Site-of-Service Differential D-330.902, which supports site-neutral Medicare payment policies for outpatient services without lowering total Medicare payments. This AMA policy also notes that the AMA supports Medicare payments for the same service routinely and safely provided in multiple outpatient settings that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting.

One attribute of the current PE methodology that contributes to this site-of-service differential is that each specialty is assigned a single blended PE/HR for all services they perform in both the non-facility and the facility settings. As part of the AMA's new 2024 PPI data submission, consolidated PE/HR for hospital-based medicine specialties, hospital-based surgeons, office-based medicine specialties, and office-based surgeons were calculated. These classifications reflect the differentiation in the relatively higher indirect practice expense for physician specialties that are predominantly non-facility based versus the indirect practice costs for specialties that are predominantly facility based, the same issue that CMS' policy attempts to address, though with a more focused

approach. Additionally, the 2024 direct PE/HR for all physicians increased by 40 percent compared to the legacy 2007 data, whereas the indirect PE/HR increased by only 5 percent. The 2024 indirect practice expense per hour percentage for all physicians decreased from the currently implemented 74 percent to 68 percent of total practice expense per hour, which, if implemented, would allocate more of the total practice expense to the non-facility setting to better compensate for those direct costs of operating a private outpatient practice.

CMS seeks comment on the amount of indirect PE hospital-based physicians incur when they furnish care within a facility. The PPI Survey data are objective, and CMS has not sufficiently considered the application of these data in the PE methodology. The results from the 2024 AMA PPI Survey showed $57 in indirect expenses per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery. These relatively similar values speak to consistency in these data. These are not expenses incurred by the facility — respondents were instructed to only include costs related to the physician practice, such as coding, billing, and scheduling. When a private practice physician performs a service or procedure in the facility setting, their physician practice still must handle coding and billing for the physician claim as well as scheduling. Physician practices must still have administrative staff, and their clinical staff often perform work supporting clinical services performed in the facility. These administrative and clinical staff, who are employed by the physician practice, often require their own administrative office space (separate from the hospital/Ambulatory Surgical Center (ASC)), require IT expenses, and are supported by other general staff (e.g., human resources, legal, practice management). **CMS should work with the AMA to better understand the 2024 PPI data and how these data could be used within the PE methodology.**

Example Impact of Indirect PE Methodology Change – Physician vs. Hospital

To ensure accurate payment, indirect costs should continue to be paid under both the professional and facility claims, while at the same time ensuring there is no overlap. As stated above, the PPI data reflects this. When private practice physicians provide services in the facility setting, their practice still incurs administrative costs that are only paid via the professional claim. Shifting all indirect payments to the facility fee would leave these independent practices uncompensated and create a financially unsustainable model for non-hospital-employed physicians providing services in the facility setting. When physicians are directly employed by the hospital, ultimately the hospital may receive payment for both the professional and facility claims. However, the physician-related costs are typically allocated internally to the relevant department, service line, or unit, resulting in reduced physician compensation.

CMS implementation of the modified indirect practice expense methodology, combined with payment updates to the 2026 Hospital Outpatient Prospective Payment System, results in decreases only to physician payment. As illustrated in the example of colonoscopy below, private practices incurred an eight percent reduction in payment in 2026, while hospital systems achieved increases whether the physician performing the procedure was in private practice (+3.7 percent) or hospital employed (+1.7 percent).

			2025 PFS Total Payment	2025 Hospital Outpatient Payment	Total 2025 Payment
Payment for CPT Code 45385 Colonoscopy w/ Lesion Removal (BEFORE PE Methodology Change)	**Scenario 1: Private Practice Physician Performs Service in Facility**	**Private Practice Receives:**	$243		$243
		Hospital working with private practice receives:		$1,179	$1,179
	Scenario 2: Hospital-Employed Physician Performs Service in Facility	**Hospital working with employed physicians receives:**	$243	$1,179	$1,422

			2026 Non-APM PFS Total Payment	2026 Hospital Outpatient Payment	2026 Total Payment	Percent Change
Payment for CPT Code 45385 Colonoscopy w/ Lesion Removal (AFTER PE Methodology Change)*	**Scenario 1: Private Practice Physician Performs Service in Facility**	**Private Practice Receives:**	$223		$223	**-8.0%**
		Hospital working with private practice receives:		$1,223	$1,223	**3.7%**
	Scenario 2: Hospital-Employed Physician Performs Service in Facility	**Hospital working with employed physicians receives:**	$223	$1,223	$1,446	**1.7%**

*Using 2026 Non-APM Medicare Conversion Factor

CMS noted that the purpose of the indirect PE adjustment was to address concern regarding potential duplicative payment for indirect costs when physicians provide services in the facility setting. CMS cites a large reduction in private practice physicians as another rationale for this proposal. The Agency notes, "This percentage had dropped to 35.4 percent by 2024, representing a 51 percent decrease, with a corresponding rise in employed physicians," citing the results of the 2024 AMA Physician Benchmark Survey. However, CMS is misinterpreting the AMA study by conflating employment status with the ownership structure of physicians' practices. According to the 2024 AMA Benchmark Survey, 42.2 percent of physicians are in private practice, 6.5 percent work for a

private equity-owned practice, and 4.6 percent work in a practice with some other practice ownership structure (i.e., insurer-owned). Although the shift in practice characteristics over the past decade has been dramatic, no one practice arrangement currently has a plurality. According to this study, 46.7 percent of physicians either work for a hospital-owned practice or are directly employed or contracted by a hospital. In other words, these data demonstrate substantial changes in physician practice arrangements, but they do not support a simple dichotomy between independent (private) and hospital-employed practice.

CMS needs to more fully understand the consequences to independent physician practices. The following table illustrates independent physicians by specialty who routinely provide care in both facility and non-facility settings. Many physicians in independent practice (41 percent) routinely provide patient care in both the facility and the non-facility settings. For several specialties, that percentage is substantially higher, including general surgery, obstetrics and gynecology, ophthalmology, and orthopedic surgery.

Distribution of Physicians in Independent Practice by Setting in Which Weekly Patient Care Hours Are Provided

Specialty	Facility and non-facility settings	Only facility settings	Only non-facility settings	
Anesthesiology	18.0%	79.1%	2.9%	100%
Cardiology	62.7%	12.1%	22.3%	100%
Emergency Medicine	6.2%	84.1%	8.9%	100%
Family Medicine	25.2%	22.2%	51.5%	100%
General Surgery	81.4%	9.4%	5.6%	100%
Internal Medicine	28.5%	22.7%	46.2%	100%
Internal Medicine Subspecialties	56.0%	18.5%	22.7%	100%
Obstetrics/Gynecology	75.2%	9.9%	14.9%	100%
Ophthalmology	68.0%	14.1%	17.0%	100%
Orthopedic Surgery	76.7%	12.2%	10.3%	100%
Other	29.0%	23.9%	43.7%	100%
Pediatrics	29.3%	24.4%	46.0%	100%
Psychiatry	35.5%	7.3%	55.5%	100%
Radiology	25.5%	58.4%	16.1%	100%
Surgical Subspecialties	77.1%	11.3%	11.0%	100%
All	41.0%	26.6%	30.9%	100%

Source: AMA 2024 Physician Practice Benchmark Survey. Note: For more information on the Benchmark Survey and estimates of the percentage of physicians in independent practice, see Physician Practice Characteristics in 2024: Private Practices Account for Less Than Half of Physicians in Most Specialties.

Potential Alternatives to the CMS Indirect Practice Expense Methodology Change

CMS has called for comment on other approaches that may be employed to address the concern regarding potential overlap in practice expense payment. Importantly, site of service is not, by itself, a reliable proxy for the practice expenses actually incurred by the physician or physician practice furnishing the professional service. Therefore, we applaud the decision to keep considering the best way forward. **Data-driven approaches should**

be utilized to address CMS' concern regarding duplication of indirect expense payment between the PFS and hospital payment systems. CMS should work closely with stakeholders to ensure that independently practicing physicians are not unintentionally harmed. A number of alternatives have been recommended by stakeholders, and the AMA urges CMS to consider each of the alternatives in lieu of the existing broad-based policy, while working with stakeholders to determine a solution that is data-driven and resource-based, including:

- Modify the current adjustment. The current 50 percent reduction of the work component within the methodology substantially overestimates any potential practice expense payment overlap. The AMA would encourage CMS to recognize at a minimum 75 percent of the physician work in the indirect cost allocation method.

- Develop a modifier to identify hospital-employed physicians. CMS seeks comment on the development of a modifier that more precisely identifies hospital-employed physicians. This would enable CMS to apply the reduction in indirect PE only to these physicians, who do not have separate administrative or clinical offices. Billing staff for facility-employed physicians could append this new modifier to claims, allowing CMS to continue applying the relevant indirect PE adjustment. If CMS proposes to adopt a modifier in lieu of the current allocation method, CMS should first share specific specialty-level impact analysis in proposed rulemaking and allow for comment.

- Consider a claims-based methodology. MedPAC's June 2025 report to Congress presents a claims-based alternative that identifies physicians most likely to be facility-employed by analyzing both clinicians who provide more than 90 percent of their services in a facility setting and services that are provided more than 90 percent of the time in the facility setting. This approach is detailed throughout the chapter, particularly on pages 44-46, where MedPAC notes: "A hybrid approach (based on information about both clinicians and services) may be more accurate than either approach on its own, but it would still be subject to judgment calls about what thresholds should be used and payment cliffs between clinicians who are subject to the payment reduction and all other clinicians." In addition, the AMA believes that use of this method should also account for independent physicians who practice predominantly in the facility setting who would be captured by a service- or clinician-based location test despite not being employed by the facility and who still incur indirect costs.

All changes to the practice expense methodology should be phased in over a four-year period to be consistent with long-standing policy to phase in new practice cost data (PPI; clinical staff wages; medical supplies and equipment policies). This would be consistent with other CMS phase-in implementation, such as in this Proposed Rule where CMS continues a phase-in to address the correction to a mathematical error in medical supply packages.

Global Surgical Packages

Recommendation:

- CMS should implement the AMA's prior recommendation that the full increase of work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239), and office visits (99202-99215) be incorporated into the surgical global periods for each CPT code with a global of 010-day and 090-day. The AMA also recommends that the practice expense inputs be modified for the inpatient hospital visits, observation care visits, and office visits within the global periods.

CMS continues to express concern about the accuracy of global surgery payment, specifically whether all post-operative visits included in 010- and 090-day global codes are being provided. This hypothesis is largely derived from a flawed attempt to require some physicians to report non-covered CPT code 99024 *Postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure for certain services*. Since July 1, 2017, Medicare physicians in nine states have been required to report on the postoperative visits they furnish during the global period of specified high-volume procedures using CPT code 99024.

In this Proposed Rule, CMS proposes to pause the data collection effort for CPT code 99024, citing undue burden to physicians. However, the Agency requests comments on whether the CPT code 99024 reporting requirement should be expanded to all physicians or if other data sources are available to demonstrate the number of post-operative visits provided. CMS also calls for comments on potential revaluation strategies to consider in future rulemaking.

As explained below, the RAND report, Office of Inspector General (OIG) audit, and RUC analysis of alternative data sources show that CPT code 99024 reporting is incomplete, burdensome, and unreliable for revaluing global surgical packages. The absence of a reported 99024 visit is not evidence that a post-operative visit was not furnished. The RUC's process, which incorporates available length-of-stay analyses, registries, claims data, and recent code-level reviews, where appropriate, provides a more targeted and less burdensome mechanism for identifying and correcting mis-valuation. Rather than expanding the flawed 99024 data collection, CMS should rely on the RUC review process and implement the RUC's prior recommendations to update the work, physician time, and practice expense inputs for visits included in 010-day and 090-day global periods.

RAND Report

In 2021, RAND released a report on the availability of 99024 in Medicare claims data. The AMA previously detailed the inaccuracies with RAND's analyses, beginning on page 31 of the AMA comment letter on the Proposed Rule for the 2022 PFS. The AMA continues to express concern that the 99024 data in Medicare claims do not accurately capture, and in fact underrepresent, the number of visits in global surgical procedures, given the limited participation of eligible physicians, as well as the current difficulty CMS and RAND researchers have encountered in aligning CPT code 99024 with specific CPT codes. For example, according to RAND's most recent report on 99024 from 2021, only 47 percent of the physicians and other healthcare professionals who were expected to participate in the effort actually submitted tracking code 99024. Fifty-three percent of physicians eligible for this data collection project were either not aware of the requirement to participate or were unable to participate for another reason. In addition, only 17 percent of eligible physicians were classified as "robust reporters," indicating that a majority of those who did participate did so intermittently, or did not begin until partway through the reporting period. Therefore, if most of the eligible physicians did not participate for a CPT code, which was the case for many codes, the median count of post-op visits would be zero, irrespective of what study participants reported, and the mean number of visits would be greatly understated. In other words, low or zero counts of reported post-operative visits for a specific code may reflect non-reporting rather than an absence of post-operative visits.

According to the 2021 RAND Report,[1] participation also varied widely by both specialty and state. Primary care physicians only participated at a rate of 16 percent, and Nurse Practitioners (NPs)/Physician Assistants (PAs) at a rate of 23 percent. Together, these specialties account for nearly 40 percent of the 40,000 eligible physicians in the 9 states and perform a large proportion of the 010-day global services included in the study. The participation

[1] Mulcahy, Andrew et al (2021). Using Claims-Based Estimates of Post-Operative Visits to Revalue Procedures with 10- and 90-Day Global Periods. RAND Corporation Research Report. https://www.rand.org/pubs/research_reports/RRA203-3.html

rate by state varied widely, with the highest participating state, North Dakota, participating at a rate 4 times higher than that of the lowest participating state, Nevada (see Figure 3.2 of the report).

There are several flaws in the RAND study. Specifically, the top three 010-day global codes studied, 17000, 17004 and 17110, make up 65 percent of the utilization for all 010-day global services in the study. These three codes are typically performed by the same specialty, dermatology, and are all from the same destruction of benign or premalignant lesions code family. As all RAND analyses that refer to 010-day global services overall are volume-weighted, the findings were heavily influenced by a small number of clinically related dermatology services and should not be considered representative of the entirety of 010-day (or other) global codes. It is important to note that the RUC recently reviewed the destruction of benign lesion codes, 17110 and 17111. These services were identified on two potentially misvalued screens, the "RUC reviewed greater than 20 years ago and Medicare utilization over 1 million" screen and in the "2025 OIG study on post-operative visits" screen. CPT codes 17110 and 17111 were surveyed as 000-day services and the post-operative office visits were removed. The RUC recommendations were submitted in May 2026 for CMS' consideration in the 2028 PFS. Additionally, destruction of premalignant lesion CPT codes 17000, 17003, and 17004 will be surveyed as 000-day global services after revision to the current code descriptors, and RUC recommendations will be submitted to CMS for the 2028 PFS.

Further, the 090-day global codes included in the analyses such as cataract surgery (CPT codes 66982, 66984) and hip/knee arthroplasty (CPT codes 27130, 27447) collectively accounted for 28 percent of the volume. However, the cataract codes (CPT codes 66982 and 66984) were reviewed for the 2020 PFS, and the post-operative visits now align with the 99024 Medicare claims data collected. The hip/knee arthroplasty codes (CPT codes 27130, 27447) were reviewed, and one hospital visit was removed due to a decrease in hospital stay for these services, and the work RVUs were decreased for the 2021 PFS. More recently, shoulder, hip, and knee arthroplasty (CPT codes 23472, 27130 and 27447, respectively) were identified via the RUC's site of service anomaly screen, as these services are no longer typically reported in the inpatient hospital setting. The RUC recommended removal of the inpatient hospital visits, adjustments to the post-operative office visits, and reductions in physician time resulting in overall lower work RVUs. CMS is considering these recommendations in this Proposed Rule for 2027.

Office of Inspector General (OIG) Report

As part of MACRA, Congress mandated that CMS gather information from physicians to assist in improving the accuracy of global surgery valuation, and that the OIG audit a sample of medical records to verify the accuracy of visits in the surgical global period. In June 2025, the OIG issued the report *CMS Should Improve Its Methodology for Collecting Medicare Postoperative Visit Data on Global Surgeries*. The OIG study audited 103 medical charts, encompassing 64 individual CPT codes. Most codes were represented by a very small number of records, with 47 codes having only one medical chart reviewed, seven codes having two charts reviewed, four codes having three charts reviewed, five codes having four charts reviewed, and one code having nine charts reviewed. The medical chart audit in this study was based on data from 2018 and compared the medical records to 2018 physician time file data from the PFS. The age of the data is relevant, because many of the services included in the audit have since undergone RUC review. In fact, of the 103 cases studied, codes related to 47 medical records have been reviewed by the RUC since 2018, and post-operative visits have already been reduced. For example, the RUC reviewed cataract surgery (CPT code 66984) for 2020, and the three post-operative visits currently align with the audit performed by the OIG. As stated above, in September 2025, shoulder, hip, and knee arthroplasty (codes 23472, 27130 and 27447) were identified via the RUC's site of service anomaly screen, as these services are no longer typically reported in the inpatient hospital setting and post-operative visits have been reduced. The RUC submitted recommendations for these arthroplasty codes to CMS in October 2025 for the 2027 PFS.

The OIG noted that, "Based on responses to our survey, we found that these errors [in reporting 99024] occurred because some practitioners and the practices' staff were either unaware that certain practitioners were required to report their postoperative visits to CMS, or they did not understand which visits were considered postoperative visits under Medicare's global surgery policy." The 2025 OIG report also observed that, "Although CMS staff stated that CMS continuously communicates with Medicare Administrative Contractors (MAC)s, CMS did not provide any documentation to support that the data collection policy was part of that communication, and according to the MACs, they did not have discussions or correspondence with CMS about the data collection policy."

The most significant takeaway from the OIG data is how, even though OIG limited its study to codes with at least one 99024, its medical chart review showed that this subset still had large errors in the quality of the 99024 data. Specifically, 45 of the 103 samples studied had 99024 data incorrectly compared to their medical chart review. This finding reinforces the AMA's concern that 99024 claims cannot be interpreted as a complete measure of post-operative care.

Post-Operative Visit Data Collection Efforts

For CY 2027, CMS requests comments on whether the CPT code 99024 reporting requirement should be expanded to all physicians or if other data sources are available to demonstrate the number of visits provided.

The AMA does not believe that expansion of the current 99024 reporting requirement is appropriate. Under the current paradigm, 99024 reporting has demonstrated limited participation, inconsistent compliance, substantial administrative burden, and significant discordance with medical records. Therefore, 99024 does not have utility and should not be used to determine the accuracy of surgical global payment. Expanding the CPT code 99024 data collection efforts to all physicians would create further burden to physicians. The recent 2025 OIG study already demonstrated that reporting CPT code 99024 proved onerous even for the limited number of physicians subject to the requirement. Expanding the reporting requirement to all physicians would only exacerbate the burden to physicians without correcting the fundamental limitations of the data. Moreover, such an effort could create an even larger dataset that remains unreliable for valuation purposes.

The AMA, instead, continues to explore opportunities to supplement the specialty society surveys with extant data or empirical data when possible.

- Electronic Health Record (EHR) Data
  AMA staff have engaged in numerous meetings with staff from Epic and Oracle (which acquired Cerner in 2022) regarding the availability of any data within their electronic health systems that may be beneficial in reviewing physician time and length of stay for individual services. Based on a list of inpatient services with 2022 Medicare utilization over 10,000, length of stay data were only available to validate one CPT code. Additionally, EHR data for an additional 12 CPT codes with a utilization below 10,000 could be obtained at a significant cost and would not prove beneficial due to the limited number of services obtainable. To date, these EHR systems do not collect meaningful physician time data that may be shared or utilized by the RUC.

- Length of Stay Data
  In September 2024, the Relativity Assessment Workgroup investigated a possible objective new screen on inpatient length of stay data and corresponding inpatient hospital visits. AMA staff identified 28 services that are typically performed in the inpatient setting and have more than 10,000 claims in the 2022 Medicare utilization.

The AMA linked physician Medicare claims data to inpatient Medicare claims data to estimate length of stay for these 28 services. The data utilized were the 2022 Medicare FFS Annual 5 percent Carrier and Inpatient Claims data. The AMA noted that patients may have undergone multiple procedures during an inpatient stay; thus, length of stay observations in the inpatient file may not solely be attributed to a single procedure code. Also, there are no available specific crosswalks between CPT codes and inpatient diagnostic related groups (DRGs).

The estimated length-of-stay data for the 28 services did not illustrate any pattern of overestimates of hospital visits included in the surgical global period. It would be difficult to expand this analysis beyond these 28 services due to a lack of an adequate number of observations in claims data.

- Extant data

  The AMA notes that several national medical specialty societies have engaged in creating patient registries and some of these registries include time data. Cardiothoracic Surgery and Cardiology have each shared registry information with the RUC, and these sources of extant data are approved for use in the valuation process. The RUC encourages other national medical specialties to share relevant extant databases with the RUC. The RUC's Research Subcommittee will continue to investigate additional valid data sources to supplement specialty surveys, registries, and claims databases that can enhance the overall RUC process.

CMS published a public use file with this Proposed Rule that estimates the imputed RVUs associated with both the 010- and 090-day post-operative visits. Calculations are based on an arithmetic approach, intended to understand the valuation of the services based on the data that were analyzed. This public use file shows the current work RVUs, the reported no-pay 99024 post-operative visits, and the hypothetical work RVUs remaining if all postoperative visits are removed.

The AMA reiterates that surgical global RVUs were not assigned via a building block methodology. Specifically, the work RVUs of individual post-operative visits were not simply added to the global service to reach a total RVU. Therefore, adjusting the work RVUs based on the number of post-operative visits included, or on, the 99024 data would not be appropriate. In other words, removing imputed E/M work from a global RVU does not reliably measure the appropriate work of the remaining surgical service.

More fundamentally, CMS has not yet corrected the opposite relativity problem: the mis-valuation of bundled post-operative E/M visits relative to analogous stand-alone E/M visits. The E/M visits have not been fully updated to reflect increases implemented in 2021 for the analogous E/M services when reported separately. Failure to adjust for the increase in post-operative visits in the global period while considering reductions based on incomplete 99024 reporting fractures relativity and prevents accurate comparison among services in the PFS.

The AMA urges CMS to implement the RUC's prior recommendation that the full increase of work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239), and office visits (99202-99215) be incorporated into the surgical global periods for each CPT code with a global of 010-day and 090-day. The RUC also recommends that the practice expense inputs be modified for the inpatient hospital and observation care visits and office visits within the global periods.

C. High-Cost Disposable Supplies

Recommendation:

- CMS should separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate Healthcare Common Procedure Coding System (HCPCS) codes. The pricing of these supplies should be based on a transparent process whereby items are reviewed and updated on an annual basis.

It is unfortunate that CMS did not include a proposal addressing high-cost disposable supplies in this year's Proposed Rule. The issue continues to grow in both magnitude and importance. As part of its direct PE input recommendations for CY 2027, the RUC considered several high-cost disposable supplies (i.e., priced more than $500) including a new high-cost supply input, *Dorsal SI joint articular fixation device*, with a cost estimate of $14,451.00 for Sacroiliac Joint Arthrodesis.

The Proposed Rule includes 96 medical supply items with a purchase price of more than $500 that are currently embedded in codes. Collectively, these high-cost medical supplies represent $1.77 billion in direct costs for the 2027 PFS and 23 percent of all direct practice expense medical supply costs in the non-facility setting. The continued embedding of high-cost disposable supplies within individual service-level PE inputs is increasingly difficult to reconcile with CMS' goals of accurate, transparent, and current resource-based payment. *Please see the analysis of high-cost supplies over $500 (Attachment 2).*

In the CY 2026 Proposed Rule, CMS stated, "we are seeking comments on whether we should create G-codes to describe the use of high-cost supplies." The resultant CY 2026 Final Rule stated, "Many commenters encouraged CMS to establish G-codes for high-cost supplies as it could improve billing accuracy and ensure appropriate reimbursement for expensive medical devices and supplies used in patient care." We appreciate that CMS sought comments on the creation of G-codes to describe the use of high-cost supplies. For two decades, the RUC has recommended that CMS separately identify and pay for high-cost disposable supplies using appropriate HCPCS supply codes.

Furthermore, in February 2025, the CPT Editorial Panel and the RUC submitted a joint recommendation letter to CMS urging the Agency to address the escalating issue of high-cost disposable supplies within the PFS. The joint letter reinforced the long-standing RUC recommendation and strongly encouraged accurate pricing and review of the high-cost supply items. W+e had anticipated a response from CMS on this important issue.

The AMA continues to call on CMS to separately identify and pay for high-cost disposable supplies priced more than $500 using appropriate HCPCS codes. The pricing of these supplies should be based on a transparent process whereby items are reviewed and updated on an annual basis.

D. Valuation of Specific Codes

The AMA appreciates that CMS proposes to adopt 88 percent of the RUC recommendations, including the RUC-recommended work RVUs for maternity care services. **The AMA encourages CMS to finalize publication of the relative values for these services.** We also acknowledge the minimal number of PE refinements and appreciate that nearly all the direct practice expense input recommendations are proposed for acceptance.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

Recommendations:

- CMS should not finalize the proposed 50 percent payment reduction for services furnished on the same date as a separately identifiable E/M visit reported with modifier -25.
- CMS should not extend the policy to procedures furnished on the same date as inpatient or other E/M services.
- CMS should address any genuine overlap through the established misvalued code and RUC valuation processes on a code-specific basis, rather than through a uniform, payment-level reduction. Where CMS believes specific codes do not fully account for such overlap, the RUC welcomes the opportunity to work with CMS to strengthen the resource-based process.

CMS proposes to reduce payment when a separately identifiable O/O E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 000-, 010-, or 090-day global procedure. Under this proposal, the service with the highest payment rate (either surgical or E/M visit) would be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. CMS states that "the 50 percent value aligns with our previous proposal from CY 2019 PFS Proposed Rule (83 FR 35840 through 35841) and matches the long-standing surgical multiple procedure payment reduction (MPPR)." According to CMS, "this proposal is meant to address the likely overlap and duplication of payment between the E/M services already paid for during the global surgical package, and any additional E/M services billed for through the use of modifier -25 as significant and separately identifiable." (91 FR 43908)

The AMA strongly opposes this proposal and urges CMS not to finalize it. CMS proposes this payment reduction on the basis of a hypothesis that payment is "likely" duplicated when an E/M visit and a procedure are furnished on the same day. But CMS does not provide evidence demonstrating that duplication exists or the magnitude of that duplication. In fact, the duplication CMS describes has, for the services typically furnished together, already been identified and removed through the very processes CMS relies on to value services. Through the potentially misvalued code initiative, CMS has identified, reviewed, and revalued codes typically furnished with a same-day E/M visit, and the RUC survey and valuation methodology are expressly designed to exclude the work and practice expense associated with a separately identifiable E/M service reported with modifier -25. Having already accounted for this overlap on a code-specific basis, CMS now proposes a second, across-the-board reduction that is untethered from the resources actually at issue, applying a 50 percent cut to the entire lower-valued service, including physician work, practice expense, and professional liability, to address, at most, a small overlap confined to portions of the pre-service evaluation, post-service time and practice expense components. Most significantly, the burden of this poorly calibrated policy would fall on office-based, independent physician practices, which bear the full costs of the clinical staff, supplies, equipment, and infrastructure, and are the very practices CMS has stated it wants to sustain and strengthen. This policy would signal the opposite of that commitment.

The AMA shares CMS' commitment to accurate valuation of services under the PFS, including for global surgical packages, and we do not dispute that payment should reflect only the resources actually required when services are furnished together. But that principle is not served by a broad, payment-level reduction imposed in place of code-specific analysis. To the extent CMS believes specific codes warrant further review, the appropriate path is to identify those codes and address them through the established misvalued code and RUC processes, and we welcome the opportunity to work with CMS on how those processes, or other resource-based approaches, can be strengthened to ensure that any genuine overlap is captured. In the sections that follow, we explain why CMS has not substantiated its premise or adequately addressed the concerns that led it to decline to finalize a similar policy in 2019; how the existing valuation processes already account for any overlap; why the proposed 50 percent

reduction bears no reasonable relationship to the resources involved; and how the policy would compound the financial pressures already threatening independent practice.

CMS has not addressed concerns that led the Agency to decline to finalize a substantially similar proposal in 2019

This is not a new proposal. CMS proposed a substantially similar policy in the CY 2019 PFS Proposed Rule and, after considering public comments, declined to finalize it. The current proposal is broader than the 2019 version, extending to 010- and 090-day global procedures and reducing payment for all same-day services other than the highest-valued one. Yet in the years since, CMS has not developed the evidentiary basis whose absence contributed to the Agency's decision not to move forward before. CMS has not presented new evidence that resolves the concerns surrounding the prior proposal.

In reviving and expanding a proposal it previously declined to finalize, the Agency should, at a minimum, come forward with the analysis and concrete safeguards that the intervening years afforded it the opportunity to develop. CMS has not done so here.

The RUC valuation process already removes the overlap CMS seeks to address

CMS states that when a physician or qualified healthcare professional performs an office/outpatient E/M visit and a procedure with a 000-, 010-, or 090-day global period on the same date of service, efficiencies occur in the resources required to furnish those services. The RUC has long recognized potential overlap and, accordingly, has recommended only physician work and direct practice expense inputs that are not duplicative when these services are typically performed by the same practice on the same date of service. While the practice expense methodology does not explicitly address reduction in indirect practice expense to account for overlap when procedure codes are typically billed with E/M visits, both physician work and direct practice expense are used to allocate indirect practice expense. Thus, the reductions in physician work and direct practice expense result in a similar downward adjustment in indirect practice expense. **Therefore, the AMA strongly disagrees with CMS' assertion that current payment rates duplicate payment for services that are typically furnished together.** Notably, CMS itself frames this overlap only as "likely," describing payment as "likely" duplicated and the efficiencies as ones it "continue[s] to believe" exist. A payment reduction of this scope and magnitude should be based on demonstrated overlap in identified services, not on an unsubstantiated assumption that overlap is "likely."

CMS states that it "appreciated the efforts of the RUC to address overlaps when they recognize that a code is often reported with a same-day E/M visit" but suggested that the RUC "tends to recommend only minor adjustments to physician time and direct PE inputs to account for overlap."." The adjustments are modest not because the process is incomplete, but because the overlap itself is modest. The resources that overlap between a same-day visit and a minor procedure are a small share of the pre-service evaluation and post-service time, not the intra-service work, the procedure-specific supplies and equipment, or the physician's technical skill and effort. Direct practice expense overlap is similarly limited as described further below, and as explained above, it flows through to the indirect practice expense once those inputs are adjusted, leaving no resource category unaddressed. That the adjustments are "minor" is therefore not a deficiency in the process; it is an accurate measure of a genuinely small overlap, and it underscores that a 50 percent reduction to the entire service bears no relationship to the limited resources actually shared.

CMS' own methodology confirms both that this overlap is limited and how it is measured. In the *Methodology for Establishing Work RVUs* section of every PFS proposed and final rule, CMS describes the specific adjustment it applies based on an assumption that roughly one-third of the pre-service evaluation and post-service time overlap with the E/M visit, and confirms that the RUC applies this same policy:

> *...in cases where a service is typically furnished to a beneficiary on the same day as an E/M service, we believe that there is overlap between the two services in some of the activities furnished during the preservice evaluation and post service time. Our longstanding adjustments have reflected a broad assumption that at least one- third of the work time in both the preservice evaluation and post service period is duplicative of work furnished during the E/M visit.* ***Accordingly, in cases where we believe that the RUC has not adequately accounted for the overlapping activities in the recommended work RVU and/or times, we adjust the work RVU and/or times to account for the overlap. ...The RUC has recognized this valuation policy and, in many cases, now addresses the overlap in time and work when a service is typically furnished on the same day as an E/M service.***

CMS has repeatedly identified specific codes through the potentially misvalued code initiative to address duplication concerns. For example, in rulemaking for CY 2017, CMS identified 83 services with a 000-day global period that may be typically reported with E/M. The RUC reviewed this list and confirmed that the majority were already addressed for overlap. The remaining 21 services were reviewed, and the overlap was removed. These codes have been reviewed and, when appropriate, revalued to remove any overlap with office E/M services. As a result, the current physician work and practice expense resources assigned to these procedures represent only those resources required in addition to the E/M service itself. If CMS were to implement this policy, it would effectively reduce payment a second time for resources that have already been adjusted to eliminate duplication. To avoid double counting those reductions, CMS would first need to restore the previously removed resource costs to affected procedure codes.

RUC processes include specific safeguards to ensure that resources associated with a separately identifiable E/M services are not also incorporated into the value of the procedure. The RUC physician work survey instructions explicitly direct respondents to exclude work associated with "distinct evaluation and management services provided in addition to the procedure (reported with modifier -25)." The RUC's established standards for pre-service, intra-service, and post-service time are specifically designed to prevent duplication between procedures and separately identifiable E/M services. CMS has further reinforced these efforts through rulemaking that has removed overlap from numerous codes. In this Proposed Rule, CMS specifically identifies "pre-operative visits" as a concern for overlap. This time is captured as pre-evaluation time and is minimal (typically only a few minutes); CMS and the RUC specifically require that this time capture only activities above and beyond an E/M service. For example, the pre-evaluation time might reflect the time the physician spends measuring a lesion or reviewing images after the E/M visit has concluded and prior to the initiation of the intra-service work.
The RUC reviews Medicare claims data to determine if a procedure is typically performed the same day as an E/M office visit and removes overlapping clinical labor time associated with the following activities when they are shared between an E/M service and a same-day procedure:

- Greeting the patient and providing gowning instructions.
- Ensuring relevant medical records are available.
- Obtaining vital signs.
- Preparing the examination room, equipment, and supplies for a typical office visit.
- Cleaning the room following the encounter.

Under the CMS standard practice expense methodology, these activities account for approximately 13 minutes of clinical labor time and are not included twice when services are commonly performed together.

In addition, practice expense supplies and equipment associated with office visits account for only $6 in direct practice expense costs. These minimal resources are not duplicated within procedure codes. In contrast, many

procedures include substantial supplies and equipment costs that are entirely unrelated to the limited supplies and equipment associated with an E/M office visit. **The AMA urges CMS to continue working collaboratively with the RUC and other stakeholders to ensure that procedure codes typically reported on the same date as E/M office visits are valued appropriately and include only those resources that are distinct from the E/M service. Where CMS believes specific codes do not fully account for that overlap, we welcome the opportunity to work with CMS on how the resource-based process can be strengthened to identify and address it. This resource-based approach ensures accurate valuation while preserving beneficiary access to convenient, high-quality care delivered in a single encounter.**

The proposed 50 percent reduction bears no reasonable relationship to the overlap it targets

CMS notes that its proposed approach is consistent with its MPPR policy, which generally applies a 50 percent reduction to the secondary surgical procedure to account for overlap in pre- and post-procedure work and practice expense resources. However, the rationale underlying the surgical MPPR does not apply to the relationship between a separately identifiable E/M service and a minor procedure. The surgical MPPR was developed to address overlap between procedural services that may include related visits and share substantial resource costs. Applying a similar reduction to an E/M service and a minor procedure fails to reflect the limited overlap that may exist between these distinct services and is inherently inequitable.

More fundamentally, when CMS reduces payment to account for overlap, it does so with precision by identifying the specific component in which the overlap occurs and calibrating the size of the reduction to the amount of overlap actually present in that component. For diagnostic cardiovascular and ophthalmology services, the reduction is confined to the technical component. And where CMS applies reductions to more than one component, it sets them at different levels to match the overlap for each: for advanced diagnostic imaging, CMS reduces the technical component substantially, reflecting the equipment, supply, and clinical staff resources that are genuinely shared when studies are furnished together, but reduces the professional component only marginally, reflecting that interpreting each study remains largely distinct work. In every case, both the component reduced and the magnitude of the reduction are tied to a specific, identified overlap.

The proposed policy reflects neither form of precision. It applies a uniform 50 percent reduction to the entire value of the lower-valued service—physician work, practice expense, and professional liability alike—without identifying which component contains overlap or calibrating the reduction to any measured amount. It reduces components in which CMS has identified no overlap at all. We do not cite these targeted reductions to suggest that any level of reduction would be appropriate here; it would not, because the overlap has already been removed through the valuation process described above. We cite them to show that CMS knows how to address overlap in a precise, evidence-based manner when it chooses to, and that the proposed reduction, which is untethered from any identified component or measured overlap, is neither reasonable nor evidence-based. For these reasons, **the AMA strongly opposes the proposed 50 percent reduction, which far exceeds any reasonable estimate of potentially overlapping resource costs and would substantially underpay physicians for medically necessary care.**

The proposal would disproportionally harm the independent, office-based practices CMS seeks to support

The CMS proposal would result in payment levels for many procedures that do not cover the direct costs of furnishing the service, let alone compensate physicians for the work involved. Physicians are already facing significant financial pressures in maintaining independent practices. These services are frequently furnished in independent, office-based settings, where the practice bears the full cost of the clinical staff, supplies, and equipment reflected in the non-facility payment and cannot offset a reduction with facility revenue. The proposal would therefore fall most heavily on precisely the practices that CMS has stated it seeks to sustain and strengthen.

A policy that leaves payment below the direct cost of furnishing care sends the opposite signal, and risks accelerating the consolidation that CMS has identified as a concern. The examples below demonstrate how the proposed payment policy could make it financially unsustainable to continue providing these services.

These examples include only the minimum pre-service and immediate post-service work incorporated into the procedure work RVUs. The supply, equipment, and clinical staff costs shown are entirely separate from, and in addition to, the resources required to furnish the office visit. Under the proposed policy, payment would not adequately support these necessary resources. For CPT code 11300, for example, the policy would leave an effective procedure payment of approximately $48 while the identified clinical staff, supplies, and equipment alone cost approximately $60, before accounting for physician work, as shown in the table on the following page.

CPT Code	% Billed w/ E/M in Non-Facility	2026 Combined Non-facility Medicare Payment* (99203 + Procedure)	Pre- & Immediate Post-Time (minutes)	Pre-service work	Post-service work	Supply & Equipment Costs	Clinical Staff Costs
11300 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	85.7%	• w/o policy: $214.10 • w/ policy: $165.84 • w/ policy effective procedure payment: **$48.27**	• Pre-pos: 1 • Pre-s/d/w: 5 • Imm Post: 5	• Position patient • Measure and document lesion • Provide local anesthetic and wait time	• Apply ointment and dressing • Provide wound care instructions • Prepare specimen for pathology • Document procedure	$47.12	$12.96
31575 Laryngoscopy, flexible; diagnostic	94.4%	• w/o policy: $244.83 • w/ policy: $186.05 • w/ policy effective procedure payment: **$68.48**	• Pre-eval: 8 • Pre-pos: 1 • Pre-s/d/w: 5 • Imm Post: 5	• Explain procedure and answer any questions • Position patient • Provide local anesthetic and wait time	• Findings are discussed and treatment options are reviewed and implemented • Document procedure	$46.55	$27.54

* "w/o policy" = 99203+ procedure payment; "w/ policy" = 100% of highest + 50% of lowest; "w/ policy effective procedure payment" = Difference between stand-alone 99203 payment and "w/ policy

CMS should not extend the policy to other E/M services

CMS also requests comments on whether this policy should be extended to procedures performed on the same date of service as other E/M services, such as inpatient visits. The AMA strongly opposes any such expansion. Inpatient and other facility-based E/M services do not include direct practice expense payments, and the physician work associated with a procedure performed on the same date generally occurs at a different time and reflects distinct clinical activities. Accordingly, there is no meaningful duplication between these services. **The AMA urges CMS not to pursue payment reductions for procedures performed on the same date as inpatient or other facility-based E/M services.**

We appreciate CMS' responsibility to ensure that Medicare payments accurately reflect the resources required to furnish care. Consistent with that goal, we urge CMS to address the following in the final rule:

- The specific evidence demonstrating that separately identifiable, same-day E/M services systematically contain duplicative resources warranting a reduction, and the basis for setting that reduction at 50 percent;
- The analysis CMS conducted regarding the policy's impact on independent physician practices and on beneficiary access, particularly in rural and underserved communities; and
- What evidence or circumstances have changed since CMS declined to finalize a similar policy in 2019.

Maternity Care Services

The AMA is pleased CMS proposes to adopt AMA's recommendations to update the Maternity Care Services coding structure. Beginning January 1, 2027, the CPT codes will be updated to comprehensively revise the maternity codes, reflecting modern obstetric practice and providing greater specificity regarding antepartum care, labor management, delivery, and postpartum services. The new code structure will provide much-needed transparency for patients, and the increased granularity will improve the ability of physicians and researchers to better understand the drivers of maternal mortality. The CPT 2027 maternity-care restructuring represents nearly two years of sustained, multidisciplinary work led by the CPT Editorial Panel and its Maternity Care Services Workgroup of obstetricians, family physicians, certified nurse midwives, payers, and other interested parties. **The AMA agrees with the CMS proposal to implement the new maternity care coding and payment structure.**

Budget Neutrality

The RUC evaluates budget neutrality for every code family that enters the process by comparing the source code work RVUs and utilization with the recommended work RVUs and anticipated utilization of the new and revised codes. In total, 17 legacy global codes were deleted, 12 new codes were added, and 6 codes were revised. The budget neutrality assumptions apply the utilization and work RVUs of the 17 deleted codes as the source codes. Each source code is then matched with its respective counterpart in the new code structure, which includes the recommended work RVU values and anticipated utilization. The new and revised RUC recommended work RVUs are informed by data from more than 650 physicians and certified nurse midwives. The utilization assumptions are not anticipated to change[2] as the total number of births in the U.S. has remained relatively stable over the last 5 years. Further, Medicare utilization trends have also remained relatively stable over the last 10 years. Therefore, the new and

[2] https://www.cdc.gov/nchs/nvss/births.htm

revised code work RVUs respective to the anticipated utilization do not exceed the current utilization and work RVUs when typical care assumptions are accounted for.

Given that the proposed coding changes have a national impact, not just a Medicare impact, the RUC used available objective data from the CDC to develop a national estimate that approximates 3.5 million births annually in U.S. hospitals.[3] The RUC used these objective CDC data in addition to Medicare and Medicaid utilization trends to inform the budget neutrality estimates on a national level. Based on this information, the RUC used the following assumptions for antepartum, labor, delivery, and postpartum care.

The budget neutrality calculations include the current antepartum care plan E/M assumptions; however, the American College of Obstetricians and Gynecologists (ACOG) released new guidance as of April 2025 that suggests a more tailored antepartum care plan between the patient and physician/qualified healthcare professional (QHP) may result in fewer antepartum visits.[4] This not only underscores the importance of the requested coding changes to specify reporting for antepartum care; it also emphasizes tailored care that the current global structure does not allow. Therefore, the budget neutrality assumptions used ACOG's longtime guidance of 1-99204, 2-99214, 8-99213, and 2-99212 office visits that were part of the previous bundled services. By using this approach, the budget neutrality assumptions would capture both a decrease in visits for healthy patients and an increase in visits for patients with additional risk factors that align with the anticipated utilization trends as demonstrated in available claims data.

It is also important to note that the statutory requirements for coverage of preventive prenatal and postpartum services without cost sharing are unchanged by the revisions to the maternity care services code set. The RUC's recommended allocation of payment between antepartum care and labor and delivery remains similar to the current global structure and is not expected to materially shift patient financial responsibility.

To determine the labor and delivery utilization, the RUC used the following objective data regarding parity, labor induction, duration of labor, cesarean delivery, repeat cesarean delivery, and vaginal birth after cesarean to estimate expected utilization. Over 50 percent (50-70 percent) of US annual births are to primiparas (i.e., women who are giving birth for the first time), and about 35 percent of all births will be induced, with most of those being in primiparas.[5] Labor inductions are generally scheduled to begin with admissions throughout the day, but usually not before six am. Typically, inductions will take an average of 24 hours, suggesting that inductions will have two days of labor management. Primiparas who go into spontaneous labor may present to the hospital at any time of the day, and it is anticipated that one-third of those will go past midnight. Based on this, it is anticipated that slightly more than half of total cases will pass midnight and have two days of labor management, and those that reach three days of labor are rare. About 30-35 percent of all US births are cesarean deliveries, and, of those, one third are repeat cesareans. It is understood that only 15 percent of women who had a previous cesarean delivery will attempt a vaginal birth after cesarean (i.e., VBAC).[6] Further, the CPT introductory guidelines state that a repeat cesarean delivery (59503) is typically a planned event without labor management. It is anticipated that most deliveries will be reported with vaginal delivery CPT code 59431 (~65 percent), followed by

[3] https://www.cdc.gov/nchs/data/databriefs/db507.pdf
[4] https://www.acog.org/clinical/clinical-guidance/clinical-consensus/articles/2025/04/tailored-prenatal-care-delivery-for-pregnant-individuals
[5] https://evidencebasedbirth.com/arrive/#:~:text=Inductions%20of%20labor%20have%20become,2018.
[6] https://www.cdc.gov/nchs/nvss/births.htm?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fnchs%2Fbirths.htm.

primary cesarean sections 59502 (20 percent), then repeat cesarean sections 59503 (10 percent), and then VBAC 59432 (5 percent).

Overall, the RUC recommended work RVUs and the expected utilization for the new and revised maternity care codes do not exceed the current utilization and work RVUs associated with the current code structure when typical patterns of care are considered. The RUC recommendations are, therefore, budget neutral.

Creation of HCPCS G-codes to Maintain Current Coding

CMS is considering and seeks comments on an alternative to create HCPCS G-codes that would maintain the historical global structure and payment for maternity care services in the PFS. CMS states that this is to ameliorate concern while it continues to consider the potential impact that changes in the maternity care code family have on clinical outcomes for maternal care. In the CY 2027 OPPS Proposed Rule, published prior to PFS rulemaking, CMS proposed to adopt the new maternity care CPT codes. Publishing HCPCS G-codes for use by physicians, while using CPT codes for use by hospitals, would be administratively complex and chaotic. Such an approach would create two competing coding structures and introduce substantial administrative complexity for physicians, hospitals, health systems, health plans and their patients. **The AMA strongly opposes CMS' alternative proposal to maintain current coding through the creation of HCPCS G-codes in the PFS as it will create unnecessary chaos and confusion. The AMA urges CMS to finalize the Maternity Care Services CPT code set without maintaining the historical global structure via HCPCS G-codes.**

Moving forward with the CMS proposed HCPCS codes in lieu of the new codes, in any capacity, disregards a multi-year, multi-stakeholder effort to thoughtfully restructure the bundled codes into individual codes based on the evolution of maternity care in the last 15 years. Specifically, contemporary maternity care includes a wider variety of provider models, greater collaboration across specialties, and more complex team-based approaches to labor management designed to improve outcomes for birthing parents and neonates. These new codes allow for the capture of escalation of care from rural hospitals to tertiary centers, differentiate between straightforward deliveries and those that require more complex labor management, and recognize the use of labor induction to safely reduce cesarean delivery rates. Further, these new maternity care codes will help increase focus on hemorrhage, cardiovascular disease, and maternal mental health to decrease key medical conditions that contribute to maternal morbidity and mortality. Lastly, it is imperative that improved claims data become available so that the care provided can be better tracked as patient populations and practice models continue to change.

The new CPT codes will support a "patient-centered" approach to care as opposed to the "one-size-fits-all" approach that comes with a 10-month bundle. As the multi-stakeholder process outlined, there are benefits to bundling approaches. However, there is now a need to understand care delivery on a visit level to inform future episode-based payment, outcome-linked payment and risk-adjusted maternity programs. This is not a reversal of value-based care models; it is an opportunity to understand areas of improvement that should not be fragmented through two code sets.

The potential administrative chaos that could come with the implementation of two code sets cannot be overstated. Given that the final PFS implementation is unclear, and the CY 2027 OPPS Proposed Rule did not propose HCPCS G-codes, there could be two different code sets within Medicare alone, which would be disastrous. Health systems and independent providers often contract with hundreds of different insurers, both public and private. If two code sets are implemented, the burden will be significant for both care teams and patients. Specifically, the legacy bundled codes undermine efforts to increase price

transparency for patients, whereas the new coding structure will allow for a better understanding of individual care delivered that is not possible with the bundled codes. As mentioned, statutory requirements for coverage of preventive prenatal and postpartum services without cost sharing are unchanged by the new CPT code set. Historically, labor and delivery have always had associated patient cost-sharing. However, it is often unclear if the costs are being managed appropriately by payors using the maternity care global codes. Therefore, the new codes will enhance long-overdue transparency for patients, who have historically been kept in the dark about cost-sharing within global bundles.

In early February 2026, the AMA and ACOG initiated a robust early release and education plan to allow for a smooth transition for all stakeholders. There are many approved code changes each year that require transition planning, and payors re-negotiate physician contracts in accordance with these changes each year. This is no different; it is perhaps even routine. The AMA and ACOG have outlined a transition plan through the end of 2026 for antepartum reporting. Starting in 2027, antepartum and postpartum care will be reported under E/M services, creating a seamless transition using an established CPT code set. The AMA and ACOG continue to work collaboratively with stakeholders such as physicians and qualified healthcare professionals, EHR vendors, and payors as they move forward with the timing of adoption of these vital revisions. **Therefore, the AMA urges CMS to finalize the Maternity Care Services CPT code set and not maintain the historical global structure through parallel HCPCS G-codes. A single, nationally consistent coding structure utilizing the new CPT code structure will better reflect contemporary maternity care, reduce administrative complexity, improve transparency, and provide more meaningful data for future payment and quality initiatives.**

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

Recommendation:

- CMS should refrain from implementing any changes to the direct practice expenses or creating G codes for Remote Physiologic Monitoring (RPM) or Remote Therapeutic Monitoring (RTM) until specialty societies and the RUC review these services in January 2027. CMS should not impose any new regulatory burdens on physicians associated with the proposed requirement for an initiating visit to precede RPM or RTM services. The proposal to restrict delivery of remote monitoring to staff employed by the medical practice should not be finalized.

Codes and Relative Values for Remote Monitoring

CMS began paying for CPT codes for RPM in 2019. Codes for RTM followed, as well as expansion of coding for RPM. Citing a lack of data regarding the typical device used in the provision of RPM and RTM services, CMS notes that this may have led to overpayments for the services. Therefore, CMS proposes to decrease the PE RVUs for several of these services using crosswalks to other services and eliminating all direct practice costs for the treatment management codes. If finalized, these changes will result in significant 2027 payment reductions for RPM and RTM services, often as much as the 19 percent statutory limit, with further reductions then transitioned into 2028 and beyond. CMS also proposes bundling the 17 RPM and RTM CPT codes and creating four new HCPCS G-codes in 2027 to describe remote monitoring services, which would lead to immediate implementation of the full cut, an 80 percent decrease.

As CMS cites that it lacks current data on the typical devices and other resources used to provide RPM and RTM services, the AMA agrees with the RUC that it would be far better to collect the needed data than to reduce payments without any data to serve as a foundation for revised RVUs.

The RUC was scheduled to begin re-examining the RPM and RTM services in January 2028. Given CMS' concern regarding the direct practice expense inputs on the typical devices used and typical clinical staff workflow/time for these services, the RUC is moving up its review of all 19 RPM and RTM codes to January 2027 to review practice expense only. The AMA urges CMS to maintain the current direct practice expenses and refrain from creating G-codes for RPM or RTM to allow time for the RUC to review the practice expenses for these services.

Proposals Responding to HHS OIG Reports

The HHS OIG has issued two reports on remote monitoring that raised concerns about whether RPM and RTM services are being delivered appropriately. Its 2024 report, "Additional Oversight of Remote Patient Monitoring in Medicare Is Needed," said that, although use of remote monitoring rose "dramatically" from 2019 to 2022, nearly half the patients who received these services did not get all three components and "Medicare lacks key information for oversight, including who ordered the monitoring for the enrollee." The report included recommendations that CMS: implement additional safeguards to ensure appropriate use and billing; require that information about the ordering provider be included on claims; and identify and monitor companies that bill for remote monitoring. One year later, its report, "Billing for Remote Patient Monitoring in Medicare," noted that use of these services had continued to grow and suggested further scrutiny in instances of billing for a high proportion of patients who have no prior history with the medical practice and for those receiving multiple monitoring devices a month.

In an OIG meeting following the 2024 report, AMA participants noted that the claims the OIG reviewed were from the COVID public health emergency and that the observed growth in remote monitoring was part of a larger digital health transformation. Responding to the report's concern that many patients for whom RPM claims were submitted had not received all three elements of the service and may not have received education and set-up or treatment management, participants explained that education and set-up is only provided once for each patient, not monthly, and some devices may not require patient education and set-up. Also, if the patient did not collect 16 days of data or the physician did not spend at least 20 minutes on treatment management, then treatment management would not be reported that month, which is an example of correct coding, not a program integrity issue.

In response to the OIG reports, CMS is making several proposed changes to its RPM and RTM policies for 2027. Although CMS has required that RPM services be furnished only to established patients since 2021, CMS proposes to extend this policy to RTM services. It also proposes that physicians reporting remote monitoring furnish a separately reportable initiating visit in association with the onset of RPM or RTM. In addition, CMS proposes to only allow payment for RPM or RTM services when performed by clinical staff employed by the practice and not when those services are delivered by contractors.

The AMA agrees that it would be good practice for the notes from the visit at which the physician determines that a patient should receive remote monitoring to include that information but does not support new regulatory burdens being imposed on medical practices to allow CMS to document these occurrences. Many Medicare administrative requirements increase compliance burdens and disrupt practice workflows without benefiting patients' care. The Trump Administration has made important strides in removing unnecessary regulations, and it should not impose new ones.

We are also concerned about the use of the phrase "separately reportable." We believe the intent is to distinguish the visit at which RPM or RTM is discussed with the patient from the delivery of the first RPM or RTM service. It is confusing, however, because it is unclear what would need to be separate. For example, the need for remote monitoring following a hospital stay could be discussed with the patient

during a hospital or discharge visit that is part of a global surgical service and not separately reported even though this visit is separate from the remote monitoring services. It would be helpful for CMS to clarify the meaning of "separately reportable."

CMS should withdraw its proposal to only allow staff who are employees of the medical practice to deliver RPM and RTM services. A variety of clinical and financial arrangements are used to deliver remote monitoring; limiting it to employed practice staff would be highly disruptive and impair patients' access. For example, nursing staff employed by a medical center or hospital may provide remote monitoring that is ordered and billed by a faculty practice plan or medical group that is a separate employer. Under the proposed policy, the faculty practice physicians would be unable to use the services of the nursing staff who perform the remote monitoring even though they are all part of the same system. There are also arrangements that have been developed to comply with state laws. In Texas, medical schools cannot own hospitals, so RPM is provided post-discharge through a partnership between the school and the hospital. Academic health systems may also serve as remote monitoring vendors for rural hospitals as part of the Rural Health Transformation Program (RHTP). Independent practices and small, rural, or safety net practices and hospitals are unlikely to have the resources to train or hire their own staff for this purpose instead of contracting with organizations that serve a larger patient population. **At a time when initiatives such as RHTP aim to improve rural patients' access to innovative technologies, this proposal would have the opposite effect.** The OIG recommended that CMS "identify and monitor companies that bill for remote patient monitoring," and CMS concurred, but the OIG did not say that CMS should no longer allow them to provide the services. If finalized, this proposal would harm patients' access to care and reverse progress in digital health transformation.

Software as a Medical Service (SaMS) Laboratory Analyses

Recommendations:

- The AMA supports CMS' proposal to change the terminology from "Software as a Service" to "Software as a Medical Service" (SaMS), consistent with our comments on the parallel CY 2027 OPPS proposed rule, and subject to the same condition that SaMS functions as an interim Medicare designation rather than a parallel clinical or coding taxonomy and that CMS draws on existing frameworks, including CPT Appendix S and the CPT Editorial Panel's ongoing Clinically Meaningful Algorithmic Analyses work, so that Medicare and coding classifications do not diverge in ways that increase administrative burden and mispricing risk.
- The AMA does not support CMS' proposal to remove the ten HCPCS codes that it characterizes as "SaMS laboratory analyses performed on laboratory tests" from the Clinical Laboratory Fee Schedule (CLFS) and contractor price them under the PFS. CMS should withdraw the proposed ten-code list pending a code-by-code technical review, conducted in consultation with the College of American Pathologists and other relevant stakeholders.

Software-based technologies, including clinical decision support software, clinical risk modeling, computer-aided detection (CAD), and other artificial intelligence (AI)-enabled tools are increasingly used to support diagnosis and treatment planning across care settings. Focusing on laboratory services, CMS has identified certain algorithmic analyses that it views as separate from a CLIA-certified laboratory's examination of human material and that, by themselves, produce a clinical test result. These services are currently treated as clinical diagnostic laboratory tests (CDLTs) and paid by Medicare under the CLFS. Because Medicare pays for CDLTs under the CLFS only when they are furnished by laboratories meeting applicable CLIA certification requirements, and because CMS believes these analyses can be performed

by non-CLIA-certified laboratories, CMS has concluded that they do not fit the statutory framework for CLFS payment. For CY 2027, CMS proposes two changes regarding software-based medical services with algorithmic analyses. We address each of these proposals below

Terminology Change from SaaS to SaMS

Consistent with the CY 2027 OPPS proposed rule, CMS proposes to replace the term SaaS with SaMS to refer to software-based technologies that support clinical decision-making through algorithmic analysis, including those providing clinical or diagnostic functionality. **The AMA supports CMS' proposal to adopt the term SaMS.** For the reasons detailed in our comments on the parallel CY 2027 OPPS proposed rule, adopting a healthcare-specific term reduces ambiguity and more accurately reflects the medical function these technologies perform for Medicare payment purposes.

At the same time, the AMA emphasizes that the SaMS designation should function as an interim Medicare classification, not as a parallel clinical or coding taxonomy that conflicts with the terminology, instructions, and service relationships established through the CPT code set. The involvement of software does not, by itself, establish the nature of a service, the resources it requires, the role of the physician or other qualified health care professional, or the appropriate Medicare payment system. Accordingly, a SaMS designation should not be construed to establish coverage, medical necessity, clinical equivalence among grouped services, or a categorical entitlement to separate payment.

This proposal is closely related to the AMA's work, through the CPT code set, to give AI-enabled services a recognized clinical identity, and the AMA encourages CMS to build on this existing framework, which would help keep Medicare and coding classifications aligned and reduce administrative complexity. The AMA would welcome the opportunity to share the CPT Editorial Panel's expertise, along with that of other stakeholders, toward that end. CPT Appendix S, developed by the CPT Editorial Panel and its Digital Medicine Coding Committee (DMCC), distinguishes assistive, augmentative, and autonomous applications according to the function performed and the relationship of the technology to the physician or other qualified healthcare professional. The DMCC is also considering a Clinically Meaningful Algorithmic Analyses framework to support more consistent identification and description of algorithmic analyses; that work remains under development and should not be characterized as finalized CPT coding.

Standardized nomenclature and coding are prerequisites to appropriate recognition and payment. Before payers and CMS can recognize a clinical AI service for reimbursement, they need a standardized way to identify what service was performed. Recognized codes supply that identifier, and reporting these services consistently produces the utilization data on which transparent, evidence-based valuation ultimately depends. Fragmenting or duplicating that nomenclature through a separate Medicare classification would add administrative burden and increase the risk of mispricing and program integrity concerns.

Removal of Codes from the CLFS

CMS proposes to remove 10 HCPCS codes that it characterizes as "SaMS laboratory analyses performed on laboratory tests" (that is, stand-alone algorithmic analyses that CMS views as separate from a CLIA-certified laboratory's examination of human material) from the CLFS and to contractor price them under the PFS, and to similarly assign any future such codes to contractor pricing under the PFS. CMS reasons that these analyses are "other diagnostic tests" under section 1861(s)(3) of the Social Security Act rather

than "diagnostic laboratory tests," do not require performance by a CLIA-certified laboratory, and should be treated consistently with other SaMS technologies regardless of setting.

The AMA does not support CMS' proposal to remove these ten codes from the CLFS and contractor price them and any future such codes under the PFS. As explained in our comments on the parallel CY 2027 OPPS proposed rule, the AMA does not accept the premise embedded in CMS' label. A genuine stand-alone algorithm ("dry lab") analysis is not itself a laboratory test, and the AMA has long worked to preserve that distinction. The AMA's objection is not that these algorithmic analyses are laboratory tests; it is the opposite. Some of the codes CMS has grouped in this proposal describe actual laboratory testing, and CMS' descriptor-based method of classification is not a reliable basis for reassigning services or changing the payment system that applies to them. In urging that these codes remain on the CLFS for now, the AMA does not suggest that a genuine stand-alone analysis belongs on a laboratory fee schedule as a permanent matter; it asks only that the current, least-disruptive payment arrangement be preserved on an interim basis until a dedicated framework and a code-by-code separability review are in place.

CMS grounds this proposal, in part, on an interest in treating fundamentally similar services the same way regardless of the setting in which they are furnished. The AMA supports site-neutral payment as a general matter, but that principle concerns paying consistently for the same service across sites of care, and it does not fit this proposal. This is not a question of where a service is furnished. Site neutrality addresses the payment differentials that apply to the same physician service depending on whether it is furnished in a hospital outpatient department, an ambulatory surgery center, or a physician office; it does not map onto a single national fee schedule such as the CLFS. It is instead a question of correct characterization and of the appropriate payment system for a category of services, including those that are integral laboratory tests. The premise that algorithmic analyses of laboratory data are substantively similar to algorithmic analyses of an imaging study, or to other services already paid under the PFS, is precisely what is in dispute: for at least one of the 10 codes at issue, the analysis cannot be separated from the wet laboratory work that generates the underlying data, and whether any genuinely stand-alone analysis is comparable to other SaMS is a determination for technical review rather than an assumption. Treating dissimilar services as though they were alike would undermine, not promote, the stability and predictability CMS' proposal is intended to advance.

The AMA is further concerned that CMS' framing does not account for SaMS technologies that use laboratory data as only one input among several, alongside imaging, clinical variables, or other non-laboratory data. Characterizing such services as analyses "performed on laboratory tests" is inaccurate, and applying that label through a descriptor review risks sweeping in technologies that are neither laboratory tests nor solely dependent on laboratory data. The AMA is concerned that CMS identified the 10 codes proposed for removal from the CLFS principally by examining whether their descriptors included a laboratory method or described a computer analysis. A CPT descriptor cannot always be evaluated in isolation. Proper classification requires consideration of the full code family, introductory guidelines, parenthetical instructions, add-on relationships, the underlying source data, data acquisition and preparation, quality control activities, the algorithmic output, and any required professional interpretation or management. CMS' own acknowledgment that it previously relied on the laboratory methods named in the code descriptors, and now regards comparison based on those methodologies as inappropriate, confirms this concern: the descriptors do not reliably capture the resources or the nature of these services, and they cannot bear the weight of a decision to change the payment system that applies to them.

The proposed list itself illustrates the limitations of descriptor-based classification. Some listed codes expressly describe gene-expression analysis, tumor-cell culture, tissue-based analysis, or other laboratory processes rather than a stand-alone algorithmic component. CPT code 81416 *Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)* is a clear example. That service requires the laboratory to perform next-generation sequencing (NGS) on the patient specimen in addition to the subsequent analysis; it is therefore a laboratory test that does not meet CMS' own definition of a stand-alone SaMS analysis, and it should be removed from the list. Moreover, CPT code 81416 is an add-on code, reported only together with its base code, 81415 *Exome (e.g., unexplained constitutional or heritable disorder or syndrome);* sequence analysis. Because CMS did not include CPT code 81415 in the proposed list, moving CPT code 81416 alone would severe an add-on code from its base and fracture the code family. A code descriptor scan that produces these results cannot substitute for a technical assessment of the complete service described.

Whether a service is subject to CLIA requirements must likewise be determined from the actual activities involved in furnishing the service, not solely from whether an algorithm could theoretically be executed outside a CLIA-certified laboratory. Data preparation, specimen-related quality controls, validation, analysis, and reporting may remain integral to the service even when the final computational step can be performed separately. CMS' contrary view, that an entity performing only algorithmic analyses of previously generated data may not qualify as a laboratory under 42 CFR 493.2 or require CLIA certification under section 1861(s)(17) of the Act, cannot be applied accurately to any individual service without the clinical and laboratory expertise that a deliberate, code-by-code technical review is best positioned to supply. To the extent CMS is concerned that continued CLFS payment presents program integrity vulnerabilities because it is not subject to beneficiary cost-sharing or budget neutrality, those concerns can be addressed through the dedicated framework and the technical review described below, rather than through a premature reassignment to a payment system that does not fit these services.

Setting aside the classification concerns, the PFS is not an appropriate payment system for these services. The PFS was developed to value physician services using a resource-based methodology, and the principal resources associated with SaMS technologies differ fundamentally from the physician work, practice expense, and professional liability inputs that underpin that framework. The lack of transparency regarding the resources associated with SaMS further complicates efforts to value these services appropriately under the PFS. CMS' proposal to contractor price these 10 codes, rather than assign RVUs, illustrates precisely these challenges and raises the question whether SaMS technologies can be appropriately valued within the existing PFS framework at all.

Even if these valuation concerns could be resolved, incorporating SaMS laboratory analyses into the PFS would raise significant concerns related to statutory budget neutrality. These analyses represent a distinct category of service that is fundamentally different from the physician services for which the PFS was designed, and the AMA does not believe they should be incorporated into the PFS in any manner that requires them to compete with physician services for the fixed pools of Medicare payment, including practice expense. Because payments under the PFS are subject to statutory budget neutrality, as these services are assigned national values and their utilization grows, the added spending would place downward pressure on payment for physician services across specialties, an outcome that is neither intended nor appropriate.

For these reasons, the AMA does not believe transitioning these services to the PFS provides an appropriate short- or long-term solution. Rather than distorting existing Medicare payment systems through ad hoc, temporary valuation approaches, **CMS should make no change for CY 2027; should**

not remove any services from the CLFS until it determines, in consultation with the College of American Pathologists and other relevant stakeholders, that the algorithmic analysis can be safely and appropriately separated from the CLIA-certified laboratory that generated the underlying data; and should engage those stakeholders to develop a dedicated and budgetarily separate payment framework that recognizes the unique characteristics of software-based medical technologies while supporting continued innovation and protecting physician reimbursement.

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS Code G2211)

Recommendations:

- The AMA is concerned that transitioning to a percentage-based modifier without assigned RVUs would remove physicians' ability to receive RVU credit for this work under RVU-based productivity models, and that CMS has not provided sufficient data, analysis, or methodology to demonstrate that ACO participation status warrants valuing MOD2 at twice the rate of MOD1.
- The AMA recommends that CMS commit to timely and transparent public reporting of MOD1 and MOD2 utilization disaggregated by specialty, care setting, and E/M visit level so that stakeholders can assess whether the modifiers are functioning as intended.

CMS proposes to delete HCPCS code G2211 and replace it with a modifier (referred to in the proposed rule as MOD1), valued at 16 percent of the associated E/M service, together with a second modifier (MOD2), valued at 32 percent of the associated E/M service and available only to participants in ACOs. In effect, this proposal is a change to the billing mechanism for recognizing visit complexity. CMS proposes to transition the same underlying work from a separately reported add-on HCPCS code to a modifier appended to the base E/M claim line. That mechanical change does not, in itself, alter the concerns the AMA has raised about G2211 since its inception, nor does it resolve them.

Since CMS first proposed a visit complexity add-on code, the AMA's central concern has not been with recognizing the resource costs of longitudinal care, but with the accuracy of the utilization assumptions CMS used to value the code and to calculate the associated budget neutrality adjustment. In our CY 2024 PFS comment letter, the AMA noted that CMS' assumption that G2211 would be reported with 38 percent of all office/outpatient E/M visits was not supported by the experience of comparable codes, and cautioned that CMS had "previously overestimated physicians' readiness and willingness to report new codes that were not revaluations of existing codes." We noted that the transitional care management codes (99495 and 99496) were dramatically overestimated in 2013, resulting in a cumulative reduction of more than $5.2 billion from the PFS through 2021, and urged CMS not to repeat that mistake with G2211.

Those concerns proved well founded. As detailed in the AMA's May 2025 letter to CMS, an analysis of 2024 Medicare claims data found that G2211 was reported with only approximately 10.5 percent of office/outpatient E/M visits through the first three quarters of the year—roughly one-quarter of CMS' 38 percent estimate. As a result, the CY 2024 budget neutrality adjustment produced a 2.18 percent reduction to the conversion factor when the actual data supported approximately a 0.79 percent reduction, resulting in a cut nearly three times larger than warranted, which the AMA estimated removed approximately $1 billion from the PFS. As we explained in both the May 2025 letter and our CY 2026 PFS comment letter, this overestimate ultimately reduced payments to all physicians, including the very primary care physicians the code was intended to support, by more than the code itself helped them. Because those funds cannot be restored retroactively, the AMA's emphasis going forward is on ensuring that CMS does

not repeat the same estimation error with the new modifiers and on establishing a durable mechanism to correct such errors when they occur.

G2211 is a real-world illustration of why the PFS needs a systematic mechanism to reconcile CMS' utilization assumptions against actual utilization. The AMA strongly supports PFS reforms in the Patients First Act of 2026 (H.R. 9693), which would, among other changes, beginning in 2029, require CMS to compare its estimated utilization against actual utilization for certain new, separately payable services and to reconcile the difference through a prospective conversion factor adjustment on a two-year lag, triggered when the gap exceeds 0.1 percent of total PFS spending, and exempt from budget neutrality. Had such a mechanism been in effect in CY 2024, the roughly $1 billion that CMS' G2211 overestimate wrongly removed from the PFS could have been prospectively adjusted for through an increased conversion factor rather than permanently lost. The AMA urges CMS to support this reform and, in the interim, to use its existing administrative authority to improve the accuracy of its utilization assumptions and to correct material misestimates prospectively, as the AMA requested in its May 2025 letter. The AMA's specific comments on the CY 2027 proposal follow.

Impact on Physicians Compensated Under RVU-based Models

One concern that the AMA has heard directly from physicians is that transitioning from G2211 to a percentage-based modifier creates challenges for physicians compensated under RVU-based productivity models. Currently, G2211 carries assigned RVUs that can be counted toward a physician's productivity and compensation when the code is reported. CMS proposes to instead value MOD1 and MOD2 as a flat percentage of the base E/M code, with no RVUs assigned to the modifiers themselves and no mechanism to attribute RVUs to the reporting physician for this work

For physicians who are compensated under RVU-based productivity models, including many employed physicians, academic faculty, and physicians in group practices, this is a meaningful, real-world consequence of this proposal. Under current policy, a physician who reports G2211 receives RVU credit. Under this proposal, that same physician, performing identical work and reporting the modifier instead, would receive no comparable RVU credit, even though CMS continues to recognize the underlying work for payment purposes. By moving away from an RVU-bearing code, the proposed transition risks taking RVUs away from the very physicians CMS states this policy is intended to support.

The AMA recognizes that the design of physician compensation arrangements is a business decision made by individual employers and practices, and is not a matter within CMS' authority. We raise this issue so that CMS has a complete picture of how this proposal would affect physicians in practice, not to suggest that compensation design is a matter within CMS' statutory authority.

Operational Questions

CMS proposes to pay MOD2 at 32 percent of the base E/M service—twice the 16 percent rate of MOD1—when the modifier is reported by Shared Savings Program ACO participants, ACO professionals, ACO providers/suppliers, and LEAD Participant Providers. The AMA recognizes and supports CMS' long-standing interest in strengthening primary care and advancing accountable care. At the same time, the proposal would, in practice, reimburse what can be the same longitudinal E/M work at materially different rates based not on the work performed or the complexity of the individual visit, but on the ACO-participation status of the billing entity. As CMS itself acknowledges, the complexity standard for the modifier turns on the relationship between the patient and the practitioner and the inherent complexity of the visit, which are characteristics that do not necessarily differ based on whether the

practitioner happens to participate in an ACO. Even accepting that ACO participation entails the additional resource costs CMS describes, CMS has not provided data, analysis, or methodology to support the specific magnitude of the proposed differential.

CMS states that "[t]his increased valuation is meant to reflect the cognitive work of providing longitudinal care, follow-up discussions through an assigned care coordinator with the beneficiary or other providers, and expanded access to educational resources, care options, and provider communication methods" associated with ACO participation. But the complexity standard that governs both modifiers turns on the relationship between the patient and the practitioner and the inherent complexity of the visit, and none of the considerations CMS cites reflect any difference in that work based on ACO status. The cognitive work of managing a patient's longitudinal, complex care needs does not change because the treating physician participates in an ACO. Follow-up discussions through a care coordinator and expanded access to educational resources, care options, and communication methods describe ACO-level infrastructure and administrative support, not the physician's work during the visit itself. Furthermore, to the extent ACO participation involves the additional infrastructure or coordination costs CMS describes, the Shared Savings Program and LEAD Model already exist to compensate ACOs for those investments, through shared savings payments tied to the quality and cost outcomes they are intended to produce. **The AMA asks CMS to explain why this differential is warranted in light of these considerations. The AMA further urges CMS to commit to timely and transparent public reporting of MOD1 and MOD2 utilization, disaggregated by specialty, care setting, and E/M visit level, and to make the underlying methodology and data available for stakeholder review.**

Proton Beam Treatment Delivery (CPT Codes 77520, 77522, 77523, and 77525)

The AMA shares concerns with other interested parties regarding CMS' proposed national pricing methodology for proton therapy under the CY 2027 PFS. As a resource-based payment system, the PFS should value these services using validated direct practice expense data that reflect the resources required to furnish care, not OPPS relative weights, which were not developed for this purpose. We note that the RUC submitted direct practice expense recommendations to CMS in May 2019. We urge CMS not to finalize the proposed national rates for CY 2027 and instead to work with stakeholders, including the RUC, to develop a transparent, resource-based national payment methodology that accurately reflects the costs of delivering proton therapy.

E. Medicare Telehealth Services

Recommendation:

- CMS should finalize its proposal to allow teaching physicians to bill for telehealth services when either they or the resident is in the same location as the patient and extend this policy to include scenarios in which the teaching physician and the resident are in the same location while the patient is receiving the telehealth service in a different location. CMS should allow public comments on the subregulatory guidance it plans to issue for the new modifiers BB and BC.

The Consolidated Appropriations Act (CAA), 2026, extended flexibilities that allow Medicare telehealth services to be delivered nationwide and patients to receive services in their homes through 2027. Audio-only services are also extended, and in-person visit requirements for telehealth for mental health services are delayed through 2027.

The CAA 2026 also requires CMS to create modifiers for telehealth furnished through a virtual telehealth

platform by a physician who contracts with or has a payment arrangement with an entity that owns the platform. In the proposed rule, CMS states that it is establishing modifiers BB and BC for this purpose, but they are for reporting only and will not affect payment rates. It also says that it will issue sub-regulatory guidance on the use of the modifiers. It is not clear what the purpose of these modifiers is. Physicians have many different types of arrangements for providing telehealth services, and they do not know which ones would be subject to these modifiers. For example, they may use a virtual platform because it is used by the health system in which they practice. The AMA recommends that CMS provide its subregulatory guidance in draft form and allow an opportunity for public comments to make sure that people understand this new policy and that it is not unnecessarily burdensome.

The AMA supports the proposal to provide more flexibility for teaching physicians providing virtual supervision of residents. The current policy requires that the teaching physician, resident, and patient be in three different locations. CMS should finalize the proposed policy to allow teaching physicians to bill for services on the Medicare Telehealth List involving residents when either the teaching physician or the resident is in the same physical location as the patient. The AMA also recommends that CMS allow for the teaching physician and the resident to be in the same location and the beneficiary to receive telehealth services in a different location.

F. Proposed Changes to the Ambulatory Specialty Model (ASM)

The AMA has worked with many national medical specialty societies on voluntary APM proposals designed to support physicians in redesigning care delivery for patients with conditions that need to be managed by a non-primary care specialist. We appreciate the efforts CMS is making to create a payment model specifically focused on ambulatory care delivered by specialists that would not hold physicians accountable for total cost of care. Instead, ASM appropriately limits accountability to the kinds of services the participating physicians deliver and the patients they treat for heart failure or low back pain. CMS issued proposed and final rules defining the key elements of ASM during the 2026 rulemaking cycle, but the AMA's detailed recommendations on ways to improve ASM were not adopted in the final rule. The AMA is also disappointed that CMS did not propose three important changes to ASM that we urged it to include in the 2027 proposed rule:

- Increase the redistribution percentage from 85 to 100 percent so that any reductions in payment rates for participating physicians are used to increase rates for other participants.
- Set ASM measure performance thresholds in advance so that physicians know what is required for success and are rewarded for achieving it, instead of penalizing them for good performance simply because other physicians had higher scores.
- Reduce the maximum risk level in the initial two years from nine percent to two percent to allow physicians to gain experience with the new model before being subject to higher levels of risk and significant penalties.

Several changes CMS has proposed for 2027 would improve ASM participation requirements, but the model would continue to exclude most physicians who manage care for patients with heart failure and low back pain while inappropriately mandating participation by specialists who may only see such patients for one visit, test, or procedure. The AMA is also concerned that a problematic, untested measure would be added to the low back pain component of ASM that will inappropriately penalize physicians for services they did not order or deliver. In addition, proposed scoring changes would inappropriately reduce payments for small practices that are unable to submit patient-reported outcome data and those located in urban areas. The AMA is concerned that ASM implementation in 2027 under the current or proposed

rules would have serious negative consequences for Medicare patients and physicians. The AMA offers the following recommendations and the rationale for each, below.

Participation (Section III.D.2.b, 91 FR 43965-43971)

Recommendations:

- Physicians should be excluded from participation in ASM if they officially redesignate their primary specialty from cardiology to a different specialty, but they should not be required to have board certification in the new primary specialty. When a physician's specialty redesignation is approved by CMS, the physician should automatically be excluded from ASM and not also be required to notify CMS within 30 days of the change in specialty.
- Physicians in all specialties should be excluded from participation in ASM if they indicate that they do not direct the care of patients with heart failure or low back pain or if only a small proportion of the patients they treat have heart failure or low back pain.
- Any physician who manages the care of patients with heart failure or low back pain should be given the opportunity to voluntarily participate in ASM if they believe that it will be beneficial for their patients.
- Physicians should be automatically exempt from ASM participation if they are no longer part of the TIN in which they practiced when their ASM eligibility was determined and should not be required to notify CMS within 30 or 60 days of TIN changes based on when they occur relative to the performance year.
- Exemptions based on specialty redesignations or TIN changes should be retroactive to the beginning of the performance year in which the change occurred and automatically apply to all subsequent performance years.
- Physicians should only be terminated from ASM for reasons that are clearly described and justified in regulations.

CMS states in Section III.D.2.b.(1) (91 FR 43965) that it designed ASM with a "focus" on clinicians who "develop longitudinal relationships with patients" and "co-manage beneficiaries with primary care providers." However, the current ASM participation requirements are not based on whether the specialist has a longitudinal relationship with patients or co-manages patients with a primary care physician. The methodology used in the model requires specialists to participate even if they only see patients who have heart failure or low back pain on a single occasion for a one-time consultation or test, or even if the services they delivered to the patients were intended to address health problems other than heart failure or low back pain. At the same time, the model excludes most physicians who manage the care of patients with heart failure and low back pain. It is essential for changes to be made that correct these problems before ASM is implemented.

<u>Primary Specialty Redesignation</u>

The AMA supports the proposal in Section III.D.2.b.(4)(b) (91 FR 43968) to create an exemption for cardiologists who redesignate their specialty type to cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, or adult congenital heart disease. We agree that most physicians in these specialties are unlikely to manage the overall care of heart failure patients.

The AMA opposes requiring physicians who redesignate their primary specialty to provide proof of board certification to qualify for the ASM exemption (91 FR 43968). Medicare already requires physicians to attest that they meet all state and federal requirements for their selected primary specialty to participate in Medicare, but they are not required to be board certified. That CMS proposes this board certification requirement for physicians to be exempt from ASM but not to be included in ASM demonstrates that CMS does not view it as a necessary requirement to care for patients under ASM. If instead CMS is concerned that physicians will inappropriately redesignate their specialty solely to be exempt from ASM, it can examine billing records to determine whether most of their services are in the specialty they have designated and whether they are providing evaluation and management services to patients with heart failure for extended periods. If CMS finalizes the board certification requirement to qualify for exemption from ASM, then it should also exclude physicians from ASM if they are not board certified in cardiology, anesthesiology, pain management, neurosurgery, orthopedic surgery, or physiatry.

We neither understand nor support the proposed requirement that physicians who have redesignated their primary specialty through the CMS-855 form or PECOS also "provide written notice of the CMS-approved redesignation within 30 days of the effective date of the CMS-approved redesignation" (91 FR 43968). If CMS has approved the redesignation, then it presumably is aware of it, and there is no need for another notification. Moreover, it is unclear whether failure to submit this notification would cause the physician to remain in ASM.

Physicians Who Do Not Direct Care of Heart Failure or Low Back Pain Patients

We commend CMS for recognizing that physicians in "highly specialized or procedure-focused practice areas" are inappropriate for ASM because they are unlikely to provide ongoing management of a chronic condition such as heart failure (91 FR 43968). While we support the proposed exemption for cardiologists who redesignate their specialty to cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, or adult congenital heart disease, this does not do nearly as much as is needed to focus the ASM heart failure cohort on physicians who manage patients with heart failure. Moreover, it does nothing to focus the ASM low back pain cohort on physicians who manage patients with low back pain. To address this issue, the AMA recommends that CMS expand the proposed exemption so that if a cardiologist does not manage the ongoing care of patients with heart failure, or if an anesthesiologist, pain management physician, neurosurgeon, orthopedic surgeon, or physiatrist does not manage the ongoing care of patients with low back pain, that physician should be able to so notify CMS and then be exempt from ASM participation.

In addition, if a physician uses Patient Relationship Codes on claims to report the types of relationships they have with patients, CMS should use those codes to determine how many of the patients attributed to the physician under the Episode-Based Cost Measures (EBCMs) for heart failure or low back pain had a "continuous" relationship with the physician. Then, CMS should only include patients with whom the physician has a continuous relationship in determining whether a physician should participate in ASM.

Finally, we recommend that if patients with heart failure or low back pain represent only a small proportion of a physician's total patient population, the physician should be able to opt out of ASM participation. It is inappropriate for CMS to evaluate a physician's performance on quality or cost based on a small and non-representative subset of their patients, and to increase or decrease the payment rates for all the services they deliver to their other patients using performance scores for only the small number of patients with heart failure or low back pain.

Voluntary Participation

Physicians should not be prohibited from participating in a payment model based on their specialty or geographic location, and patients should not have to worry whether they will be able to receive the most appropriate services for their health problem because of where they happen to live or the specialty of the physicians who are available to provide services. The AMA recommends that any physician who manages the care of patients with heart disease or low back pain should be able to voluntarily participate in ASM regardless of where they practice, where their patients receive services, or what specialty code is assigned to them by CMS. CMMI should evaluate ASM and other new APMs by comparing participating and non-participating physicians using appropriately designed cost and quality measures, and by examining the changes in physician performance compared to years preceding the payment model, rather than mandating participation by some types of physicians in some geographic areas and preventing participation by others. The AMA also advocates that practices be exempt from mandatory participation in ASM when they meet certain criteria indicating limited capacity to participate, including but not limited to small practice size, lower Medicare revenue, low attributed patient volume, or practice location in rural or Health Professional Shortage Areas, unless they voluntarily elect to participate.

TIN Changes

The AMA agrees with CMS that physicians should be exempt from participation in ASM if they stop reassigning their billing rights to the TIN in which they practiced when their eligibility for ASM was determined. As CMS has proposed in Section III.D.2.b.(4)(a) (91 FR 43967), this should include physicians who change TINs prior to the start of an ASM performance year and physicians who do not reassign their billing rights to a new TIN, as well as the current exemption for physicians who reassign their billing rights to a new TIN during the performance year. The AMA opposes limiting these exemptions to physicians who notify CMS of the change within narrow windows of time, however. CMS will know which physicians it has assigned to ASM and the TINs where they practiced during the period used for assignment, so CMS can easily determine directly whether those physicians have begun billing under a different TIN or stopped billing for services altogether. Moreover, the proposed rule does not make it clear what happens if the physician fails to meet the deadline for notifying CMS of the change – do they automatically continue to participate in ASM even under a different TIN? Could CMS later decide to retroactively assign the physician to MIPS even though the physician thought they had been part of ASM? These arbitrary, short deadlines create unnecessary burdens and uncertainties for physicians that have nothing to do with the quality or cost of care they provide.

Automatic Exemptions

CMS proposes to modify §512.710(c)(1) so that an exemption related to a specialty redesignation or TIN change would be determined by CMS "in its sole discretion" (91 FR 43968), and to modify §512.710(c)(3)(i) to state that the exemption would be effective "on the CMS-determined date," and apply "for the ASM performance year specified by CMS" (91 FR 43970). This appears to give CMS the ability to deny an exemption even if the physician's specialty or TIN has changed. There is no explanation of what is meant by the "CMS-determined date" or what performance year CMS could specify. It is not clear whether CMS is proposing that it could delay the effectiveness of the exemption until a future performance year or make the change effective for only a portion of a year. We urge that the regulation clearly state that the exemption would take effect automatically and be retroactive to the beginning of the performance year in which the change occurred.

CMS also proposes that an exemption related to a TIN change would be limited to a single performance year (91 FR 43970). It is not clear whether this means that the physician would have to notify CMS of the change every year in order to continue the exemption. The rationale given for limiting the exemption to a single year is that it would allow CMS to "select the ASM participant with the exception … for a future ASM performance year should the NPI again reassign billing rights to the same TIN." The AMA recommends that CMS state clearly that the exemption or exception "would continue in each subsequent performance year unless the NPI reassigns billing rights to the same TIN."

Terminating Physicians from ASM

CMS proposes changing §512.710(h) so that it could "terminate an ASM participant" in its "sole discretion" if CMS determines "that their continued participation would be inconsistent with the purposes of ASM or applicable law" (91 FR 43971). The only example provided for how this vague provision might be used is in "circumstances involving egregious conduct." This type of open-ended discretion is inappropriate, and we oppose making this change.

Data Submission (Section III.D.2.c, 91 FR 43971-43974)

Recommendations:

- Physicians should be able to submit data on quality measures and improvement activities at either the group (TIN) level or the individual (TIN/NPI) level. A group-level submission on behalf of a subset of the ASM participants in the TIN should also be permitted.
- Practices should be allowed to submit information for any or all quality measures at both the TIN level and the TIN/NPI level.

Improvement Activities (IA)

Physicians who work as a team should have the ability to be scored as a team. The AMA continues to believe that the IA requirements under ASM are impractical and burdensome, and they will discourage specialists from treating Medicare patients who need their skill and expertise. There is no recognition in ASM of specific efforts by physicians to improve treatment and outcomes for patients with heart failure or low back pain. Instead, ASM participants are required to find a primary care practice willing to sign a collaboration agreement that meets CMS requirements and to help patients find a primary care physician if they do not have one.

When CMS adopted the requirement for information on these IA to be submitted at the TIN level, it stated that this would decrease administrative burden associated with this requirement. However, CMS then determined that all ASM participants in the TIN would be deemed to have failed to satisfy the IA requirement if any one of them failed to do so. This would unfairly penalize all of the TIN's ASM participants that took the necessary steps to meet the requirements.

The AMA supports CMS' proposal in Section III.D.2.c.(3) (91 FR 43972) to allow reporting of IA information at the individual level as a way of solving this problem. However, this approach would also increase the burden on the subgroup of physicians who meet the requirements. We recommend that CMS also allow TINs to submit IA information for a subgroup of ASM participants that are meeting the requirements, while allowing other ASM participants in the group to submit information as individuals.

Quality Measure Submission

Current ASM regulations allow ASM participants in a small practice to submit quality measure information either at the group (TIN) or individual level, similar to what is done in MIPS. In Section III.D.2.c.(4)(a) (91 FR 43973), CMS proposes that if quality performance information is submitted at the TIN level in a small practice, the score based on that TIN-level data would be used for all individual ASM participants, even if one or more of the participants had submitted quality performance information at the individual level for themselves.

CMS states that the proposed change is designed to prevent a practice from submitting individual-level data for higher-performing ASM participants and group-level data for lower-performing participants (91 FR 43973). However, the proposed change would also prevent a practice from submitting individual-level data for the subset of ASM participants in the practice who can individually meet the minimum case requirements for a measure, then submitting TIN-level data for those participants without enough patients to be scored individually on the measure. The result could be differences in the numbers of measures that ASM participants can report, which would be contrary to CMS' goal of accurately comparing performance across participants.

The proposed change would also prevent a combination of individual and group reporting in a group where one or more ASM participants focus on a specific type of patient (e.g., those with more complex conditions), while the remaining ASM participants work as a team to share the delivery of care to other types of patients. This would also result in less accurate comparisons of quality across ASM participants.

The AMA recommends that CMS allow both group and individual reporting for the same quality measures. This should be done at least in the initial year of ASM, which would allow CMS to monitor the nature of the reporting to determine whether changes are needed, rather than precluding reporting at multiple levels based on purely speculative concerns. We also recommend that dual levels of reporting should be available to all practices, not just small practices, since ASM participants in small practices do not necessarily treat different numbers or types of patients than ASM participants in large practices.

Finally, we request that CMS include language in the rule to explicitly indicate that submission by a small practice of information for one quality measure at the TIN level does not mean that information for all quality measures must be submitted at the TIN level. Section III.D.2.c.(4)(a) of the preamble states that the "proposal would mean than any individual-level (that is TIN/NPI-level) submission received for any ASM participants in that small practice would not be scored if any group-level quality data submission is received" (91 FR 43973). This could be interpreted as requiring TIN-level submission of data for all quality measures, particularly since MIPS requires clinicians to report all quality measures at the same level, i.e., all measures are reported at the TIN level, or all are reported at the TIN/NPI level.

Low Back Pain Quality Measure Set (Section III.D.2.d.(2), 91 FR 43974-43978)

Recommendation:

- CMS should not include the "Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain" measure, the "Functional Status Change for Patients with Low Back Pain Impairments" measure, or the "Functional Outcome Assessment" measure (MIPS Q182) in ASM.

The quality measures used in ASM would not adequately or accurately assess whether Medicare patients with low back pain achieve better outcomes, nor would they protect them from undertreatment caused by efforts to reduce episode spending.

"Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain" Measure

CMS again proposes to include a measure of MRI Lumbar Spine for Low Back Pain (91 FR 43974) after dropping its original proposal for such a measure in previous rulemaking. The stated rationale for its inclusion is that (a) none of the other low back pain quality measures are "focused on excess utilization or efficiency" and (b) a utilization measure is necessary to have a "well-rounded measure set." However, it is unnecessary and duplicative to add a measure focused on one specific type of utilization because the low back pain episode-based cost measure in ASM already provides a comprehensive way of assessing utilization, and that measure already creates an incentive for physicians in ASM to avoid ordering unnecessary MRIs for patients with low back pain.

If anything, ASM is missing measures of *underutilization*, not overutilization. The episode-based cost measures used in ASM reward efficiency, but they also create a problematic financial incentive to delay or withhold necessary testing and treatment services. The measure CMS has proposed cannot assess whether MRIs are being underutilized because it explicitly excludes many of the patients who need to receive them. A true value-based payment program should have complementary quality and cost measures that enable a determination of whether quality has been maintained or improved for the same patients for whom utilization and cost have been reduced, and the quality measures in ASM do not do that.

Moreover, the OP-8 measure on which the proposed measure is based was removed from the Hospital Outpatient Quality Reporting Program partly due to evidence that it had not improved outcomes and concerns that it could delay diagnosis of patients' problems. CMS indicates that it has made "targeted specification modifications to improve the measure's applicability and statistical reliability in the ASM context," but CMS has not provided any evidence that the proposed measure will improve outcomes or avoid delays in diagnosis. Moreover, CMS has not provided the full details of the modifications it has made nor the results of any measure testing that has been conducted. The AMA strongly opposes placing physicians at financial risk for performance on a measure that has not been rigorously tested at the individual physician level and that has not been reviewed or endorsed by an entity such as the Partnership for Quality Measurement.

As described below, the limited information about the specifications provided in the proposed rule indicates that there are many serious problems with the measure. Most of the changes to the OP-8 measure definition are clearly being made solely or primarily to increase the number of physicians who are measured, not to increase the accuracy of the measure.

Inappropriate Use of Claims Data Rather Than Clinical Data to Assess Appropriateness

CMS is proposing to use claims-based diagnosis information to determine which low back pain patients should not receive an MRI. A physician determines whether an MRI is appropriate based on a complete assessment of the patient's history and current condition, and all relevant factors may not be captured on claims. Consequently, a claims-based measure alone cannot be used to determine whether a physician is ordering MRIs appropriately. At best, such a measure can identify "potentially" unnecessary MRIs so that a more detailed review of clinical information could be performed to determine whether those MRIs were actually appropriate. That claims-based measures impose no additional reporting burden on physicians is

only a benefit to them if the claims data result in accurate measurement and access to timely and meaningful data, and this measure would not do that.

Expansion of Measure Denominator Without Adequate Physician Input

In addition, in Section III.D.2.d.(2)(a)(i) (91 FR 43975), CMS indicates it has removed many diagnosis codes for cancer, neurological impairment, and autoimmune and inflammatory conditions that were used as exclusions in the OP-8 measure. CMS states that "physicians assessed each code under these categories for appropriateness to include in the measure denominator," but it is not clear which physicians made this assessment, and no opportunity has been provided for the relevant specialty societies to comment on these changes. CMS states that "most" conditions for which imaging would be warranted were maintained as denominator exclusions, but it has not provided a list of the specific codes that are being removed. The fact that the exclusions are the same as those in the HEDIS Use of Imaging Studies for Low Back Pain measure does not mean that they are appropriate for a measure to evaluate physician performance, since the HEDIS measure is used to evaluate health plans, not physicians. CMS indicates that 52 percent of cases that were not considered as potentially inappropriate in the OP-8 measure will now be included in the measure it proposes to use; that type of dramatic change requires more careful review and greater transparency than CMS has provided.

Attribution of Tests to Physicians Who Did Not Order Them

Using the OP-8 measure for physicians instead of hospitals requires an attribution methodology, i.e., a way of determining which physician will be held accountable for an MRI. Although it would seem obvious that the physician who ordered the MRI should be accountable for the MRI, Section III.D.2.d.(2)(a)(iii) (91 FR 43976) indicates that CMS wants to attribute the MRI to "all physicians who provided qualifying services to the patient," even if those physicians were unaware that the MRI had been ordered or if their "qualifying services" were delivered after the MRI was performed. The justification given for this is that it enables CMS to attribute 26 percent more MRIs to ASM participants, not that it does a better job of identifying the physicians who were involved in the decision to order the MRI. The single-physician attribution alternative that CMS examined and rejected is no better, because it also would not attribute the MRI to the physician who ordered the test; instead, it would attribute it to the ASM participant who had the highest number of encounters with the patient prior to the MRI, even if none of those encounters had anything to do with the MRI that triggered the attribution. In addition, in Section III.D.2.d.(2)(a)(v) (91 FR 43977), CMS proposes to use a 365-day "lookback period" in the attribution process, i.e., if a physician in ASM delivered a service to a patient with low back pain a year before the patient received an MRI, that MRI will be attributed to the physician, even if the physician no longer had any involvement in the patient's care when the MRI was ordered or performed. CMS states that the lookback period needs to be "long enough to capture clinical encounters that inform decisions about imaging," and that a 365-day period "better reflects the longitudinal nature of chronic low back pain management," yet no analysis is presented demonstrating that the attributed physicians had any involvement or influence over the decision to order an MRI a year later. The justification for the 365-day lookback is that it attributed 27 percent more MRIs to ASM participants than a 90-day lookback period, not that the additional physicians attributed in that way had any meaningful influence over or involvement with those MRIs.

Inappropriately Low Minimum Case Count

In Section III.D.2.d.(2)(a)(iv) (91 FR 43976), CMS proposes to apply the measure to physicians who have been attributed as few as 20 cases. This would be a significantly lower threshold for individual physicians

than the minimum case counts used in the OP-8 measure for hospitals, where the minimums ranged from 31 to 67 and varied depending on the hospital's performance rate. It is unlikely that the proposed measure would be sufficiently reliable for a physician with 20 cases to justify using it in ASM. The proposed rule states only that the measure "showed stronger reliability" with a threshold of 20 than with a threshold of 10, but that is not a justification for using the threshold of 20, because almost any measure will show stronger reliability with a larger number of cases. If a physician has only 20 attributed cases, the MRI rate will differ by 5 percent depending on whether one patient receives an MRI or not. The 2024 Annual Reevaluation Report for the OP-8 measure showed that even with minimum case counts much higher than 20 patients, a 5 percentage point increase in the rate would have moved a hospital in the 10th percentile to the 25th percentile, moved a hospital in the 25th percentile to the 50th percentile, moved a hospital in the 50th percentile to the 75th percentile, and moved a hospital in the 75th percentile to the 90th percentile. This means that a physician could easily be penalized under the measure for ordering an MRI for a single patient who did not meet one of the specific exclusions in the measure definition but for whom the MRI was necessary and appropriate.

Problematic Performance Period

In Section III.D.2.d.(2)(a)(ii) (91 FR 43976), CMS proposes to calculate the measure over a two-year performance period, which is problematic for several reasons. First, it would mean that this measure would assess a different set of patients than any other measure used in ASM. Whereas CMS justifies using a minimum case count of 20 for the measure because it "aligns with the case minimums for the other quality measures in the ASM low back pain set," a two-year performance period would *not* be aligned with the one-year performance period used for other measures. Second, use of a two-year performance period would mean that in the initial year of ASM, physicians would be held accountable for MRIs performed before ASM even began. Third, because it is a rolling two-year period, physicians would be penalized twice for what the measure classifies as poor performance in any given year – once in the current ASM performance year and again in the next ASM performance year. Since CMS only plans to provide performance feedback to physicians after the end of each year, if a physician makes changes in response to the feedback, it would not affect most patients in the measure until two years later. As with the other aspects of the measure, it appears that the primary reason for using a two-year performance period is to increase the number of physicians measured, not to obtain a more accurate assessment of their performance.

"Functional Status Change for Patients with Low Back Pain Impairments" Measure

The AMA strongly supports the proposal to remove the "Functional Status Change for Patients with Low Back Pain Impairments" measure (MIPS Q220) from ASM (91 FR 43977). We expressed serious concerns about this measure in comments on the 2026 proposed rule and are pleased that CMS plans to remove it.

"Functional Outcome Assessment" Measure (MIPS Q182)

It is neither necessary nor desirable to add the Functional Outcome Assessment measure (MIPS Q182) to ASM. It does not assess whether patient outcomes have worsened, so it does not protect patients against undertreatment, and it does not enable physicians to be rewarded for improving patient outcomes. Relatively few ASM participants currently report this measure in MIPS, and those who do report it are largely physical therapists and occupational therapists. Since most clinicians reporting the measure have 100 percent performance, it is highly problematic to compare performance using the CMS decile scoring system. Based on the 2026 MIPS benchmark data, clinicians who score 100 percent would be assigned to

the 10th decile and receive the maximum points for the measure, whereas a clinician with 99.9 percent performance would be assigned to the 2nd decile and receive less than 3 points. This means that a clinician with 1,000 low back pain patients would receive a significant penalty if a single patient did not receive a functional assessment or plan of care. Since a physician with only 20 low back pain patients would also be included in ASM, failure to document the functional assessment or plan of care for a single one of those 20 patients would reduce that physician's performance to 95 percent. Under the 2026 MIPS benchmark data, a clinician with 95 percent performance would be assigned to the 1st decile and receive less than two points on the measure. We do not believe this is an appropriate way of measuring "quality" or comparing physician performance in ASM.

Scoring and Benchmarks for Quality Measures (Section III.D.2.d.(4), 91 FR 43978-43979)

Recommendations:

- The AMA strongly recommends that ASM benchmarks be based solely on performance data from previous years, not from the current performance year.
- We urge CMS to score physicians in small practices on administrative quality measures at the TIN level if they report other ASM quality measures at the TIN level.

Establishing ASM Benchmarks

Physicians need to know in advance what level of quality or cost they need to achieve to avoid a payment reduction due to ASM participation. The ASM regulations at §512.725(h)(2)(i) allow CMS to base the benchmark for each measure on performance information reported for that measure during (A) the ASM performance year, (B) a previous year, or (C) "another period determined by CMS." Basing the benchmark for an ASM participant's performance in the current year on the performance of other ASM participants in that same year means that physicians in ASM would have no way of knowing in advance what level of performance they need to achieve to receive a high score on the measure. It also means that physicians could be penalized even if they significantly improved quality simply because other physicians had even higher performance. This "tournament" approach will discourage physicians from collaborating on care improvement initiatives and sharing best practices because the only way that a physician could achieve a high score would be to perform better than other physicians during the same year.
In MIPS, quality measure benchmarks are based on physician performance in the previous year, so physicians know in advance what level of performance is both desirable and feasible for them to achieve; ASM should use the same approach. During the first year of ASM, benchmarks can be established based on performance on the same measures in MIPS during the prior year. This would allow a smoother transition from MIPS into ASM for the ASM participants, and it would also facilitate a smoother transition back to MIPS for those ASM participants who do not meet the thresholds required for continued participation in ASM.

Scoring at the TIN Level

Physicians who work as a team should have the ability to be scored as a team, rather than as individuals. CMS has proposed to score all ASM participants on administrative quality measures at the individual (NPI/TIN) level (91 FR 43978) even though physicians in small practices are allowed to report quality measures at the practice (TIN) level. Group reporting of quality measures is desirable not only because it reduces burden for physicians, but also because it enables physicians in a practice where multiple physicians share responsibility for patient care to be assessed on the quality of care delivered by the entire

team, rather than based only on the subset of patients who happened to have received services from that specific physician during the performance period. Calculating administrative claims-based quality measures at the individual level for these practices could inappropriately penalize or reward physicians who focus on subsets of patients who are at higher or lower risk of hospital admission or who are more likely to require testing, and it could penalize group practices in which individual members focus on different subsets of patients based on how well the skills of the physicians match the unique needs of the patients. We recommend that, if ASM participants in a small practice choose to report their other ASM quality measures at the TIN level, administrative quality measures should also be calculated at this level.

Development of Patient-Reported Outcomes (Section III.D.2.d.(5), 91 FR 43979-43983)

Recommendation:

- Quality Performance Category scores should not be increased as a way of encouraging ASM participants to submit voluntary patient-reported outcome (PRO) data. Instead, CMMI should provide grants to both ASM participants and non-ASM participants to enable them to collect and submit PRO data. CMS should also encourage collection and submission of PRO data by minimizing the administrative burden of the requirements and maintaining the stability of the requirements over time.

Encouraging Voluntary Submission of PRO Data

CMS proposes to increase an ASM participant's quality category score by five points if they voluntarily submit PRO data to CMS based on CMS-defined specifications (91 FR 43980). CMS says this is intended to serve as an "incentive" for ASM participants to collect and submit PRO data, but it does not provide an estimate of the cost to collect and submit the data, nor is there any analysis of whether the payment change resulting from the additional 5 points would offset the additional costs of providing the data. In many cases, the additional points will merely result in smaller cuts in the ASM participants' payments, not an actual increase in their payments. Because of the logistic exchange function that CMS has decided to use in ASM, the "incentive" will be larger for participants with scores closer to the median.

Although CMS says that it is not proposing to require ASM participants to collect or submit PRO data, the proposed incentive would penalize ASM participants who do not submit PRO data. This is because under the ASM payment methodology, increasing payments for some ASM participants requires reductions in payments for all other participants. As a result, if larger practices can submit PRO data and smaller practices cannot afford to do so, the proposed change would result in reductions in the payments for physicians in small practices.

This is illustrated in the AMA hypothetical scenario below. For simplicity, the scenario assumes that ASM participants fall into 4 groups – 30 percent receive an ASM score of 80, 20 percent receive a score of 55, 30 percent receive a score of 45, and 20 percent receive a score of 37, for a median score of 50. The scenario further assumes that the total Part B payments for the participants are all the same. Under the ASM payment methodology, the ASM participants with a score of 80 receive a 3.86 percent increase in their Part B payments two years later, whereas all other ASM participants receive a reduction. (The ASM payment methodology inappropriately forces most participants to receive a reduction in payments to guarantee savings for Medicare.) The scenario then assumes that the ASM participants in the two groups with the highest scores all submit PRO information and receive the scoring incentive; the 5-point increase in their quality performance score would increase their total ASM score by 2.5 points because the quality category receives a 50 percent weight.

ASM Participant Group	% of Total TIN-NPIs	Average Part B Payments	ASM Score	Payment Adjustment Factor	Change in Payment	PRO Submission	Bonus Points	Revised ASM Score	Payment Adjustment Factor	Change in Payment	Difference
A	30%	$250,000	80.0	3.86%	$9,649	Yes	2.50	82.5	4.06%	$10,139	$489
B	20%	$250,000	55.0	-0.60%	($1,492)	Yes	2.50	57.5	-0.12%	($307)	$1,185
C	30%	$250,000	45.0	-3.90%	($9,758)	No	0.00	45.0	-4.25%	($10,621)	($863)
D	20%	$250,000	37.1	-6.09%	($15,220)	No	0.00	37.1	-6.34%	($15,845)	($625)
Total	100%			-1.35%					-1.35%		
Median			50.0					51.3			

As shown in the table, the result is:

- Participants in the highest scoring group receive a small increase in their payment adjustment factor (0.2 percent). This results in an increase of $489 in their total Part B payments two years later (assuming their total Part B payments then are about the same as in the performance year).
- Participants in the second-highest scoring group receive a reduction in their payment adjustment factor (0.48 percent), so all their Part B payments will still be cut, but by a smaller amount.
- All ASM participants who did not submit PRO information would receive larger reductions in their Part B payments than they would have if the PRO scoring incentive did not exist.

If CMS wants to encourage voluntary submission of PRO data, we urge that it provide cash grants directly to the practices that do so, rather than distorting the ASM scoring system in the way it has proposed. Since ASM is being created as a CMMI model, CMMI can and should use a portion of its $10 billion appropriation from Congress to pay for these grants. The amount of the grants should be based on the cost of collecting and submitting the data, so that small practices as well as large practices can participate if they wish to do so.

Minimizing Burden of Voluntary PRO Data Submission

If CMS establishes an incentive program for voluntary collection and submission of PRO data, it should make every effort to minimize requirements for which compliance is difficult, expensive, or time-consuming for physicians and practice staff. This will maximize the number of ASM participants who can participate in the program if they wish to do so. In addition, once CMS establishes an initial set of requirements, those requirements should not be increased for the remainder of the ASM program, and the opportunity to submit data should continue until the end of the ASM program. ASM participants who make the investment to collect and submit data should not be subjected to changes that increase the cost or time involved, nor should they find that the program is being terminated earlier than expected. CMS should also make a commitment now that if problems are identified after submission of PRO data begins, it will consult with the ASM participants who are submitting the data to determine the best way to solve those problems rather than making the changes unilaterally.

Promoting Interoperability ASM Performance Category (Section III.D.2.e, 91 FR 43983-43988)

Recommendation:

- The Promoting Interoperability category should be eliminated from ASM. It should not be expanded to include requirements for electronic prior authorization, and bonus points should not be provided for use of electronic prior authorization.

The PI component of ASM is burdensome and unnecessary, and the proposed changes would make it even more problematic, particularly for small practices. We do not agree that PI measures will "enhance the quality of care, reduce costs by encouraging upstream chronic condition management, empower patients to engage in their care, or promote collaboration between specialists and primary care" (91 FR 43983). ASM participants will inherently have an incentive to utilize EHRs, HIEs, e-Prescribing, patient portals, and other systems if they will improve outcomes and control costs for patients. The lengthy list of measures and attestations required under ASM in the PI category will merely increase the burden for ASM participants without any corresponding benefit for patients with heart failure and low back pain. Because ASM is being established under the statutory authority of CMMI, not as part of MIPS, there is no need to include PI in ASM or to align it with MIPS PI. We urge that it be eliminated from ASM.

We do not support requiring practices to use electronic prior authorization as part of ASM as CMS has proposed (91 FR 43987). Although we strongly support the use of electronic prior authorization and we believe that it will be beneficial to most physician practices, we do not believe it is appropriate to subject ASM participants to as much as a 20 percent penalty for failure to use it. It will likely be more difficult for small practices and solo practitioners to comply with this requirement, which means that small practices will disproportionately receive penalties for failure to comply. A 10- or 20-point penalty for failure to comply with PI requirements will negate the benefits of the 10- and 15-point scoring bonuses for small and solo practices. We do not support providing bonus points for use of electronic prior authorization because adding bonus points for any subset of ASM participants will result in larger payment penalties or smaller payment increases for all other ASM participants.

We support the proposal to eliminate the requirement in ASM for a security risk analysis attestation (91 FR 43987). This will reduce the reporting burden on physicians and avoid imposing an unreasonably high penalty for failure to do this.

Final Score (Section III.D.2.f, 91 FR 43988-43990)

Recommendations:

- CMS should not add a rural scoring adjustment to ASM but should instead remove the interoperability requirements for participants in rural areas. These requirements should be waived for participants in non-rural areas if they represent a hardship because of conditions in the community where they practice.
- A pre-defined threshold established at a level expected to be achievable by most participants should be used in the exchange function rather than the median score in the performance year.
- ASM participants should be given quarterly performance data and analysis during each performance year. This information should be provided for services delivered during each calendar quarter no later than the end of the following quarter. ASM participants should not receive a payment reduction if they have not received these reports in a timely manner.

Physicians should know in advance what performance score they must achieve to avoid a penalty, and that score needs to be set at a level that is expected to be achievable by the majority of participants. If physician subgroups face barriers in meeting specific ASM requirements, these requirements should be

adjusted or waived for those physicians. It is essential that physicians receive frequent and timely feedback on their performance.

Scoring Participants in Rural Areas

We commend CMS for recognizing that physicians who practice in some rural communities face greater challenges in staffing and electronic exchange of information than physicians in other areas (91 FR 43987). However, there are many non-rural communities where physicians face similar or greater challenges due to factors unique to those communities, and there are many rural communities where physicians do not face these challenges. We do not believe that increasing the final scores for participants solely based on their rural location is an appropriate way to address the specific challenges that individual physicians will face in ASM.

In the 2026 final rule, CMS declined to establish a rural adjustment because it "found in our analysis of historical MIPS performance data among likely ASM participants there was not a systematic difference in the performance data between likely ASM participants in rural and non-rural participants" (90 FR 49675). AMA analysis of the 2024 QPP Public Use File shows that this continues to be true. Among the physicians whom CMS has identified as likely participants in ASM, the average MIPS score for those in rural areas was 80.7, virtually identical to the 80.8 score for those in non-rural areas. ASM participants in small practices had much lower MIPS scores than large practices (73.6 vs. 84.6), but the average scores for small practices in rural and non-rural areas were almost identical (72.5 vs. 73.7) and the average scores for large practices were almost identical in rural and non-rural areas (83.8 vs. 84.7).

There is clearly a large, systematic difference between small and large practices that justifies the additional points CMS plans to award to small and solo practices in ASM, but there is not a large, systematic difference between rural and non-rural practices that justifies an additional scoring adjustment based on rurality. Moreover, while the proposed rural scoring adjustment would benefit physicians located in rural areas, it would also penalize all non-rural participants. In addition, the rural adjustment would penalize most ASM participants in small practices because most small practices are not in rural areas. Under the ASM payment structure, any increases for some ASM participants require decreases for all other participants.

This is illustrated in the AMA hypothetical scenario below. For simplicity, the scenario assumes that all rural ASM participants receive a score of 50, which is the median for all participants. Under the ASM payment methodology, all participants who score near or below the median, both those in rural and urban areas, would receive a payment reduction; only those with scores much higher than the median (such as 80 in the example below) could receive a payment increase. Creating a 5-point scoring adjustment for the ASM participants in rural areas would result in a smaller payment cut for those participants, but it would result in larger payment cuts or smaller payment increases for all other participants.

ASM Participant Group	Rural/ Urban	% of Total TIN-NPIs	Average Part B Payments	ASM Score	Payment Adjustment Factor	Change in Payment	Rural Points	Adjusted Score	Payment Adjustment Factor	Change in Payment	Difference
A	Urban	30%	$250,000	80	4.02%	$10,055	0	80	3.74%	$9,357	($697)
B	Rural	10%	$250,000	50	-2.16%	($5,412)	5	55	-0.67%	($1,683)	$3,730
C	Urban	40%	$250,000	50	-2.16%	($5,412)	0	50	-2.31%	($5,778)	($366)
D	Urban	20%	$250,000	30	-7.37%	($18,426)	0	30	-7.41%	($18,513)	($87)
Total		100%			-1.35%				-1.35%		
Median				50				50			

It is unfair to penalize non-rural participants in order to reduce penalties on rural participants, and it is unfair to increase scores for all rural participants regardless of whether they actually face significantly greater challenges in ASM than other participants.

Addressing Interoperability Barriers

The specific issue that CMS says the proposed rural adjustment is supposed to address is the "additional interoperability barriers faced by rural clinicians." CMS states that "ASM's existing scoring methodology may not adequately address the complex factors that may affect rural ASM participant's [sic] performance particularly because ASM has a unique focus on incentivizing interoperability improvements to strengthen care coordination" (91 FR 43989). The most direct and effective way of addressing this concern would be to exempt practices in rural areas from the ASM interoperability requirements. In addition, because some participants in non-rural areas may face similar barriers, CMS should establish a mechanism for waiving the requirements if a participant demonstrates that they would represent a hardship because of conditions in the community where they practice.

Setting Performance Standard

Instead of setting a performance standard in advance (as in MIPS), payment adjustments under ASM would be based on comparing each physician's final score to the median score of other ASM participants during the same year. This "tournament" approach means that physicians could be penalized even if they significantly improved quality or reduced avoidable spending. In addition, physicians who are mandated to participate in ASM would have no way of knowing in advance what level of performance would enable them to avoid a penalty. Moreover, it would discourage physicians from collaborating on care improvement initiatives and sharing best practices, because the only way to avoid a payment reduction would be to receive a significantly higher score than most other physicians.

We urge CMS to establish a performance standard prior to the beginning of the performance year. This standard should be based on an analysis to determine a performance level that will be achievable by the majority of ASM participants.

Quarterly Performance Data

To improve patients' care, reduce avoidable costs, and succeed in ASM, physicians need timely data about their performance on quality and cost measures. Currently, CMS plans to only provide ASM participants with an annual performance report after the end of each performance year, and it has not established any specific deadline for when physicians can expect to receive the information (91 FR 43990). Information provided after the end of the year will do nothing to help physicians identify opportunities to improve patient outcomes or reduce costs during the performance year, and it will not arrive until after the next performance year has already begun. CMS can and should provide detailed data and analysis to ASM participants on at least a quarterly basis. CMS should commit to delivering information on services delivered during each calendar quarter no later than the end of the following quarter. Since CMS is holding ASM participants accountable for their performance, CMS should hold itself accountable for delivering performance feedback to them on a timely basis by exempting ASM participants from payment reductions if they have not received these reports in a timely manner.

Payment Approach (Section III.D.2.g, 91 FR 43990-43991)

Recommendations:

- Increase the redistribution percentage from 85 to 100 percent.
- Reduce the maximum risk level in the initial two years from nine percent to two percent.

The model should allow every physician to avoid a payment reduction by meeting a level of performance that is known to be feasible and established in advance. Downside risk should be phased in over several years as it has been in every other CMS APM.

Redistribution Percentage

We again urge CMS to change the "redistribution percentage" in ASM from 85 percent to 100 percent. In contrast to the budget neutral redistribution in MIPS, the current ASM redistribution percentage guarantees that, no matter how well physicians perform, most participants will face payment cuts. These cuts could make it more difficult for all Medicare patients to access services from specialists required to participate in ASM because ASM would cut payments to most of these specialists for all services they deliver, not just those that are relevant to ASM.

A true value-based payment model achieves Medicare savings by enabling and encouraging improvements in the delivery of patient care that lower avoidable Medicare spending, not by cutting physician payments. No such redistribution percentage is used in MIPS or the Hospital Value-Based Purchasing program. Instead, any penalties for lower-performing physicians and hospitals are used to fund increases for high performers, and all participants can avoid a penalty by performing at high levels. We strongly oppose implementing ASM unless it is modified so that it will no longer result in payment cuts for most participating physicians no matter how much they improve quality or reduce spending.

Maximum Risk Level

Payment models designed to reduce spending, particularly those involving significant financial risk, have the potential to harm patients as well as physicians. It is inappropriate for CMS to require physicians and their patients to participate in a new payment model that could significantly reduce physician payments before any testing or evaluation has been completed.

The AMA has serious concerns that imposing cuts of up to nine percent immediately, beginning in the first year of ASM implementation, could have detrimental impacts on the physicians required to participate and negatively affect their patients' access to care. Although the maximum payment penalty under MIPS is also nine percent, ASM is very different from MIPS, and it is inappropriate to impose high penalties on physicians in the first year of a completely new payment model. For other payment models, including the voluntary Medicare Shared Savings Program that involves organizations managing care for thousands of Medicare patients and the mandatory Transforming Episode Accountability Model that involves large hospitals, CMS has provided a phase-in period or glide path before requiring any downside financial risk.

A key reason physicians leave private practice is that hospitals and other large organizations are better able to manage the financial risks of participating in APMs. Experience with other CMS models also shows that unanticipated problems arise during implementation. Phasing in risk under the model allows

time for adjustments to be made so that physicians do not receive payment cuts solely due to problems with the model itself.

We strongly urge CMS to reduce the maximum risk level in ASM to no more than two percent for at least the first two model years. A transition will allow physicians to gain experience with the new model before subjecting them to higher risk levels and more significant penalties, and it will also allow time for CMS to identify and resolve any problems with the methodology and measures.

Applicability of CMS-Sponsored Model Safe Harbor (Section III.D.2.h, 91 FR 43991-43992)

Recommendation:

- Protect ASM participants under the CMS-sponsored model arrangements and patient incentives safe harbor every model year, even if they do not meet the ASM eligibility criteria for that year.

The rules for ASM state that "a clinician selected by CMS as an ASM participant for any ASM performance year and who furnishes covered services during any applicable ASM performance year remains an ASM participant for the duration of the ASM test period unless CMS terminates ASM … or the ASM participant receives notice of termination" (§512.710(a)(1)). However, if a physician treats fewer than 20 heart failure or low back pain patients during a year after being selected for ASM, they would not be subject to either the ASM requirements or protections during the corresponding performance year, even though they would "remain an ASM participant" (§512.710(a)(2)). CMS proposes that the safe harbor for CMS-sponsored model arrangements and patient incentives would also not be available to ASM participants during years in which they do not meet the minimum eligibility criteria (91 FR 43991).

Adoption of this proposal would mean that if, because of the availability of the safe harbor, an ASM participant establishes patient incentives or remuneration arrangements with primary care practices during the initial ASM performance year (2027), those incentives and arrangements could be prohibited in 2028 if the number of attributed patients falls below the 20-patient eligibility threshold for that year. If the number of attributed patients subsequently is above 20, the safe harbor would become available again in 2029, and if it then falls to fewer than 20 patients, the safe harbor would be removed again in 2030.

This on-again, off-again approach is completely inconsistent with the stated goal of improving the care of patients with chronic conditions, and it has the potential to harm both patients and physicians. The fact that a physician has slightly more than 20 attributed patients one year and slightly fewer the next year does not mean that the physician should change the way they deliver care to the patients who remain under their care in both years. However, under the CMS proposal, an item or service that the physician provided to improve the care of one of their patients in the first year of ASM would have to be withdrawn during the second year solely because of a decrease in the number of other patients treated by the physician for heart failure or low back pain. Similarly, an arrangement that an ASM participant had made to assist a primary care practice in providing effective care to patients might have to be stopped solely because of a small change in the number of heart failure or low back patients the ASM participant treated.

In the rule that created ASM, CMS stated that it was allowing ASM participants the option of providing in-kind patient engagement incentives because "as part of CMS' commitment to empower patients to actively participate and be accountable for quality and whole health outcomes, we invited ASM participants to think outside the box with regards to physical and lifestyle factors that contribute to the ASM's targeted chronic conditions" (90 FR 49709). Adopting the proposal described at 91 FR 43991 would likely force ASM participants with small numbers of patients to stay "inside the box" for fear that

they would have to tell a patient they could no longer provide assistance the patient had been receiving and benefiting from. We urge CMS to modify the ASM rule so that all ASM participants would continue to be protected in every year under the CMS-sponsored model arrangements and patient incentives safe harbor, even if they do not meet the minimum eligibility criteria for the year.

Collaborative Care Arrangements (Section III.D.2.i, 91 FR 43992-43997)

Recommendations:

- Eliminate the Improvement Activities (IA) category or allow ASM participants flexibility to choose activities they believe will result in the greatest improvements in patient outcomes.
- Permit ASM participants in a group practice to use a single Collaborative Care Arrangement (CCA) with a primary care practice to meet IA requirements.
- Permit ASM participants in separate practices to use the same CCA.
- Eliminate the limits on the amounts of remuneration permitted under CCAs.

The AMA appreciates CMS' efforts to promote care coordination between specialists and primary care practices through the ASM model. However, as proposed, the CCA requirements are too rigid and burdensome to achieve that goal effectively. CMS should not attempt to dictate the ways in which physicians will deliver care to their patients nor how specialists should interact with primary care practices. If physicians are going to be required to have CCAs with primary care practices, the specific requirements should impose as little burden as possible on both ASM participants and primary care practices.

The ASM requirements for CCAs are extremely burdensome and unlikely to result in better patient care. Many ASM participants are likely to treat patients whose primary care physicians are in many different practices. It will be impractical to have detailed formal arrangements with all or most of these practices since there may only be one or a few patients from each practice. There is limited value in having an agreement with one primary care practice that shares only a few patients with the specialist. Moreover, there is no requirement that any primary care practice execute such an arrangement with an ASM participant and no compensation for the time required to do so, so it will likely be very difficult for specialists to convince primary care practices to engage in these agreements. We urge CMS to eliminate the IA requirement and allow specialists to determine the best way to engage with primary care practices in the communities they serve. Alternatively, ASM participants should have the flexibility to choose activities other than a CCA to meet the IA requirement.

If CMS continues to mandate participation in ASM and to mandate that the participants have a CCA with a primary care practice, there is no reason to also require each individual physician in a group to have a separate CCA if those CCAs are with the same primary care practice. CMS is correct that requiring a separate CCA for each ASM participant would impose administrative burden without a corresponding programmatic benefit (91 FR 43993). This unnecessary burden would not only fall on ASM participants and their practices, but also on the primary care practices, which would be asked to sign multiple separate agreements with the specialty practice even though one would suffice. This would make primary care practices even less interested in signing such agreements than they might otherwise be. It seems likely that many CCAs will not involve "remuneration" of any type, so it is inappropriate for CMS to make all CCAs more burdensome solely to facilitate CMS' ability to track remuneration when there is such an arrangement. Consequently, we support the proposal at 91 FR 43993 to allow a single CCA for multiple ASM participants.

There is also no reason for CMS to limit this flexibility to ASM participants in the same TIN and to prohibit multiple solo practitioners or small group practices from having a common CCA with a primary care practice. If two independent ASM participants or two participants from different practices collaborate with each other in delivering care to patients with heart failure or low back pain, then the most effective way for them to collaborate with a primary care practice will be through a single agreement involving both physicians, not separate CCAs for each. A primary care practice would likely be far more willing to sign a single agreement with both physicians than to sign separate agreements with each of them. CMS states that it is "unclear how a single arrangement could establish cohesive terms regarding shared responsibilities with a primary care partner in a manner consistent with the intent of CCAs" (91 FR 43993). However, many small practices work together through Independent Practice Associations specifically for the purpose of jointly contracting with health plans, hospitals, and other entities, and so it will likely be easier for them to create joint CCAs than CMS believes is possible. We urge CMS to allow multiple ASM participants to have a single CCA with a primary care practice, regardless of whether the specialists are part of the same TIN.

Remuneration Permitted under CCAs

Not all ASM participants will need or want to include "remuneration arrangements" as part of CCAs with primary care practices, nor will all primary care practices want to have such arrangements with ASM participants. However, the limits CMS has established on the amount of the remuneration could be highly problematic in those cases where a remuneration arrangement would be desirable.

CMS currently requires that any payment exchanged under a CCA must "not exceed the sum total of the payment adjustments made to an ASM participant's claims" (§512.771(a)(7)). However, under the ASM payment methodology, the majority of ASM participants will receive a *negative* payment adjustment, which appears to mean that most ASM participants could not pay *any* amount to the primary care practice under the CCA. Instead, ASM participants would only be permitted to demand a payment *from* the PCP. (In the 2026 rule at 90 FR 49713, CMS gave an example of an ASM participant who received a payment adjustment of -4 percent, saying that the ASM participant cannot "recover" from their CCA partners more than the difference between the amount of Part B payments they do receive and the amount they would have received without the ASM adjustment.) It is unlikely that primary care practices would be willing to enter into a CCA arrangement with ASM participants in which the primary care physicians are expected to pay a portion of payment reductions CMS imposes on the ASM participants.

CMS now proposes to expand this restriction to any form of "remuneration," not just "payments" (91 FR 43995). It appears that this means that if ASM participants want to provide in-kind support to a primary care practice, such as assistance from a care manager employed by the ASM participants, the primary care practice would have to agree to pay the ASM participants for the cost of the care manager's time if the ASM participants receive a payment reduction. It is unlikely that primary care practices would be willing to accept in-kind support under such an arrangement, particularly since most ASM participants will receive a payment reduction because of the way the payment methodology in ASM is being structured.

CMS has acknowledged that this restriction is even more unworkable because the actual dollar amount of an ASM participant's payment adjustment would not be known until 2 years after the payment or remuneration was provided (91 FR 43995). Rather than eliminating the restriction, however, CMS proposes to require that the CCA "specify a methodology for identifying and calculating the total value of remuneration exchanged under the arrangement for the ASM performance year and determine whether the total value exceeds the applicable limitation" (91 FR 43996). This change will add additional burden and confusion for ASM participants.

We urge CMS to eliminate the limit on remuneration entirely or, at a minimum, eliminate the requirement that remuneration be limited to the amounts of performance-based payment adjustments or estimates of those amounts. CMS has established requirements that the remuneration be reasonably related to the CCA's purpose (§512.771(a)(3)) and that it cannot be conditioned on referrals of patients (§512.771(a)(6)), so it is not clear why an additional restriction on the amount is necessary. If CMS continues to believe there should be a restriction on the amount, a fixed dollar amount per ASM participant would be the simplest and most straightforward approach to use.

G. Limiting Medicare Coverage of Certain Individuals

Recommendation:

- Maintain the original definition of "eligible noncitizen" to ensure that a greater percentage of legally present individuals can continue to qualify for Medicare.

The proposed rule would add a new Medicare specific definition of "eligible noncitizen." Specifically, an "eligible noncitizen" would be an individual who is (1) an alien lawfully admitted for permanent residence under the Immigration and Nationality Act; (2) an alien who has been granted the status of a Cuban or Haitian Entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96-422); or (3) an individual who lawfully resides in the United States in accordance with a Compact of Free Association (COFA) referred to in 8 U.S.C. 1612(b)(2)(G). The rule expressly states that noncitizen U.S. nationals who are eligible for Medicare under section 1899C(a)(1) of the Act would no longer be considered "eligible noncitizens." However, legal permanent residents who meet the five-year continuous residency requirement and other applicable Medicare requirements would maintain their Medicare benefit. On January 1, 2027, individuals who do not meet the proposed revised definition of an "eligible noncitizen" would no longer be able to obtain benefits under Medicare. CMS also included a proposed termination, enrollment, and notification framework to implement these changes within the proposed rule.

Prior to the passage of the One Big Beautiful Bill Act (OBBBA), all lawfully present immigrant workers who had paid Medicare payroll taxes https://www.govinfo.gov/content/pkg/USCODE-2024-title8/pdf/USCODE-2024-title8-chap14-subchapI-sec1612.pdf for at least 40 quarters and were 65 or older or disabled were eligible for premium-free Medicare Part A. Those who did not qualify for premium-free Part A coverage could still be eligible for the coverage by paying premiums, if they met the five-year continuous residency requirement, and accordingly these individuals were then also eligible for Medicare Part B, C, and D. However, with the passage of the OBBBA, the categories of lawfully present immigrants who can now qualify for Medicare have been reduced, and the proposed rule would implement some of these changes. For example, the proposed rule would remove most refugees, self-petitioners, individuals with deferred action, asylum seekers, and those with temporary protected status from the definition of eligible noncitizens. With these changes, it is estimated that at least 100,000 people will lose access to Medicare coverage as soon as this proposed rule is implemented. The AMA supports the development and implementation of public health policies and programs that aim to improve access to healthcare and minimize systemic health barriers for immigrant communities including ensuring medically appropriate care for refugees and asylees. Accordingly, the AMA urges CMS to maintain as broad a definition of "eligible noncitizen" to ensure that those who are legally in the United States, and have paid into our Medicare system, can continue to maintain and gain access to this healthcare coverage.

H. Medicare Shared Savings Program

The AMA supports many of the proposed changes in this year's rule, particularly those intended to expand program participation to small, independent, rural, and specialty practices, reduce burden, including more flexibility in quality reporting options and CEHRT use requirements, and sustain participation for ACOs that have spent years in the program and may experience issues with benchmark "ratcheting." However, we believe more needs to be done to address program sustainability for mature ACOs. In addition, we have concerns about the lack of analysis around several proposals and their potential negative impact on ACO financial performance and program participation, particularly disparate impacts on ACOs serving rural, underserved, and safety net populations.

CMS states that in total, the changes will result in $5.5 billion in programmatic savings over a decade, which means $5.5 billion less in shared savings to ACOs. Extrapolating 2024 shared savings payments of roughly $4.1 billion, this would represent about a 13.5 percent decrease over the next decade for ACOs, a not insignificant impact that could seriously compromise incentives to remain in the program, particularly for those that are already high performing compared to their region, or mature ACOs. We worry these changes will directly undermine other well-intentioned proposals to expand program participation.

As explained in greater detail below, we urge the Agency to reconsider or delay several proposed financial methodology changes so that additional analyses can be performed and to provide the public with a more detailed accounting of the financial impact of each proposed policy. In the rule, CMS provides only a general accounting of the total combined impact of all proposed changes, which makes it impossible to offer comments on the respective impacts of the individual policies on ACOs as well as participating practices and physicians.

Beneficiary Assignment Changes

Recommendations:

- The AMA does not support expanding the number of assignable ACO beneficiaries at this time and urges CMS to delay these changes pending additional modeling and public comment.
- If CMS finalizes this policy, we urge CMS to adopt strong guardrails to mitigate adverse effects on gross savings/losses.

The AMA understands that CMS seeks to increase the assignable beneficiary population. CMS proposes changes including excluding allowed charges for primary care services billed through a non-ACO TIN and loosening eligibility criteria pertaining to Medicare enrollment status. However, CMS provides little detail about the impact these specific changes would have, other than to say that because these newly assignable beneficiaries are anticipated to have higher costs and be more medically complex, these changes are anticipated to negatively impact gross savings/losses overall. Additionally, both changes would slightly increase the number of assignable ACO beneficiaries for the vast majority of ACOs, with a larger impact on a select few. Given the lack of specificity around the impacts this would have particularly across ACOs, geographic areas, and patient populations, we urge CMS not to finalize this policy at this time to allow more time to model the impacts on disparate ACOs and patient populations. These findings should be made public, and followed by an additional opportunity for public comment. Should CMS advance this policy, at a minimum, we urge the Agency to institute guardrails to protect the small number of ACOs that would have their shared savings/losses drastically negatively impacted by this change.

Financial Methodology Changes

Recommendations:

- The AMA strongly supports increasing the sharing rate for ACOs in BASIC Level E from 50 to 60 percent and urges the Agency to finalize as proposed.
- The AMA has concerns about lowering the maximum positive regional adjustments for ENHANCED ACOs and urges the Agency to conduct more modeling and solicit more public feedback before finalizing. Should it move forward, CMS should allow higher adjustments for certain ACOs.
- The AMA strongly supports increasing the prior savings adjustment from 50 to 75 percent and encourages the Agency to finalize as proposed.
- The AMA strongly supports adding a new "growth adjustment factor" and encourages CMS to finalize with modifications regarding the risk adjustment cap.
- The AMA supports risk-adjusting benchmark adjustment caps; however, CMS must go further by aligning with LEAD risk adjustment methodologies and/or increasing the cap, at least in certain cases.
- Regarding proposed changes to the Accountable Care Prospective Trend (ACPT) factor, we recommend not finalizing it to allow for additional modeling and public comment. Should CMS finalize the proposal, we strongly support guardrails.
- The AMA supports adding a rural component and replacing Area Deprivation Index with a flat rate for certain beneficiaries for advance investment payments.
- The AMA seeks more information about utilization assumptions used to value the two modifiers proposed to replace visit complexity add-on code G2211.
- The AMA urges CMS to maintain and ease restrictions on prepaid shared savings.
- The AMA supports removing legacy TINs and CCNs from experience with performance-based risk calculations and urges CMS to finalize as proposed.

The AMA strongly supports CMS' proposal to increase the sharing rate for ACOs in BASIC Level E from 50 to 60 percent and urges the Agency to finalize this proposal. We agree this will help to make the BASIC Level E Track more attractive compared to the ENHANCED track and could help prevent ACOs from advancing to risk too quickly then dropping out of the program.

The AMA has concerns about the potential impact of CMS' proposal to lower the maximum positive regional adjustments for ENHANCED ACOs from 50 to 35 percent. CMS provides little analysis on the potential impact of this policy change on program participation and financial performance of ACOs in the ENHANCED Track, particularly for ACOs that have low spending compared to their region. We urge the Agency to conduct more modeling into potential program impact and to release those detailed findings to the public and solicit another round of input before finalizing this proposal. We disagree that CMS needs to "recalibrate incentives" between the BASIC Level E Track and ENHANCED tracks by making the ENHANCED track fundamentally less appealing for ACOs, and we worry this change will result in departures from the program. From a signaling standpoint, actively discouraging participation in higher level risk tracks appears to conflict with CMS' broader messaging encouraging participation in risk-bearing APMs. In addition, removing incentives for the ACOs that are high performers seems counterintuitive. Given the accompanying proposal to increase the sharing rate for the BASIC Level E Track, we urge the Agency to allow the effects of this policy an opportunity to play out before lowering the maximum positive regional adjustment for ENHANCED ACOs unnecessarily. Lowering the maximum regional adjustment to 35 percent in SSP would also substantially differ with ACO LEAD.

Should CMS move forward with this change, we urge it to consider applying the lower maximum regional adjustment rate on a tiering basis whereby certain ACOs, such as those that have been in the program longer and are running into "ratcheting" issues, are in higher risk tracks, and/or more rural regions would have a higher maximum positive regional adjustment to calibrate risk and reward more appropriately and maintain sufficient incentives to continue program participation. Furthermore, the Agency should consider alternative, complementary flexibilities if it is going to lower the maximum positive regional adjustment, such as raising the adjustment cap, particularly for renewing ACOs and those in higher risk tracks.

The AMA strongly supports CMS' proposal to increase the prior savings adjustment from 50 to 75 percent and encourages the Agency to finalize this change as proposed. We agree with CMS' logic and that of other interested parties that the existing prior savings adjustment is not sufficiently high to recognize the significant anchoring impact that prior savings can have on performance, and we believe this change will have a positive impact on maintaining participation in the program for high-performing ACOs, which will be even more important as the new growth adjustment factor takes effect.

To incentivize ACOs to expand into new participating practices and beneficiary populations, CMS proposes to add a new "growth adjustment factor" that would be applied on top of the existing adjustment factors up to the cap. The AMA strongly supports this addition. We agree that it fills an important void to incentivize ACOs to bring new practices and patient populations into accountable care arrangements. We believe this, combined with other proposed policies such as risk adjusting the adjustment cap, will work in tandem to positively encourage ACOs to expand into previously uncharted territories of more complex beneficiary populations, which stand to particularly benefit from accountable care relationships. However, if CMS does not combine this new growth adjustment factor with a sufficiently commensurate increase in the overall adjustment cap, few ACOs will benefit and there will be little practical impact. Accordingly, for this new adjustment factor to reach its full potential, CMS needs to expand on its proposals regarding the adjustment cap, as explained below.

CMS proposes to risk-adjust the five percent benchmark adjustment cap to allow ACOs with complex patient populations to more fully benefit from benchmark adjustments. While the AMA appreciates and supports risk adjusting the cap, the proposed approach does not go far enough to counter benchmark ratcheting concerns, offset the impact of reducing the maximum regional adjustment for ENHANCED ACOs, or allow ACOs to capitalize on the new growth adjustment factor. Accordingly, we urge CMS to build on this proposal by increasing all benchmark adjustment caps to 7 percent, especially for the new growth adjustment factor and for certain types of ACOs, such as those that have been in the program longer and/or that are at higher levels of risk.

The AMA appreciates the appeal of the added simplicity of adjusting the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor on an annual basis and applying the same annual rate to all ACOs regardless of start date. However, it is unclear whether CMS would apply this new methodology to all ACOs at once, or as ACOs are renewing their benchmarks, which would have disparate effects. We also understand that making calculations closer to the performance year has the potential to improve accuracy. At the same time, it reduces predictability and makes calculations more susceptible to annual abnormalities, such as we saw with high spending due to skin substitutes, which CMS thankfully intervened to address. Should such a policy be finalized, it would require close monitoring for any adverse consequences. It seems CMS' goal with proposing this policy is in part to address benchmark ratcheting, but this proposed solution would address ratcheting only indirectly while introducing additional unknowns, as noted above. We believe it would be more effective to propose policies more directly aimed at addressing benchmark ratcheting, such as offering longer agreement

periods like the ten-year agreements offered for LEAD ACOs, particularly for renewing ACOs that have already completed at least one SSP five-year agreement period. Like other proposed financial methodology changes in this rule, we do not believe sufficient analysis is provided to justify this change or for interested parties to sufficiently evaluate the impact of this change on ACOs and participants. Therefore, we recommend the Agency not finalize this policy at this time to allow for more robust analysis of the impacts, particularly any disparate impacts on specific types of ACOs, geographic regions, or patient sub-populations, and to allow for additional public comment. Should this policy be finalized, we recommend robust guardrails, particularly in the initial years of implementation.

The AMA generally supports proposals to add a rural component and replace Area Deprivation Index with a flat per beneficiary rate for non-rural, non-Low-Income Subsidy/dually eligible beneficiaries for advance investment payment calculations. We agree these changes will both help to improve the accuracy of calculations between rural and urban populations and make those calculations more straightforward.

As noted earlier, AMA seeks more information about the utilization assumptions CMS used to value the two modifiers intended to replace the visit complexity add-on code G2211 at 32 percent of the E/M base code for ACO participants, and 16 percent for non-ACO participating physicians, especially considering usage of the code has steadily gone up since its introduction in January 2024. Furthermore, we would like evidence that CMS fully considered the disparate impacts this may have across the physician community. For example, employed physicians will not directly see the money from the add-on code and they also will not get credit for billing the RVU in their employment contracts so they could see their reimbursements impacted significantly in two different ways.

The AMA urges CMS to reconsider its proposal to discontinue prepaid shared savings and to lift unnecessary restrictions on qualified spending categories and oversight requirements. Prepaid shared savings have so far only been available for one performance year (2026). Often with new funding opportunities or codes, utilization picks up steadily over time. CMS should allow more time for ACOs to familiarize themselves with and take advantage of prepaid shared savings. Furthermore, uptake was more than likely limited due to strict guardrails CMS imposed unnecessarily related to qualified spending categories, and overly burdensome oversight requirements including itemized spend plans. Out of 23 ACOs that applied for prepaid shared savings, only four were approved by CMS. We therefore urge the Agency to allow prepaid shared savings to continue and to lift strict limitations on qualified spending categories and overly burdensome oversight requirements, particularly as it makes other programmatic changes in an attempt to expand the program's reach to new practices, particularly small, rural, and independent practices, all of which tend to have less capital. Since this is not a grant but a loan, the advantage of or reason for taking such a restrictive approach is unclear. Furthermore, even if relatively few ACOs take up this option, if some would benefit, the benefit of discontinuing this option is not clear.

The AMA supports CMS' proposal to remove legacy TINs and CCNs from calculations used to determine prior experience with performance-based risk as we agree it would align with the intent behind the original policy and allow for additional flexibility for a select group of ACOs in their participation and advance financing options.

Beneficiary Engagement Changes

Recommendations:

- The AMA generally supports revising beneficiary notification requirements to reduce operational burden on ACOs but requests more consideration into alternative beneficiary education strategies.
- The AMA strongly supports allowing ACOs to elect to reduce or waive beneficiary cost sharing for certain services.

The AMA generally supports CMS' proposal to revise beneficiary notification requirements to reduce operational burden on ACOs. Specifically, CMS proposes that timing for initial beneficiary notification requirements would be a set date that aligns with the ACO REACH Program, rather than prior to or at the first primary care service visit. The AMA agrees this makes sense and will reduce operational burden on ACOs while still providing beneficiaries with initial communication about their involvement in an ACO. Regarding the Agency's proposal to eliminate the beneficiary follow-up communication requirement, we appreciate that the Agency did not find this particular method effective at improving beneficiaries' understanding of ACOs or value-based care. However, we have some concerns about eliminating this requirement without alternative proposals to otherwise educate beneficiaries about the benefits of value-based care. While we do not oppose necessarily eliminating this requirement, we do request more information from the Agency regarding what efforts have been made to explore the relative benefits of alternative beneficiary education strategies.

The AMA strongly supports CMS' proposal to allow ACOs to elect to reduce or waive beneficiary cost sharing for certain services, including deductibles and/or coinsurance amounts. We agree this change will provide ACOs and the participating physicians with enhanced tools to encourage patient uptake of preventive, disease management, and other low-cost, high-value services and interventions and is aligned with the goals of population health models to provide physicians with more flexibility in treating patients provided they are held accountable for outcomes and total costs.

Proposal to Simplify Shared Savings Program CEHRT Use Requirements

Recommendations:

- The AMA strongly supports CMS' proposal to sunset, beginning with PY 2027, the requirement that SSP ACO participants, regardless of track, report all MIPS PI measures and requirements and earn a PI performance category score in order to satisfy CEHRT Use requirements. We urge CMS to finalize this proposal without modification.
- The AMA also strongly supports CMS' proposal to reverse the requirement that every ACO provider/supplier in the ACO must successfully report on a PI measure for an ACO to satisfy CEHRT use requirements and finalize its new policy that ACOs be allowed to attest "Yes" to CEHRT use metrics if at least one ACO provider/supplier in each of the ACO's participating TINs performed the relevant action. We urge CMS to finalize this proposal while maintaining exclusions for those with special status, a MIPS exception, or a hardship exception.

In response to unified stakeholder concerns raised by the AMA and other stakeholders, we applaud CMS' proposal to reverse its previously finalized change from the 2024 PFS final rule that SSP ACO participants, regardless of track or Advanced APM QP status, must report all MIPS PI measures in order

to satisfy SSP CEHRT use requirements. Instead, CMS proposes to allow SSP ACO participants to satisfy CEHRT use requirements through one of three flexible options as outlined in further detail below.

CMS also proposes to reverse another previously finalized burdensome requirement under which every ACO provider/supplier in the ACO would need to successfully report on a PI measure for an ACO to satisfy CEHRT use requirements. Under CMS' new proposal, ACOs would be allowed to attest "Yes" to CEHRT use metrics for purposes of satisfying CEHRT use requirements if at least one ACO provider/supplier in each of the ACO's participating TINs performed the relevant action, with certain exclusions for those with special status, a MIPS exception, or a hardship exception.

These proposals are significant and welcome changes that address prior concerns raised by the AMA urging CMS to eliminate this unnecessarily burdensome reporting requirement, which diverted ACO resources from patient care, care coordination, and meaningful improvements in health information exchange. The reversal of these policies also signifies an important appropriate move in the right direction, recognizing that APM participants, who are already being held responsible for costs and patient outcomes, should be given more flexibility than MIPS participants, not less.

The AMA likewise supports CMS' proposal to sunset, beginning with PY 2027, the requirement that ACOs publicly report the number of participants, providers, suppliers, and professionals who earned a MIPS PI performance category score. This is a necessary conforming change following the proposed elimination of the underlying PI reporting requirement. We urge CMS to finalize the proposal.

The AMA also appreciates CMS' decision to exercise enforcement discretion for PYs 2025 and 2026 so that failure to satisfy the existing CEHRT use and related public reporting requirements during either year will not affect an ACO's eligibility to earn or receive shared savings, shared loss calculations, continued participation in the Shared Savings Program, or other compliance decisions. The AMA agrees that ACOs should not face retrospective consequences for requirements that CMS has determined it will not enforce.

CMS should also clarify in the final rule that its enforcement discretion for PYs 2025 and 2026 means that ACOs are not required to generate or publicly report PI score counts for either year. Requiring ACOs to calculate and publish information associated with requirements CMS will not enforce would create unnecessary work and produce incomplete or potentially misleading information.

New Alternative Pathways for Demonstrating CEHRT Use

Recommendations:

- The AMA strongly supports CMS' proposal to establish three alternative pathways through which an ACO may satisfy the SSP CEHRT use requirement beginning in PY 2027, which reflect years of AMA calls for more flexible ways for physicians to demonstrate their use of CEHRT. The AMA strongly urges CMS to finalize and permanently maintain all three pathways, with certain clarifications and targeted modifications.
- The AMA urges CMS to confirm that all three pathways will remain viable options in future performance years to capture the myriad ways physician practices are leveraging innovative technologies in their practices and in recognition of the fact that ACOs and participating practices within the same ACO may differ substantially in their technical capabilities, reporting infrastructure, and ability to aggregate data across multiple EHR systems.

- The AMA urges CMS to add the MIPS small practice special status and to establish exclusions or transition protections for new ACOs, newly participating TINs, and partial-year participants.
- The AMA urges CMS to publish the applicable metric specifications, attestation language, exclusion criteria, documentation standards, and acceptable forms of evidence before the beginning of PY 2027.

The AMA strongly supports CMS' proposal to establish three alternative pathways through which an ACO may satisfy the SSP CEHRT use requirement beginning in PY 2027: 1) successfully reporting at least one ACO-reported measure in the APP Plus quality measure set through eCQMs or Medicare eCQMs; 2) attesting to using Fast Healthcare Interoperability Resources (FHIR) capabilities in certified health IT to support reporting of at least one ACO-reported measure; or 3) attesting to one of three ACO CEHRT use metrics.

The proposed framework reflects a more flexible and administratively feasible approach to CEHRT use requirements and is consistent with the AMA's longstanding position that such policies should be minimally burdensome and account for variation in ACO and practice capabilities. The proposal recognizes the myriad ways physician practices are clearly leveraging innovative technologies in their practices, and the fact that ACOs and participating practices within the same ACO may differ substantially in their technical capabilities, reporting infrastructure, and ability to aggregate data across multiple EHR systems. The AMA believes that these three new flexible options will pair with CMS' proposal to add a new "growth adjustment factor" to incentivize ACOs to expand into new participating practices and beneficiary populations, recognizing that new practices may need time to ramp up their CEHRT capabilities, including re-investing earned savings from the ACO, which takes time. **Accordingly, the AMA urges CMS to finalize all three pathways with certain clarifications and targeted modifications as described in more detail below.**

CMS should confirm that the three pathways are and will remain coequal alternatives. **ACOs should be free to select the pathway best suited to their circumstances and to change pathways between performance years without penalty.** CMS should not establish formal or informal preferences that pressure ACOs to adopt the eCQMs or FHIR pathway before their systems, participating practices, and vendors are ready.

CMS should publish the applicable metric specifications, attestation language, exclusion criteria, documentation standards, and acceptable forms of evidence before the beginning of PY 2027, as explained in greater detail for each pathway below. In general, ACOs should be permitted to rely on CMS status determinations, claims data, the CHPL, vendor records, intermediary representations, and participant certifications.

- **Option 1: Successfully reporting at least one ACO-reported measure in the APP Plus quality measure set through eCQMs or Medicare eCQMs.** The AMA supports providing automatic CEHRT credit to an ACO that completely reports at least one APP Plus measure through the eCQM collection type using qualifying certified technology. This approach appropriately recognizes work already performed through quality reporting and avoids a separate attestation. CMS should clearly explain how it will determine that a measure has been "completely reported," provide timely confirmation of compliance, and allow ACOs to correct technical or data completeness errors.

- **Option 2: Attesting to using FHIR capabilities in certified health IT to support reporting of at least one ACO-reported measure.** The AMA also supports recognizing an ACO's use of certified FHIR capabilities to collect data supporting an APP Plus measure. **However, CMS must establish a clear and attainable standard for demonstrating that FHIR "supported" data collection.** The final rule should confirm that this pathway does not require all measure data, patients, participant TINs, or EHR systems to use FHIR. ACOs should be permitted to combine standardized API data with other valid data acquisition methods. CMS should also permit ACOs to rely reasonably on the Certified Health IT Product List (CHPL) and representations made by EHR developers, API operators, and other intermediaries.

- **Option 3: Attesting to one of three ACO CEHRT use metrics.** The AMA particularly supports the third pathway, which would allow an ACO to attest that at least one provider or supplier in each participant TIN performed one of three CEHRT use activities. This pathway provides the most practical option for small, independent, and multi-EHR ACOs that cannot aggregate complete electronic measure data across numerous systems. CMS should preserve at least one broadly attainable attestation metric in every performance year. Future changes should remain subject to rulemaking and should not convert this pathway into numerator/denominator reporting.

The proposed exclusions are essential, but they do not adequately protect small practices. **The AMA urges CMS to add the MIPS small practice special status.** CMS' assumption that ACO participation necessarily provides small practices with sufficient technical and financial support does not reflect the experience of all practices. EHR licensing, interfaces, configuration, training, and workflow changes require upfront resources, while shared savings are uncertain and generally received after the performance year. ACO participation should help small practices develop these capabilities over time, not disqualify them from protections available to similarly situated practices outside an ACO. **CMS should also establish exclusions or transition protections for new ACOs, newly participating TINs, and partial-year participants.** In addition, an isolated deficiency involving one participant TIN should not place an entire ACO out of compliance. CMS should provide an opportunity to cure a participant deficiency before determining that the ACO failed the CEHRT use requirement.

The AMA supports CMS' proposal to replace existing public reporting requirements with public disclosure of the CEHRT pathway selected by the ACO. Although the selected pathway offers limited practical information about an ACO's performance, this narrowly tailored disclosure is substantially less burdensome than the existing requirement. CMS should collect the pathway selection once and use that submission to populate any CMS public reporting. ACOs should not be required to complete a duplicative submission or separately update their websites. CMS should provide standardized disclosure language and limit the requirement to identification of the selected pathway. ACOs should not be required to report participant, clinician, vendor, patient, or other supporting information. CMS should also make clear that the selection is solely a compliance disclosure. It should not be characterized, displayed, or used as an indicator of care quality, interoperability performance, patient engagement, or comparative ACO performance.

Auditing and Enforcement of CEHRT Use Requirements

Recommendations:

- Before Performance Year 2027, CMS should publish the minimum documentation necessary to demonstrate compliance under each CEHRT use pathway, using representative sampling or other

minimally burdensome means where appropriate, in order to balance appropriate oversight against unnecessary documentation burden on ACOs and participating practices.

- CMS should clarify that an ACO and its participants should not be found noncompliant when an otherwise valid submission fails because of a CMS system, EHR developer, data intermediary, or other technical problem outside the ACO's control.
- CMS should reserve severe enforcement consequences for repeated, material, or knowing noncompliance after an ACO has had an opportunity to correct the deficiency. A reasonable documentation error, an isolated participant failure, or a failure involving technology controlled by a vendor or intermediary should not jeopardize an ACO's participation or eligibility for shared savings.
- CMS should adopt a graduated and proportionate enforcement approach.

The AMA recognizes the importance of appropriate oversight and CMS' authority to audit ACO compliance with the proposed CEHRT use requirements. **However, CMS should establish a clear, proportionate, and predictable audit framework that does not impose unnecessary documentation burdens or hold ACOs responsible for technology and conduct outside their control.** Before Performance Year 2027, CMS should publish the minimum documentation necessary to demonstrate compliance under each CEHRT use pathway, including the evidence required to support participant TIN exclusions.

CMS should use representative sampling and other minimally burdensome means, where appropriate, rather than routinely requiring documentation from every participant TIN. ACOs should be permitted to rely on the CHPL, vendor certification information, participant certifications, and other reasonable evidence of the qualifying activity. **CMS should not require extensive records when certification information and reasonable administrative evidence are sufficient.** If additional records are necessary to resolve a specific discrepancy, CMS should narrowly tailor its request to that issue. A broader review should be reserved for circumstances in which the initial sample identifies a material or systemic compliance concern.

The AMA also urges CMS to clarify the utility of a CMS EHR Certification ID. An identification number demonstrates that a product or module was certified, but it does not establish that specific functionality was available or operating successfully during a particular transaction.

ACOs should not be held strictly liable for failures involving functionality controlled by an EHR developer, vendor, HIE, API operator, or other data intermediary outside of an ACO's control when the ACO reasonably relied on certification information or representations from that entity.

Finally, CMS should adopt a graduated and proportionate enforcement approach. Before determining that an ACO is noncompliant or imposing any compliance action, CMS should provide written notice of the specific deficiency and a meaningful opportunity to supplement or correct the documentation. When the deficiency is remediable, CMS should provide technical assistance and a reasonable cure period. An isolated participant TIN deficiency, reasonable documentation error, or failure outside the ACO's control should not affect shared savings or result in termination or another severe consequence. Such actions should be reserved for repeated, material, or knowing noncompliance that remains unresolved after the ACO has received notice and a meaningful opportunity to correct the deficiency.

II. UPDATES TO QUALITY PAYMENT PROGRAM PROVISIONS

A. Merit-based Incentive Payment System (MIPS)

Performance Threshold

Recommendation:

- The AMA supports CMS maintaining the performance threshold at 75 points for the next two performance periods, as previously finalized.

The AMA appreciates CMS' decision to maintain stability and continuity with the MIPS program by maintaining the performance threshold at 75 points for the next two performance periods (through the CY 2028 performance period/2030 payment year), as previously finalized. Maintaining the current performance threshold provides physician practices a greater opportunity to avoid a penalty and earn an incentive, and it aligns with President Trump's Executive Order 14192, Unleashing Prosperity Through Deregulation. We urge CMS to be cognizant of the impact the transition to MVP and digital quality measure (dQM) reporting will have on practices as it reviews CY 2026 performance period/ 2028 payment year data. We are concerned that if CMS raises the performance threshold prematurely, and in combination with requiring mandatory MVP reporting, practices will be challenged with meeting a higher threshold, especially given the limited number of measures within an MVP.

B. MIPS Value Pathways (MVPs)

Proposal to Mandate MVPS and Sunset Traditional MIPS

Recommendation:

- The AMA strongly opposes CMS' proposal to sunset traditional MIPS after the 2028 performance period/2030 MIPS payment year and require MVP reporting for all eligible clinicians participating in MIPS starting in 2029.

Since CMS has introduced MIPS Value Pathways (MVPs) for MIPS reporting, the AMA, together with the house of medicine, has repeatedly emphasized the need to maintain traditional MIPS reporting and has not supported mandatory MVP reporting. MVPs must be redesigned to focus on specific health conditions that an individual physician would treat, rather than physician specialties or broad groups of different health conditions. The current set of MVPs cannot fairly or accurately assess physician performance because CMS has created MVPs primarily based on certain physician specialties and broad categories of health problems, rather than focusing each MVP on a specific type of health condition, procedure or episode of care that would reasonably be treated by the same clinician. Therefore, the AMA is extremely disappointed that despite these long-standing concerns CMS proposes to sunset traditional MIPS after the 2028 performance period/2030 MIPS payment year and require MVP reporting for all eligible clinicians who are participating in MIPS who are not reporting the SSP APP Plus measure set.

We recognize that CMS claims that 98 percent of specialties will be covered by an MVP if CMS finalizes the three new proposed MVPs. However, CMS must ensure that 100 percent of all specialties have a relevant MVP because MACRA mandates that all eligible clinicians are subject to MIPS. Therefore, it is imperative that CMS design a program that meets the needs of all specialties and subspecialties. For

example, clinicians who specialize in allergy and immunology or radiation oncology do not have a relevant MVP, despite these specialties making several recommendations to CMS over the years.

We are also deeply concerned that the 98 percent figure is an overestimation, as it does not take into consideration whether an existing MVP has enough measures to cover a condition, procedure, or episode of care. CMS should perform a more thorough analysis before sunsetting traditional MIPS. The current minimum number of quality measures that must be reported for each MVP is four, plus the population health measure, yet most MVPs do not include that number of relevant measures for a specific condition, procedure, or a connected episode-based cost measure. For example, the "Improving Care for Lower Extremity Joint Repair MVP," which we prefer because it is procedure specific, is not relevant to orthopedic surgeons who specialize in other areas, such as hand, shoulder, or sports medicine, and leaves those sub-specialists without a condition- or procedure-specific MVP to report. Unfortunately, the other most applicable MVP is the "Surgical Care MVP," but that only includes three general surgery-related, four cardiothoracic, and three lumbar spine measures, which leaves a subset of orthopedic surgeons without an applicable MVP to report. The AMA and impacted surgical groups have also repeatedly stated our lack of support for the "Surgical Care MVP" because it lumps various unrelated surgical specialties together—general, colorectal, neurological, and thoracic surgeons—all under the same MVP. Importantly, this does not support CMS' goal of better informing patients on where to seek care.

The "Prevention and Treatment of Infectious Disorders Including Hepatitis C and HIV MVP" is another example, with three measures on HIV, two for Hepatitis C, and one on upper respiratory infection. No measures for other relevant conditions such as sepsis and pneumonia are included, which again demonstrates the lack of a comprehensive set of quality measures by which a clinician who specializes in infectious disease can report.

While gastroenterology may have the "Gastroenterology Care MVP," the specialty's assessment is that most gastroenterologists will not be able to report clinically meaningful measures or be reliably scored on some measures. The quality measures in the MVP do not align with where gastroenterologists are spending the majority of their time and effort with patient care, resulting in low case volumes for some measures, and there is a dearth of measures for the procedure most commonly provided. Specifically, this MVP potentially only includes two measures for colonoscopy (if CMS finalizes its proposal to remove 320, Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients and NHCR4, Repeat Screening or Surveillance Colonoscopy Recommended), three Hepatitis C measures, and one inflammatory bowel disease measure.

Similarly, the "Advancing Heart Disease MVP" is applicable to cardiology, but important cardiovascular subspecialties and clinical conditions are missing. As a result, the MVP does not appropriately capture procedural cardiology subspecialties, such as interventional cardiologists or the treatment of hypertension. Examples include:

- Adult Congenital Heart Disease (ACHD)
- Advanced Heart Failure and Transplant (heart transplant. LVAD/VAD mgmt., Advanced HR therapies, cardiac amyloidosis)
- Structural Heart Disease/ Valvular Heart Disease (TAVR, mitral interventions, tricuspid interventions)
- Cardiovascular Imaging (echo, nuclear, cardiac CT, MR).

An MVP that nominally applies to orthopedic surgery, gastroenterology, cardiology, or any specialty but does not offer a viable reporting pathway to most physicians within the specialty should not be used as the exclusive reporting mechanism for the specialty. Therefore, the lack of a comprehensive set of measures for each procedure and/or condition within each MVP will force physicians to select measures that do not reflect their scope of practice and will continue to exacerbate the ongoing challenge of this program: quality reporting is completed to satisfy reporting requirements rather than drive quality improvement efforts and provide useful information on the quality of care provided to patients. It also contributes directly to scoring discrepancies between different subspecialists within the same MVP. Essentially, CMS is just rearranging the deck chairs and giving a new name to MIPS reporting. We urge CMS to work with the impacted specialties to create meaningful MVPs.

We reiterate the following key recommendations to improve MVPs:

- *MVP By Patient Health Conditions:* While there is no one-size-fits-all approach to MVPs that will work for every medical specialty, in order to support patient-focused care, MVPs must focus on patient health conditions rather than medical specialties and MUST prioritize alignment of quality and cost measures. Many MVPs have quality measures for specific health conditions without corresponding cost measures for those conditions, and some have cost measures without matching quality measures. As a result, some physicians in an MVP can be scored vastly differently on both quality and cost, some can be scored on quality for some patients and costs for other patients, and others can be scored only on quality, all due to the availability of measures, which is beyond their control. This means that neither the individual performance category scores for cost and quality nor the final MIPS scores based on both categories will be comparable for different physicians in the same MVP, which is the purported goal of MVPs.
- *MVP Clinical Groupings:* If CMS continues to maintain specialty-specific MVPs, MVP clinical groupings MUST also prioritize alignment of quality and cost measures and be clinically relevant. We continue to have concerns that even with the clinical groupings, MVPs still ignore the variation in care provided by subspecialists, differences among patient populations, and the relevancy of the cost measures. For example, the proposed Hospitalist MVP is based around a specialty rather than a specific health condition or group of similar conditions. It also ignores that the majority of hospitalists participate in MIPS through the Facility-based option.
- *Newly Proposed Condition Specific MVPs:* We appreciate CMS considering the AMA's feedback by proposing two condition specific MVPs for the 2027 program (Diabetic Disease and Hypertension), but refinements are needed. They are overly broad, and the groupings within the MVP are by specialty. For detailed feedback, please see our comments on the proposed new MVPs for the 2027 performance period/2029 payment year.
- *Facility-based Option:* CMS must provide the option to apply facility-based scoring to MVP participants that otherwise qualify for this scoring option in traditional MIPS to encourage alignment of quality improvement efforts between physicians and the facilities where they provide care.
- *Group Reporting:* We are concerned that requiring group practices to form multiple subgroups to report MVPs will add significantly to the burden of compliance and reduce the reliability of their scores. At a minimum, to reduce the burden on multispecialty practices of forming subgroups and reporting multiple MVPs, we recommend CMS establish a maximum number of MVPs for multi-specialty groups and develop guidelines for choosing MVPs for multi-specialty groups, such as MVPs that correspond with the highest volume of services and/or largest number of clinicians.
- *Benchmark Methodology:* Update the quality measure benchmark methodology to align with the administrative claims quality measures and cost measures methodology.

- *Data Completeness:* We continue to strongly urge CMS to reduce the data completeness requirement for satisfactorily reporting on a measure in MIPS, MVP, SSP, and ASM. Alternatively, consider a proposal like the modified data completeness proposal CMS proposes for SSP. Please see FHIR RFI for more specific information.
- *Total Per Capita Cost (TPCC) Measure:* We urge CMS to remove the TPCC Measure from MVPs, particularly for MVPs that have other available episode-based cost measures. Should CMS continue to use the TPCC measure in MVPs, it should be substantially revised to exclude costs for preventive services and services outside the control or influence of the physician being evaluated.

Therefore, **we urge CMS to incentivize the reporting of MVPs, rather than mandate it, and the AMA does not support sunsetting traditional MIPS.** In 2024, which is the most recent data CMS has published, only about 11,000 clinicians received a MIPS score through an MVP. Those scores were based on the performance of only 634 separate entities – 216 groups, 16 subgroups, and 402 individuals. In many cases, MVP participants received a default score of 75, rather than a score based on their actual performance on the measures in the MVP, because they were exempt from submitting one or more of the required measures. For many participants who did receive a score other than 75, it was often based solely on quality measures and improvement activities, not on cost or promoting interoperability. It is likely that many of our recommended changes to MVP would encourage and lead to voluntary participation in MIPS, and, as a result, increased MVP participation, which should be CMS' focus before mandating.

<u>Development of New MVPs</u>

For the 2027 MIPS performance period/2029 MIPS payment adjustment CMS proposes three new MVPs. The AMA offers the following specifics comments on each below:

- *Diabetic Disease MVP*

Recommendation:

- We recommend that CMS revise the MVP to focus on the core elements of diabetes care and patient health conditions rather than medical specialties.

The AMA appreciates that CMS has proposed a condition-specific MVP for diabetes and made some refinements during the candidate MVP feedback process. However, we believe to support patient-focused care, MVPs should focus on patient health conditions rather than medical specialties. Therefore, we are concerned that this MVP is not currently structured in a truly patient-centered way. Specifically, several quality measures within the MVP focus on whether and how individual medical specialties ("ophthalmology" and "podiatry") deliver specific types of services, rather than on whether Medicare beneficiaries with diabetes receive the comprehensive services that are most important for achieving optimal outcomes.

While good care related to their eyes and their feet is vital for a patient with diabetes, neither ophthalmologists nor podiatrists manage the patient's overall diabetes care. A primary care physician who is managing a patient would endeavor to ensure the patient gets eye exams, but they cannot be held responsible for achieving "improved visual acuity after vitrectomy," and the *Q019 measure, Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care* is, by definition, focused on a physician who does not manage ongoing diabetes care. Moreover, the current structure

allows clinicians to pick and choose MVPs, and report only one specialty-specific measure. If ophthalmologists select this MVP and report only the "ophthalmology" measures, if podiatrists select the MVP and report only the "podiatry" measures, and primary care physicians and endocrinologists select the MVP and report only the "multispecialty" measures, it defeats the intended purpose of using the MVP to meaningfully compare clinicians on how well they are providing comprehensive diabetes care to patients. As a result, the MVP would not provide useful information to patients about which physicians provide the best care for their diabetes. Moreover, since physicians are only permitted to report one MVP, if an ophthalmologist did report this MVP, patients without diabetes would not be able to compare the performance of the ophthalmologist to other ophthalmologists for other types of eye care.

Given that this MVP is focused on diabetes and there are clinical standards for how diabetes should be managed, and there are existing measures of how well those standards are being met, **we recommend CMS revise the MVP to focus on the core elements of diabetes care.** It is widely recognized that the best way to achieve good outcomes for a patient with diabetes is to help the patient control their blood pressure, reduce bad cholesterol, control their blood sugar, eliminate tobacco use, and use aspirin appropriately. Despite the importance of blood pressure control for a patient with diabetes, the proposed Diabetic Disease MVP only includes a screening measure for high blood pressure but does not include a measure related to blood pressure control. While the HbA1c and BP measures are not ideal and could use refinements to incorporate tailored targets based on patient characteristics, they do a better job of assessing the overall quality of care for a patient with diabetes than many of the other proposed measures.

In addition, because there is an episode cost measure specifically designed for Diabetes, there is no reason to include the Total Per Capita Cost (TPCC) measure. While the AMA supported the attribution improvements to TPCC finalized by CMS last year, TPCC remains fundamentally flawed because it holds physicians accountable for costs associated with medical conditions that the physician did not treat, medical decisions made by another provider, or care that the physician was not involved in. It also includes aspects and types of costs they cannot influence, such as changes in the prices of physician-administered drugs and coverage decisions for high-priced supplies (e.g., skin substitutes). Furthermore, because TPCC includes all Medicare Part A and B spending, not just the portions of spending that physicians can control, the measure provides physicians with little or no actionable information about how to lower their spending, and it gives patients little or no useful information about how to lower their out-of-pocket costs or how to select physicians. Because of these fundamental flaws and the inclusion of the diabetes episode-based cost measure in this MVP, we strongly urge CMS to remove TPCC from the Diabetes MVP.

- *Hypertension MVP*

Recommendation:

- We appreciate that CMS is proposing a condition specific MVP. However, we recommend that CMS either: 1) narrow the focus of the "Hypertension" MVP to treatment of hypertension; or 2) expand the "Advancing Care for Heart Disease" MVP to include measures for treatment of hypertension as well as the current measures related to heart failure and other cardiac conditions.

The AMA appreciates that CMS is attempting to create a condition-specific MVP related to treating hypertension, which is consistent with our longstanding preference for MVPs focused on specific conditions, procedures, or episodes of care. However, the proposed "Hypertension MVP" as structured, is not truly condition-specific. Effective management of hypertension requires distinct approaches for

prevention and treatment, yet the proposed MVP conflates these two goals and targets both patients with hypertension and those at high risk of developing this diagnosis. In doing so, the proposal undermines the concept of condition-specific reporting. As the AMA has previously emphasized, physicians who provide different services to different types of patients should not be directly compared to each other.

While we strongly support efforts to prevent hypertension and other types of heart disease, primary prevention efforts should, by definition, be focused on patients who do not have hypertension, while treatment efforts are focused on those patients who have been diagnosed with hypertension. Many cardiologists treat hypertension, but they often see the patient too late in the disease progression process to be able to focus on prevention. On the other hand, a cardiologist may be treating multiple heart problems, not just hypertension, yet creating an MVP for hypertension that is separate from the MVP for "Advancing Care for Heart Disease" forces cardiologists to choose one or the other and is not consistent with patient-centered care for heart disease.

Conversely, prevention of hypertension is an important element of primary care, but prevention involves things such as diet and exercise, not just BMI screening, and BMI screening helps to prevent a variety of problems, not just hypertension. The "Value in Primary Care" MVP includes a measure for controlling high blood pressure and the *Preventive Care and Wellness composite measure* includes the blood pressure screening measure. Therefore, it does not make sense for primary care physicians to report on the "Hypertension" MVP since it includes only prevention and treatment for hypertension, but no measures of the other types of prevention and treatment services that are required for good primary care. We recommend either:

1. narrowing the focus of the "Hypertension" MVP to treatment of hypertension; or
2. expanding the "Advancing Care for Heart Disease" MVP to include measures for treatment of hypertension as well as the current measures related to heart failure and other cardiac conditions.

Regarding the cost measures, as outlined above, we have significant concerns with the TPCC measure. If CMS continues to include TPCC in this MVP, it should be revised so that it is either limited to or focused on the aspects of cost that physicians can reasonably control, and so that it avoids disincentivizing preventive care. We recommend two changes to TPCC:

1. Excluding all preventive services from the cost calculations, to avoid penalizing primary care physicians for the costs of these services; and
2. Grouping the services and costs in the measure into patient condition categories (e.g., separately calculating the costs of services for cardiovascular conditions, services related to cancer, musculoskeletal care services, trauma care services, etc.), so that it is clear which aspects of costs are more likely to be controlled or influenced by primary care services or by specific types of specialists.

The rationale for the first change is that TPCC currently penalizes physicians for delivering services designed to prevent health problems or treat them at early stages, because it counts the costs of those services but does not account for the savings that will accrue in the future by preventing health problems from occurring or avoiding the higher costs associated with treating more advanced illnesses. For example, patients who enroll in a diabetes prevention program will have higher costs in the performance period but will have lower costs in future periods if they avoid or delay the onset of type 2 diabetes. Thus, TPCC penalizes physicians for taking actions today that will reduce future spending in the Medicare program, which runs counter to the goal of the Cost Category.

The rationale for the second change is that the specialty adjustment in TPCC assumes that differences in total cost are based on differences in the specialty of the physician who is providing primary care services rather than differences in the types of treatments the patient needed during the year for their specific health problems. Moreover, the risk adjustment methodology is based only on chronic conditions in a prior year and does not consider current acute conditions or newly diagnosed chronic conditions that are treated for the first time during the current year. For example, a primary care physician who has a higher-than-average number of patients diagnosed with cancer during the year, particularly expensive-to-treat cancers, will be penalized by the TPCC because neither the risk adjustment methodology nor the specialty adjustment addresses this. However, by calculating costs related to cancer as a separate subcategory within TPCC, it would be clear whether the primary care physician's total cost per patient was higher due to those costs, or because that physician provides more services or more expensive services for the health conditions they manage directly. Similar changes are needed for specialty practices providing "primary care" services; for example, when an oncology practice is attributed a patient under TPCC, it could also be penalized under the current methodology, as research has shown.

- *Hospitalist MVP*

Recommendation:

- We appreciate the improvements CMS has made to the Hospitalist MVP in response to the AMA and specialty societies. However, CMS should further improve the MVP to better distinguish the different types of patients and health problems hospitalists manage.

Overall, it is a specialty-based MVP, as opposed to focused on patient health condition or group of similar conditions. In addition, creating categories titled "Medications" and "General Clinical Care" does nothing to distinguish the different types of patients and health problems hospitalists are managing. The measures are only relevant to a small subset of the patients this specialty cares for and a fraction of the types of complications they try to prevent. For example, two of the nine quality measures are focused on heart failure, even though most of the patients that hospitalists treat do not have heart failure. Furthermore, the vast majority of the measures are either QCDR or eCQM measures, which will require access to the hospital EHR to extract and package the data to submit the measures to CMS. Hospitalists also do not have the ability to seamlessly aggregate data from the EHR or registry. As a reminder, hospitals use certified EHRs based on facility requirements, not physician requirements, so the EHRs are not certified or designed to support physician-level eCQMs, only hospital eCQMs.

MVP Maintenance

There are currently 27 MVPs for the 2026 performance period/2028 MIPS payment year. CMS is proposing modifications to 23 of those MVPs by adding and removing measures and IAs, as well as changes to all 27 MVPs to align each MVP with the proposed implementation of MIPS core measures. The AMA performed an analysis of the current suite of MVPs against the MIPS specialty sets and found the MIPS specialty sets provide a wider array of measures that could be reported by a specific specialty as opposed to an MVP. For example, the internal medicine set has more conditions on which clinicians can report (52 measures) as opposed to selecting the two MVPs identified as most applicable to this specialty: Value in Primary Care (12 measures) and Advancing Care for Heart Disease (18 measures). Only 17 measures overlap between the specialty set and two MVPs, narrowing the potential applicable measures from which this specialty can select. Other examples include:

- Family Medicine: 59 specialty set measures vs. 19 in Value in Primary Care and Advancing Care for Heart Disease MVPs.
- Orthopedic Surgery: 21 specialty set measures vs. 7 in Improving Care for Lower Extremity Joint Repair MVP (which only covers hip/knee replacement).
- Urology: 21 specialty set measures vs. 8 in Optimal Care for Patients with Urologic Conditions MVP.
- Otolaryngology: 19 specialty set measures vs. 7 in the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP.

A move to MVP reporting reduces the flexibility of clinicians to report and focus their quality improvement efforts on appropriate topics. This reduction, paired with the limited number of cost measures available, will further reduce the usefulness and relevance of MIPS. **We also seek clarification regarding the outstanding MIPS measures that are not part of an MVP. CMS has provided no clarification regarding its plans for MIPS measures that have no home within an MVP.** For example, two of the measures that have not been included in any MVP (394: Immunizations for Adolescents and 418: Osteoporosis Management in Women Who Had a Fracture) have at least 2,000 and 3,000 clinicians and groups, respectively, reporting on the measures, and there are relevant MVPs in which these measures should be incorporated.

Any shift to required MVP reporting must include a robust identification of the remaining gaps in measures and a measure development plan – both for those specialties for which no MVP exists and, within each specialty, on which subspecialties, clinical conditions, and/or procedures are not yet adequately addressed. This work would then assist medical specialties and others to focus efforts on filling those gaps and enable CMS to determine a more appropriate timeframe within which a move to MVP-only reporting is possible.

Qualified Clinical Data Registry Measures

The AMA strongly urges CMS to recognize and prioritize the value of specialty-led Qualified Clinical Data Registries (QCDRs) and actively select QCDR measures for MVPs. We remind CMS that Congress specifically referenced and acknowledged the importance of QCDRs in MACRA and incorporated a provision to allow for a separate pathway for measure review outside of the formal Measure Under Consideration (MUC) process. However, CMS has significantly limited the number of QCDR measures available for use. Based on our review of the 2026 QCDR file, there are 200 distinct QCDR measures. Of those, only 57 are referenced in the MVP inventory, which leaves 143 QCDR measures—about 72 percent of the total—that are not included in any MVP. We believe that this is a missed opportunity to recognize efforts, such as those to reduce post-operative complications and related spending, and it demonstrates a lack of understanding about the level of detail and rigor with which specialty society QCDRs collect and continually validate the data.

Capturing data through a registry allows for its collection and tracking across settings and disease states, including but not limited to acute episodes versus chronic disease and resource-intensive versus relatively inexpensive therapies, and the data are used for other purposes including quality improvement, clinical guideline development, and research. It also allows for quality measurement to advance towards digital data sources and move beyond snapshots of care which focus on random individual measures to a learning system with a broad focus. As a result of CMS' restrictions placed on QCDRs, the number of available QCDRs has greatly dwindled, and more QCDRs will stop participating in the program, which is counter to the policy intent of the MACRA statute.

Sub-group reporting

Recommendation:

- The AMA continues to oppose mandatory subgroup reporting.

We recognize CMS has not made any formal proposal regarding sub-group reporting in the 2027 PFS but continue to have concerns and oppose mandatory MVP subgroup reporting due to the large administrative burden and ongoing flaws with MVP design. While we support a subgroup reporting option to allow specialists in a multi-specialty group to report and be evaluated on relevant measures, we strongly believe this participation method should remain voluntary. The structure of physician practices are not homogeneous, and we are concerned that multi-specialty practices of all sizes will face numerous operational challenges to implement subgroup reporting for MVPs, which will disincentivize reporting on MVPs.

If CMS continues to require subgroup reporting, it must revise the compliance policy. We recommend several steps to reduce the regulatory and administrative burden on multispecialty practices of forming subgroups and reporting multiple MVPs and, thus, achieve the goals of Executive Order 14192, Unleashing Prosperity through Deregulation:

- Establish a maximum number of MVPs for multi-specialty groups. CMS may want to develop guidelines for choosing MVPs for multi-specialty groups, such as MVPs based on the highest volume of services or largest number of clinicians.
- Apply facility-based scoring to MVP participants that otherwise qualify for this scoring option in Traditional MIPS to encourage alignment of quality improvement efforts between physicians and the facilities where they provide care. We encourage CMS to work with the national medical specialty societies to determine appropriate application of facility-based scoring across existing and future MVPs.
- Promote care coordination across group practices by continuing to evaluate certain measures, such as TPCC and Medicare Spending Per Beneficiary (MSPB) Clinician, and improvement activities at the group practice level.

Virtual Group Reporting

Recommendation:

- CMS should allow reporting as a virtual group for MVPs and streamline registration by allowing clinicians to select the virtual group option when they register for MVPs.

The AMA supports maintaining flexible reporting options, including virtual groups, as one strategy to minimize reporting burden on physicians. While we continue to oppose mandatory MVPs, should CMS move in this direction, offering additional flexibilities including virtual group reporting could be valuable. We agree with the Agency that it should look for ways to streamline registering, including allowing clinicians to select virtual groups as an option during their MVP registration. CMS should continue to look for ways to ease the burden of MVP registration and forming virtual groups more generally, especially if it moves towards mandatory adoption, including allowing reporters to register during the data submission period.

C. Proposals Specific to MIPS Quality Performance Category

For the 2027 performance period/2029 MIPS payment year, CMS proposes a measure set inventory of 180 MIPS quality measures (177 of which are available in traditional MIPS and 3 of which are available only for MVPs), including 20 measure removals, 10 new measures for 2027 and one new measure for 2028, and 43 substantive changes to existing measures. The AMA offers the following measure-specific comments:

New Measures

There is an urgent need for CMS to consider and accept more measures into MIPS to better ensure alignment with the growing number of episode-based cost measures, APMs, and other quality and certification programs. In addition, new measures would further equip patients with usable quality information and provide physicians with the opportunity to be successful in CMS' quality programs and APMs. If these gaps are not filled, we believe that the future of the program, specifically the transition to and adoption of meaningful MVPs, is in further jeopardy.

The AMA is concerned that there is an assumption among the Administration, CMS, and its contractors that decreasing the number of measures and MVPs will minimize burden, and there appears to be a desire to reduce the work for CMS and its contractors. **However, it is not the number of measures or MVPs that cause physician burden, but rather the overly complex reporting requirements and poorly designed programs.** The program should allow physicians to track and measure individual health conditions, episodes of care, or major procedures that can be directly linked to and drive quality improvement activities. Therefore, **CMS must maintain a robust portfolio of quality measures that enable quality improvement in addition to promoting accountability.**

The AMA offers the following comments on these proposed new measures:

- *Functional Improvement for Patients with Neck Impairments*
- *Functional Improvement for Patients with Upper Extremity Impairments*
- *Functional Improvement for Patients with Back Impairments*
- *Functional Improvement for Patients with Lower Extremity Impairments*
- *Functional Improvement for Patients with Knee Impairments*

Recommendation:

- The AMA does not support including these measures in MIPS until detailed measure specification and testing information is made available.

The AMA was unable to find the detailed measure specifications, including the factors included in the risk-adjustment model, or the results on the feasibility, reliability, and validity testing of these measures. MACRA specifically requires MIPS measures to demonstrate feasibility, reliability, and validity testing. It is also necessary to know the process by which these measures were developed, including whether a technical expert panel was convened, which specialties and experts were included, and other important details relevant to the measure development and testing process. This information is particularly important since the developers are two for-profit companies rather than a medical specialty society with well-established measure development and testing processes. We believe that this information is crucial to

ensuring that measures follow a rigorous process and are free from conflicts and biases. Accordingly, the AMA does not support including these measures in MIPS until this information is made available.

SGLT2 Inhibitors for Patients with Chronic Kidney Disease (CKD) With or Without Type 2 Diabetes Mellitus,

Recommendation:

- The AMA does not support including these measures in MIPS until detailed measure specification and testing information is made available.

We were unable to find the detailed measure specifications or the results on the feasibility, reliability, and validity testing of these measures. It would also be important to know the process by which these measures were developed, including whether a technical expert panel was convened, which specialties and experts were included, and other important details relevant to the development and testing process. This information is particularly important since the developer is a for-profit company rather than a medical specialty society with well-established measure development and testing processes. We believe that this information is crucial to ensuring that measures follow a rigorous process and are free from conflicts and biases. Accordingly, the AMA does not support including these measures in MIPS until this information is available.

Rate of Timely Follow-up on Abnormal Screening Mammograms for Breast Cancer Detection

Recommendation:

- The AMA supports the intent of the measure, but testing data have demonstrated that the measure is not appropriate or reliable at the individual clinician or group level. As a result, we do not support inclusion of the measure.

The AMA supports the intent of this measure; however, we have many concerns when considering this measure for inclusion in MIPS. During the Pre-Rulemaking Measure Review process, the testing provided at the individual clinician and group level demonstrated that the measure is not appropriate for this program. Specifically, we identified the following issues:

- The performance scores provided across the three health systems and at all levels (clinician, group, and health system) were generally above 90 percent across several years. The current MIPS benchmarking approach will not allow this high rate of performance to be spread across the 10 deciles, and we believe that this measure could quickly become topped out. While no information was provided on the characteristics of the health systems (e.g., state or region, rural vs. urban, academic medical center vs. community hospital), we are also concerned that any scores that are below 90 percent may reflect staffing challenges or decreased access to imaging facilities in a region rather than true performance. Additional investigation into why performance that was generally high, even during the COVID-19 public health emergency, decreased in a subsequent year would be beneficial in understanding whether there are other factors outside the control of the clinician, group, and/or health system.
- The electronic clinical quality measure (eCQM) specification requires integration of the Breast Imaging – Reporting and Data System (BI-RADS) into the EHR system; however, the feasibility assessment and data element testing demonstrated that the BI-RADS data are not consistently

captured in discrete fields. In fact, one of the testing sites used a simple string search to capture the unstructured data, which is inconsistent with current MIPS requirements that there be end-to-end reporting from EHRs without manual manipulation. Additional testing must be completed to demonstrate the agreement rates for each data element in a manner that is consistent with the current eCQM requirements (i.e., not include data from the string search unless it is integrated into discrete fields).

- The reliability results were acceptable at the health system and facility group levels, and while the median signal-to-noise ratio (SNR) at the individual clinician level was over 0.9, the minimum SNR was 0.142. All results were based on a minimum sample size of 40 patients; however, MIPS benchmarks are determined based on minimum sample sizes of 20 patients. We are extremely concerned that the reliability scores will be significantly lower when the 20-patient minimum is applied.

Given these concerns, the AMA does not support inclusion of this measure in MIPS.

Measures Proposed for Removal

Recommendation:

- We urge CMS to expand its analysis beyond current benchmarking data when proposing a measure for removal from MIPS. Benchmarking data alone do not provide a complete picture of whether a measure is representative of true, widespread performance across a specialty.

We urge CMS to implement a more thorough and thoughtful process based on specific criteria when identifying whether a measure is topped out and potentially considered for removal from MIPS. A recent review of reporting rates on MIPS topped out measures during the first six years of the program identified that, of the 137 topped out measures, the vast majority were not reported by a large percentage of clinicians and groups.[7] In fact, the median reporting rate across those measures was not more than 5 percent.

Using data from the 2024 QPP Experience Public Use File,[8] we examined the degree to which measures that were identified as topped out could be considered representative of widespread performance across an applicable specialty and the percentage of those reporters with unique characteristics (e.g., small practices, practices providing care within a health professional shortage area, or practices in rural areas). Our review revealed that the findings of the recent study continue to hold. Examples include:

- *143 Oncology: Medical and Radiation – Pain Intensity Quantified*: This measure was reported by just over 1,000 individuals and groups out of the more than 12,000 oncologists who reported at least one measure and over 40 percent were small practices and 30 percent served in a health professional shortage area.
- *320 Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients*: Just over 800 individuals and groups out of the 7,000+ gastroenterologists reported this measure and 33 percent were small practices.

[7] Chung Y, Nicola LP, Rula EY. Reporting rates of topped-out merit-based incentive payment system (MIPS) quality measures, 2017-2023. *Health Aff Sch*. 2026;4(4):qxag061. Published 2026 Apr 12. doi:10.1093/haschl/qxag061

[8] https://data.cms.gov/quality-of-care/quality-payment-program-experience/data

- *384 Adult Primary Rhegmatogenous Retinal Detachment Surgery*: No Return to the Operating Room Within 90 Days of Surgery: This measure only had 154 individuals and groups out of the possible 11,000+ ophthalmologists reporting the measure, with almost half classified as a small practice.
- *415 Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 18 Years and Older:* Just under 2,000 out of the 25,000+ emergency medicine physicians reported this measure with roughly 30 percent of them serving within a health professional shortage area; a similar percentage were also classified with safety-net status, and a quarter were rural.

In addition, one of the measures proposed for removal, 350 Total Knee or Hip Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy, was reported primarily through MVPs with more than 2,500 of the 4,000+ reporting groups using the MVP pathway.

These findings also confirm for us that using the current benchmarking data alone does not provide a complete picture of whether a measure is representative of true performance gains across a specialty, and that there are likely continued opportunities for improvement with these measures. Two of the measures highlighted above were reported by less than one percentage point of the applicable specialty, and the other two were reported by only roughly 10 percent. We noted in previous comments that we believed that some of the measures that appeared to be topped out were likely reflecting the top performers and these numbers further confirm this belief. In addition, CMS should consider the potential impact on small practices, practices in health professional shortage areas, and rural practices of removing a measure. In addition, removing the one measure where most reporters leveraged the MVP option would be shortsighted. We urge CMS to consider evaluating additional information, such as our analysis, on any measure before determining that it is appropriate to remove it from MIPS.

Substantive Changes to Existing Measures:

Preventive Care and Screening: Screening for Depression and Follow-Up Plan

Recommendation:

- The AMA supports CMS' proposed updates to the measure specifications. However, the proposal does not fully address ongoing data aggregation and alignment challenges that ACOs and physicians face across practices, specialties and reporting options.

The AMA appreciates that CMS' proposed inclusion of the denominator exception addresses ongoing concerns with the measure, specifically when a clinician is aware that the depression screening was previously completed by another clinician but does not have the actual results. However, the proposed change does not completely address the challenges that ACOs and physicians encounter when aggregating data across multiple practices and specialties. We believe that the implementation challenges lead to results that do not match the intent of the measure, which is to reflect the quality of services provided for patients screened for depression. The results may be more reflective of the ongoing need for interoperability and timely information at the point of care to facilitate care coordination and appropriate screening and management for depression.

Currently, the numerator calls for screening for depression and, if the result is positive, a follow-up plan to be documented on the date or up to two days after the date of the qualifying encounter. While the

specifications state that this is a patient-based measure with the screening only required once, it is very possible that a patient will have more than one qualifying encounter in a reporting period. Any initial screens could be replaced by what does or does not occur in a subsequent qualifying visit with a different clinician whose EHR does not include the previous screen and therefore triggers a best practice alert. As ACOs implement and aggregate data, the most recent quality data code is what must be used, and it may be the one from a specialist or urgent care visit at which the screening did not occur or was incomplete, regardless of what occurred previously. The proposed exception is only useful in those instances where the clinician knows that the screening happened but does not have visibility into the result. It does not address those instances where a more recent encounter results in a numerator failure (e.g., the best practice alert is not addressed during the urgent care visit) even when at some point in the performance period the appropriate screening and follow-up plan if positive is documented.

We are also concerned with the lack of alignment with the eCQM versions of this measure since the addition of this new exception is omitted from the eCQM specification for 2027. For those ACOs that may decide to collect data for more than one reporting option or find that they must switch from reporting an eCQM to a MIPS CQM measure mid-year, this addition will require them to maintain two separate pathways and increase reporting complexity and burden. CMS should avoid such inconsistencies, and should evaluate whether this proposed change sufficiently addresses the concerns raised. CMS should coordinate any updates to ensure that all specifications, regardless of data source, are the same for the same reporting year.

If the goal of the measure is to ensure that patients are screened for depression at least once a year, then we recommend that the measure specifications across all reporting options are revised to clarify that intent. Specifically, the presence of a screen and follow-up, if appropriate, at least once in a performance period should be sufficient and if multiple screens are completed, then the most recent should be used. This change would address the current issues when aggregating the data across practices and eliminate the need for the denominator exception, which removes patients due to the lack of available and discrete data and not due to clinical reasons.

Our questions and concerns regarding this proposed denominator exception highlight the ongoing challenges that ACOs experience implementing measures that were intended to capture the quality of care provided by individual clinicians or practices. Applying such measures at the ACO level requires workarounds and new operational pathways. If CMS continues to apply physician-level measures at the ACO level, it should incorporate the perspective of ACOs into the measure development, review and update process to ensure a measure is appropriate, feasible and reliable at the ACO level. CMS should also coordinate updates to measures to ensure that specification changes are consistent across all reporting options within a reporting year.

Preventive Care and Wellness (composite)

As the AMA stated in our comments on the 2026 PFS proposed rule, we continue to oppose the proposed changes to the MIPS CQM specifications for the Submission Criteria 3 (Breast Cancer Screening) and 4 (Colorectal Cancer Screening [CRC]) included within Preventive Care and Wellness (composite), specifically the addition of a definition for “reviewed” to qualify as meeting the quality action. We believe that this change is an expansion beyond the original intent of the measure, which will increase documentation burden without any value added to the patient or physician.

We are also concerned that these changes could lead to a negative unintended consequence of overuse of these procedures since the timeframe includes data from previous years (for CRC this lookback period

can be up to 10 years if a patient received a colonoscopy). It is very unlikely that a review and discussion of the findings will be documented in an easily accessible way and as a result, a repeat mammogram or CRC screening may be ordered to fulfill the measure even when the patient is due for this screening. We oppose any change that could encourage overuse of services, particularly a revision that is not directly tied to improving patient care.

We are further concerned that physicians may also be compelled to discuss the results from previous years, and potentially on a test that was ordered and reviewed by another provider, to enable them to meet the numerator. There is also a risk that discussing old test results for no reason other than to satisfy a quality measure will lead to patient confusion and unnecessary alarm.

Lastly, we recommend that CMS consider including patient refusal as an exception in the future. This addition will acknowledge and reflect that patients have a choice in the medical care that they receive and allow practices to understand screening hesitancy for quality improvement efforts at the point of care.

Requirement to Report an Outcome or High-Priority Measure and Removal of Designation

Recommendation:

- The AMA supports CMS' proposal to eliminate the requirement that physicians must report one outcome or high-priority measure to satisfactorily meet the quality category requirements, and to remove the outcome/high-priority measure designation.

The AMA supports advancements in measurement that identifies and tracks improvements in outcomes, including those that are reported by patients. However, due to the limited number of meaningful outcome measures available the requirement has been a challenge to meet, especially for small practices since they primarily report through the claims reporting option and there are a limited number of claims outcome or high-priority measures. The requirement also disadvantaged certain specialties, rural practices and practices that treat high risk patients due to ongoing methodological issues, such as the need for better risk-adjustment models at the measure level (not just the program level), improved benchmark methodology, and stratification by specialty. Therefore, the AMA supports CMS' proposal to eliminate the requirement that a physician or group practice report on one outcome or high-priority measure to satisfy the quality category reporting requirements.

Requirement to Report a MIPS Core Measure and Core Measure Designation

Recommendations:

- The core measure requirement that CMS proposes is an improvement over the outcome/high-priority requirement for satisfactorily meeting the quality category. However, CMS should delay the requirement until CY 2028 MIPS performance period to obtain more input into which measures should classify as a core measure and ensure EHR and registry vendors are ready to support the core measures.
- The AMA supports the attestation process for those clinicians for whom no core measures are applicable and CMS' proposal to exempt small practices from the core measure quality requirement.

CMS is proposing that starting with the CY 2027 MIPS performance period, physicians would be required to report a MIPS core measure as 1 of their 6 quality measures for traditional MIPS and 1 of their 4 quality measures for MVPs. Physicians and group practices would be able to select any measure in the MIPS quality measure inventory with the MIPS core measure designation or specialty measure set, as applicable and available. For MVP, physicians or groups practices would select any measure with the MIPS core measure designation for their selected MVP. If a clinician, group, virtual group, subgroup, or APM Entity reporting an MVP or traditional MIPS doesn't have an applicable MIPS core measure available to report, CMS is proposing to implement a self-attestation process. CMS also proposes to exempt small practices from this requirement.

The AMA supports removing the outcome and high-priority reporting requirement and the attestation process for those clinicians for whom no core measures are applicable, as well as exempting small practices from this requirement. In addition, we agree that the concept of core measures may prove useful as MVP reporting increases. However, we do not believe that the current set of core measures meet the desired goal of this change, which CMS stated was to identify "measures that are most reflective of the care that is unique to each MVP's specialty or medical condition." While we do not disagree with the defined set of factors on which a core measure would be selected (e.g., measure collection type availability, measure adoption), we question the degree to which some of the core measures meet the last factor: whether the measure is most reflective of care central to the clinical focus of the MVP, represents best practices, or addresses important areas for improving care. **We also believe that it is critical that at least one of the core measures should be considered in relation to one or more of the cost measures.**

Based on our review of the core measures proposed for each MVP, this concept works well when applied to the disease-specific MVPs (e.g., Diabetic Disease, Hypertension) rather than for those that are broadly applicable across a specialty where selection appears to be based on the limited number of applicable measures and/or the desire to avoid including QCDR measures. This misalignment is very apparent on review of a few MVPs:

- **Advancing Cancer Care**: No breast cancer measures are included among core measures despite it being one of the most prevalent cancers and the MVP already includes a relevant measure.
- **Dermatological Care**: No measures on melanoma are included despite it being an important diagnosis treated by this specialty and several measures are available withing the MVP. In addition, no core measure is aligned with the Melanoma Resection cost measure.
- **Gastroenterology Care**: The general preventive care measure is less relevant to this specialty and the other two are limited in focus. The only gastrointestinal-focused outcome measure in the MVP is omitted because it is a QCDR measure and as a result, no core measure is aligned with the Screening/Surveillance Colonoscopy cost measure.
- **Hospitalist**: Two of the three measures are focused on cardiovascular conditions and while they are important, they are narrow in scope when compared to the various conditions managed by this specialty.

As a result, we believe that the applicable specialty societies should be consulted regarding which measures should be included, and a rationale provided for the ones that are not most reflective of the clinical focus for a specialty.

In addition, we recommend that CMS establish a process by which specialty societies and others can nominate measures to be considered as core measures. **Specifically, the AMA requests that CMS consider including 515: Screening for Abnormal Glucose Metabolism in Patients at Risk of**

Developing Diabetes in the core measure list, and specifically as a core measure within the Value in Primary Care MVP. A recent study published in *JAMA* evaluated more than 1,100 Medicare patients after 21 years and found that those who participated in a lifestyle intervention program reduced the chance of developing multiple comorbidities.[9] This randomized clinical trial further supports the importance of this measure as it identifies the individuals with prediabetes who may benefit from interventions to prevent disease progression. As a result, we recommend CMS delaying the core measure requirement.

Furthermore, we are concerned with vendor readiness to support the core measures requirement starting in 2027 given the proposal was only included in the 2027 PFS proposed rule and is not subject to be final until November 2027. It is our understanding that EHR vendors do not support all eCQMs and will need a minimum of six months to update their systems. The delay of the requirement until 2028 would also allow CMS to refine the core measure definition, applicability to MVP and work with specialty societies to identify the most appropriate core measures. Therefore, **we recommend that CMS delay the requirement until the CY 2028 MIPS performance period/2030 MIPS payment period.**

D. Quality Measure Scoring

Topped Out Measures

Recommendation:

- We support CMS' proposal to not cap core measures and instead score core measures according to the defined topped out measure benchmark (with a 10-point maximum), however we urge CMS to apply the policy to all topped-out measures.

The AMA supports CMS' proposal that beginning in the CY 2027 performance period, topped out MIPS core measures subject to the 7-point scoring cap (i.e., are topped out for 2 or more consecutive performance period) would no longer be subject to that cap and would instead be scored according to the defined topped out measure benchmark (with a 10-point maximum), but urge CMS to expand the policy to all topped-out measures. Limiting it to a select set of measures (Core and select set of MVP measures) is confusing and arbitrary.

The AMA appreciates CMS' recognition of the ongoing challenges physician encounter when reporting on relevant but topped-out quality measures. We continue to support the use of a flat benchmark methodology but believe it should be refined. We recommend that if CMS is going to omit one decile out of 10, that it should be the first rather than the ninth as the distribution across the deciles appears to be somewhat random. Clinicians should be able to achieve the highest number of points possible, and we do not believe that CMS adequately justified why the ninth percentile was chosen when finalized in the 2025 PFS Final Rule.

In addition, we continue to urge CMS to apply the policy to ALL topped-out measures. Limiting it to a select set of measures adds complexity to the program, is subjective, and favors some specialties over others.

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[9] Salive ME, Tjaden AH, Ames JR, et al. Lifestyle and Metformin Interventions and Risk of Multimorbidity in Adults With Prediabetes. *JAMA*. Published online June 15, 2026. doi:10.1001/jama.2026.8492

Alternative Payment Model (APM) Performance Pathway (APP)/APP Plus Quality Measure Set

CMS Shared Savings Program ACOs are required to report the APP Plus quality measure set. The existing APP Plus quality measure set was established for the CY 2025 performance period and subsequent performance periods. The measure set was updated in the CY 2026 PFS final rule to reflect changes to the MIPS quality measure inventory. For the CY 2027 performance period, CMS is proposing to adopt substantive changes to the following measures that are part of the APP and APP Plus measure set and the AMA offers the following comments:

- *Diabetes: Glycemic Status Assessment Greater Than 9 percent (Quality Id: 001) (eCQM)*
- *Hospital-Wide, 30-day All Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479)*

The AMA supports the proposed revisions to these measures except for the *Preventive Care and Screening: Screening for Depression and Follow-Up Plan (*Quality ID: 134). Those comments are outlined under the *Substantive Changes to Existing Measures section*.

- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measures (Quality ID: 305)*
- *Adult Immunization Status (Quality ID: 493)*

For the CY 2027 performance period, CMS is proposing to remove two previously finalized measures from the set. If finalized there would be 8 measures in the APP Plus quality measure set in the CY 2027 performance period and subsequent performance periods.

We support the removal of these two measures, particularly as ACOs continue to focus on successfully reporting the existing measures within the APP Plus set. Removal of the measures eases administrative burden as ACOs have found the measures extremely burdensome and challenging to collect the data.

Modifications to Data Completeness Criteria

Recommendation:

- We appreciate the revisions proposed to enable ACOs to successfully meet the data completeness requirements but recommend CMS make modifications to the proposed policy exclusions. Specifically, removal of the language “intended for specialty use”.

To address ongoing data completeness requirements ACOs face, CMS proposes beginning on or after January 1, 2026, that ACOs may exclude one or more ACO participant TINs from an ACO’s submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM (if finalized) data (as applicable) for each measure if certain exclusions are met, including due to unforeseen circumstance(s) outside the ACO’s control (such as the unexpected closure of a group or individual practice that bills under the ACO’s participant TIN), an ACO participant TIN having CEHRT that is intended for specialty use and does not support the measure(s) included in the APP Plus quality measure set, or other circumstances as determined by CMS, so long as the ACO can report on ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the ACO before applying the measure specifications. Under the proposal, ACOs would still be required to meet the MIPS data completeness requirement (that is, the

ACO must report on at least 75 percent of the APM Entity's applicable beneficiaries who meet the measure's denominator).

The AMA appreciates the revisions proposed to enable ACOs to successfully meet the data completeness requirements given the ongoing challenges. We agree that most of the proposed changes will address the barriers encountered in capturing data from some practices. However, **we request that CMS consider a modification to one of the applicable exclusions, specifically "the ACO participant TIN has a CEHRT that is intended for specialty use and does not support the measure included in the APP Plus quality measure set."** Several ACOs were unable to successfully report eCQMs because a specific vendor did not support one of the measures from the APP Plus set; however, this issue was not limited to a vendor system designed for specialty care. As a result, we believe that this exclusion may be too narrow in its description and recommend removal of "that is intended for specialty use."

We also request clarification on how ACOs will be able to determine what would satisfy the last exclusion of "other circumstances as determined by CMS." Specifically, CMS should explain whether there will be a formal process by which ACOs must seek approval. Additional guidance on what this process will entail would be helpful.

Lastly, ACOs would be required to provide data on at least 95 percent of the beneficiaries assigned to the ACO; however, we believe that this may prove challenging for those ACOs under prospective assignment since the assignment window for prospective ACOs does not align with the performance period (as it does for ACOs under retrospective assignment). Specifically, beneficiaries are assigned to these ACOs based on primary care services received prior to the performance period and there will be some prospectively assigned beneficiaries who do not receive a primary care service during the performance period. The proposed rule language assumes that these beneficiaries would be excluded from the numerator calculation but still included in the denominator; however, this discrepancy could result in fewer than 95 percent of assigned beneficiaries being included without excluding any TINs, potentially making this policy unusable for prospective ACOs. To create fairness in the policy across types of ACOs in the program, CMS should simplify the calculation of assigned beneficiaries for this policy by utilizing the ACO's final assigned beneficiary list as the starting population for both the numerator and the denominator. This is also a more sensible approach because ACOs are still financially accountable for assigned beneficiaries, regardless of whether or not they receive a qualifying primary care service during the performance year. We strongly encourage CMS to finalize these proposals with the modifications outlined above to ensure the policy achieves its intended impact.

Collection Types for Shared Savings Program ACOs

Recommendation:

- The AMA supports CMS' proposal to extend the availability of the MIPS CQM collection type and establish a new collection type, Medicare eCQMs for SSP ACOs.

CMS is proposing to extend the availability of the MIPS CQMs collection type for Shared Savings Program ACOs reporting the APP Plus quality measure set. If finalized, the MIPS CQMs collection type would remain available for ACO reporting in the CY 2027 performance period and subsequent performance periods. For the CY 2027 performance period and subsequent performance periods, CMS is also proposing to establish a new collection type, Medicare eCQMs, which would only be available to Shared Savings Program ACOs reporting the APP Plus quality measure set. Similar to Medicare CQMs,

the Medicare eCQM patient population would be based on the ACO's assigned beneficiaries. The AMA supports these proposals. Both proposals assist ACOs with easing the transition to dQMs.

APP Plus Quality Scoring

Recommendation:

- The AMA supports CMS' proposal to apply flat benchmarks to score SSP ACOs reporting Medicare CQMs or Medicare eCQMs.

CMS is proposing that all measures of the Medicare CQMs and Medicare eCQMs collection type would be scored using flat benchmarks for the CY 2027 performance period and subsequent performance periods. The AMA supports this proposal as it provides better consistency with setting benchmarks.

Revisions To the Scoring Policy for Excluded APP Plus Measures and APP Plus Measures That Lack a Benchmark

Recommendation:

- We understand the need to revise the scoring policy when a measure is excluded from calculation or lacks a benchmark. However, the policy needs further refinements to ensure that ACOs are not ONLY scored on the administrative claims-based measures and CAHPS for MIPS.

Under the existing scoring policy for excluded APP Plus measures and APP Plus measures without a benchmark, SSP ACOs can meet the quality performance standard if one measure in the measure set is excluded or is without a benchmark and the ACO will not be evaluated on their quality performance on the remaining quality measures that it reported. CMS now proposes to revise the scoring policy for PY 2027 and subsequent PYs so the policy would apply only if the SSP ACO's MIPS quality performance score is calculated on fewer than five measures for the PY due to measure exclusion under MIPS. We understand the need to revisit this scoring policy since there are more measures included within the APP Plus set; however, we recommend CMS reconsider the proposed approach of applying this policy only when the quality performance score would be calculated using less than five measures. There is the potential for ACOs to be scored using the two administrative claims-based measures, CAHPS for MIPS, and only two of the ACO-reported measures. In that scenario, transparency on current performance and the ability to drive improvement will be minimal since data will only be available to the ACO for the two measures that they report. We encourage CMS to modify this proposed revision to ensure that at least three of the five measures must be the ones reported by ACOs.

E. Cost Category

Recommendation:

CMS should work with the AMA and other interested parties to overhaul MIPS cost scoring and feedback processes, particularly to refine the Total Per Capita Cost (TPCC) and Medicare Spending Per Beneficiary (MSPB) measures to focus on spending that is within the clinician's ability to influence and incentivize what is best for the patient long term.

CMS proposes no new, nor does it propose substantive changes to any of the existing 35 cost measures for the CY 2027 performance/2029 payment year. The AMA appreciates recent progress that has been made to improve the accuracy of the cost category, including overhauling benchmarking methodologies, instituting a two-year informational only feedback period, and refining attribution for the TPCC measure. We appreciate the Agency's willingness to hear from stakeholders and its interest in improving this category. While these changes are a promising start, more can and needs to be done to improve the relevance and accuracy of cost scoring within MIPS.

The AMA agrees that measuring clinicians on their ability to meaningfully control cost is important. However, equally, if not more important is ensuring this is done accurately, including appropriately calibrating risk adjustment and evaluating clinicians on what is within their control. If not, CMS not only risks evaluating physicians at random chance, as has been argued, worse, it risks systematically penalizing physicians that treat rural, underserved, or medically and/or socially complex communities, a pattern which unfortunately has indeed borne out in MIPS feedback reports. With MIPS penalties now at a staggering nine percent, more than any other CMS quality program, the stakes are now higher than ever. More must be done to prevent critical resources from being actively being ripped away from practices serving vulnerable patient communities before it is too late, particularly with cost worth 30 percent of a physician's total MIPS score and being the lowest scoring category every year.

CMS should engage in a comprehensive measure-by-measure evaluation in coordination with relevant medical specialties. The AMA, along with our Federation of national medical specialty and state medical societies, stands ready to do this work. We refer CMS to our previous detailed comments on improving cost measurement and scoring, and welcome future opportunities to discuss. In particular, we urge the Agency to start with reforming the TPCC and MSPB measures to maintain the comparative spirit/intent behind them, while reforming them to group services and focus on spending that would be reasonably within the clinician's ability to influence, rather than unrelated conditions or complications. CMS must also consider long-term spending implications. Preventive care may cost more up-front, and eventually pays dividends in the form of reduced complications and potentially avoidable visits to more expensive acute care settings, but this can take time. However, preventive care that should be encouraged is being penalized under existing cost measure methodologies. Ideally, CMS should seek ways to capture more long-term spending impacts. Recognizing this is a complex undertaking, the Agency should seek to exclude certain preventive care and other high-value services from counting against clinicians. At a minimum, CMS should discontinue TPCC and MSPB in MVPs where there are already alternative episode-based measures.

In addition to improving cost calculation methodologies, timely, accessible feedback is paramount. Physicians cannot be expected to draw insights and drive meaningful changes in patient care from data provided up to 18 months after-the-fact. Furthermore, the information currently provided in the patient-level and supplemental reports is non-intuitive, often incomplete or not useful without additional context, and in some cases, inaccurate. Consequently, in tandem with its efforts to overhaul cost scoring, equally important is overhauling cost feedback to ensure it is timely, accurate, complete, and actionable. The AMA has previously offered granular feedback with suggestions to improve MIPS cost reports, which we urge the Agency to review and consider in full. In particular, we urge more granular itemized data for the TPCC and MSPB measures. Furthermore, it has come to our attention that CMS has discontinued publishing the annual QPP experience report, a change the AMA vehemently opposes because it calls into question the Agency's and commitment to transparency and supporting the use of MIPS data insights to drive meaningful improvements in patient care. Rather than discontinue the reports, we urge CMS to work with the AMA and other interested parties to improve them in hopes of making them more useful.

F. Merit-based Incentive Payment Systems (MIPS) Promoting Interoperability Performance Category

Removal of Family Health History and Patient Health Information Capture Certification Criteria

Recommendation:

- The AMA supports the removal of the family health history and patient health information capture criteria from the CEHRT definition only if CMS and Office of the National Coordinator for Health Information Technology (ONC) first establish enforceable safeguards ensuring that these capabilities remain available to physicians.

We support CMS' objective of reducing unnecessary certification burden, but these criteria should not be removed unless there are safeguards that guarantee that these functionalities are in place for physicians. CMS believes these functions are embedded in certified health IT and anticipates that developers will retain them, however, those expectations do not guarantee that developers will continue providing the same functionality, structure, portability, or affordability once certification is no longer required. Some physicians rely on this information to support risk assessment, patient engagement, and clinical decision-making. Removing the criteria without adequate safeguards could allow developers to reduce the functionality, convert it into a separately purchased module, impose new fees, or designate previously standard capabilities as custom features.

CMS should work with ONC to ensure that certified EHR developers preserve these capabilities as structured, usable, and exportable functions within their base products, without additional charges or reduced functionality. CMS and ONC should also establish ongoing monitoring to identify whether developers discontinue these functions, impose new costs, or otherwise shift implementation and workflow burdens to physician practices.

Accordingly, **CMS should delay the proposed removal until CMS and ONC have coordinated appropriate certification oversight and enforceable developer safeguards.** If ONC cannot establish these protections before the proposed January 1, 2027, effective date, CMS should retain the existing certification requirements. The mere expectation that developers will voluntarily preserve longstanding functionality is not an adequate substitute for continued federal oversight.

Removal of Automated Numerator Recording and Automated Measure Calculation Certification Criteria

Recommendation:

- The AMA opposes the removal of the automated numerator recording and automated measure calculation criteria while CMS continues requiring measures dependent on numerator and denominator data.

The AMA supports reducing unnecessary health IT certification burden but **opposes removing the automated numerator recording and automated measure calculation criteria while CMS continues to require measures that depend on numerator and denominator data.** CMS acknowledges that measures such as e-Prescribing and Provide Patients Electronic Access to Their Health Information will continue to require these calculations, yet the Agency assumes EHR developers will voluntarily retain the necessary functionality after certification testing ends. CMS should not eliminate the federal requirements governing these capabilities while continuing to hold physicians accountable for data produced by them.

CMS should retain the existing certification criteria until it has eliminated every measure across CMS programs that requires numerator and denominator data. Eliminating certification while preserving dependent measures would remove a federal testing and accountability mechanism, increase reliance on unverified vendor calculations, and expose physicians to reporting errors, audit risk, and scoring consequences for functionality they cannot independently validate or control. These risks would fall most heavily on small and less resourced practices that lack the technical expertise and financial resources to reconstruct measure calculations.

If CMS removes these certification criteria, it must also commit not to establish future measures that require EHR numerator and denominator data. CMS should codify this commitment in regulation. At minimum, the final rule preamble should state unequivocally that CMS will not adopt such measures and announce its intent to codify that policy through future rulemaking. Until all existing affected measures and certification requirements are eliminated, CMS must allow reasonable reliance on developer reports and hold physicians harmless from scoring, audit, payment, or compliance consequences caused by inaccurate, unavailable, or improperly calculated EHR data.

Removal of the ONC Direct Review Attestation

Recommendation:

- The AMA supports the removal of the ONC Direct Review Attestation.

We urge CMS to remove the required ONC Direct Review Attestation beginning with the CY 2026 performance period. Because the underlying ONC requirements remain in effect, this separate attestation provides little additional program integrity value and creates an unnecessary administrative risk for physicians. CMS should finalize the proposal and automatically disregard any missing attestation for the CY 2026 performance period and subsequent years. This modest change will reduce administrative burden and prevent an inadvertent omission from resulting in a zero Promoting Interoperability performance category score.

Removal of the Optional ONC-Authorized Certification Body (ACB) Surveillance Attestation

Recommendation:

- The AMA supports CMS' proposal to remove the optional ONC-ACB Surveillance Attestation.

The AMA recommends the removal of the ONC-ACB Surveillance Attestation beginning with the CY 2026 performance period. Because the attestation is optional and carries no Promoting Interoperability points, its removal will modestly simplify reporting without affecting program integrity. CMS should finalize the proposal without establishing a replacement physician attestation.

Removal of the Security Risk Analysis Measure

Recommendation:

- The AMA supports CMS' proposal to remove the Security Risk Analysis measure.

The AMA urges CMS to remove the Security Risk Analysis measure beginning with the CY 2027 performance period. The measure duplicates existing legal requirements and creates an unnecessary MIPS

attestation without strengthening security. Cybersecurity remains a priority for all physicians and is a critical patient safety issue. However, as included in previous comments, we have regularly questioned the need to require eligible clinicians to attest "yes" to having conducted a security risk analysis in the MIPS PI performance category, given its duplicative reporting requirements with what is already required for Covered Entities in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule. CMS should finalize the proposal and clarify that its removal does not alter physicians' applicable obligations under the HIPAA Security Rule.

Electronic Prior Authorization (ePA) for Prescription Drugs Measure

Recommendation:

- The AMA opposes the proposal to make the ePA for Prescription Drugs measure mandatory beginning with the CY 2028 performance period.

The AMA supports the goal of replacing manual, fragmented prescription drug prior authorization processes with electronic workflows that improve patients' timely access to medications and reduce administrative burden. **However, the AMA opposes finalizing CMS' proposal to make the ePA for Prescription Drugs measure mandatory beginning with the CY 2028 performance period.** Under the proposal, a physician who does not attest "Yes" to completing at least one ePA request or claim an exclusion would receive a zero for the entire Promoting Interoperability performance category. This consequence is disproportionate, particularly because successful participation depends substantially on technology and actions controlled by EHR developers, health plans, pharmacy benefit managers, pharmacies, and other intermediaries.

CMS should postpone the mandatory measure and use that time to conduct a comprehensive readiness review. The review should evaluate whether EHRs have the necessary capabilities, whether those capabilities are affordable and integrated into physician workflows, and whether prescription drug ePA functions effectively across the communication channels connecting prescribers, EHR developers, pharmacies, pharmacy benefit managers, and health plans. Of note, only 24 percent of physicians participating in the 2025 AMA Prior Authorization Physician Survey reported that their EHR system offers ePA for prescription medications, suggesting that physicians currently lack access to the technology needed for succeed in this measure. **Most importantly, CMS must determine whether these workflows provide meaningful value to practicing physicians and patients. The review should include real world, end-to-end testing demonstrating that the entire process functions reliably across all participating entities.** The ability to transmit an electronic transaction is not sufficient to demonstrate meaningful value. CMS should assess whether the technology measurably reduces physician and staff administrative burdens, mitigates delays accessing medication, eliminates duplicative documentation, and limits reliance on payer portals, fax, and telephone.

CMS should obtain direct feedback from practicing physicians and medical staff, including those in small, independent, rural, and low-resource practices, rather than relying primarily on reports from payers, pharmacy benefit managers, and technology developers. **Feedback gathered from entities that self-report their own success dilutes the honest feedback physicians will provide.** Moreover, physician participation in this evaluation must be voluntary and must not become a new MIPS reporting, attestation, or documentation requirement. CMS should field a voluntary survey to collect physicians' firsthand experiences, and the AMA would welcome the opportunity to help publicize the survey through AMA's communication channels.

CMS should publish the review's findings and establish clear readiness criteria addressing system availability, standards conformance, successful end-to-end exchange, workflow integration, affordability, manual fallback rates, and demonstrated burden reduction. CMS should use these findings to determine whether a mandatory measure is warranted and address any future requirement through subsequent rulemaking. CMS should not assume that payer or EHR support for an individual standard demonstrates operational readiness across the complete drug prior authorization workflow.

CMS must also distinguish clearly between ePA and Real Time Prescription Benefit (RTPB) functionality. RTPB functionality is distinct from ePA, although the two may be connected within the same prescribing workflow. An RTPB inquiry may identify patient costs, alternatives, and/or whether prior authorization is required, but it does not independently complete an ePA request. CMS should clarify the respective roles that the NCPDP SCRIPT and RTPB standards will play in facilitating ePA transactions, reconcile any inconsistencies, and explain precisely which certified capabilities are necessary to complete the ePA measure.

Nevertheless, **if CMS chooses to move forward with a drug prior authorization measure in 2028, at the very least CMS should provide physicians a voluntary 10-point bonus opportunity**, as it proposes for the CY 2027 ePA measure for medical items and services. **Physicians who attest "No," do not report the measure, or cannot complete a transaction should experience no reduction in their Promoting Interoperability score**. This approach would encourage voluntary adoption while allowing CMS to gather implementation experience without penalizing physicians for immature or unavailable technology.

CMS should allow physicians who do not complete the measure to select a standardized reason through a simple drop-down menu, such as that their EHR does not offer prescription drug ePA, the functionality is not integrated into their workflow, or the transaction cannot be completed because of a system, network, or interoperability failure. Selection of one of these reasons should prevent any reduction in the physician's Promoting Interoperability score and should not require additional documentation or a separate hardship application. CMS should also offer physicians the ability to submit ePA experiences at the time of reporting their MIPS participation on CMS' website. CMS could also use these structured responses to identify the most common barriers to implementation and assess whether the infrastructure is sufficiently available to support a future mandatory measure. Physicians should not be required to document individual system failures or determine which entity caused an unsuccessful transaction.

Physicians should also be held harmless automatically whenever required functionality is unavailable, unaffordable, not integrated into their EHR workflow, or fails because of a payer, pharmacy benefit manager, pharmacy, EHR developer, network, or other third party. Physicians should not be required to document individual failed transactions or identify the specific entity responsible for a technical or interoperability failure. At minimum, CMS must establish a hardship exception aligned with other MIPS exceptions for physicians who lack affordable, reliable, and integrated drug ePA functionality.
Until CMS demonstrates that prescription drug ePA works end-to-end, replaces manual processes, and provides tangible value to physicians and patients, it should remain a voluntary incentive rather than a mandatory gateway to the entire Promoting Interoperability performance category.

ePA for Medical Items and Services

Recommendation:

- The AMA supports CMS' proposed modifications to the ePA measure for Medical Items and Services for the CY 2027 performance period, including making the measure optional, awarding 10 bonus points to physicians who attest "Yes," and imposing no scoring consequence on physicians who do not report the measure.

We recommend that CMS move forward with proposed modifications to the ePA measure for Medical Items and Services for the CY 2027 performance period. In particular, the AMA appreciates CMS' responsiveness to concerns raised in our prior comments and its recognition that physicians need additional time and flexibility because they are downstream from payers and health IT developers responsible for implementing the underlying standards and technology. We consider making the measure optional, awarding 10 bonus points to physicians who attest "Yes," and imposing no scoring consequence on physicians who do not report the measure as appropriate and constructive changes. **CMS should finalize this voluntary approach and retain it through at least the CY 2028 performance period.**

The AMA also supports allowing physicians to satisfy the CY 2027 measure using the combination of certified Health IT Modules necessary for the ePA workflow, rather than requiring every physician to use all three certified modules immediately. This flexibility appropriately recognizes that implementation of the Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR), and Prior Authorization Support (PAS) capabilities will vary across payers, EHR developers, physicians, and clinical circumstances. **In public forums, and in discussions with AMA staff, ePA stakeholders have confirmed that only CRD will be available by 2027.** For at least the first half of 2027, ePA functionality would be limited to receiving a basic "yes" or "no" response from the payer indicating whether prior authorization is required. Neither electronic documentation nor standard electronic end-to-end prior authorization communications will be supported. **The promise of full end-to-end ePA will not be realized in the near future.** CMS should not interpret the availability of certified modules or publication of implementation guides as evidence that these capabilities are affordable, integrated into physician workflows, connected to every applicable payer, or operational in real world care settings. **In 2027, ePA will function more like "electronic notification" rather than electronic prior authorization.**

CMS should further revise the measure so that a physician's successful electronic query satisfies the measure regardless of whether the payer responds that prior authorization is required. The physician has used the certified technology and completed the action within the physician's control by submitting the query. A response stating that prior authorization is not required is a successful and valuable outcome because it allows the physician and patient to proceed without unnecessary administrative work or delay. **Denying measure credit based on that response would make physician performance contingent on a payer determination and would discourage use of the very functionality CMS seeks to promote.** CMS should therefore finalize the additional flexibility on which it seeks comment and count a successfully submitted query regardless of the payer's response.

The AMA opposes CMS' proposal to make the measure mandatory beginning with the CY 2028 performance period. Requiring physicians to use all three certified Health IT Modules to complete an end-to-end transaction, while assigning a zero for the entire Promoting Interoperability performance category when a physician cannot attest "Yes" or claim an exclusion, would be premature and disproportionate. Successful completion depends on the readiness and performance of EHR developers,

payers, intermediaries, and health systems, as well as the availability, affordability, configuration, and integration of the technology. As previously stated, end-to-end ePA will not be available until at least 2028. **Availability cannot be conflated with functionality.** EHRs, payers, and intermediaries must test end-to-end ePA throughout 2028, and this means that the full promise of ePA may not be realized until 2029 at the earliest. **CMS should retain the voluntary 10-point bonus structure through at least 2028 and use that period to evaluate implementation under real-world conditions.**

CMS should also use the voluntary measure to investigate why physicians may not be using ePA. When a physician attests "No," CMS could offer a simple, optional menu within its reporting website through which the physician may identify barriers such as unavailable EHR functionality, a health system's decision not to deploy the capability, added vendor costs, payer connection failures, or workflow problems. **Providing a reason must remain entirely voluntary and must have no effect on scoring, audits, or eligibility.** CMS should analyze and report only aggregate trends through at least 2028, without publicly identifying individual physicians or practices. CMS and ONC should use those findings to identify payer, developer, and intermediary barriers, pursue corrective action, and publicly explain how those barriers are being addressed.

The AMA would welcome the opportunity to work with CMS to explore how best to capture physicians' real-world perspectives on ePA, including through voluntary EHR feedback or during MIPS reporting. Ultimately, however, any approach CMS elects to adopt must be simple and voluntary, create no new reporting burden, and have no effect on MIPS scoring or audits.

Finally, the AMA strongly opposes replacing the current attestation approach with a performance-based measure. Such a measure could force physicians and practices to track and reconcile prior authorizations conducted through APIs, payer portals, fax, telephone, and other channels. It could also inadvertently hold physicians accountable for the availability and performance of technology controlled by other entities. ePA should remain, at most, an attestation measure until CMS has demonstrated that the technology is broadly available, reliable, affordable, integrated, and effective in reducing burden. CMS' objective should be to determine if ePA is effectively reducing prior authorization burdens for patients and physicians, rather than using physician utilization attestations to assess whether payers and their vendors have successfully implemented fully functional, end-to-end ePA.

Facilitating ePA

Recommendation:

- The AMA strongly supports CMS' broader efforts to ensure that prior authorization processes are electronic and interoperable.

We urge CMS to continue pursuing comprehensive initiatives to advance prior authorization processes that are electronic and interoperable. To help make sure that prior authorization is more efficient, and substantially less burdensome, **the AMA is developing and deploying a baseline, foundational, high-quality, trustworthy Systematized Nomenclature of Medicine – Clinical Terms (SNOMED CT®) and CPT® codes mapping specific to prior authorization workflows and informed by Da Vinci Implementation Guides (IGs) and CMS-0057-F.** The HL7 Da Vinci project illuminates the need to translate clinical data encoded within EHRs in SNOMED CT to CPT/HCPCS codes required by payer systems.

The AMA SNOMED CT® to CPT® Maps represent associations between clinical concepts in SNOMED CT to candidate CPT codes for prior authorization requests and claims submitted for payment. Furthermore, the maps provide stakeholders with the flexibility to deploy the maps within their own workflow-specific refinements and operational logic. **AMA is providing the maps at no cost for the prior authorization use case (as defined in the CMS-0057-F regulation).**

The AMA is conducting ongoing outreach to and coordinating with stakeholders (including AHIP, BCBSA, EHRA, HL7, WEDI, and their members). The purpose of this outreach is to obtain input and feedback to help create, test, and maintain usable maps for the PA use case.

The AMA urges CMS to publicly endorse this standards-based approach and collaborate with the AMA, HL7, SNOMED International, Medicare Administrative Contractors, health systems, payers, EHRs, and technology developers to test and incorporate the mappings into impacted payers' prior authorization APIs and workflows.

G. Improvement Activities

Recommendations:

- CMS should finalize the six proposed new improvement activities but reconsider plans to consolidate existing improvement activities.
- Should CMS proceed with consolidating activities, it should ensure all specialists have sufficient relevant activities to report and minimize burden as much as possible, including incorporating flexibility and not being overly prescriptive, particularly when it comes to factors beyond a physician's control.

The AMA supports CMS' proposed six new improvement activities, which generally emphasize leveraging technology-based insights to improve coordination and deliver whole-person focused care while deferring to the physician's expertise in how best to execute. Particularly with regards to "*clinician use of AI to improve patient care*," clinicians would establish their own policies for evaluating and monitoring AI tools or participate in developing and refining AI-enabled resources. CMS provides several examples but ultimately defers to the physician and practice in how best to implement. We also agree that ongoing physician involvement in broader efforts to develop and refine AI-technologies is essential. The AMA also supports "*Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues,*" which draws attention to social drivers and their proven impact on health, which is critical to overcoming barriers and combating chronic disease.

The AMA has concerns with CMS' proposals to modify five existing activities to "combine them with elements of similar improvement activities to make their descriptions more robust" while proposing to delete 11 activities, largely due to duplication. We are concerned that doing so unnecessarily increases reporting burden by giving physicians less credit for the same level of effort, while reducing the available inventory of activities overall, which could hinder specialists' abilities to satisfy IA requirements in the future.

It is important to maintain a sufficiently robust inventory of improvement activities that are clinically relevant to a particular clinician or specialty, particularly as CMS looks to encourage more MIPS reporting at the specialty level. In one case, CMS proposes to reduce four separate improvement activities into just one: "Implementation *of Documentation and/or Operational Improvements for Practice/Process*

Improvements." Before finalizing any changes, CMS should conduct an in-depth analysis to ensure that every specialist has a sufficiently robust selection of clinically relevant improvement activities to report.

Increase in burden is another core concern. As one example, CMS proposes not only to combine glycemic screening services and glycemic referring services into one activity, mandating a physician to now do both to receive credit for one activity, but at the same time, it proposes to increase documentation thresholds, offering no basis for doing so. As part of mitigating burden, it is important that activities are not overly prescriptive and retain a sufficient level of deference for the physician on how to implement based on the unique needs of their practice and patients. Making a particular activity too onerous to report by requiring a physician to complete two, three, or even four distinct criteria to receive credit for one activity will result in fewer practices selecting the activity, which could end up undercutting important strategies for improving patient care or Administration priorities. More "robust" reporting requirements do not equal better care for patients.

It is particularly important that activities are not overly prescriptive when certain elements are not within an individual physician's ability to control. For example, CMS proposes to modify "*use decision support—ideally platform-agnostic, interoperable CDS tools, including AI-enabled predictive decision-support interventions—and standardized treatment protocols to manage workflow on the care team to meet patient needs*," to explicitly mandate using only decision support tools that are AI-enabled. While the AMA understands wanting to advance AI-assisted technology, the previous definition struck a more appropriate balance by including AI-assisted technology in the description without making the activity contingent on the CDS technology being AI-assisted. Additionally, while ONC's HTI-5 proposed rule would modify decision-support interventions (DSI) within EHR certification, some certified DSI requirements will still apply to EHR developers. The rate at which AI is incorporated is driven by technology vendors, not individual physicians or practices, so technology-based capabilities like this would be more appropriately targeted at vendor requirements, rather than a program that solely measures clinician compliance.

H. MIPS Final Scoring and Public Reporting

Using Alternative Data Sources to Determine Clinician Eligibility for the Automatic Extreme and Uncontrollable Circumstances (EUC) Policy

Recommendation:

- CMS should use alternative data sources <u>in addition to</u> (not in lieu of) PECOS data for purposes of determining clinician eligibility for EUC policies.

We appreciate that CMS seeks to ensure all clinicians affected by natural disasters and public health emergencies are accurately identified. To this end, we generally support CMS leveraging the most current data available, including zip codes on billing claims. However, we suggest a slight amendment to CMS' proposed policy. Alternative data sources should be used in addition to zip codes included in the PECOS address system, as opposed to "in addition to or in lieu of" as proposed by CMS. If CMS' goal is to capture all impacted clinicians, it should take a conservative approach for EUC determinations. There are several scenarios in which a clinician's PECOS address may not align fully with their practicing location, such as if they are practicing in two locations, or if a practice or health system's billing location is separate from each practice location, which is common. If the PECOS data are several years old, CMS may seek clarification from the clinician or practice in question, but should always err on the side of

caution, particularly as these exemptions are temporary and the clinician in question may be dealing with a hardship that makes it difficult to respond in a timely fashion.

Extending Reweighting Request Deadline due to Third Party Intermediary Failure to Submit Data

Recommendations:

- CMS should finalize its proposal to extend the deadline for clinicians to request re-weighting due to a third-party intermediary's failure to submit from November 1 to December 31 of the year preceding the payment year.
- To further reduce program complexity and enhance protections for clinicians who are unable to submit MIPS data due to circumstances beyond their control, we encourage CMS to build on this proposal by applying this same year-end deadline consistently across all EUC and reweighting requests, regardless of reason.

The AMA strongly supports extending the deadline to submit MIPS reweighting requests due to failure by a third-party intermediary to submit data from November 1 to December 31 of the year preceding the MIPS payment year. We believe this provides clinicians with additional protections where failure to report was not in their control. In this same spirit, we encourage CMS to consider applying this same calendar year-end deadline for all other reweighting and EUC hardship requests. We believe setting a consistent December 31 deadline for all reweighting or hardship exemption requests regardless of reason will reduce program complexity, improve clinician understanding, and further protect clinicians from MIPS penalties when they are genuinely unable to submit MIPS data due to circumstances beyond their control. Because CMS reserves the right to review requests on a case-by-case basis, this change would not compromise program integrity, but it would provide important flexibilities and protections and would reduce unnecessary complexity in the program.

Proposal to Publicly Report IA and PI Data New to MVPs

Recommendation:

- The AMA urges CMS not to adopt its proposal to resume public reporting of IA and PI data in their first year of inclusion in an MVP. Instead, the AMA urges CMS to expand its existing policy for public reporting of MIPS quality and cost measures so that it would not publicly report any MIPS data for the first two years of appearance in MIPS or MVPs, regardless of category.

The AMA understands the importance of data being available to patients so they can make informed decisions about their care. However, it is equally important that publicly reported data presents an accurate portrayal of physician performance. Reporting measure or activity-level data for nascent measures that are still volatile due to low reporting rates and/or which may be undergoing further refinement in their initial performance years risks unduly penalizing clinicians due to factors like inaccurate risk adjustment rather than their performance on a measure, with a disproportionate impact across specialties and clinicians treating high-complexity patient populations, reducing reimbursement for these types of practices, and potentially exacerbating patient access issues. This could have a much longer-lasting negative impact on patient care than simply not reporting brand-new measures for two years to allow for further refinement and education before performance is made public.

Maintaining certain protections for physicians who report new measures is an important way to encourage reporting of new measures and activities, which is critical to ensuring MIPS and MVPs remain clinically relevant well into the future, but particularly as CMS looks to fill gaps for certain specialties and subspecialties, which will be even more important to do quickly should CMS advance its mandatory MVP proposal. As we know, the first couple of years of a new measure or activity's inclusion in the program are critical to making technical refinements to measure attribution, calculation, and risk adjustment methodologies, as well as setting benchmarks. We also know that it often takes several years for a new activity or measure to become more widely reported, particularly after it gains a benchmark. If CMS were to finalize this policy, it would create further hesitation for physicians to report MVPs, directly undercutting CMS' goal of trying to encourage more physicians to report MVPs. For all these reasons, the AMA urges CMS not to finalize this policy to resume public reporting of new IA or PI activities or measures during their first year of inclusion in an MVP.

In the interest of reducing program complexity and encouraging development of new measures and activities, particularly for specialists and subspecialists, the AMA encourages CMS to instead broaden its policy for quality and cost measures and to not publicly report on clinician performance of any new measures or activities for the first two years of appearance in MIPS or MVPs, regardless of performance category. We believe this streamlined approach would reduce programmatic complexity, promote more consistency between MIPS and MVPs, as well as the performance categories, encourage measure and activity development, and improve the accuracy of publicly reported data. This would be a temporary status reserved for new measures, so its effects on patient transparency would be limited, while its potential effects on spurring future measure development could be substantial.

I. Advanced APMs

Recommendations:

- CMS should not finalize its policy to apply APM-related financial incentives only to NPI/TIN combinations for TINs participating in an APM Entity, particularly for the differential conversion factor for APM participants, due to statutory limitations and logistical feasibility concerns and the negative impacts it would have on future APM adoption.
- If CMS moves forward with this policy, the Agency should redirect funding towards initiatives to advance APM adoption, particularly by small, rural, independent, safety net, and specialty practices.

CMS proposes to apply any APM-related financial incentives, including APM Incentive Payments and the QP conversion factor differential, only to claims associated with Advanced APM-participating TINs, rather than all TINs associated with a qualifying NPI. The AMA understands wanting to direct APM incentive payments to practices and physicians that participate in APMs. However, we have several practical concerns with unintended consequences this change would have on physician participation in APMs and physician reimbursement, starting with logistical complexity.

Because the 0.5 conversion factor differential for APM participants is designed to be cumulative each year under MACRA, applying the policy to each unique TIN/NPI combination has the potential to get complicated quickly from a logistical standpoint, particularly multiple years into this cumulative differential. Before CMS finalizes such a policy, the Agency should provide a detailed accounting of how it plans to account for this including its interaction with possibly simultaneous MIPS adjustments to the same NPI/TIN combinations under this new policy, which is notably absent from the proposed rule.

The Agency should also clarify what would happen in various scenarios, including if a physician works and qualifies for APM incentives under a TIN affiliated with ACO A, then moves to a different TIN affiliated with ACO B, would the physician still then receive their incentive payment because they are still part of a TIN that is participating in an ACO, even if it is not the same ACO they qualified under during the relevant performance year? Should the Agency move forward with this policy, at a minimum, they take the latter approach, as the individual would have demonstrated commitment to APM participation not once but twice.

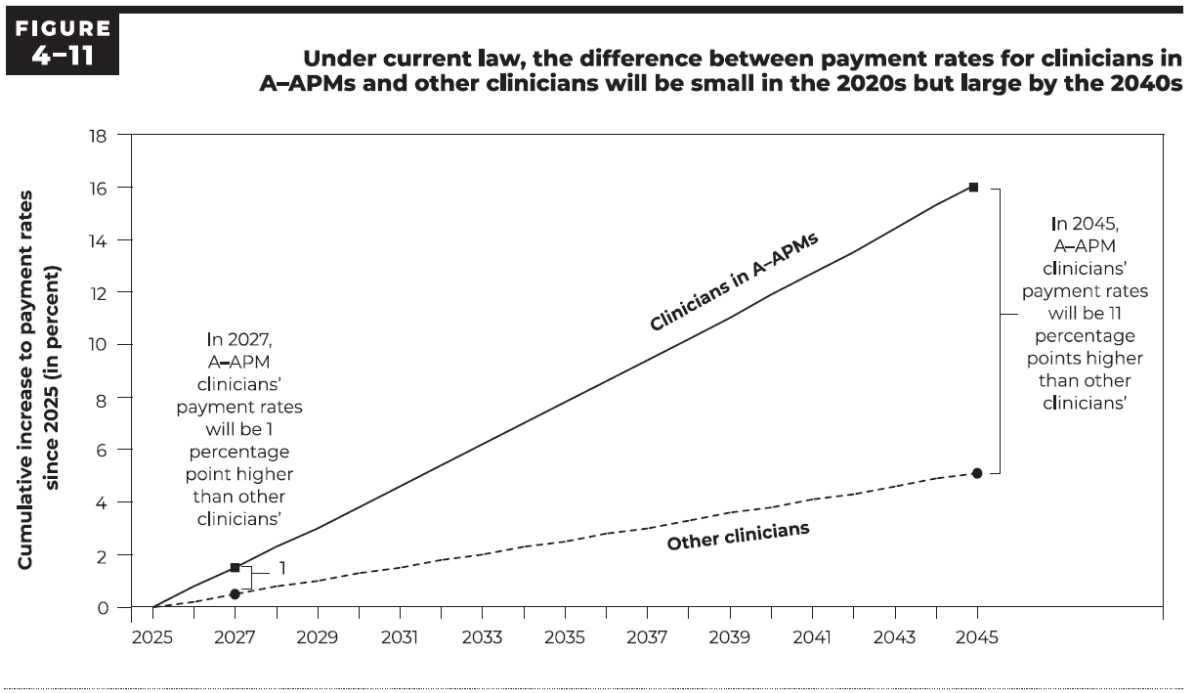
Before finalizing such a policy change, CMS should also demonstrate that it has adequately considered the complex market dynamics this new policy would engender, along with subsequent potential harms to patient access. Due to the lag between qualifying for participation in an Advanced APM and receiving APM payment incentives, physicians who have earned the APM payment incentive in the performance year would be faced with the possibility of losing access to that earned incentive in the payment year and therefore would be disincentivized from moving to or opening new practices under the new policy. As a result, the market would become less flexible to meet evolving patient demands.

Making this change would run counter to Congress' intent and design of APM incentive payments, particularly with regard to the conversion factor. The MACRA stature states simply: "There shall be two separate conversion factors for each year beginning with 2026, one for items and services furnished by a qualifying APM participant… and the other for other items and services…" The definition of a qualifying APM participant for a year is by statute established based on the eligible professional's APM participation in a prior performance period, not in the payment year to which the conversion factor would be applied. Thus, CMS' proposal to "no longer apply [QP status] to a clinician as a whole" is not congruent with the statute and extends well beyond its statutory authority to distinguish between different services furnished by a qualifying APM participant across different TINs in this manner. Attempting to draw this distinction would defy Congress' statutory intent with establishing the differential conversion factor to incentivize APM participation. Congress designed the APM conversion factor purposefully in this way to be applied to <u>all</u> of a clinician's payments during the applicable payment year to reward them for participation in an APM during the relevant performance period. If a clinician were to move to new practices between the performance and payment year, this in no way negates their previous commitment to an APM. The clinician has already earned the incentive.

Furthermore, this approach would be inconsistent with other CMS programs and models that render the full adjustment earned during the relevant performance year to the payment year. For APM incentive payments, CMS previously established a hierarchy in which it would prioritize TINs participating in Advanced APMs but allowed for payment to be sent to other, non-participating TINs if that was the only place it could find the clinician active at the time of payment, in recognition of the fact that the clinician rightfully earned that incentive based on their <u>past</u> performance. In the case of MIPS adjustments, which are also paid at the TIN/NPI combination level, a clinician's past performance, good or bad, follows them to their new practice, so CMS' proposed change to apply APM incentives only to APM-participating TINs during the <u>payment</u> year would be incongruent with both policies. This proposal is especially problematic in the case of APM incentive payments because physicians already had to meet quite a high bar to qualify in the first place in the form of the Qualifying APM Participant threshold.

It is inappropriate to propose this change solely as a means of generating savings for Medicare. Applying payment-year policies to strip fairly-earned incentives based on past performance from physicians would make already thin Medicare reimbursement margins even thinner. As it stands, Medicare physicians are the only Medicare providers that do not have an inflation-based update. As a result, after adjusting for rising practice costs, physicians' real reimbursement has fallen 33 percent since 2001. Physicians simply

cannot afford additional cuts to their bottom line, particularly ones that nobody asked CMS to make. Beyond making it harder for practices to survive in the first place, this will certainly undercut, not incentivize future APM adoption as CMS tries to argue, because at the end of the day, it's at least $2.38 billion less in investments going to physician practices, which means that much less to re-invest in technologies and infrastructure that could prepare practices for future APM participation. While $2.38 billion is not an insubstantial amount, it will get exponentially greater in future years, due to the compounding effect of the higher conversion factor each year for APM participants. See the following figure from MedPAC's March 2026 report poignantly illustrating this point. As noted previously, due to physicians remaining the only Medicare provider without an automatic annual inflation-based payment update, this differential conversion factor is a literal lifeline for practices to attempt to keep pace with rising practice costs, and that was indeed part of Congress' original intent as an incentive to drive physicians into APMs over time. Should Congress act to extend the Advanced APM incentive payment (bonus) beyond the 2026 performance year, this will also add to the losses in total APM incentive payments for qualifying APM participants.



Note: A–APM (advanced alternative payment model). Graph does not show adjustments to payment rates prompted by budget-neutrality requirements, which take into account additions, deletions, or modifications of fee schedule billing codes and can result in payment updates that are larger or smaller than specified in statute. Graph also does not show (1) annual Merit-based Incentive Payment System adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or (2) annual A–APM participation bonuses available from 2019 through 2026 because these adjustments are one time only and not built into subsequent years' payment rates. Graph also does not show the effects of the expiration of the 2 percent sequester that applies to payment rates through February 2033.

This hindrance to future APM adoption will be felt most acutely among the physicians and types of practices that have thus far been locked out of APM participation, not because of a lack of interest, but due to a lack of relevant models and pathways. To date, the majority of APMs have been total cost of care models and/or those aimed at primary care specialists so we agree with CMS that as the APM landscape looks presently, "for the majority of clinicians in Advanced APMs, this policy will not change their participation in QPP, because they are already participating with an APM Entity in an Advanced APM with all of their TIN reassignments." However, there is a very strong chance that this will not be the case even a few years from now, particularly as CMS is actively working on more dedicated

pathways within existing models, and hopefully developing targeted models that specifically target rural, specialty, and independent and small practice clinicians, which the AMA strongly supports. If CMS finalizes this change now, the impact on future APM adoption by rural, specialty, and safety net practices could be particularly detrimental.

For these reasons, the AMA urges CMS not to finalize its policy to only apply APM incentive payments to NPI/TIN combinations associated with an APM-participating TIN, particularly with respect to differential conversion factor updates. We believe this proposal is inconsistent with the statutory intent, exceeds CMS' statutory authority, and would result in myriad logistical complications and market consequences with negative impacts on specialty and rural participation in APMs and patient access to care. It is not clear based on its very brief explanation in the rule that CMS has fully considered all of these potential unintended consequences.

If CMS moves ahead with this change, it should consider ways to fulfill Congress' statutory intent of investing meaningfully in APMs by reappropriating any "savings" into APM adoption and growth. That could include standing up new models, offering advance funding opportunities for practices to join new or existing APMs, or helping practices to make the necessary infrastructure investments to facilitate future participation in APMs. We believe this would align with the spirit of this proposal to reward and drive APM participation in more targeted fashion while not reducing CMS' overall investment in APMs, especially at this critical juncture for enhancing participation by specialty, rural, small practice, and independent clinicians.

III. REQUESTS FOR INFORMATION (RFIs)

The AMA appreciates CMS' inclusion of numerous requests for information (RFIs) throughout the proposed rule and its willingness to seek stakeholder input on a broad range of important policy and operational issues. We commend the Agency for seeking input at an early stage, particularly on topics that would benefit from careful evaluation before future policy changes are considered. The AMA responds to the RFIs below.

A. Request for Information: Current Procedural Terminology (CPT)

CMS is seeking comments on the CPT as the national coding standard to describe physician and other healthcare professional services. The Request for Information (RFI) also questions the AMA's influence on the coding system and physician payment policy. CPT is the common language of American medicine. It gives physicians and other qualified healthcare professionals, hospitals, payers, researchers, and federal agencies a common language—grounded in a rigorous clinical process and the latest clinical evidence—to describe the care that is delivered, so that a service means the same thing wherever it is furnished and whoever is paying for it. Claims processing, quality measurement, interoperability, clinical research, and program integrity all rest on that shared description, enabling all interested parties to measure whether care is working. Quality measures, registries, and value-based payment models are specified in CPT codes, so the same vocabulary that documents a service also supports evaluating outcomes and rewarding better patient care. New and emerging services, including AI-enabled services, enter that same framework through Category III codes and the Appendix S taxonomy, which is how innovation becomes trackable and, where the evidence supports it, payable.

The CPT code set is a 60-year standard best suited to describe physician and other healthcare professional services, and it does so at no cost to the federal government. Over that history, the CPT Editorial Panel has evolved to meet the challenges of a rapidly changing healthcare industry, broadening participation, opening its meetings, and expanding the ways in which new codes reach the field, including the semi-annual release of Category III codes for emerging technologies and the quarterly release of proprietary laboratory analyses codes. The result is a code set that captures innovation as it arrives while remaining stable enough for the rest of the healthcare system to rely on. The process of continuous monitoring and updating, while still remaining true to a strong clinical foundation, is critical to the Panel's work.

There are two points in the preamble of the RFI that require clarification and are important to our response. As key distinctions of the CPT and RUC processes are frequently misunderstood, an accurate understanding of how the code set is created is essential to evaluating the questions the RFI raises. The paragraph we refer to in the preamble reads as follows:

> *"New CPT® codes are introduced by the CPT® Advisory Committee. This committee was established following the initial publication of the CPT® coding system in 1966, which provides advice on procedure coding and appropriate nomenclature as relevant to the committee member's specialty and consists of ''members of national medical specialty societies seated in the AMA House of Delegates.'' When a new CPT® code is defined by the CPT® Advisory Committee, it is then assigned a payment value by the AMA Relative Value Scale Update Committee or RUC."*

First, this paragraph incorrectly asserts that new CPT codes are introduced by the CPT Advisory Committee. The CPT Editorial Panel creates, revises, and deletes CPT codes. The Panel is an independent

body of volunteer physicians and other qualified healthcare professionals that holds the authority to modify the code set. The CPT Advisory Committee is a separate body, composed of more than 200 physicians and other healthcare professionals nominated by national medical specialty societies and other healthcare organizations, that provide clinical expertise and advises the Panel. The Advisory Committee does not create codes. The Advisory Committee may submit coding applications, but that same opportunity is provided to any stakeholder, and nearly 70 percent of applications are submitted by individuals not on the CPT Advisory Committee.

Second, the same paragraph incorrectly asserts that when a new code is defined, it is "assigned a payment value" by the AMA/Specialty Society RVS Update Committee (RUC). The RUC is a private entity exercising its First Amendment right to petition the Federal Government. During the creation of the Resource-Based Relative Value Scale (RBRVS) in the 1980s, the AMA worked with the government and its contractor to organize clinical expert panels of physicians. It was recognized then, and holds true today, that only individuals performing healthcare services can understand and articulate the resources required in the provision of the clinical services. When Congress passed legislation to establish and implement a national Medicare physician payment system based on the RBRVS, the AMA worked with national medical specialty societies and other healthcare organizations to create the RUC and its Advisory Committees. The RUC, a 32-member volunteer committee, meets three times per year to consider specialty society recommendations on the resource costs required to provide physician services. The RUC is supported by more than 200 physician advisors and other healthcare professionals who share their clinical insights. Outside observers are also welcome to attend the RUC meetings.

The RUC does not assign, and cannot assign, a payment or value. It recommends the relative resources involved in furnishing a service: physician work and the direct practice expense inputs of clinical staff time, supplies, and equipment. Whether and how any such recommendation is translated into a payment amount is a separate determination reserved entirely to CMS. The RUC submits publicly transparent recommendations to CMS following each of its three meetings, at no cost to the Federal Government. CMS has no obligation to adopt the RUC recommendations. However, the RUC provides information to CMS based on clinical expertise, using CMS standards and policies. The data and information are released to the public by CMS in a Proposed Rule and go through a formal notice and comment rulemaking process before they are incorporated into the Medicare payment system. CMS' high rate of use of RUC recommendations reflects the operational value of timely, specialty-specific clinical input in a highly technical payment system. That reliance does not diminish CMS' independent review; rather, it reflects that clinical resource recommendations are most useful when informed by physicians and other healthcare professionals with direct experience furnishing the services at issue.

Even where CMS accepts a RUC recommendation on relative resources, the payment a physician ultimately receives is governed by the statutory framework that Congress enacted (the budget-neutrality adjustment required under §1848(c)(2)(B)(ii)(II), the conversion factor under §1848(d), and the geographic practice cost indices under §1848(e)) and by the practice expense methodology CMS developed under the resource-based mandate of §1848(c)(2)(C)(ii) to allocate inputs into practice expense relative value units. The RUC has no role in any of these steps, whether prescribed by Congress or administered by CMS.

These distinctions are frequently misunderstood, which can lead to inaccurate conclusions about intent. We hope this clarification, and the following answers are helpful.

The following responses directly address the specific questions in the RFI:

1) **What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for healthcare entities? Please cite potential improvements to patient care diverted or delayed due to AMA's monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT licensure.**

CPT became the national standard for reporting physician services because it was, and remains, the most comprehensive, clinically precise, trusted, and rigorously maintained system of its kind. When HHS implemented the administrative simplification provisions of HIPAA, it adopted the combination of HCPCS and CPT as the national code set for physician and qualified healthcare professional services, radiologic procedures, clinical laboratory tests, and other medical services. That selection reflected the fact that CPT already served this function across public and private payers and did so more comprehensively than any available alternative.

The AMA respectfully disagrees with the premise that stewardship of CPT is best understood as a monopoly concern. CPT functions as a national standard because the healthcare system benefits from a single, clinically authoritative, continuously maintained nomenclature for physician and other qualified healthcare professional services. AMA stewardship serves a public-interest function by convening the clinical, payer, hospital, industry, and governmental expertise needed to maintain that standard in a way that is nationally uniform, operationally reliable, and responsive to changes in medical practice. More than 200 CPT Advisors drawn from over 100 national medical specialty societies and other healthcare organizations participate in the process, and the Editorial Panel includes representatives from medicine, other qualified healthcare professionals, payers, hospitals, industry, and federal agencies. Any stakeholder may submit an application for a code change, provide comments, and observe Panel proceedings subject to applicable process rules. In this way, the code set is maintained through broad clinical and operational participation rather than unilateral decision-making. We strongly believe that practicing clinicians should lead the discussion on how medicine is practiced, focusing on the well-being of the patient first.

There are concrete advantages to maintaining a single national nomenclature, and they accrue directly to the Medicare program.

- **A single national vocabulary.** One CPT code means the same service to every payer, clinician, vendor, and government agency in the country. That shared meaning is what makes claims interoperable across the healthcare system and allows Medicare claims to be processed, audited, and compared consistently.
- **Clinical specificity for professional work.** CPT outlines physician and other qualified healthcare professional activities with enough detail to differentiate services based on the time, skill, and resources involved. This level of specificity ensures precise and differentiated payment. Additionally, it supports value-based care models that need to accurately reflect the care delivered, even when payment is bundled or capitated as part of a value-based payment arrangement.
- **Support for preventive medicine.** Preventive care is central to modern medicine, and CPT codes make these services visible, reportable, and reimbursable across the healthcare system. With more than 120 codes covering screenings, immunizations, counseling, and chronic disease detection, CPT helps remove barriers to access, supports mandated coverage, and enables early detection that reduces long-term costs.
- **A defined pathway for emerging technology.** Category III codes and the Appendix S taxonomy for artificial intelligence give new and AI-enabled services a structured route from innovation to trackable reporting and, where the evidence supports it, to payment. This pathway is a national asset for bringing new technology into clinical use in a structured, predictable way.

- **Longitudinal data continuity.** Decades of claims history coded consistently in CPT enable actuarial analysis, quality measurement, health services research, medical information interoperability, and program integrity. That continuity is a public resource, and it exists because the code set has been maintained on a stable basis over time.

Two examples of the benefits this system provides to physicians, care teams, and their patients are highlighted below.

One current example is the restructuring of maternity care services effective January 1, 2027. The previous global reporting framework, which had remained largely unchanged for decades, bundled antepartum, labor, delivery, and postpartum care in a way that limited visibility into the care furnished across the course of pregnancy. The revised structure, developed with extensive input from the American College of Obstetricians and Gynecologists and other specialty societies, allows distinct phases of care to be reported more accurately. This supports more individualized patient care, better recognition of the services clinicians actually furnish, and improved opportunities to measure maternal care across the full episode rather than inferring it from a single code reported after delivery.

Care coordination is a second example. Before CPT created transitional care management codes 99495 and 99496 in 2013 and chronic care management code 99490 in 2015, the work of managing a patient between visits, following up after a hospital discharge, reconciling medications, coordinating across specialists, and keeping a care plan current had no way to be described or reported. Patients with multiple chronic conditions received that support only where a practice could absorb the cost. Once the services could be described and reported, practices could build care teams around patients whose needs do not fit neatly within a traditional office visit.

On the specific matter of licensure, the AMA provides CPT to the federal government under a royalty-free license, as the RFI acknowledges. CMS uses the CPT code set at no cost. The revenue that supports the maintenance of the code set funds a continuous, resource-intensive process of clinical review that would otherwise have to be paid for by the government or by another party. Moreover, entities that typically pay royalties are for-profit and utilize CPT in revenue-generating services.

CMS has asked commenters to identify harms, and we expect the agency will receive comments raising concerns about cost of access, the pace at which new services receive codes, and whether the process gives adequate voice to every group that delivers care. These are valid discussion points to which we pay close attention; several have already prompted change. Category III codes were created so that a new service can be reported and its use tracked while evidence accumulates toward a permanent code. The Panel recently approved an expedited release calendar for Category III codes to release them three times per year, with an effective date that is three months later. This schedule aligns with all other codes that do not require submission to the RUC and CMS for valuation, like Proprietary laboratory analyses (PLA) codes, which are consistently released every quarter.

Participation in the CPT process has also grown substantially due to our direct efforts to reduce administrative barriers to accessing materials and make it easier for all stakeholders to participate. The number of interested parties has increased by 168 percent over the past five years, and the average number of attendees has grown by 84 percent over the same time period.

The Editorial Panel has also consistently looked at ways to modernize the code set beyond traditional, in-person services and procedures, including creating Appendix S, which classifies AI-enabled services by

the work the algorithm performs. The Panel is also developing a framework for clinically meaningful algorithmic analyses to describe services generated by algorithms without embedded physician work. At the same time, the AMA is evolving the CPT platform through a dedicated workstream to modernize the end-to-end CPT process with AI-enabled intelligence layers, large language model integration, and structured crosswalks to existing code sets and clinical terminologies. This is a journey we have embarked on over the last few years to make CPT better, more accessible, and useful across the entire healthcare ecosystem. We welcome further collaboration on additional measures that can modernize both the code set and the process and make it more transparent.

2) **What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?**

CPT is a nomenclature. It provides standardized descriptions of the services and procedures that physicians and other qualified healthcare professionals perform. It describes what a service is. CPT does not determine whether that service is medically necessary for a particular patient, and it has never been designed or intended to make that determination. This separation is an attribute, not a flaw. It preserves the distinction between accurate clinical description on the one hand and patient-specific coverage determinations on the other.

Medical necessity is a coverage determination. It is made by payers, including Medicare, in the context of an individual patient and a specific clinical circumstance. Medicare makes these determinations through national and local coverage determinations and related policy. The existence of a CPT code does not establish coverage, does not establish medical necessity, and does not obligate any payer to pay for the service. CMS has stated this directly in its own guidance, noting that the existence of a code does not determine coverage.

A code must describe a service accurately, whether or not a given payer covers it, and whether or not it is appropriate for a given patient. That separation preserves judgment where it belongs. The physician or other qualified healthcare professional at the bedside recommends what a patient needs, and each payer, including Medicare, decides independently what it will cover. Had those determinations been embedded in the code set, both the clinical recommendation and the coverage decision would be constrained by a decision made elsewhere, by people who have never seen the patient and who are not accountable for the coverage policy. Preserving the separation is what allows the same code set to serve Medicare, Medicaid, and commercial payers, each of which sets its own coverage policy.

To establish a CPT code, the Panel uses a set of published criteria that are applied to every application and are available on the AMA website. To receive a Category I code, a service must satisfy all of the following: all devices and drugs necessary to perform it have received FDA clearance or approval where that is required; the service is performed by many physicians or other qualified healthcare professionals across the United States; it is performed with frequency consistent with its intended clinical use; it is consistent with current medical practice; and its clinical efficacy is documented in the literature. General criteria apply as well, including that the descriptor be unique and well-defined and not a fragment of a service already described in the code set. An application that does not meet these criteria is not approved.

These criteria are always clinically focused, and they are designed to be comprehensive. They establish that a service is real, well-defined, and clinically effective before it receives a permanent code. What they do not establish, and cannot establish, is whether that service is appropriate for an individual patient in a

specific clinical circumstance. The first question can be answered from published evidence and from the practice patterns of the profession. The second depends on facts that exist only at the point of care. The CPT process answers the first question rigorously and leaves the second to the physician and the payer, who are the parties best positioned to answer it.

The process by which a service comes forward for consideration is equally open. Any individual or entity may submit a code change application, and the criteria against which it will be evaluated are published on the AMA website. Each application is reviewed by staff, evaluated by the CPT Advisory Committee, opened to public comment, and decided by the Editorial Panel in a meeting that anyone may attend. The same criteria and the same process apply to every applicant.

Because the criteria are clinical and are applied consistently, payers can rely on CPT descriptions as a sound foundation for their own independent coverage determinations. The clinical focus of code creation is what makes the code set useful to every party that must reach its own conclusion about a service, and it is a principal reason the code set has been trusted across the public and private sectors for decades.

If the underlying concern is that the existence of a code is sometimes read as implying coverage, that concern can be addressed directly through coverage policy, which CMS already administers. It does not require any change to the code set. We would very much welcome the opportunity to work with CMS on targeted issues related to program integrity in which coding and coverage can be better aligned to limit waste, fraud, and abuse. In fact, as part of its effort to identify and address potentially misvalued codes, the RUC analyzes Medicare claims data. Clinical experts will often determine that modifications in CPT or further explanation may be necessary to prevent misreporting of services. CMS is often involved in this feedback loop, with all entities working together to ensure that CPT specificity supports mutually agreed priorities for accurate reporting.

3) **A combination of CPT-4 and HCPCS codes were formally adopted by HHS as the legal standard for national coding for physician and other services as part of implementing HIPAA (45 CFR 162.1002 (a) (5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services?**

The question presumes a set of alternatives, and it is worth being clear at the outset about what those systems are and how they relate to CPT. Importantly, these code sets (SNOMED CT, LOINC, ICD-10-CM/PCS), while applied to the same clinical encounter, each describe something different within that encounter and are not interchangeable with one another. ICD-10-CM records the patient's diagnosis. SNOMED CT captures clinical findings and observations in the medical record. CPT describes the service the physician or other qualified healthcare professional performed. LOINC identifies the laboratory tests ordered and the results returned. These are layers of a coordinated stack, built to work together. CPT occupies a specific position in the stack as the layer that connects clinical documentation to payment, which is why the AMA invests in mapping between CPT and the terminologies that surround it. Replacing CPT would not substitute one code set for another. It would require rebuilding every linkage between these systems at once, across every payer, EHR, clearinghouse, and billing system in the country. Other standards are important, but they serve different functions and are best understood as complementary rather than interchangeable.

With that context, we are not aware of an existing code set that could replace CPT as the national coding standard for physician services. However, as we noted in response to the previous question, there are opportunities to provide further linkages between each. The systems most commonly discussed as

alternatives are not designed to identify professional services for payment. We address the four raised most often below and return to ICD-10-PCS in greater detail under Question 5.

ICD-10-PCS

ICD-10-PCS is a procedure classification that CMS itself restricts to hospital inpatient reporting. The official coding guidelines, published by CMS, state that the system is used for classifying procedures performed in hospital inpatient settings. It has no structure for describing the evaluation and management services that make up a large share of physician work, and it has no pathway for emerging services. We address this code set more fully under Question 5.

HCPCS Level II

HCPCS Level II is not an alternative to CPT. It operates in combination with CPT today. CPT is HCPCS Level I, and Level II covers products, supplies, and services not described in Level I. CMS already maintains Level II and uses it to create codes for its own programmatic needs, including the G codes that CMS establishes through rulemaking to describe services it wishes to identify for Medicare purposes. In other words, the mechanism for CMS to code a service outside the CPT process already exists, is controlled entirely by CMS, and is in active use. This demonstrates that the current system already accommodates program-specific coding needs without replacing the national standard.

SNOMED CT

SNOMED CT is an expressive, computable clinical terminology and a comprehensive tool for representing clinical findings in the medical record. It is not designed for use in billing. SNOMED International, which maintains it, describes classifications rather than terminologies as the appropriate tools for billing, precisely because a smaller, disciplined set of codes is what makes assigning and maintaining prices feasible. SNOMED CT contains hundreds of thousands of concepts and supports composing expressions that were never separately enumerated, which is a strength for documentation and an obstacle for payment. It can only map to billing code sets; it cannot replace them.

Ultimately, these two systems are complementary, and the AMA is actively investing in the connection between them. In July 2026, the AMA launched an interoperability initiative to develop and deploy SNOMED CT to CPT mappings, beginning with electronic prior authorization. We invited health plans, health IT developers, and standards organizations to participate in testing and implementation. The initiative is designed to support the CMS Health Technology Ecosystem and the industry transition to FHIR-based prior authorization workflows ahead of the January 1, 2027 compliance date. CMS has made connected, interoperable health data a stated priority, and we share that goal. Mapping clinical terminology to procedural nomenclature is how each system becomes more useful.

LOINC

LOINC is the standard for identifying laboratory tests and clinical observations. Its scope is laboratory and observational data. It does not describe surgery, anesthesia, radiologic procedures, or evaluation and management services, and it identifies what was measured rather than the professional service that was furnished. It addresses a portion of one of the six sections of CPT and cannot serve as a general code set for professional services.

Would CMS need to specify a separate legal standard, or could CMS allow private competition to supplement the existing CPT-4 coding standard?

With respect to private competition or supplementary coding, the principal value of a national standard is uniformity: one clinically grounded interpretation across Medicare, Medicaid, commercial payers, EHRs, physician practices, coders, researchers, and developers. For that reason, there would need to be a separate legal standard, and private competition should not be introduced in a way that creates an environment of competing code sets for the same physician and other healthcare services. Multiple competing code sets for the same physician services would increase administrative burden, create mapping inconsistencies, and undermine comparability across payers, clinicians, vendors, and government programs. Importantly, CMS already has tools to address program-specific coding needs without fragmenting the standard. HCPCS Level II and Medicare-specific G-codes already provide a mechanism, fully under CMS control, to identify services outside the CPT process when the Agency determines that such coding is needed.

This does not mean the current system should not change. The AMA is committed to improving the CPT process and platforms so that it is more accessible, efficient, interoperable, and clinically useful to all stakeholders. In that vein, there is certainly significant room, which we welcome, for private company innovation around CPT, including AI-enabled coding support and large language model integration, which would further strengthen authoritative, standard CPT content.

It should be noted that any change to the uniform standard would carry a measurable cost and require a lengthy timeline. The most recent comparable effort was the industry's transition from ICD-9 to ICD-10, and it is instructive on both counts. While cost estimates varied, work commissioned in 2014 by the AMA placed implementation costs for a typical small practice between $56,639 and $226,105, and for a large practice between roughly $2 million and $8 million, a significant burden on physicians and on patient care. Contemporaneous industry analysis estimated that the entire healthcare industry, including facilities and clinicians, would spend approximately $14 billion over a two- to three-year period.[10][11] CMS reached its own conclusions about the magnitude of the investment. In the rulemaking that moved the ICD-10 compliance date, the Agency estimated that a single additional year of delay would add 10 to 30 percent to what covered entities had already spent or budgeted.

Transitions of this nature have also been shown to result in delays of many years due to their myriad complexities. In the case of transitioning from ICD-9 to ICD-10, more than six years elapsed between the final rule and implementation, and the last extension required an act of Congress. The transition was also dependent on other work being completed first, as the industry had to migrate from version 4010 to version 5010 of the HIPAA transaction standards before ICD-10 could be implemented, and delays in that predecessor effort contributed to the first postponement.

Replacing CPT would be a significantly larger structural undertaking than ICD-10. ICD-10 replaced diagnosis coding and inpatient hospital procedure coding. Replacing CPT would replace reporting for professional services, payment schedules, payer contracts, and relative values. Every physician payment

[10] Nachimson Advisors, LLC. The cost of implementing ICD-10 for physician practices: updating the 2008 Nachimson Advisors study. A report to the American Medical Association. February 12, 2014. Accessed August 2, 2026. https://docs.house.gov/meetings/IF/IF14/20150211/102940/HHRG-114-IF14-Wstate-TerryW-20150211-SD001.pdf.

[11] Grider D. Roadmap to ICD-10-CM: the impact on the payer and system readiness. AAPC Knowledge Center. Accessed August 2, 2026. https://www.aapc.com/blog/24445-%EF%BB%BFroadmap-to-icd-10-cm/.

schedule in the country is built on CPT codes, payer contracts reference them, the resource-based relative value scale is constructed around them, and quality measures are specified in them. Much of the work would also be sequential rather than parallel, since descriptors must exist before services can be valued, values must exist before payment schedules can be rebuilt, and payment schedules must exist before contracts can be renegotiated.

The scale of what would require rebuilding can be estimated using the Agency's own data. More than 1.5 million Medicare non-institutional providers report professional services. Clinicians participating in the Medicare Promoting Interoperability program reported using certified health IT from 193 distinct developers, and hospitals reported 88. Each of those systems embeds procedure coding in charge capture, order entry, clinical documentation, and billing, and each would require rebuilding, revalidation, and recertification. This work would take many years and billions of dollars to complete.

AI, Large Language Models and Coding Standards

We also address a question implicit in the RFI's framing, which is whether advances in artificial intelligence provide an entry point for private competition that did not previously exist. A language model can generate a list of procedure descriptions. It cannot make that list a standard, and no amount of additional model capability changes that.

The most comprehensive published benchmark specific to CPT coding, conducted in 2024, found that the best-performing model of that period achieved an exact match rate of roughly 50 percent[12], with errors concentrated in complex, guideline-dependent cases and including fabricated codes. We acknowledge that models have improved considerably since that study. The same study found, however, that injecting authoritative coding knowledge into these systems substantially improved accuracy, which indicates that the constraint is informational rather than computational. A model is only as good as its inputs.

It is important to note that defining a service is a matter of clinical judgment rather than a data problem. Whether a new technique is meaningfully distinct from an existing one, whether a change in practice warrants a new descriptor, and how a service furnished by several specialties should be described in terms all of them recognize are questions answered by clinicians applying clinical knowledge. They cannot be derived from data like claims history, because claims history records only what has already been done. When a genuinely new service appears, no prior data describes it. Only a process that convenes clinical experts can produce the description an automated system would then apply.

That process also supplies what an automated system cannot: an open comment period before a decision is made, a documented rationale, a body of practicing clinicians accountable for the result, and continuous maintenance reflecting necessary changes made to the code set each year as medicine changes. Federal agencies, state Medicaid programs, Medicare and commercial plans, health systems, professional coders, employers and self-insured plans, researchers, and public health authorities all depend on a code set whose clinical validity someone is accountable for maintaining.

While we maintain that clinical rigor should be at the heart of code set maintenance, the AMA is not standing in the way of AI-enabled innovation. In fact, we are building AI-enabled capabilities into our CPT educational products so that the guidance clinicians and coders rely on is available in the formats

[12] Soroush A, Glicksberg BS, Zimlichman E, et al. Large Language Models Are Poor Medical Coders - Benchmarking of Medical Code Querying. NEJM AI. 2024; 1(5) Idbp2300040. Doi:10.1056/AIdbp2300040.

modern software consumes. We are also working with technology companies to make CPT content accessible in structured, machine-readable form, so that automated tools can ground their output in the authoritative source. Our objective is that CPT be straightforward to build on. Innovation in AI-enabled tools depends on developers having reliable access to an authoritative standard that reflects how medicine is actually practiced.

Change, improvement, and innovation are foundational to the AMA, but it is equally important to recognize that change can be disruptive and requires a considered approach. We intend to be a constructive partner to the organizations doing that work and would welcome the agency's input on where improvement can occur.

4) What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes?

The CPT and RUC processes are structured, criteria-based, clinically grounded, and increasingly transparent. Over time, the AMA has taken deliberate steps to broaden participation, improve visibility into decision-making, and modernize both processes while preserving the clinical rigor necessary to maintain a national standard.

Clinically Driven and Open Process

As discussed in response to the first question above, the 21-member CPT Editorial Panel approves and revises the code set. Its voting seats include physicians nominated by national medical specialty societies, qualified healthcare professionals, and representatives of commercial payers (e.g., AHIP and Blue Cross Blue Shield Association), the American Hospital Association, and the healthcare industry. Non-voting seats provide direct input from CMS, the FDA, and the CDC, along with coding professionals. This composition ensures that clinical, operational, payer, and regulatory perspectives are all present when a code is decided.

The process is open at both ends. Any individual or entity may apply for a code, may attend a Panel meeting, and may comment on an application before a vote. Agendas and Panel actions are posted for anyone to review. Each application moves through a defined cycle that includes staff review, literature review, dialogue with the applicant, and open public comment before any vote is taken. This transparency extends to Panel member conflicts of interest. Panel members' applications, including any conflicts of interest, are posted on the Panel meeting website for all attendees to view. The Panel's conflict of interest policy is also available on the AMA website.

Likewise, the RUC process is rigorous and objective, relying on CMS-defined criteria and standards, the clinical expertise of hundreds of physicians and healthcare professionals, and multidisciplinary review. The RUC is transparent: its minutes, recommendations to CMS, and voting reports are available on the AMA website. The AMA also produces a database application, the RBRVS DataManager, to provide end users easy access to all of the data related to each individual CPT code. Observers are also welcome to attend the RUC meetings, which are publicly announced on the AMA website.

Broad-Based Participation

The rigor of the CPT process is most visible in the scale of participation, which has grown substantially. Formal engagement through the Interested Party process expanded from 289 Interested Parties in 2021 to 3,297 in 2025. Panel meetings are now hybrid and open, and each meeting draws more than 1,100

registrants, including physicians, other healthcare professionals, industry innovators, payers, government agencies, and patient representatives, any of whom may comment before and during deliberations. The process relies on more than 200 CPT Advisors from over 100 national medical specialty societies, so that every major clinical discipline has a voice in evaluating applications. Over the past five years, the Panel has averaged nearly 400 changes to the code set annually, constituting the continuous maintenance that keeps the standard current.

The RUC meetings are currently attended by 350 to 400 individuals. More than 450 participants (physicians, non-MD/DO healthcare professionals, and staff from national medical specialty societies and other healthcare organizations) are actively involved in the RUC process. These individuals largely volunteer their time to collect data, meet to discuss their professional services, and present information to the RUC at one of three annual meetings. In addition to individuals representing clinicians, the RUC has welcomed observers from CMS, MedPAC, the United States Government Accountability Office, the HHS Office of Inspector General, and the HHS Office of the Assistant Secretary for Financial Resources, as well as research institutions and others to its meetings. It is not uncommon for the RUC to host international delegations. In nearly every country, medical organizations actively negotiate payment rates and provide clinical expertise to their governments.

Recent and Planned Improvements

The AMA and the Panel have pursued a sustained effort to broaden transparency and participation. The steps already delivered include the move to fully hybrid, open meetings in 2020, which more than doubled average participation; the expansion of the Panel in 2021 from 17 to 21 members to add clinical and technical expertise, a seat for a physician with industry experience, and non-voting liaison seats for the FDA and CDC; incorporation of regular, structured feedback sessions on emerging areas such as value-based care, digital medicine, and AI-enabled services; and a 2025 revision that reduced the scope of confidential information, creating greater transparency of the Panel meeting proceedings.

Further steps are planned. Following the September 2026 Panel meeting, full meeting minutes will be published on the AMA public website, and work is underway to reduce the need to sign confidentiality forms to access agenda materials and archived meeting materials. These policies exist to protect confidential materials related to regulatory submissions and other sensitive documentation that may be submitted by industry applicants and may not otherwise have been redacted. Additionally, the Panel takes its established anti-lobbying policy seriously to allow open and fair debate. That said, the AMA is taking a thorough look at all steps in the process with the aim of limiting the impact these necessary policies have on stakeholders' ability to appropriately engage with the Panel process. These steps widen visibility into how decisions are made while preserving the candor and clinical rigor that the deliberative process depends on.

The AMA and RUC recently updated their process for releasing RUC recommendations on the AMA website to allow for early release of the upcoming CPT codes and the RUC's submissions to CMS. RUC recommendations related to CPT 2028 revisions are currently available.

We recognize that the agency may see further opportunities to advance transparency in the process, and we reiterate our desire to work closely to advance improvement initiatives.

The CPT Editorial Panel currently includes a non-voting CMS liaison seat. A voting seat is available to the agency should it wish to hold one, and we would welcome that participation.

To advance innovation, we are prepared to expedite review for emerging technologies where federal priorities warrant it. The Panel has modified its process before at the request of the federal government and industry, including establishing the early release of Category III codes and accelerating code issuance during declared public health emergencies. We note the Regulatory Alignment for Predictable and Immediate Device (RAPID) coverage pathway, which CMS and FDA first announced on April 23, 2026, and issued as a proposed procedural on August 7, 2026, is designed to align Medicare coverage more closely with FDA market authorization for Breakthrough Devices. As CMS considers approaches to accelerate coverage for new technologies, it is important to recognize that coverage and payment for a new technology require an appropriate code to describe it. We are prepared to align the CPT pathway with that rapid timeline so that coding is not the step that delays patient access.

We are also building a public resource where any stakeholder can raise a concern, propose an improvement, identify a potentially unknown conflict of interest with a participant in the Panel process, or escalate an issue regarding their experience in the code development process, and receive a response. Applicants who disagree with a Panel decision already have a pathway for reconsideration, and this online webpage will make that and other avenues for input clearly visible in one place. Our aim is that anyone with a stake in the code set knows how to reach the AMA and knows their input will be considered.

More broadly, we welcome the agency's views on where the process could be improved, and we are prepared to meet with CMS on any issue it wishes to raise. Our goal is that every stakeholder feels able to participate in the CPT process, and we will make the changes necessary to achieve that.

How would these alternatives support or inhibit innovation?

The current process supports innovation in a way that the alternatives under discussion would not. Category III codes give a new service a reportable identity while its evidence base is still forming, allowing real-world data to accumulate in a structured way and supporting later conversion to a permanent Category I code. Appendix S provides a taxonomy for AI-enabled services, classifying them by the work the algorithm performs and the role the physician retains; the Panel refined this taxonomy in 2026. More than 30 percent of new codes in recent years have been tied directly to novel healthcare innovation. The current process is the mechanism that brings innovation into the system in an orderly way. While the process can be improved, replacing it would slow that pathway rather than accelerate it.

We believe it is important for CMS to consider the consequences of creating an entirely new code set to replace or compete with CPT. CPT is essential national health data infrastructure, not merely a payment tool. It provides the common, clinically grounded vocabulary that enables physicians, hospitals, EHRs, health plans, public programs, patients, and technology developers to exchange and consistently interpret information about medical services. Introducing a competing code set would add substantial complexity and require significant, ongoing investment in new technical infrastructure, governance, and system changes across EHRs, payer systems, APIs, quality programs, patient applications, and longitudinal datasets to preserve consistent clinical meaning. The resulting fragmentation would directly undermine CMS' Interoperability and Patient Access Rule, Interoperability and Prior Authorization Rule, and broader digital health infrastructure strategy, each of which depends on standardized data that can be exchanged and reliably understood. It would also weaken CMS' Innovation, Modernization, and AI Enablement initiative and its commitment to responsible AI.

AI systems are only as reliable as the data used to develop, validate, deploy, monitor, and audit them. Inconsistent representations of medical services would reduce data comparability, introduce ambiguity and bias, impair model performance, and create avoidable risks to patient safety and physician

confidence. Replacing CPT would not suddenly simplify the healthcare data environment. It would create a costly parallel semantic infrastructure fundamentally at odds with CMS' goals of seamless interoperability, meaningful patient access, and safe, trustworthy AI.

What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code?

Based on CMS' own guidance, ICD-10-PCS cannot serve as the basis for paying physician services. ICD-10-PCS is used only for the reporting of inpatient procedures by hospitals. CMS maintains the system, and the restriction is stated in the ICD-10-PCS official coding guidelines that CMS publishes. Given the inherent restrictions in the code set itself, physician services delivered in offices, clinics, and other ambulatory settings could not be coded using a classification that the Agency itself restricts to hospital inpatient reporting.

Every ICD-10-PCS code is a seven-character string in which each position describes an attribute of an inpatient procedure: the body system, the root operation, the body part, the approach, the device, and a qualifier. That grammar describes something done to a patient in a facility. It has no place to record the evaluation and management work that constitutes a large share of physician services, which involves history, examination, and medical decision-making rather than a procedure performed on a body part. It also has no place for the many professional services, including care management, counseling, care coordination, and behavioral health services, that have no inpatient procedural equivalent. These are categories of care that CMS has been actively working to recognize and pay for, and a shift to ICD-10-PCS would stand in the way of the Agency's long-term effort to support these initiatives.

Furthermore, ICD-10-PCS has no mechanism for provisional coding of emerging services. There is no equivalent to the Category III pathway, so a new service would have no way to be identified and tracked while its evidence base develops.

How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be group or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS-DRGs), or Outpatient Prospective Payment System (OPPS) Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or group procedural services?

Medicare Severity Diagnosis Related Groups (MS-DRGs) and Hospital Outpatient Prospective Payment System Ambulatory Payment Classifications (APCs) are payment systems intended to capture a hospital inpatient or outpatient department's overhead, supplies, staffing, and other costs. Both, moreover, are built on granular procedure coding rather than replacing it: APCs group services reported in CPT/HCPCS, and MS-DRGs are assigned in part from ICD-10-PCS codes reported alongside the physician's separately billed CPT professional services. These costs are structurally different from a physician's professional work (time spent, intensity of service), practice expense, and liability costs. ICD-10-PCS compounds this mismatch: it is used only for inpatient hospital procedure reporting, not in the office, ASC, or hospital outpatient department settings where the majority of PFS services are furnished. It contains no evaluation and management construct, so it cannot describe the cognitive services that account for a substantial share of physician work.

While bundling does exist within CPT and the physician payment system, bundling at the same level as hospital payment is impractical. The number of different physician specialties and health professions,

combined with various practice models, requires more granular coding and payment to preserve accurate relativity and budget neutrality across services. Bundled payment, currently a component of the coding and payment system, includes: surgical global period (example: care provided within the first 90 days following surgery); bundling of imaging when inherent to a procedure; and monthly bundles of services. Several value-based care models group procedural and other services. CMS has used episode-based bundled payment models for surgical care, most recently the mandatory Transforming Episode Accountability Model. That model began January 1, 2026, succeeding the Comprehensive Care for Joint Replacement model, which ended December 31, 2024. However, the bundle is retrospective, as physicians code using CPT and are paid via the RBRVS. The payment model relies on an episode target to provide incentives to enhance care coordination and reduce costs, while relying on granular coding to articulate the services performed, underscoring that bundling operates as a payment architecture layered on granular coding rather than a replacement for it.

Beyond episode-based bundles, other grouping and payment architectures exist along a spectrum of increasing aggregation: per-visit or per-diem payment; blended fee-for-service and population-based payment; and fully capitated or global-budget arrangements, as reflected in Medicare Advantage and total cost of care accountable care organization models. Each aggregates spending at a progressively higher level, but none eliminates the need for granular procedural coding beneath it. Capitated and population-based models continue to rely on encounter-level CPT/HCPCS and ICD-10 data to attribute patients, construct benchmarks and target prices, risk-adjust payment, measure quality, and reconcile performance. Grouping and bundling are therefore best understood as payment architecture layered on a granular coding foundation, which is the foundation that CPT currently provides and that any alternative would have to reconstruct.

The CPT code set works because it is maintained continuously by the physicians and other qualified healthcare professionals who deliver the care it describes, through a process open to everyone the code set affects. That work is never complete, and we are constantly looking for ways to improve access to and understanding of this vital process. We welcome CMS' examination of it, and we welcome the Agency's views on where it could be strengthened. We are committed to making CPT accessible to the developers and innovators building healthcare technology, so that the authoritative standard supports innovation. We would be glad to meet with the agency and other affected stakeholders to discuss ways to further collaborate on improving how care is delivered to patients across the U.S.

B. Request for Information: Redesigning Primary Care to Make America Healthy Again

The AMA appreciates CMS' focus on strengthening primary care as a foundation for improving health, preventing disease, and reducing avoidable healthcare spending over time. We agree that Medicare payment policy should support investment in high-value primary care and recognize that the current payment structure does not fully align with how longitudinal, team-based primary care is delivered. We therefore welcome CMS' examination of new payment approaches and offer the following comments on how Medicare can better align payment with the delivery of comprehensive, longitudinal, coordinated primary care.

Reconsidering Relative Primary Care Payment in the PFS

Office and Outpatient Evaluation and Management Visits

What updates to G2211, MOD1, and MOD2 should CMS consider to ensure these policies identify practitioners serving as the focal point for ongoing care?

The AMA's concerns with CMS' proposal to replace G2211 with MOD1 and MOD2—including its valuation, budget-neutrality effects, and ACO differential—are discussed in Section I; the comments below address the RFI's distinct question of how the policy should identify the practitioners it is intended to recognize. If CMS continues to recognize additional resources associated with E/M services furnished as part of an ongoing patient-physician relationship or ongoing care for a serious or complex condition, eligibility should turn on the physician's ongoing clinical responsibility for the patient or condition rather than completion of a standardized set of activities during each encounter. Preventive care, risk-factor reduction, and care coordination are important components of longitudinal care, but their relevance and timing vary according to the patient's needs. Requiring physicians to document that each element was performed whenever the modifier is reported would add burden without identifying additional physician work or practice expense and would convert a resource-recognition policy into a documentation exercise.

CMS should also establish the resource basis for MOD1 before finalizing a percentage-based valuation. A percentage modifier automatically increases the dollar value of the additional payment as the level of the underlying E/M service rises. CMS should therefore determine whether the incremental physician work and practice expense associated with the qualifying longitudinal relationship increases proportionately with the resource intensity of the underlying visit. If the evidence does not support proportional scaling, CMS should preserve the existing G2211 valuation methodology while collecting the data necessary to determine an appropriate alternative. CMS should likewise base eligibility for MOD2 on the resources and clinical capabilities the modifier is intended to recognize rather than participation in a particular Medicare payment model. Participation in the Shared Savings Program or another accountable care arrangement is not itself a PFS resource input. If CMS believes that particular capabilities associated with serving as the focal point for a patient's care require additional physician work or practice expense, it should identify those capabilities and measure their resource costs directly. Practices outside an ACO that furnish the same qualifying care should be eligible for the same recognition.

Should CMS create separate longitudinal, acute, and consultative O/O E/M visit categories or Medicare-specific G-codes, and how could any such categories be differentiated and valued?

The AMA strongly opposes creating separate longitudinal, acute, and consultative O/O E/M visit categories or Medicare-specific G-codes based on those classifications and urges CMS not to pursue this approach. The proposed categories overlap in clinical practice and do not consistently correspond to differences in physician work or practice expense. As a result, they cannot provide a sound basis for coding, valuation, or payment.

First, the proposed visit types do not fully reflect how care is delivered in clinical practice, as illustrated by CMS' own definitions. The Agency describes a longitudinal care visit as care furnished "during and between encounters as part of an ongoing comprehensive care relationship" and contrasts it with an acute care visit that addresses a "discrete, episodic problem that is generally resolved after treatment." However, these definitions conflate two distinct dimensions of care. Longitudinal care describes the relationship between a patient and physician across time, and its natural counterpart is episodic care.

Acute care describes the presentation or course of a clinical problem, which frequently persists after treatment, and stands in contrast to chronic care. Because "acute" characterizes the clinical problem while "longitudinal" characterizes the care relationship, a single encounter can be, and routinely is, both.

The proposed definition of a consultative visit is equally problematic. CMS would define such a visit by its focus on a "specific clinical question" and by the specialist's communication of findings or recommendations back to the referring practitioner. Neither is a defining feature of consultation. Many referrals are prompted not by a discrete clinical question, but by the need for ongoing specialist care. Nor do specialists separately communicate with the referring physician after every encounter with a shared patient. Physicians communicate when clinically appropriate, and in many health systems, specialist notes and recommendations are already available to the rest of the patient's care team through the EHR. Treating communication back to the referring practitioner as a defining feature of a consultative visit would therefore impose an extraordinary new administrative burden on specialists that bears little relationship to how physicians coordinate care.

A single clinical encounter demonstrates how quickly the proposed taxonomy breaks down. Consider a patient who presents to a longstanding primary care physician with an episode of recurrent acute sinusitis. The physician prescribes antibiotics and counsels the patient on smoking cessation, delivering a preventive service opportunistically during a problem-oriented visit. Because the sinusitis is recurrent, the physician refers the patient to an otolaryngologist. CT imaging then reveals chronic rhinosinusitis with nasal polyps, and the otolaryngologist assumes ongoing responsibility for managing this condition over several months with medical therapy and reassessment before ultimately performing endoscopic sinus surgery.

Under the proposed taxonomy, neither physician could determine with confidence how to bill these encounters. The patient presented with an acute complaint that resolved after a course of antibiotics, which would suggest an "acute" visit per CMS' definition. Yet the patient saw a physician with whom they have a longstanding relationship, and that physician furnished preventive care during the same encounter, which would suggest a "longitudinal" visit. The otolaryngologist faces a parallel dilemma. Would the initial encounter be billed as a consultative visit and each subsequent encounter as a longitudinal visit? How would the otolaryngologist classify the initial encounter if the referral posed no specific clinical question, or if the otolaryngologist did not separately report back to the primary care physician, as is routinely the case in practice? The categories CMS proposes to treat as mutually exclusive visit types are not mutually exclusive at all, and no payment methodology can rest reliably on a classification scheme whose categories overlap by design.

Even if the categories could be distinguished from one another, they do not track physician work or resource intensity in any reliable way. CMS nonetheless appears prepared to assume that they do, stating that "[a]s a general matter, we would expect to consider consultative visits to be less complex than longitudinal care visits." That is not a valid conclusion. An acute presentation can demand far more of the physician than a routine longitudinal follow-up. A patient with new, unexplained shortness of breath may be experiencing a life-threatening event, and evaluating that patient requires the physician to generate a broad differential diagnosis, take an extensive history, review medications, perform a multi-system physical examination, and review and interpret diagnostic information, all culminating in a high-stakes judgment about whether the patient can be managed safely as an outpatient or must be admitted for a higher level of care. By contrast, physicians routinely furnish ten-minute "longitudinal" visits to follow up on normal laboratory results, encounters that involve a fraction of the time and little medical decision-making. **The existing E/M framework exists precisely to capture this variation, valuing each**

encounter according to the medical decision-making it involves or the time it consumes. Assigning a categorically higher or lower value because CMS has labeled a service "longitudinal" or "acute" would discard that measurement and substitute the Agency's characterization of the encounter for the resources physicians expend to furnish it.

Furthermore, CMS could not operationalize these categories without creating substantial billing complexity, documentation burden, coding ambiguity, and retrospective audit risk. The agency would first have to translate concepts that have no clear boundaries in clinical practice into enforceable billing rules, such as when a patient-physician relationship becomes sufficiently established or comprehensive to qualify as longitudinal, how a physician should classify an encounter that includes both acute and longitudinal care, when an initial specialist evaluation constitutes a consultation rather than the beginning of ongoing management, and what evidence a physician must document to substantiate each classification. Once payment turns on these distinctions, they would become conditions of payment and, in turn, potential grounds for retrospective denials, recoupments, and audit findings. A physician who sees a new patient expecting to assume ongoing responsibility for that patient's care, and who bills the visit as longitudinal on that basis, would be at risk if the patient never returns. The same ambiguity would arise whenever a physician furnishes both acute and preventive care during a single encounter. The proposal would therefore expose physicians to payment consequences not because they furnished or documented the underlying E/M service incorrectly, but because an auditor later disagreed with the label assigned to it.

Rather than creating new O/O E/M visit types to pay for longitudinal care, The AMA recommends that **CMS first identify the specific physician work, clinical staff time, and practice expenses that existing Medicare payment mechanisms do not already recognize**. Medicare already pays for encounter-based physician work through O/O E/M services, provides additional payment through G2211 for certain visits furnished as part of an ongoing care relationship, and pays separately through the Advanced Primary Care Management (APCM) program for a broad range of activities performed across encounters. The relevant question is whether a remaining payment deficiency exists and, if so, where.

CMS should focus that analysis on three questions. First, is APCM underused because of barriers such as beneficiary cost sharing, consent requirements, administrative burden, staffing or infrastructure requirements, or is it inadequately valued relative to the physician work, clinical staff time, and practice expense required to furnish it? Second, do the existing APCM tiers and G2211 appropriately distinguish and compensate differences in patient resource needs and encounter-related longitudinal work? Third, are there material longitudinal activities or standing capacity costs that are not captured by E/M services, G2211, APCM, or another existing payment mechanism?

CMS can answer these questions using a representative sample of practices and combining Medicare claims with EHR audit logs, time-motion studies, direct observation, staffing and payroll records, and practice cost data. The analysis should capture work occurring both within and outside the EHR, distinguish patient-specific activities from the standing costs of maintaining longitudinal-care capacity, and test whether APCM tiers correspond to meaningful differences in actual resource use.

CMS should then address the specific deficiency the evidence identifies. If limited APCM uptake is the principal problem, CMS should address the barriers preventing its use. If APCM or G2211 is misvalued, CMS should revise the relevant payment. If APCM tiers do not correspond to meaningful differences in resource use, CMS should recalibrate them. If particular longitudinal activities or standing capacity costs fall outside existing payment mechanisms, CMS should determine how those resources should be

recognized. The threshold question should not be how much more Medicare should pay for an encounter labeled "longitudinal." It is whether longitudinal primary care requires physician work or practice resources that existing Medicare payment mechanisms do not adequately recognize and, if so, which existing mechanism should be corrected or supplemented to address that specific gap.

If CMS finalizes longitudinal or primary care visit types, what service period, bundling of care-management services, and resource data should inform their design?

For the reasons discussed above, the AMA would not support attaching a fixed service period to a longitudinal E/M visit or bundling subsequent care-management services into the visit for a standardized number of days or months. Longitudinal care does not begin and end according to a fixed interval after an encounter, and the amount and timing of follow-up vary substantially according to the patient's clinical needs and circumstances. A 30-, 60-, or 90-day period would therefore reflect an administrative convention rather than the actual distribution of physician work. Care-management services should remain separately recognizable unless CMS establishes, through empirical resource analysis, that particular activities are consistently furnished as part of the proposed service and can be appropriately valued within it.

CMS likewise does not need a separate resource study organized around the proposed "longitudinal," "acute," and "consultative" categories. As discussed above, CMS should use EHR audit logs, time-motion studies, direct observation, staffing and payroll records, and practice cost data to determine the physician work and practice resources associated with longitudinal care and whether those resources are already recognized through E/M services, G2211, APCM, or other existing payment mechanisms. Those data should be used to identify actual resource differences—not to validate arbitrary visit categories.

Care Management Code 'Family'

What additional requirements should CMS consider to reduce fraud, waste, and abuse in care management services?

The AMA recommends that CMS focus its program-integrity safeguards on whether the beneficiary is under the care of the billing physician or practice, whether that practice determined that care management was clinically appropriate and remains responsible for the care plan, whether qualifying care-management activities were actually furnished, and whether the practice—not a technology vendor—determined that Medicare billing requirements were satisfied. CMS should use targeted claims analytics and review to enforce these requirements rather than impose additional universal documentation and reporting requirements on all practices.

What is the appropriate "trigger" or initiating visit for care management services? How would this change if it were an initiating visit versus another event?

For a beneficiary who does not already have an established relationship with the practice, the AMA's view is that care management should begin through a clinical encounter that establishes the treatment relationship, identifies the need for ongoing management, and allows the physician to establish or approve the care plan. An existing office or outpatient E/M visit, Initial Preventive Physical Exam (IPPE), Medicare Annual Wellness Visit (AWV), or appropriate post-discharge encounter should satisfy this requirement; CMS should not require a separate visit solely to initiate care-management billing. For an established patient, CMS should not require a new initiating visit at fixed intervals. A hospitalization, new

diagnosis, significant change in clinical status, or information generated through monitoring may prompt reassessment, but no such event should automatically initiate a billable service. The responsible practice should determine whether care management is clinically warranted.

A beneficiary's interaction with a digital tool likewise should not independently trigger a Medicare care-management service. Information from a patient-facing application, screening tool, remote monitoring system, or other technology may identify a potential need for intervention, but that information should enter the beneficiary's clinical care pathway for review and an appropriate response.

Should CMS consider changing supervision requirements in care management services to prevent fraudulent billing? What is the appropriate supervision requirement?

The AMA recommends that CMS retain general supervision for care-management activities appropriately performed by members of the physician-led care team. Requiring direct supervision would unnecessarily constrain between-visit, team-based care and would not address the central program-integrity risk: billing for services that are not meaningfully directed by the practitioner responsible for the beneficiary's care. CMS should instead make the requirements for clinical direction clear. The physician or other qualified practitioner responsible for the service should establish or approve the care plan; establish appropriate protocols and escalation thresholds; remain responsible for matters requiring medical judgment; review clinically significant information escalated by staff or technology; and retain responsibility for modifying the plan of care and determining appropriate follow-up. General supervision should continue to permit clinical staff employed by or under contract to the practice to furnish appropriately delegated activities. The relevant question is whether the billing practice directs and remains accountable for the care, not whether every individual performing a delegated task is employed directly by the practice.

How should data submission to CMS change to verify services are received?

The AMA urges CMS not to require routine submission of encounter-by-encounter activity logs, technology-generated activity data, or monthly attestations from every practice. Such requirements would recreate the administrative burden that CMS is attempting to reduce and would not necessarily provide better evidence that clinically meaningful care occurred. CMS should instead strengthen claims-processing edits for mutually exclusive or duplicative services and use claims analytics to identify patterns warranting targeted review. Potential signals include systematic billing for overlapping monthly services, unusually rapid increases in care-management billing, beneficiary panels inconsistent with a practice's staffing and clinical capacity, or substantial numbers of beneficiaries entering care management without an established relationship with the billing practice. These indicators should trigger review rather than automatic denial.

During targeted review, CMS should seek evidence of a coherent clinical chain: the beneficiary was under the practice's care; the practice determined that care management was appropriate; a care plan was established or approved; qualifying activities were furnished through the care team; clinically significant information was appropriately routed and addressed; and the billing practitioner or practice determined that the Medicare service had been furnished before submitting the claim.

What guardrails should CMS consider to prevent inappropriate billing?

The AMA recommends that CMS' principal guardrail should be to require Medicare-covered care management to originate with and operate through the physician or physician-led practice responsible for

the beneficiary's care. A technology vendor should not independently recruit Medicare beneficiaries, enroll them in a care-management program, and subsequently attach an employed or contracted Medicare-enrolled practitioner principally to generate claims. The responsible practice should determine that care management is clinically appropriate, establish or approve the care plan and relevant clinical parameters, receive clinically significant information generated by staff or technology, determine the appropriate clinical response and follow-up, and determine that billing requirements have been satisfied. Vendors may provide software, analytics, communications infrastructure, administrative support, or other capabilities on behalf of the practice, but they should not independently establish the care-management relationship or determine that a billable Medicare service occurred.

What proportion of care management services must be delivered by the supervising provider versus auxiliary personnel?

The AMA recommends that CMS not establish an arbitrary percentage of care-management time that the supervising practitioner must personally furnish. Such a requirement would encourage physicians to perform delegable activities without providing a meaningful program-integrity safeguard. CMS should instead distinguish functions that require the responsible practitioner's clinical judgment from activities that can appropriately be delegated. The practitioner should retain responsibility for the care plan, clinical direction, significant changes requiring medical judgment, and decisions about treatment and follow-up. Other members of the care team should remain able to perform appropriate outreach, coordination, monitoring, education, and other delegated activities under general supervision.

Are there specific data on the resources used in furnishing advanced primary care, including population health management, enhanced communication technology, and longitudinal care management?

The AMA recommends that CMS distinguish the resources required to maintain advanced primary care capacity for a patient population from the resources associated with caring for a particular beneficiary in a particular month. This distinction is especially important for longitudinal care management because practices incur substantial fixed or panel-level costs—including registries, interoperability, software, data analytics, cybersecurity, extended-access capabilities, and care-management staffing—even when the amount of beneficiary-specific activity fluctuates from month to month.

CMS should therefore measure physician and clinical staff time; care-manager, pharmacist, and other team resources; patient communication and coordination; and the fixed infrastructure required to maintain these capabilities. It should also examine how beneficiary-specific resource use varies with disease instability, treatment complexity, recent care transitions, cognitive and functional limitations, and barriers to carrying out the care plan rather than assuming diagnosis count alone predicts resource use.
The AMA's Physician Practice Information Survey can inform estimates of relevant practice expenses, and RUC surveys can inform physician and clinical staff time associated with particular services. Where existing sources do not adequately capture panel-level infrastructure or variation in longitudinal management needs, CMS should obtain representative data in collaboration with national medical specialty societies rather than create new routine reporting requirements for practices.

To what extent are current care-management codes duplicative, and how should CMS simplify or standardize the code family to improve appropriate utilization?

Some care-management codes increasingly overlap, but the AMA recommends that CMS distinguish duplication from legitimate differences in clinical function. In particular, APCM and traditional CCM

both support comprehensive longitudinal management and warrant examination for unnecessary overlap. By contrast, Principal Care Management supports focused management of a single high-risk condition, often by a specialist who is not assuming responsibility for comprehensive primary care; Transitional Care Management recognizes an intensive, time-limited period following discharge; and behavioral health integration reflects a distinct model of care. Simplification should not collapse clinically different services into a single catch-all code.

CMS should pursue consolidation through the CPT Editorial Panel and valuation through the RUC rather than continue expanding a parallel family of Medicare-specific G-codes. CCM and PCM are CPT services, while APCM was established through HCPCS G-codes that now overlap with portions of the existing care-management family. A coordinated CPT and RUC process would allow CMS to pursue a more coherent code set without creating additional inconsistencies across Medicare and other payers.

For comprehensive longitudinal primary care management, CMS should evaluate movement toward an untimed, prospective monthly structure as experience with APCM develops. Continuous responsibility for a patient is not necessarily well represented by repeated documentation of 20- or 30-minute increments. CMS should examine where APCM and timed CCM are serving substantially the same clinical function and reduce unnecessary duplication while preserving distinct services where their clinical functions differ.

Whether or not CMS ultimately reduces the number of codes, it should harmonize requirements that serve the same purpose across the family. Common standards should address the treatment relationship and beneficiary consent; initiating-visit requirements; permissible members of the care team and applicable supervision; responsibility for establishing and updating the care plan; beneficiary access to the responsible practice; escalation of clinically significant information; documentation of meaningful care-management activity; and rules governing overlapping services. Individual codes should add only those requirements necessary to distinguish the service's clinical purpose.

CMS also should not assume that reducing the number of codes alone will materially increase appropriate utilization. Beneficiary cost sharing, uncertainty about overlapping billing requirements, reporting obligations, and the resources required to establish care-management infrastructure remain barriers even under a simpler code structure. CMS should therefore address these barriers alongside code consolidation.

In particular, CMS should decouple APCM payment from mandatory reporting through the Value in Primary Care MIPS Value Pathway. Conditioning payment for a care-management service on participation in a particular quality-reporting pathway creates an additional barrier for practices, including practices that are not otherwise required to participate in MIPS or that report quality through another mechanism. Program integrity should be addressed directly through the clinical-accountability and claims-based safeguards described above rather than through an unrelated reporting requirement.

CMS should also continue pursuing mechanisms to reduce beneficiary cost sharing for care-management services where it has authority to do so. Monthly coinsurance can discourage beneficiaries from participating in services intended to support ongoing management and prevent avoidable acute care, particularly when much of the work occurs between visits and beneficiaries may not understand why a separate charge was generated. Although CMS does not have authority to eliminate this cost sharing across Medicare generally, it should use available Shared Savings Program and Innovation Center authorities to test or permit reductions where legally available. A Medicare-wide solution will require legislation, which the AMA continues to support.

As care management becomes increasingly technology-enabled, how should CMS change the code family and relative valuations; should CMS create technology-enabled care-management codes or a two-track approach; and how should CMS ensure that automated billing reflects actual care delivered?

The AMA recommends that CMS remain technology neutral in defining the clinical service. It should not create a separate technology-enabled care-management track merely because software performs or facilitates portions of the workflow. Medicare should distinguish services according to the care furnished and the clinical functions performed, not the tool used to perform them. Technology likewise should not lead CMS to presume that a care-management service requires fewer physician or practice resources. As discussed elsewhere in these comments, technology may reduce the time required for particular tasks while creating costs and work associated with implementation, integration, licensing, clinical oversight, exception handling, and maintenance. Any change in the relative valuation of care-management services should therefore be based on empirical evidence of the net effect on physician work, clinical staff work, and practice expense rather than a generalized assumption of technological efficiency.

The same program-integrity principles described above should govern technology-enabled care management. Technology may identify patients requiring attention, aggregate information, facilitate communication, prepare information for the care team, or automate nonclinical functions. It should not independently determine that a Medicare care-management service is medically necessary, establish or modify the plan of care, make patient-specific clinical decisions, or determine that the requirements for billing have been met.

For timed services, automated processing should never generate billable minutes. For untimed services, CMS should determine whether the billing practice actually maintains longitudinal responsibility and performs the clinical functions represented by the code rather than treating software activity, alerts, or automated communications as evidence that a monthly service occurred. Where technology creates a genuinely distinct clinical service rather than simply changing how an existing service is furnished, the CPT Editorial Panel provides the appropriate mechanism for determining whether distinct coding is warranted. Existing remote physiologic monitoring and remote therapeutic monitoring services illustrate the distinction between a service in which technology is integral to what is being furnished and an existing clinical service whose workflow happens to be technology-enabled.

CMS therefore should not establish a parallel care-management pathway under which technology companies can independently recruit beneficiaries, create a care-management relationship, and generate recurring Medicare claims. If CMS wishes to test a fundamentally different digitally delivered model of care management, the Innovation Center would provide a more appropriate setting to evaluate its effects on clinical accountability, utilization, program integrity, quality, and spending before establishing a permanent Medicare billing pathway.

Payment Implications of Technology Enablement of Primary Care

Changes to Primary Care and Care Management Due to Technology and Clinical AI

What AI applications are most commonly used in primary care, and which additional tools have demonstrated high accuracy, safety, and clinical benefit?

Clinical information retrieval, summarization, and documentation are currently among the most common physician uses of AI. The AMA's 2026 Physician Survey on Augmented Intelligence found that 81

percent of physician respondents reported awareness or use of AI in their practices. The most commonly reported use was summarizing medical research and standards of care (39 percent), followed by creating discharge instructions, care plans, or progress notes (30 percent), documenting billing codes, medical charts, or visit notes (28 percent), and generating chart summaries (28 percent) However, evidence of improved clinical outcomes has not advanced as quickly as adoption. At present, few emerging clinical AI applications in primary care have mature evidence demonstrating technical accuracy, safety in routine clinical use, and improved clinical outcomes.

How has incorporating technology and AI tools impacted the resource costs associated with primary care practice, in terms of the time and intensity of services delivered?

Technology and AI tools can reduce the time and intensity required for some components of primary care while adding or shifting work elsewhere. Ambient documentation tools provide the clearest evidence of reductions in both time and intensity. A 2025 JAMA study found that use of an ambient AI scribe reduced median total EHR time by approximately 20 minutes per day, and a subsequent multicenter study of 263 ambulatory clinicians found that ambient-scribe use was associated with less after-hours documentation and lower note-related cognitive task load, including a 2.64-point improvement on a 10-point cognitive task load scale. The largest study to date, however, shows that reduced documentation time does not necessarily translate into reduced physician work. That study, which followed roughly 1,800 clinicians who adopted AI scribes across five academic medical centers from 2023 to 2025, found that adoption was associated with 16 fewer minutes of documentation time and 13 fewer minutes of total EHR time per eight hours of patient care but no significant change in after-hours EHR work. The authors concluded that physicians redirected the time freed from documentation to other clinical tasks, such as responding to portal messages, rather than reducing their total workload.

Other new technologies, such as remote monitoring, add entirely new work outside the encounter. A 2024 study of 20 primary care physicians using RPM for hypertension or diabetes found that the technology created a continuing stream of data, alerts, emails, and messages requiring review, interpretation, and follow-up between visits. Physicians frequently worked additional hours, including nights and weekends, to review incoming data, and they described the information as distracting and difficult to integrate with visit-based care because its frequency and urgency were unpredictable. Beyond the ongoing clinical work that technology can generate, adoption itself can require substantial physician and staff time. A 2026 Cleveland Clinic report on deployment of an ambient AI scribe across more than 4,000 clinicians found that implementation required dedicated governance, clinician training and onboarding, EHR build and maintenance, ongoing technical support, and continuous workflow adjustment. During rollout alone, the system fielded more than 900 support inquiries and uptake was limited by variation in clinical workflows and concerns about the quality and reliability of AI-generated notes. This experience shows that even technologies designed to reduce physician workload can require substantial physician and staff time for implementation and clinical oversight before delivering any efficiencies.

Thus, the AMA recommends that CMS should not assume that technology adoption produces a uniform or immediate reduction in physician work. Technology can reduce the time or intensity of certain tasks while generating new clinical work elsewhere, and implementation itself can require substantial physician and staff time before workflows stabilize. For valuation, CMS should consider the net effect of a technology on physician work, accounting for both time and intensity, rather than infer a reduction in work from greater efficiency in a particular task, and it should distinguish the resources required during implementation from those required once the technology is integrated into routine

practice. Each of these determinations can rest on empirical evidence that already exists or can readily be collected.

For time, CMS should rely primarily on EHR audit-log data, which major vendors already generate and which the informatics literature has standardized into seven core measures covering total EHR time, work outside scheduled hours, documentation time, inbox time, and order entry, normalized to eight hours of scheduled patient time. These data are particularly valuable because they can detect work that technology shifts across tasks or outside the encounter rather than eliminates. CMS should supplement them with time-motion observation or work sampling for activities that occur outside the EHR, including telephone calls, care-team communication, and review of external monitoring data, as well as platform-level measures of the alerts, messages, and patient-generated data a technology produces. The Agency should separately measure implementation time, including time spent on training, workflow redesign, and other activities required to integrate the technology into practice.

For intensity, CMS should evaluate whether technology changes the established dimensions of physician work intensity: mental effort and judgment, technical skill and physical effort, and psychological stress due to the potential risk to the patient. A reduction in the time required to perform one task does not establish that the intensity or total physician work of the service has declined, particularly if technology changes the amount or complexity of information the physician must review, the clinical judgment required to evaluate technology-generated outputs, or the work required to address exceptions and clinically significant findings. Any change in valuation should therefore reflect representative evidence of the net effect on physician work and proceed through established RUC processes with relevant specialty input.

If AI tools are increasing productivity, what are clinicians doing with the additional time and bandwidth?

Clinical AI has not consistently created additional physician time or bandwidth. Ambient documentation is the clearest exception: among physicians who use these tools, studies consistently find reductions in documentation time of roughly 13 to 20 minutes per day. Even there, however, reduced documentation time has not translated directly into free time or expanded capacity, for two reasons.

First, physicians frequently absorb recovered time into other uncompensated work. As documentation burden falls, time shifts toward responding to a growing volume of inbox messages, reviewing patient-generated data, and completing other between-visit tasks that existing payment does not capture. Second, ambient documentation generally does not shorten the encounter itself; it changes how physicians spend time within it. Rather than dividing attention between the patient and the record, physicians redirect recovered minutes to listening and clinical engagement. The 2025 *JAMA* study on AI scribe adoption cited above found that physicians' ability to give patients undivided attention improved by 2.05 points on a 10-point scale, and a Singapore time-motion study similarly found that documentation time fell while consultation duration and total time per patient remained unchanged—indicating that physicians reinvested the recovered minutes in the visit rather than compressing it. A large Permanente Medical Group evaluation found similar improvements: 84 percent of physicians reported better visit interactions, and nearly half of patients said their physician spent less time focused on the computer.

CMS should therefore not conclude that existing AI tools increase physician productivity or assume that task-level efficiency gains allow physicians to see more patients. That assumption would be especially harmful in primary care, where physicians already manage unsustainable patient panels, high daily visit

volumes, and substantial work between encounters—conditions that have long contributed to burnout and compromised patient care**.** Although AI may eventually produce broader efficiency gains, the evidence does not show that it has done so to date.

Where are clinical AI tools in primary care not well captured in the current coding and payment system, and how can these be incorporated to facilitate high-value, technology-enabled primary care?

The principal gaps in the current coding and payment system arise not from the use of AI itself, but when technology supports clinical work that does not map well to an existing discrete service or itself furnishes a distinct medical service. Many common AI applications in primary care—including ambient documentation, clinical summarization, registry functions, and decision support—support physician work already recognized under the PFS and generally do not require separate coding or payment. CMS should continue to pay for the underlying service and ensure that associated physician work and practice expenses, including technology costs, are accurately reflected in valuation without allowing growth in technology inputs to erode payment for physician work.

A more significant gap arises when technology supports longitudinal functions that do not map well to discrete encounters. Panel management, proactive outreach, ongoing monitoring, and coordination across settings may involve substantial physician and clinical staff work without corresponding to a particular visit or procedure. Prospective primary care payment can support these functions without requiring a new Medicare code each time the technology or workflow changes and allows practices to determine the appropriate combination of physicians, clinical staff, technology, and other infrastructure for their patients.

When software itself furnishes a distinct medical service, CMS should rely on established coding processes rather than create a parallel code family for "AI-enabled" care. CPT Appendix S provides a framework for distinguishing assistive, augmentative, and autonomous AI based on the function the software performs and its relationship to the physician or other qualified healthcare professional, while recognizing that "AI" alone does not define a distinct clinical service. Existing codes may already capture physician work associated with such technologies; where software produces a genuinely distinct service with established clinical utility and resource requirements, stakeholders can pursue coding through the existing CPT process.

Any Medicare-specific designation for software-enabled services should therefore complement, rather than duplicate, existing coding frameworks and should not by itself establish coverage, medical necessity, clinical equivalence, or entitlement to separate payment. The AMA does not recommend a single payment construct for clinical AI. Payment should depend on whether the technology supports an existing service, enables longitudinal work not readily captured through discrete services, or itself furnishes a distinct medical service.

From an outcomes-based perspective, how should CMS evaluate and monitor the impact of technology-enabled care in primary care, and what short- and long-term outcomes would accurately capture its effects on clinicians and beneficiaries?

The AMA recommends that CMS evaluate technology-enabled primary care according to the clinical function the technology is intended to perform and focus on outcomes that can be attributed to the technology itself. Evaluation should rely on developer- and system-generated data wherever possible

rather than create new documentation, reporting, or attestation requirements for physicians. Where standardized technical capabilities or information from certified health IT are needed, CMS should work with ONC to establish appropriate developer-facing requirements through the ONC Health IT Certification Program.

For AI-enabled documentation tools, evaluation should focus on the accuracy and completeness of generated documentation and the physician work required to review and correct it. Where the technology relies on recorded encounter audio, and retention and use of that audio are permissible under applicable federal and state privacy and record-retention requirements, developers should retain sufficient source audio to validate whether the generated documentation accurately reflects the encounter and to identify material differences between the AI-generated and final notes. This information could also help developers identify recurring errors and improve model performance without requiring physicians to separately report those errors.

CMS should also evaluate whether technology reduces physician work, shifts work elsewhere in the clinical workflow, or creates new work. Rather than rely on physician surveys or manual reporting, CMS should use passively generated data wherever feasible. For capabilities incorporated into certified health IT, CMS should work with ONC to support standardized use of EHR audit logs and application telemetry to assess changes in time spent reviewing or correcting technology-generated output, task switching, inbox and alert volume, after-hours EHR activity, and other indicators of workflow disruption. These measures can help determine the net effect of a technology on physician work rather than assume that greater efficiency in one task reduces overall workload.

Across these evaluations, CMS should not create new physician-level quality measures, technology-use measures, manual data-submission requirements, or separate reporting systems for technology-enabled care. When additional information is necessary, CMS should obtain it from developers, existing EHR data, audit logs, application telemetry, or other automatically generated sources whenever feasible rather than shift the burden of evaluating technology onto physicians and practices.

> **Are there other payment structures, beyond outcomes-based and prospective, that would be more suited to the unique nature and impact of these technologies? If so, please describe.**

Yes, technology-neutral fee-for-service payment for the underlying medical service remains appropriate when AI assists or augments a service Medicare already recognizes. In those circumstances, payment should continue to reflect the physician work and practice resources required to furnish the service rather than create a separate payment merely because AI is used.

A different approach may be appropriate when the software itself furnishes a distinct medical service. For example, autonomous software may independently generate a clinically meaningful interpretation that itself constitutes the medical service rather than merely assisting a physician in furnishing an E/M visit or other recognized service. A genuinely distinct service should have separately established clinical utility and resource requirements and should proceed through established coding and coverage processes. Where such a service can appropriately be valued under the PFS, separate service-level payment may be warranted.

For high-cost, stand-alone software-based medical services whose costs cannot reasonably be incorporated into an existing physician service, however, CMS should consider a payment mechanism that recognizes the cost of the technology separately from payment for physician work rather than forcing

the full software cost into the budget-neutral PFS. Doing so would avoid allowing rapidly increasing technology costs to reduce payment for unrelated physician services. The appropriate mechanism will depend on the nature of the service and CMS' statutory authority, and the AMA does not recommend a single payment structure for all clinical AI technologies.

Technology and AI-Augmentation in Primary Care via the Medicare AWV

How can CMS improve the effectiveness, efficiency, personalization, and beneficiary experience of the IPPE and Medicare AWV?

The IPPE and AWV have several persistent shortcomings. Beneficiaries often misunderstand their purpose and scope; the visits require an extensive and largely uniform set of activities regardless of their relevance to the individual patient; and Medicare concentrates preventive assessment and planning in a single annual encounter even though preventive care is delivered longitudinally, across settings, and by physician-led teams. CMS should make two near-term changes to improve the existing visits and, over the longer term, fundamentally redesign how preventive care is delivered for Medicare beneficiaries.

First, the AMA recommends that CMS address persistent beneficiary confusion about the purpose and scope of the IPPE and AWV. Beneficiaries frequently arrive expecting a routine physical examination, evaluation of acute or chronic conditions, laboratory testing, or other services that fall outside the preventive benefit. This mismatch leads to one of two unsatisfactory outcomes. If problem-based care is deferred, patients leave frustrated that their immediate medical needs were not addressed and need to return for another visit; if those needs are addressed, they may face unexpected cost sharing when additional medically necessary services are furnished during the same encounter and separately billed with modifier 25. Medicare.gov and other beneficiary-facing materials should explain the IPPE and AWV in plain language, clearly distinguish them from routine physical examinations and problem-oriented visits, and explain when additional same-day services may result in cost sharing.

Second, CMS should give physicians greater flexibility to focus these visits on the preventive needs most consequential for the individual patient. The IPPE and AWV require physicians to complete an extensive, time-consuming, and largely uniform set of assessments and preventive activities for every beneficiary, regardless of their relevance or priority. Requiring so many elements within a single encounter encourages superficial completion, limits physicians' ability to prioritize the issues most likely to affect the patient's health, and leaves insufficient time to evaluate and act on important findings. A study of beneficiaries who first reported memory concerns during an AWV illustrates the problem: a memory screen was documented in less than 5 percent of those visits, and roughly 1 percent resulted in a specialist referral. Fall-risk screening shows a similar pattern, with one study finding that only 7.5 percent of beneficiaries who screened positive for fall risk and failed a confirmatory mobility test subsequently received appropriate follow-up. Identifying a clinically significant risk accomplishes little if the visit leaves insufficient time to evaluate the finding, discuss its implications with the patient, and arrange appropriate follow-up.

CMS has clear authority to streamline these requirements: the statute requires a health risk assessment and personalized prevention plan but gives the Secretary authority to determine which additional elements must be furnished during each visit and how often. CMS should use that authority to revise IPPE and AWV requirements so that additional components are required only when indicated by the beneficiary's risks, clinical circumstances, and preferences. This would allow physicians

and physician-led care teams to devote limited encounter time to the preventive needs and positive findings most likely to affect the patient's health.

These changes would improve the existing IPPE and AWV, but they would not address a more fundamental problem: evidence does not support organizing preventive care for healthy, asymptomatic adults around a routine annual preventive visit. Decades of research on annual preventive visits, including general health checks and AWVs, has found little or no improvement in mortality or other major health outcomes. At the same time, routine annual visits can contribute to overdiagnosis, low value testing and procedures, and higher healthcare spending. CMS should therefore go beyond modifying the existing visits and work with physicians and relevant experts to redesign preventive care for Medicare beneficiaries around individual risk and expected net benefit. The first task should be to determine which preventive interventions provide meaningful net benefit for defined beneficiary populations, considering the strength of the evidence, magnitude of expected benefit, potential harms and burdens, cost-effectiveness, and beneficiary characteristics that affect the balance of benefits and harms. CMS should then use those determinations to establish which services are appropriate for different beneficiaries and when and how often they should be offered.

Once CMS determines what preventive care is appropriate and for whom, it should determine how to deliver that care most effectively over time. CMS should identify which activities require physician judgment, which activities physician-led care teams can perform, which require an encounter and which can occur asynchronously or between visits, and where technology can support risk identification, information collection, outreach, monitoring, and follow-up. CMS should use the resulting clinical and delivery framework to design the payment and infrastructure needed to support coordinated preventive care across settings and over time. It should then test alternative models against the current approach and assess whether they increase appropriate use of high-value preventive services, improve health outcomes, reduce low-value care and preventable utilization, and improve the value of Medicare spending.

Which, if any, AWV components are being delivered, or could be delivered, more efficiently through technology and clinical AI-enabled tools? Which activities require direct involvement by a physician?

Many information-gathering and administrative components of the AWV can be performed or supported efficiently through existing technology. Patients can complete or update the HRA before the visit; standardized tools can collect information on depression, functional status, substance use, physical activity, nutrition, and other risks; and electronic systems can update medication, medical history, and provider information, identify preventive services already completed, flag potentially overdue services, and support outreach and follow-up. CMS already permits the patient or practitioner to update the HRA before or during the AWV. CMS should build on that flexibility by clarifying that additional standardized information-gathering, reconciliation, and preparatory functions that do not require clinical judgment may be completed before or asynchronously from the AWV. This would allow more of the encounter to focus on interpreting findings, counseling patients, and engaging in shared decision-making.

Clinical AI may add further value by synthesizing the patient-specific context needed to interpret and act on an identified preventive need. Conventional rules-based systems can determine, for example, that a beneficiary meets criteria for statin therapy based on age, lipid values, and cardiovascular risk. But that alert may not reveal whether statins were previously offered; whether the patient declined because of cost, concerns about adverse effects, or a preference for lifestyle changes; whether the patient experienced adverse effects during prior treatment; or whether a prescription was written but never filled. That information may be dispersed across clinical notes, pharmacy records, and patient messages. Generative

AI may be able to synthesize these sources and surface the relevant history for the physician, helping distinguish among the reasons recommended care has not occurred and informing the appropriate next step. A recent *JAMA* Perspective uses this statin example to illustrate a broader distinction: deterministic methods remain well suited to applying clearly specified clinical rules, while generative AI may be particularly useful when clinical decision-making requires synthesizing heterogeneous information from across the patient record to understand the patient's circumstances and determine the appropriate response.

Even with that additional context, AI cannot determine the appropriate course for the individual patient. In the statin example, the physician must decide how the patient's cardiovascular risk, prior adverse effects, affordability concerns, treatment preferences, and other clinical circumstances should affect the recommendation—whether to address an access barrier, reconsider statin therapy, discuss an alternative, or pursue a different course. The same principle applies across the AWV. **Technology may ultimately be well suited for identifying potential needs and assembling relevant information. However, AI-enabled technologies should continue to function as a collaborative member of the care team and should not replace the clinical judgment of a treating physician.** The ultimate goal of incorporating AI into Medicare preventive visits should be to reduce the time clinicians spend assembling information so that more of the encounter can be devoted to the clinical judgment and relationship-building that technology cannot replace.

What existing requirements may create barriers to AI technology companies delivering AWV-related services, when should CMS permit technology-enabled organizations to participate in AWV delivery directly or through Medicare-enrolled providers or suppliers, what program-integrity safeguards are needed, and how should CMS evaluate these models and hold technology companies accountable?

Technology-enabled AWV services should be furnished through the beneficiary's treating physician or physician-led practice. The treating practice should control the clinical protocols, retain access to information generated through the service, review clinically significant findings, and remain responsible for facilitating appropriate follow-up.

Within that framework, the AMA is not aware of Medicare enrollment, licensure, or clinical-accountability requirements that should be relaxed specifically to facilitate technology company participation. CMS should, however, examine whether requirements governing the timing or manner in which individual AWV components are furnished unnecessarily constrain appropriate use of technology. HRA administration, standardized information collection, record retrieval and reconciliation, screening administration, patient outreach, and other functions that do not require clinical judgment could occur before or asynchronously from the encounter through technology-enabled workflows. Technology companies could also retrieve and synthesize longitudinal information, identify potential preventive needs, and support outreach and follow-up at the direction of the treating practice.

Program-integrity safeguards should focus on incentives to increase assessment volume, diagnosis capture, or downstream utilization without corresponding clinical benefit. Medicare Advantage experience with health risk assessments illustrates this risk. In 2024, the HHS Office of Inspector General found that diagnoses appearing only on HRAs or HRA-linked chart reviews generated an estimated $7.5 billion in risk-adjusted payments for 2023; for 1.7 million enrollees, encounter data showed no other service related to those diagnoses. OIG identified particular concerns when assessments were conducted by MA organizations or third-party vendors rather than beneficiaries' regular clinicians. Although these findings do not establish similar conduct in AI-enabled AWVs, they demonstrate the risk of separating

large-scale assessment and diagnosis generation from responsibility for subsequent clinical care. CMS should therefore monitor technology-enabled AWVs for anomalous growth in AWV volume, diagnosis capture, separately billed services, testing, referrals, and downstream utilization. Clinically significant AI-generated findings should undergo appropriate clinical review before informing diagnosis reporting or treatment decisions.

How could CMS optimize information sharing from AWV throughout the duration of the primary care relationship? Where could AI-enabled tools facilitate this process?

The AMA recommends that CMS work with ONC to establish the standards and certified health IT capabilities needed for preventive-care information to follow beneficiaries across EHRs, health systems, and care settings. Those standards should support a longitudinal preventive record that reflects not only what was identified during the AWV but also relevant care delivered afterward. Documentation of screening results, completed preventive services, patient decisions to defer or decline a service, barriers to completion, and follow-up plans should be available for exchange in a form that other health systems can incorporate and use, along with the information needed to determine whether additional preventive services are due. CMS should work with ONC to advance these capabilities through health IT certification criteria, USCDI and related standards-development processes, and alignment with nationwide exchange infrastructure such as TEFCA, rather than impose new physician attestation, reconciliation, or documentation requirements.

This functionality is essential because preventive care is increasingly delivered across multiple settings, health systems, EHRs, and visit types. A beneficiary may receive diabetes screening during an endocrinology visit, a vaccination at a pharmacy, or STI testing during an emergency department visit for urinary symptoms. Information generated in each of these encounters must be available across systems so that every treating clinician can see what preventive care has already occurred and what remains to be addressed. When systems fail to exchange that information, clinicians repeat work and Medicare pays for duplicative outreach, testing, and services—wasting substantial physician time and healthcare dollars.

AI-enabled tools can address a related problem that standards-based exchange alone will not solve: even when records move between systems, much of the information needed to assess a preventive need remains buried in unstructured data. Relevant information may appear in narrative notes, discharge summaries, specialist documentation, scanned records, pharmacy records, or patient messages rather than discrete fields. AI-enabled tools could reconcile these sources with structured data, identify conflicting, incomplete, or outdated information, and surface evidence that may change the status of a preventive need for clinician review. For example, a tool could identify documentation in a specialist note that a screening was completed, detect in a patient message that a beneficiary who previously declined a service now wishes to proceed, or identify a newly documented contraindication that may explain an apparent care gap. These findings should be presented with their source and date for reconciliation or clinical review rather than automatically written into the record as established facts. **CMS should evaluate interoperability and AI-enabled capabilities alike by a practical measure: whether they give physicians and care teams a more complete, accurate, and current view of the beneficiary's preventive care across settings**.

Developing Prospective Payment in the Shared Savings Program

The AMA supports CMS' continued exploration of voluntary prospective payment approaches that better align Medicare payment with longitudinal, coordinated, and team-based primary care. A successful

approach should combine prospective payment with continued service-level payment where FFS remains appropriate, establish payment amounts based on the resources required to furnish high-quality primary care, and avoid transferring financial responsibility to physicians for expenditures outside their control. Prospective primary care payment should ultimately be judged by whether it improves care and supports sustainable practice transformation, not by whether it generates short-term Medicare savings.

ACO and ACO Participant Readiness

> **To what extent are Shared Savings Program ACOs and ACO participants ready to take on hybrid capitation, full primary care capitation, or broader population-based payments, and what changes would be necessary to support participation?**

The AMA urges CMS not to treat "readiness for capitation" as a single organizational characteristic. The capabilities needed to receive a prospective payment for a defined set of primary care services are substantially different from those required to administer population-based payment across a broader range of Medicare services or to accept total care capitation. A primary care practice receiving a monthly prospective payment should be able to identify the beneficiaries for whom it is responsible, use clinical and claims information to manage its patient population, and coordinate with specialists and community-based supports when needed to address barriers to care. An ACO receiving the payment must also be able to distribute funding accurately and transparently to participating practices and meet applicable reporting and program-integrity requirements. By contrast, total care capitation requires substantially greater actuarial, financial, contracting, claims-administration, and risk-management capabilities. **CMS should therefore establish readiness standards proportionate to the payment arrangement and the financial risk involved. Readiness for prospective primary care payment should not depend on experience with downside risk or infrastructure designed to manage total cost of care.**

CMS should also recognize that the transition from claims-based payment to prospective payment is itself operationally demanding. Practices currently organize their revenue-cycle infrastructure around the submission and adjudication of claims for individual services. Prospective payment requires them to reconcile an attributed population against monthly payments, account for revenue independently of visit volume, maintain encounter information even when a claim does not determine payment, and understand how beneficiary additions, departures, deaths, coverage changes, and attribution changes affect revenue. The Milbank Memorial Fund has identified these changes in accounting, encounter reporting, beneficiary reconciliation, and payment management as important implementation issues and has emphasized the value of technical and financial support during the transition.

For this reason, the AMA recommends that CMS provide participating ACOs and practices with a shadow-payment period before prospective payment becomes financially operative. During this period, CMS should provide beneficiary-level files showing which beneficiaries would have generated a prospective payment, the amount associated with each beneficiary, the FFS payments that would have been replaced under the prospective arrangement, and the effect of attribution changes on prospective revenue. Practices should be able to compare those simulated payments with their actual claims revenue before conversion. This would allow ACOs and practices to test attribution, accounting, encounter-reporting, and downstream-payment systems and identify material discrepancies before existing FFS payments are reduced. A sufficiently detailed shadow period would be particularly important for small and independent practices that do not have dedicated actuarial or revenue-modeling staff.

CMS should not, however, respond to differences in infrastructure by limiting participation to organizations that already possess the greatest administrative and financial resources. Smaller, independent, rural, and safety-net practices may face higher transition costs precisely because they lack the centralized analytics, contracting infrastructure, and capital available to larger systems. **CMS should therefore pair predictable prospective revenue with targeted technical assistance and upfront support so that practices are not excluded from participation simply because they lack the resources needed to finance the transition.**

> **If an ACO receives capitated payments for primary care services, what should those payments support and how should CMS ensure that the payments support primary care practices directly?**

The AMA recommends that capitated primary care payments support the resources practices need to deliver comprehensive, longitudinal care, including physician and care-team capacity, care management and coordination, patient communication and outreach, behavioral health and social supports integration, and the clinical and technological infrastructure needed to manage a patient population. The payment should give practices predictable resources to build and sustain these capabilities rather than prescribe how funds must be allocated among individual activities.

Where operationally feasible, CMS should pay prospective primary care payments directly to participating practices. When payments instead flow through an ACO, CMS should require transparent reporting of the amount generated by each practice's attributed beneficiaries, the amount distributed to the practice, and any amount retained by the ACO. ACOs may appropriately retain funding for shared care-management staff, data analytics, health information technology, or other infrastructure, but retained funds should directly support participating primary care practices. Otherwise, CMS could increase prospective funding for primary care without materially increasing the resources available to the physicians and practices delivering it.

Eligibility for Participation

> **Should CMS limit primary care capitated payments to ACOs participating in two-sided risk tracks or require prior experience with financial risk?**

The AMA does not support conditioning primary care prospective payment on participation in a two-sided Shared Savings Program risk track or prior experience bearing total-cost risk. Primary care capitation makes an entity financially responsible for furnishing a defined set of primary care services within a prospective payment; two-sided Shared Savings Program risk extends financial accountability across a much broader range of Medicare Part A and Part B spending. Requiring the latter as a prerequisite for the former would unnecessarily link distinct forms of financial responsibility and could prevent ACOs and practices from gaining experience with prospective payment incrementally.

Eligibility should instead reflect whether the ACO and participating practices can administer the prospective payment arrangement, including beneficiary attribution, payment reconciliation, encounter-data submission, and distribution of payments to participating practices. Broader actuarial, financial, and operational requirements should apply only as organizations assume broader population-based or total-cost accountability.

Should CMS permit some, but not all, ACO participants to participate in capitated arrangements?

The AMA recommends that participation in prospective payment be entirely voluntary at the ACO participant or TIN level. CMS should neither require an ACO to transition all participants simultaneously nor require an individual participant to adopt prospective payment as a condition of remaining in the ACO. Practices within the same ACO differ in infrastructure, patient mix, financial capacity, and readiness for prospective payment, and each should be able to determine whether and when the arrangement is appropriate for its practice. CMS should pair this flexibility with safeguards against beneficiary-level selection. Once a TIN elects prospective payment, the arrangement should generally apply to all eligible beneficiaries attributed to that TIN for the performance period, with participation elected prospectively rather than beneficiary by beneficiary. This structure would preserve voluntary participation for practices while preventing selection based on beneficiaries' expected resource use.

Should CMS establish a minimum percentage of attributed beneficiaries receiving care-management services as a condition of eligibility?

No, the AMA recommends that CMS not condition eligibility on the percentage of attributed beneficiaries receiving a separately billable care-management service. Doing so would use the volume of billed services to determine eligibility for a payment model intended in part to reduce dependence on discrete FFS billing and could encourage practices to furnish or code services to meet an administrative threshold rather than because they are clinically appropriate. If CMS wants to ensure that prospective payment is substantial enough to support meaningful changes in care delivery, it should instead consider the share of the practice's eligible patient panel and primary care revenue covered by the prospective arrangement. The relevant question is whether prospective payment represents a meaningful component of practice financing, not whether an arbitrary percentage of beneficiaries receives a particular separately billable service.

Payment Design and Structure

How should CMS structure and calculate primary care capitation, including the share of payment made prospectively and the timing of payment?

The AMA urges CMS to first determine the full value of the primary care services and supports included in the payment model based on the resources required to furnish them. This valuation should be based on empirical data on physician work, clinical staff, technology, and other practice resources and should be risk adjusted for differences in expected primary care resource needs. The risk-adjustment methodology should be designed and validated for the primary care services covered by the payment model rather than simply importing an HCC-based model designed primarily to predict total Medicare spending. CMS should consider clinical, functional, and social factors that materially affect primary care resource needs and test payment adequacy across different practice sizes, geographic areas, and beneficiary populations.

CMS should offer practices a limited set of payment options that vary the share of payment made prospectively, including both a hybrid option and a fully prospective option. Under a hybrid arrangement, the prospective payment should replace a corresponding portion of FFS payment for the included services rather than operate as an add-on to otherwise unchanged FFS payment. Under a fully prospective arrangement, the full value of the included services should be paid prospectively. Practices should be able

to select the option appropriate for their readiness and care-delivery model and move to a different level of prospectivity at defined intervals without changing the underlying set of covered services.

Prospective payments should be made monthly, with practices receiving an updated beneficiary-level roster identifying the beneficiaries generating payment. Monthly payment provides predictable resources to support ongoing staffing, infrastructure, and care-delivery capacity.

What services should primary care capitation include, and when should CMS provide an enhanced or supplemental payment?

The AMA recommends that CMS establish a clearly defined set of services that primary care practices can reasonably furnish and manage within a prospective payment. Covered services could include office and outpatient E/M services, preventive visits, care-management services, transitional care management, behavioral health integration, advance care planning, and defined virtual communication services. The base payment should also account for the routine non-visit work required to deliver comprehensive, longitudinal primary care, including care coordination, patient outreach, between-visit management, team-based care, and population management, rather than limiting payment to activities that generate discrete FFS claims. By contrast, items and services with substantial variable costs that cannot reasonably be managed within a primary care prospective payment—such as physician-administered drug and vaccine products, advanced imaging, and high-cost diagnostic or procedural services—should remain separately payable.

CMS should provide enhanced or supplemental payments when practices are expected to furnish services or capabilities, or meet patient needs, that require resources beyond those reflected in the base payment. These payments could support, for example, more intensive care management for beneficiaries with complex needs, enhanced behavioral health integration, or additional staffing and infrastructure required to furnish higher-intensity primary care. CMS should clearly define the additional resources or capabilities each supplemental payment is intended to support and base the payment amount on empirical evidence of the incremental physician work, clinical staff, technology, and other practice resources required. Supplemental payments should not duplicate resources already incorporated into the base prospective payment.

Should CMS offer broader prospective-payment arrangements, including total care capitation?

The AMA urges CMS to continue to offer broader prospective-payment arrangements, including total care capitation, as **voluntary options** for ACOs with the financial and operational capacity to administer them. Consistent with NASEM's recommendations for primary care payment reform, CMS should distinguish prospective payment for primary care from arrangements that impose broader population-based cost accountability. Recent empirical evidence reinforces that distinction: in a study of 92,997 primary care physicians participating in 14 Traditional Medicare APMs, hybrid payment models without financial risk were the only model category associated with improvement across all measured dimensions of access, comprehensiveness, continuity, and coordination. Total care capitation transfers responsibility for expenditures across Part A and Part B services and therefore represents a fundamentally different level of financial risk. CMS should apply stronger readiness standards to organizations electing that option and should not make progression to total care capitation a condition of participating in primary care capitation.

Care Delivery Requirements

What care-delivery and accountability requirements should apply to practices receiving capitated primary care payments, and should those requirements vary with the share of payment made prospectively?

The AMA recommends that CMS establish a targeted set of expectations grounded in the five comprehensive primary care functions used in CPC+ and Primary Care First: access and continuity; care management; comprehensiveness and coordination; patient and caregiver engagement; and planned care. CMS used this same framework across both models, while allowing practices flexibility in how they satisfied the associated care-delivery requirements. Practices should similarly retain flexibility under any new prospective payment approach based on their patient population, staffing, geography, and organizational structure. CMS should not replace FFS billing requirements with extensive process measures, attestations, prescribed staffing models, or other administrative requirements that undermine one of the principal advantages of prospective payment: allowing practices to organize care around patient needs rather than billable activities.

The standards for high-quality primary care should not vary according to the percentage of payment made prospectively. More fully capitated arrangements may warrant additional financial and operational safeguards appropriate to the greater degree of prospective payment but should not automatically trigger additional clinical reporting requirements. Evidence of potential deficiencies in care should prompt appropriate oversight and corrective action rather than automatically result in payment recoupment.

Prospective Primary Care Payment Outside the Shared Savings Program

The AMA supports a voluntary prospective payment pathway for physician practices furnishing primary care in Original Medicare outside the Shared Savings Program. ACO participation should not be the only mechanism through which practices can adopt prospective payment for longitudinal primary care. Additionally, CMS should use "prospective primary care payment" or "hybrid primary care payment," rather than "global period," which has an established and materially different meaning in Medicare payment.

How should CMS structure prospective primary care payment outside the Shared Savings Program, including the service bundle, degree of capitation, risk adjustment, and relationship to ACO-based payment?

The AMA recommends that CMS offer practices a voluntary menu of payment options that vary the degree of capitation, including both hybrid and fully prospective primary care payment. Under a hybrid arrangement, CMS should convert a defined share of expected payment for the covered primary care services into prospective payment and correspondingly reduce FFS payment for those services. Under a fully prospective arrangement, the full risk-adjusted value of the covered primary care services should be paid prospectively. Practices should be able to select the degree of capitation that best reflects their readiness and care-delivery model and move between CMS-defined options over time. FFS payment should continue for services outside the prospective payment and for beneficiaries not attributed to the practice.

CMS should align the outside-ACO pathway with the primary care payment framework available through the Shared Savings Program to the extent practicable, including the definition of covered services, risk-

adjustment methodology, encounter-data requirements, and technical payment adjustments. This alignment would reduce administrative complexity for practices that move between the two pathways while preserving participation outside an ACO.

Financial accountability should correspond to the scope of services included in the payment arrangement. A practice receiving prospective payment for defined primary care services should be financially responsible for furnishing those services within the payment amount, but should not thereby become responsible for hospital, specialty, post-acute, or other Medicare expenditures outside the payment. Extending accountability to those expenditures would transform a primary care payment arrangement into a broader total-cost-of-care risk model and require substantially different actuarial, financial, and administrative capabilities. Practices that wish to assume broader population-based financial risk should be able to do so through separate voluntary arrangements.

Risk adjustment should reflect differences in beneficiaries' expected primary care resource needs rather than rely solely on models designed to predict total Medicare spending. The methodology should account for differences in patient complexity that materially affect the resources required to furnish the covered primary care services.

How should beneficiaries be attributed to practices, when should prospective payment begin and end, and what role should the IPPE or AWV play?

The AMA recommends that CMS prioritize voluntary beneficiary designation and use claims-based attribution when a beneficiary has not designated a practice. The IPPE and AWV should not determine attribution or be required to initiate prospective payment. Either service may provide evidence of an established primary care relationship, but requiring an IPPE, AWV, or other particular billed encounter to activate payment would make prospective payment contingent on discrete FFS utilization rather than the beneficiary's longitudinal relationship with the practice. Additionally, attribution should identify the practice responsible for the primary care services included in the prospective payment without restricting beneficiaries' ability to receive care from other clinicians in Original Medicare.

Prospective payment should begin when a beneficiary becomes attributed to the practice and end when that attribution terminates. CMS should align payment changes with a regular monthly payment cycle and establish safeguards to prevent overlapping prospective payments when beneficiaries change practices or otherwise become ineligible for attribution.

What reporting and accountability requirements should apply, and should CMS require a minimum number of visits or clinical outcome reporting?

The AMA urges CMS not to impose a minimum visit requirement, which would recreate the volume incentive prospective payment is intended to reduce. Accountability should instead focus primarily on outcomes: specifically, on whether beneficiaries continue to receive needed care and whether the arrangement produces evidence of under-service or inappropriate shifting of services. CMS can monitor changes in primary care use, emergency and urgent care, ambulatory care-sensitive hospitalizations, preventive and chronic disease outcomes, continuity, beneficiary experience, and use of services outside the bundle. A decline in visit volume accompanied by stable or improved access and outcomes should not be treated the same as a decline accompanied by worsening acute-care use, loss of continuity, or beneficiary complaints. CMS also should not require a new clinician-reported outcomes regime where

performance can be assessed through claims, encounter data, existing quality measures, and beneficiary-experience data. Any additional clinical reporting should be limited to information CMS cannot obtain elsewhere and should rely on routinely generated data wherever possible.

The AMA views this RFI as the beginning of an extended dialogue rather than a prelude to a single rulemaking. The concepts CMS describes cannot be evaluated apart from the operational details that would govern them, and those details will determine whether new payment approaches strengthen or destabilize primary care. We urge CMS to work directly and continuously with practicing physicians through the AMA and the national medical specialty societies as it develops these policies, and to test and refine specific proposals with that input before implementing them broadly.

C. Request for Information: Applying Electronic Prior Authorization Measures to Shared Savings Program ACOs

The AMA appreciates CMS' interest in using electronic prior authorization (ePA) to improve patient access, strengthen care coordination, and reduce reliance on payer portals, fax, telephone calls, and other manual processes. The AMA has long supported ePA when it reduces actual administrative work, is integrated into physician workflows, and expedites approvals. **However, digitization alone does not reduce burden, and ACOs should not be held accountable for payer requirements, technology, or determinations they do not control.**

The RFI does not propose requiring ACOs to administer prior authorization programs or make coverage decisions. Rather, CMS is considering whether completion of an ePA transaction could be required or recognized as a measure of CEHRT use. While this distinction is important, several questions warrant further consideration. **CMS should more clearly explain how a mandatory ACO ePA measure would assess the quality of care furnished by an ACO, reduce administrative burden, and ensure that ACOs have a fair and consistent opportunity to comply.**

The AMA opposes establishing a mandatory ACO ePA measure. CMS should instead consider ePA only as a voluntary, coequal option for satisfying the Shared Savings Program CEHRT use requirement. ACOs should remain free to select any available CEHRT use pathway and to change pathways between performance years without penalty. An ACO's decision not to select the ePA option should not affect its quality score, eligibility for shared savings, loss calculation, participation status, or other compliance determination.

Electronic Prior Authorization for Medical Items and Services

The AMA supports further consideration of a voluntary CEHRT use option under which an ACO could attest that a participating physician or practice successfully submitted at least one ePA request for a medical item or service**. CMS should not require the ACO to receive a payer determination to satisfy the option.** ACOs and participating physicians control whether they submit a request, but the payer controls whether and when it processes the request, returns a determination, or provides a technically valid response. Conditioning ACO compliance on the receipt of a payer response would improperly make the ACO responsible for payer performance.

CMS should also permit the voluntary option to be satisfied through a qualifying ePA request involving any patient and payer. Limiting qualifying transactions to assigned Medicare beneficiaries would create uneven opportunities among ACOs because traditional Medicare applies prior authorization only to certain items and services. Specialty composition, patient populations, payer mix, and local coverage

policies would further affect whether an ACO has a qualifying transaction. **A voluntary CEHRT use option should demonstrate that the ACO or its participating practices used electronic functionality, not test whether an ACO happened to encounter a payer requirement.**

A successful electronic submission should be sufficient. CMS should not require every component of the Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR), and Prior Authorization Support (PAS) workflow to be used in a single transaction when a particular authorization does not require every function. CMS should recognize the portions of the workflow that are applicable to the transaction and within the physician's control.

Readiness and Implementation Safeguards

CMS should not implement even a voluntary option beginning in performance year 2028 unless it first demonstrates that the necessary payer and provider technology is operational, broadly available, conformant, and reliable. Before implementation, CMS should conduct a pilot involving diverse ACOs, including small, rural, independent, safety net, and specialty organizations. The pilot should include testing among payers, EHR developers, intermediaries, ACOs, and participating practices under real-world workflows.

CMS should delay the option if testing shows that payer APIs, certified health IT, or ePA workflows are not sufficiently reliable or widely available. Certification of individual health IT modules does not establish that the complete transaction will work across multiple systems. CMS should evaluate endpoint availability, conformance with applicable standards and implementation guides, data quality, authentication, documentation exchange, acknowledgments, error handling, response delivery, and the availability of effective support when transactions fail.

The AMA also urges CMS to ensure that physicians and ACOs can access the necessary functionality without additional module, interface, transaction, configuration, or implementation fees. **A voluntary option will not provide meaningful flexibility if selecting it requires an ACO or its practices to purchase costly software.** CMS should coordinate with ONC to require transparent disclosure of the capabilities included in certified products, associated costs, dependencies on third-party modules, and known limitations.

Most importantly, CMS should determine whether the electronic workflow replaces manual work. A successful electronic request should not be treated as evidence of burden reduction if physicians and staff must continue using payer portals, fax, telephone calls, duplicative data entry, or manual status checks. **CMS should not incentivize an electronic transaction that merely adds another channel to an already fragmented process.**

Attestation, Documentation, and Accountability

CMS should permit an ACO to satisfy the voluntary option through a simple attestation supported by reasonable administrative documentation. CMS should not require submission of protected health information, detailed numerator/denominator reporting, or retention of extensive transaction records. Appropriate evidence could include confirmation that a request was successfully submitted, together with information identifying the certified functionality used.

An ACO should be permitted to rely on payer endpoint information and representations from EHR developers, vendors, clearinghouses, health information networks, and other intermediaries. An ACO

should not be found noncompliant when a request fails because a payer API is unavailable or nonconformant, certified functionality does not operate as represented, or an intermediary fails to transmit or return information properly. **CMS should direct its initial monitoring and accountability toward the entities that control the electronic infrastructure.**

Reliable ePA could support accountable care, but a new ACO measure should not become a mechanism for shifting responsibility for payer and vendor implementation failures to physicians. CMS should first establish that the technology works, is affordable, replaces manual processes, and improves patient access. **Until those conditions are demonstrated, ePA should remain a voluntary, coequal CEHRT use option and should not become a mandatory Shared Savings Program requirement.**

D. Request for Information: Community-based Palliative Care

Where should CMS focus on potential fraud, waste, and abuse in community-based palliative care?

The AMA has found that available evidence does not show that fraud is prevalent in community-based palliative care. The more consistent problems are underuse, inadequate reimbursement, difficulty identifying and enrolling appropriate patients, and difficulty financing the interdisciplinary work that high-quality palliative care requires. As CMS considers additional support, it should build program-integrity oversight around four questions: whether payment corresponds to substantive palliative care, whether Medicare pays twice for the same clinical work, whether an organization's enrollment or business practices depart from expected patterns, and whether financial incentives create a risk of undertreatment.

On the first question, CMS can rely on tools it already uses rather than new documentation requirements. The payment should identify the physician or other qualified healthcare professional who directs the plan of care and assesses the beneficiary at enrollment and at clinically appropriate intervals, in person or by telehealth. Each monthly claim should report the discipline, modality, and duration of the team's contacts, as hospice claims already do, and programs should record a standardized symptom and function assessment comparable to the HOPE instrument hospices now use. Those data would allow CMS to build a claims-based index for palliative care, modeled on the Hospice Care Index, that flags programs with long gaps between contacts or visit intensity in the lowest decile and directs review to them while sparing compliant programs. The NQF-endorsed patient-reported measures that AAHPM developed under a CMS cooperative agreement would confirm from the beneficiary's side that the team addressed pain and communicated well.

To address duplication, the AMA recommends that CMS define which services the payment includes and use claims analytics to identify duplicate payment for the same work, while preserving appropriate concurrent disease-directed, specialty, home health, and other care management services. Consistent with AAHPM's program-integrity recommendations, CMS should concentrate scrutiny on organizations, ownership structures, and administrators that present elevated risk, triggering review on indicators such as unusually rapid enrollment, high market penetration, unusual common-ownership or management arrangements, or beneficiary complaints.

For any future supportive or palliative care service for Medicare beneficiaries, should eligibility be restricted to certification of a likely life expectancy duration?

No, the AMA recommends that Medicare not condition eligibility for supportive or palliative care on a certified life expectancy. The clinical and financial benefits of palliative care accrue before the final

months of life, physicians cannot certify prognosis with the precision such a requirement assumes, and a prognostic threshold would reproduce the late-enrollment pattern that already constrains the Medicare hospice benefit.

Randomized trials demonstrate that patients benefit when palliative care begins well before the end of life. In a trial of 461 patients with advanced cancer and an estimated survival of 6 to 24 months, early palliative care improved quality of life, symptom burden, and satisfaction with care by four months. A subsequent trial that enrolled only patients with advanced cancer who were not terminally ill found that early palliative care improved existential well-being and patients' capacity to cope with their illness and improved quality of life at 18 weeks. The benefit is not confined to cancer. A meta-analysis of 43 randomized trials involving more than 12,000 patients with cancer, heart failure, chronic lung disease, and other serious illnesses found that palliative care consistently improved quality of life and symptom burden. Professional guidelines reflect this evidence: the American Society of Clinical Oncology recommends specialist palliative care early in the course of advanced cancer, alongside active cancer treatment, and the National Consensus Project's clinical practice guidelines define palliative care by patient need rather than prognosis.

Beyond improving health outcomes, earlier access to palliative care also reduces downstream spending. In a population-based study of more than 72,000 matched patients with cancer, patients who received palliative care six to 12 months before death used significantly less inpatient care in the final month of life than matched patients who did not receive palliative care during that period; average health system costs in that month were $12,753 among early recipients compared with $14,147 in the comparison group, a difference the authors attributed largely to avoided hospitalizations. A meta-analysis of six observational studies similarly found that palliative care consultation within three days of hospital admission was associated with significantly lower direct hospital costs.

Experience with the hospice benefit illustrates how a prognostic eligibility threshold can impede timely access. Although the benefit requires physician certification of a six-month prognosis, the median length of stay has remained 17 to 18 days since 2000, and one quarter of decedents enroll for six days or fewer. Physicians overestimate survival: in a prospective study of prognostic accuracy at hospice referral, only 20 percent of physicians' estimates were accurate, and physicians overestimated survival by a factor of more than five. Prognostic uncertainty also directly affects referral decisions; in a physician survey, difficulty predicting death within six months was identified as the foremost barrier to hospice referral by 37 percent of respondents. Using the same prognostic gate for palliative care would import a documented barrier to timely hospice referral into a benefit intended to reach patients earlier in serious illness.

The AMA understands the importance of guarding against inappropriate enrollment. However, eligibility should be tied to whether a beneficiary has needs that palliative care is designed to address rather than to predicted survival. Eligibility should rest on documented need—a diagnosis of serious illness together with clinical indicators such as symptom burden, functional decline, or recent acute care use—confirmed by physician attestation at initiation and periodic reassessment and supported by claims-based monitoring to identify outlier utilization. CMS has already used a non-prognostic eligibility structure for another high-need population: the GUIDE Model relies on clinician attestation of a dementia diagnosis without imposing a life-expectancy criterion. This approach would align eligibility with the clinical purpose of the service while allowing CMS to protect program integrity through documentation, reassessment, and claims-based monitoring.

If eligibility is restricted to those beneficiaries with a terminal prognosis, is there evidence to suggest a reasonable interval?

No, the available evidence does not identify any life-expectancy interval as an appropriate threshold for palliative care eligibility. Palliative care needs do not arise at a predictable point before death, and the evidence does not establish a survival period at which patients begin—or cease—to benefit. As discussed above, randomized trials have demonstrated benefits both in patients who were not terminally ill and in patients with estimated survival of up to 24 months. A fixed prognostic interval would therefore impose an eligibility boundary that is not supported by the clinical evidence**.** Even if CMS were to select an interval administratively, clinicians could not apply it with sufficient precision**.** A 2024 systematic review of nearly 69,000 patients evaluated the "Surprise Question," which asks clinicians whether they would be surprised if a patient died within the next year. Among patients whom clinicians identified as likely to die within a year, only 40 percent did. Clinicians therefore frequently identified patients as being within a one-year prognosis when they survived longer than a year. In another prospective cohort of 468 patients referred to hospice, physicians' survival estimates were accurate only 20 percent of the time, 63 percent were overoptimistic, and physicians overestimated survival by a ***factor of 5.3*****.** A prognostic interval would therefore exclude beneficiaries who would benefit and, for those who qualify, would be applied late, because the physicians asked to certify prognosis systematically believe their patients have more time than they do.

Should CMS nonetheless include a prognostic element in eligibility, that element should take the form of a physician attestation that death within the next 12 months would not be surprising, without a certification cycle, face-to-face encounter requirement, or audit liability for prognostic error, and it should operate alongside, rather than in place of, the need-based criteria described above. Any interval shorter than 12 months would replicate the hospice benefit's late-enrollment pattern and exclude the populations in which the trials cited above demonstrated benefit.

For any future supportive or palliative care service, how should CMS consider functional impairment and caregiver strain in determining eligibility, and how can it minimize burden?

The AMA acknowledges that functional impairment and caregiver strain can help identify beneficiaries who need palliative care, but recommends that CMS not require a beneficiary to satisfy both criteria or establish rigid thresholds for either. Functional impairment is a particularly relevant indicator because serious illness often creates needs for assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), including mobility, self-care, medication management, transportation, and other activities necessary to remain safely at home. Palliative care guidelines similarly recognize functional status as a core domain of assessment, and established referral criteria identify declining ability to perform ADLs as one of several indicators of unmet palliative care needs. **CMS should therefore permit functional impairment to qualify a beneficiary for the service, but should not require a specified number of ADL limitations.** Patients may have substantial symptom burden, cognitive impairment, treatment-related complications, or other palliative care needs before becoming dependent in multiple ADLs.

Caregiver strain should be considered separately rather than required in addition to functional impairment. High caregiver burden can itself signal that a beneficiary's needs exceed what the existing care arrangement can safely sustain, but making caregiver strain a mandatory eligibility condition would disadvantage beneficiaries who live alone, lack an available unpaid caregiver, or rely on several people rather than a single identifiable caregiver. It would also make the beneficiary's access to care depend

partly on the health, employment, financial resources, and other circumstances of another person. CMS should therefore treat functional impairment and substantial caregiver strain as alternative indicators of need, while using caregiver burden to determine whether additional caregiver education, support, respite, or greater service intensity is warranted. CMS uses a similar distinction in the GUIDE Model: caregiver burden is assessed and used to determine care intensity and payment, but it is not a condition of beneficiary eligibility for the model.

The AMA recommends that CMS also avoid creating a new palliative-care-specific eligibility instrument or requiring practices to administer and report a prescribed assessment solely for billing. Physicians should be permitted to establish functional impairment from information already documented in the medical record, including ADL or IADL assessments or other validated functional measures used in routine care. When caregiver strain is relevant, practices should similarly be able to use an existing brief validated measure or information already obtained during the encounter rather than complete a separate CMS form.

E. Request for Information: Specialty Care in the Shared Savings Program (SSP)

The AMA has been recommending for many years that CMS provide more opportunities for specialists to participate in APMs, and we appreciate CMS' interest in increasing specialist engagement in the SSP and other ACO models. Although primary care physicians play an essential role in prevention, diagnosis, and treatment for a wide range of health conditions, many patients have health problems that require diagnosis or treatment from one or more specialists. A high proportion of total Medicare spending in an ACO is related to services delivered or ordered by specialists, so the way specialists provide care can significantly impact an ACO's success. However, barriers in current Medicare payment systems make it difficult for specialists to deliver the highest quality care to their patients at the lowest feasible cost, and ACOs do not currently have the ability to remove most of these barriers.

Specialists have identified many opportunities for reducing spending without harming patients if barriers in the current payment system could be removed. For example, many patients with chronic or serious acute conditions do not correctly take their medications or adjust their diet and activities, which can lead to exacerbations of their condition that require emergency care and hospitalizations. Current payment systems do not enable specialty practices to hire staff for education and support services that could help patients better self-manage their conditions or monitor their symptoms so physicians can intervene quickly when exacerbations occur. Current payment systems also do not support the time needed for specialists to engage in shared decision-making processes with patients about alternative treatment plans or to deliver alternative treatments that would achieve good outcomes for the patient at a lower cost.

CMS wants every Medicare beneficiary to be in "a care relationship with accountability for quality and total cost of care," but physicians cannot take accountability unless they have the tools to successfully improve quality and control costs. The AMA urges CMS to take the following three steps to increase the ability of specialists to deliver high-quality, affordable care to their patients:

1. Provide improved data to all physicians on the services their patients are receiving and the cost of those services
2. Ask physicians to identify changes in Medicare payment systems that would enable them to improve care and/or lower costs for the specific health conditions they diagnose, treat, and manage.

3. Create new payment models and new options for payments within ACOs that are focused on enabling specialists to make improvements in care delivery, not short-term savings relative to existing FFS spending or "target" pricing on discrete sets of bundled services.

Data on Cost and Utilization

An important first step is for CMS to begin providing timely, accessible, and actionable data on utilization and costs to all specialists who submit Medicare claims. CMS has created almost three dozen episode-based cost measures and several claims-based quality (utilization) measures as part of MIPS, but physicians do not receive any information about these claims-based measures until long after the services have been delivered. Even then, physicians find that the information CMS provides is difficult to access and nearly impossible to use to identify ways to improve patient care. Physicians who participate in ACOs are not scored on the cost measures, so they do not receive even this limited information from CMS, and they may or may not be able to receive actionable information about services and costs through the ACO.

To enable specialists to take greater accountability for both the cost and quality of the care they provide to patients, CMS should provide better and more timely information to all specialists who submit Medicare claims, regardless of whether they are part of an ACO. CMS should provide each physician with information on all episode-based cost measures and claims-based quality measures that are applicable to the physician's patients on at least a quarterly basis, if not more frequently. To enable physicians to use this information effectively, CMS should make improvements in the current reports on cost measures and claims-based quality measures that the AMA recommended in a letter to CMS in February 2026:

- The physician should receive a patient-level list of each individual service that is included in the cost or utilization measure, and services defined by CPT codes should include any modifiers reported with the codes, as these modifiers can significantly alter payment amounts.

- Each record should include:
    - site of service, e.g., physician office, ASC, or outpatient department;
    - name, specialty, location, and type of provider for each service (current reports include only the NPI, requiring physicians to manually look up codes to determine who performed the service and where);
    - the actual payment for the service in addition to the "standardized cost;" and
    - the subgroup to which the episode is assigned (for cost measures that define separate subgroups for episodes).

- Expected costs should be included for each episode, taking into account geographic location, patient complexity, and other factors, so the physician can identify which episodes were considered to have higher-than-expected costs and why.

CMS should also make improvements to the existing claims-based measures so that they more accurately and fairly assess aspects of costs and utilization that physicians can control. The AMA identified several problems with the current cost measures in our February 2026 letter, which we reiterate here, and we urge CMS to work with the AMA and other interested parties to correct these problems immediately, particularly with regard to the two population-based measures.

Ask Specialists to Identify Changes Needed in Medicare Payments

When specialists have access to data on the costs of the services they deliver or order themselves for their patients, on the services their patients receive from other physicians, and the facilities where these services are being provided, they will be able to better identify opportunities to improve care and better manage resources and costs. This could lower out-of-pocket costs for the patient, and benefit the system as a whole. For example, if patients are better able to access their specialists out of traditional hours for emergent issues pertaining to their condition, they may be able to avoid a trip to the emergency department. Over time and at scale, this can help reduce unnecessary ED visits and ED overcrowding. Timely and accessible data feedback will allow specialists to see if their patients are getting duplicative imaging or blood tests, unnecessary or unnecessarily expensive medications, frequently visiting emergency departments and urgent care centers, having trouble filling prescriptions or adhering to their treatment plan, or seeing multiple specialists as part of a diagnostic odyssey to try to determine what condition they have or identify an effective treatment for it. These situations occur far more often than they should, even for patients whose primary care physician is part of an ACO.

In some cases, the physicians will be able to make improvements in care delivery based on this information. However, in many cases, they will not be able to do so because of the way current Medicare payments are structured. To address this, the AMA urges CMS to ask specialists to identify barriers in the current payment system that are preventing them from improving care for the types of health conditions they diagnose, treat, and manage.

The following table shows some examples of opportunities for improving care that specialists have identified for various types of health conditions, as well as the barriers in the current payment system that prevent them from making the necessary changes in care delivery.

<table>
<tr><th colspan="4">EXAMPLES OF OPPORTUNITIES FOR SAVINGS AND PAYMENT BARRIERS</th></tr>
<tr><th>Condition</th><th>Specialists</th><th>Opportunities for Savings</th><th>Payment Barriers</th></tr>
<tr><td>Asthma, COPD</td><td>Allergists, Pulmonologists</td><td rowspan="3">• Reduce misdiagnosis
• Avoid unnecessary testing
• Avoid unnecessarily expensive medications
• Reduce ED visits and hospitalizations</td><td rowspan="3">• No payment for shared decision-making about treatment
• No payment for patient education and self-management support
• No payment for virtual symptom monitoring to prevent exacerbations</td></tr>
<tr><td>Heart Failure</td><td>Cardiologists</td></tr>
<tr><td>Headache</td><td>Neurologists</td></tr>
<tr><td>Unscheduled Acute Care</td><td>Emergency Physicians</td><td>• Reduce hospital admissions after ED visit
• Reduce ED revisits
• Connect patients with PCPs</td><td>• No payment for discharge planning & coordination with PCP
• No payment for transitional care management after ED visit</td></tr>
<tr><td>Chest Pain & Ischemic Heart Disease</td><td>Cardiologists</td><td>• Reduce unnecessary stress tests and angiograms
• Reduce unnecessary stenting</td><td>• No payment for detailed assessment and symptom monitoring in conjunction with PCP needed to avoid unnecessary testing</td></tr>
</table>

Cancer	Oncology	• Reduce unnecessary & unnecessarily expensive testing & treatment • Reduce ED visits and hospitalizations	• No payment for shared decision-making about prognosis & treatment • No payment for symptom monitoring and rapid intervention
Cataracts	Cataract Surgeons	• Remove cataracts from both eyes on the same day for appropriate patients	• Payment reduced by 50% if surgery is performed on the same day even though costs are not 50% less

Payment changes to address the barriers in several of these examples were developed into APM proposals and some were pilot tested or implemented by private payers or through CMMI's Health Care Innovation Awards. However, none of those payment changes are currently available in the Medicare program or through ACOs.

Implement New Payment Models to Support Specialists' Ability to Improve Care Delivery

In response to a request from CMMI, the AMA developed a framework called "Payments for Accountable Specialty Care" (PASC) to address barriers preventing specialists from the type of meaningful engagement with ACOs that this RFI addresses. Under PASC, an ACO and a specialist or specialty practice would be able to enter a voluntary PASC Agreement designed to improve care for ACO patients with specific health conditions. The specialist would take accountability for delivering specific types of services to each patient in a way designed to improve outcomes and/or reduce avoidable spending, and the specialist would receive an Enhanced Condition Services (ECS) payment from Medicare for each ACO patient to support the improved approach to care delivery. A description of the PASC approach, examples for different types of chronic and acute conditions managed by different specialists, and the way the ECS payments could be structured are available in an AMA letter to the Physician-focused Payment Model Technical Advisory Committee (PTAC) on Improving Care Delivery and Integrating Specialty Care in Population-Based Models.

Besides the PASC approach, another option would be for CMS to test alternative payment models proposed by national medical specialty societies. As shown below, many of these models have already been developed and several were submitted to the PTAC and recommended to HHS but have not been further developed, tested, or implemented by CMMI. Implementing them as part of an ACO would allow these improvements in care delivery to become available to Medicare patients, and they could help ACOs lower spending for patients who have the conditions that the APMs are designed to address. As CMMI considers developing these models, it should seek meaningful and transparent involvement of actively practicing physicians, nominated by relevant national specialty societies, throughout the model development process, prior to approval for testing or implementation.

EXAMPLES OF CARE DELIVERY AND PAYMENT MODELS ALREADY DEVELOPED BY SPECIALISTS THAT COULD BE ADAPTED TO THE SSP		
Condition	**Specialists**	**Changes in Care with Payment Reform**
Asthma	American College of Allergy, Asthma & Immunology (ACAAI)	Improving diagnosis and treatment to reduce ED visits, hospital admissions, and drug spending
Headache	American Academy of Neurology (AAN)	Improving diagnosis and treatment to reduce ED visits, hospital admissions, and drug spending
Unscheduled Acute Care	American College of Emergency Physicians (ACEP)	Improving discharge planning and follow-up to reduce need for hospital admissions
Joint & Back Pain	American Academy of Orthopaedic Surgeons (AAOS)	Pre-habilitation to improve surgical outcomes & reduce post-acute care use for obese patients
Cancer	American Society of Clinical Oncology (ASCO)	Improving treatment planning and symptom management to reduce hospitalizations and reduce drug costs
Inflammatory Bowel Disease	Lawrence Kosinski, MD (Gastroenterology)	Symptom monitoring and treatment modifications to avoid hospitalizations and slow disease progression
Rheumatoid Arthritis	American College of Rheumatology (ACR)	Improving diagnosis and treatment to reduce drug spending and slow disease progression
Chest Pain	American College of Cardiology	Accurate, timely diagnosis and treatment of chest pain that avoids unnecessary testing and unnecessary invasive procedures

A third option would be for CMS to provide grants to support specialty care models for patients in ACOs, much as CMMI did with the Health Care Innovation Awards. Unlike these awards, however, CMS should also develop a plan to provide ongoing payment support for the effective specialist models as part of the SSP so that they are not discontinued as soon as the grant funding ends.

To conclude, the AMA strongly agrees with CMS that specialists should have opportunities for meaningful engagement in the SSP. This would improve specialty care for patients in an ACO, improve teamwork between primary care physicians participating in an ACO and specialists who also provide care to their patients, and could also improve patient health outcomes and lower Medicare spending. However, we also believe that specialists should be given the information and resources they need to improve care for patients regardless of whether they are part of an ACO.

F. Request for Information: Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability

The AMA agrees that incomplete access to laboratory results and diagnostic images can lead to delays, unnecessary repeat testing, avoidable costs, and patient harm. We recommend that CMS address these issues through a coordinated, standards-based interoperability strategy before adopting payment edits that presume a test was duplicative based on claims data.

A CPT or HCPCS code establishes what service was billed, but it does not provide enough clinical information to determine whether a later test is duplicative. That determination may depend on the specimen, methodology, body site, laterality, imaging modality, acquisition protocol, result status, clinical indication, time elapsed, intervening treatment, change in the patient's condition, and whether the prior result was complete, clinically current, and available in a usable form. Claims for the same code or tests associated with the same diagnosis therefore should not automatically trigger nonpayment.

The AMA supports requiring structured, standards-based exchange rather than relying primarily on narrative reports. A FHIR R4 Diagnostic Report resource and a Portable Document Format/Archive (PDF/A) rendition would be a useful starting point, but a Diagnostic Report alone is not a sufficient interoperability specification. It generally serves as a container that references the structured observations, specimens, orders, imaging studies, and other information required to interpret and reuse the result. PDF/A can provide a human-readable copy, but it should supplement, not replace, computable data.

For laboratory services, a minimum exchange package should include the applicable FHIR Service Request, Diagnostic Report, Observation, Specimen, and Provenance resources. The data should identify the ordered and performed test, code system and version, specimen type and source, collection and result times, method where clinically significant, result status, quantitative value, units, reference range, abnormality flag, performing organization, and any corrected or amended results. Logical Observation Identifiers Names and Codes (LOINC), Unified Code for Units of Measure (UCUM), and SNOMED CT should be used where appropriate, with implementation guidance for local-code mapping and terminology-version management. The AMA has been actively working with colleagues from the Regenstrief Institute to explore terminology mappings in this space. We endeavor to generate a maintainable, rules-informed framework that can use multiple terminologies or ontologies, logical relationships, and workflow context to narrow candidate CPT codes.

For imaging, the exchange package should include the order, imaging report, Imaging Study metadata, relevant provenance, and access to the complete image set using Digital Imaging and Communications in Medicine (DICOM) and DICOM web standards. The data should identify modality, body part, laterality, acquisition date and time, study and series identifiers, performing organization, result status, and the endpoint from which authorized users can retrieve the images. A narrative report without access to the source images will not prevent repeat imaging when the treating physician needs to independently review or compare the studies.

The AMA also emphasizes that delivery only to the ordering physician's designated endpoint is insufficient. Subsequent treating physicians must be able to discover and retrieve the result through authorized query-based exchange. CMS should coordinate endpoint discovery with national directory standards and should address patient matching, organizational identity, authentication, authorization, consent, and provenance. Participation in a national network will not solve the problem if these foundational capabilities remain inconsistent.

CMS should work with ONC, standards-development organizations, laboratories, imaging providers, physicians, health systems, and health IT developers to establish a single implementation approach. That approach should align Medicare requirements with applicable United States Core Data for Interoperability (USCDI) and USCDI+ work, FHIR R4 implementation guides, DICOM web, certified health IT capabilities, and national network exchange rather than creating a separate CMS-specific interface.

Expanded conformance testing would also be highly valuable. CMS and ONC should provide reference implementations, standardized test data, automated validators, implementation guides, and end-to-end

testing that covers ordering, result creation, endpoint discovery, exchange, retrieval, display, correction, and reconciliation. Conformance testing must assess semantic accuracy and clinical usability, not merely whether a syntactically valid FHIR resource was transmitted.

CMS should initially use incentives, technical assistance, and phased implementation to advance these capabilities, particularly for rural providers, small practices, independent laboratories, and imaging centers with limited technical resources. Payment penalties should not be applied until the required standards, directory services, conformance tools, and exchange infrastructure are demonstrably available and reliable across care settings.

If CMS subsequently considers payment edits, a repeat test should not be treated as duplicative when the prior result was unavailable within the clinical decision window, could not be located or matched to the correct patient, lacked the necessary structured data or source images, was incomplete or preliminary, could not be securely retrieved, was clinically outdated, or was not responsive to the patient's current condition. The treating physician should not be penalized for repeating a test when another entity failed to make the prior result timely and reusable.

The AMA recommends that CMS:

1. Refrain from determining duplication solely from CPT or HCPCS claims, diagnosis codes, or fixed time intervals.
2. Develop laboratory and imaging exchange profiles that include the complete set of FHIR, terminology, DICOM, provenance, and endpoint requirements needed for clinical reuse.
3. Treat PDF/A as a supplemental human-readable format rather than a substitute for structured data and source images.
4. Require both delivery to the ordering clinician and authorized query-based retrieval by subsequent treating clinicians.
5. Establish national conformance testing, reference implementations, and phased implementation support.
6. Define objective criteria for when a prior result is considered available, complete, current, and clinically reusable before applying any payment consequences.
7. Ensure that physicians are not penalized when repeat testing is necessary because prior data were unavailable, unusable, or no longer clinically appropriate.

G. Request for Information: Fast Healthcare Interoperability Resources® (FHIR)-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs

The AMA commends the Administration for focusing resources on interoperability and advancing measurement. Advancing to a standard based on Fast Healthcare Interoperability Resources (FHIR) represents an important step toward a more flexible and scalable measurement framework. If implemented thoughtfully, this transition has the potential to allow physicians, hospitals, and alternative payment model entities to incorporate additional and more clinically meaningful sources of data into quality reporting, which in turn could ease longstanding reporting burdens. In particular, a FHIR-based approach will allow specialties such as radiology and gastroenterology, as well as other physician specialties, providers, and alternative payment model (APM) entities, to leverage digital data sources that historically have not been fully integrated into EHR workflows. However, we are concerned about CMS' proposal to mandate use by 2030, since there are still outstanding **health information technology standards and** Certified Electronic Health Record Technology **(CEHRT) issues that need to be**

resolved, as well as the need for real-world testing and end-to-end testing, not just individual measure testing. We even question whether individual measures have been tested with the FHIR standard.

The glidepath to adoption must also include appropriate positive incentives to support providers and physician practices, particularly those that are small and rural, through the transition to FHIR adoption. In addition, the capabilities of the measure stewards and ongoing expense of working with measure developers also must be considered. Successful FHIR-based dQM development requires not only technical infrastructure but also sustained expertise in measure specification, maintenance, and testing, which can be costly and is not uniformly available across organizations. **We are eager to assist CMS in this move, and we welcome the opportunity to participate in its planning and execution.**

We offer feedback on the following questions within the RFI:

Transition Approach and Design:

- *What factors should be considered in determining the structure of the 2-year transition period, during which FHIR-based reporting options and existing electronic quality reporting options for CQMs and eCQMs would be available concurrently?*

The AMA is concerned about CMS' consideration of a two-year transition period. The re-specification of the existing electronic clinical quality measures (eCQMs) to the new standard is useful; however, rapid deployment of these new dQMs without sufficient testing, validation, and a clear pathway to implementation will result in increased reporting burden, particularly for small and rural practices and hospitals, and measure scores that are not accurate or representative of the true clinical care provided. Real-world implementation and assessments of feasibility of data collection across broader digital data sets and entities of varying sizes and locations will be imperative to ensure a seamless glidepath to these new measures in CMS quality programs. It is critical that any potential challenges or barriers to implementation are identified and resolved before practices are required to capture and report data beyond what is captured in EHRs and represented in FHIR. These steps must be taken before CMS finalizes any move to FHIR dQMs.

What are the scoring implications that CMS must consider during the transition period, when multiple reporting options are available?

Given the unreliability of eCQMs and the unknowns associated with new dQMs, we urge CMS to score eCQMs and dQMs separately, which is the current process for other reporting types in the Merit-based Incentive Payment System (MIPS). Ideally, the same measure should produce comparable results regardless of how it is reported, but unfortunately that is not the case. CMS should also assess the maturity and reliability of health information networks (HINs) and their ability to obtain and provide the data needed for dQMs from outside a physician practice's EHR. Meaningful digital quality measurement will often require data from external sources, making HINs an important part of the underlying infrastructure. However, HIN capabilities remain uneven. Large EHR developers may offer more robust network functionality, while smaller EHR developers and under-resourced or rural communities may lack even basic capabilities to search for or access medical records. Recent litigation involving an EHR developer and a HIN has also raised concerns about inappropriate data access and potential risks to patient privacy. These gaps in data availability, interoperability, and privacy protections could compromise the accuracy and fairness of dQM scoring. CMS should address these foundational issues before relying on dQMs for physician performance assessment or payment.

In order to align data availability, representation, and measure requirements, CMS should publish a measure-by-measure matrix of mandatory elements, profile paths, terminology, permissible alternate representations, export/search behavior, completeness expectations, and the treatment of absent, unknown, and not-performed data. This would distinguish between USCDI+ Quality V1 (the policy data-element set), US Quality Core (FHIR implementation of quality data), QI-Core (the calculation-oriented profile model), and each measure's generated data requirements.

How should CMS approach data submission criteria, completeness, and other regulatory elements around quality measurement during the transition period?

Data completeness requirements are a challenge that continues to surface and that the AMA has repeatedly highlighted because of the administrative burden they create. High data completeness thresholds in the Quality or Promoting Interoperability (specifically public health measures) categories are particularly problematic for physicians who practice at multiple sites of service, are part of an ACO or APM entity, and report from more than one location. We believe there is a lack of understanding about the maturity of health IT standards to seamlessly aggregate data from EHRs or registries across different care settings. Challenges include lack of agreed-upon semantic and syntactic standards (with regard to version misalignment, optionality, local mappings, profile gaps, incomplete conformance, etc.), data privacy concerns, and patient misidentification. Many physician practices also lack knowledge on how to access providers' "digital endpoints" (i.e., FHIR API endpoints) to collect the data needed for aggregation. FHIR R4 and CQL are sufficiently mature to serve as the foundation for digital quality measurement; however, the quality-measure implementation stack remains at mixed maturity. Several key artifacts (including QI-Core, the Quality Measure IG, DEQM, US Quality Core, dQM-specific test kits, certification criteria, and the CMS receiving architecture) are still evolving or have not been demonstrated end to end across heterogeneous production environments. CMS should therefore condition mandatory use of each dQM on objective readiness criteria rather than on the calendar alone.

As we have stated in previous public comments, data completeness reporting requirements run counter to CMS' goal of reducing administrative burden within the MIPS/MVP, SSP, or ASM programs, and our concerns have not been adequately addressed. CMS should work with the physician, ACO, APM, and EHR developer communities to find solutions to these data aggregation problems. Until the technology standards are more mature, we recommend CMS reduce the data completeness requirement.

Since 2020, CMS has required physicians to successfully report on a quality measure for 70 percent of all eligible patients (otherwise known as the data completeness requirement within the MIPS program). Starting in 2024, CMS increased this requirement to 75 percent of all eligible patients, and we continue to question the feasibility and necessity for such a high threshold. The challenges will be further exacerbated for participants in the SSP since all MIPS quality policies now apply to the SSP quality requirements. ACOs report that they continue to encounter barriers to capturing data from some practices due to issues such as an EHR that is unable to produce a quality reporting document architecture (QRDA I) file or a small practice that continues to operate with paper medical records. **We urge CMS to work with the physician, ACO, and EHR vendor communities to find solutions to these data aggregation challenges. Until the technology standards are more mature, CMS should reduce the quality measure data completeness requirement and delay mandatory eCQM or dQM adoption.**

We understand that CMS may justify the increased requirement based on a perception that the reporting rates received for many of the eCQMs within MIPS are 100 percent.[13] This may be the case for physicians who practice at one site of service and bill under a single tax identification number (TIN). However, we do not believe that vendors truly understand what is intended with data completeness and therefore the percentage received by CMS does not accurately capture the eligible population for each TIN. Some physicians and almost all ACOs provide services across multiple sites using the same National Provider Identifier (NPI) or TIN combination, but not all sites may participate in MIPS or use the registry or EHR that the physician opts to use for MIPS reporting. Therefore, vendors or practices capture only the cases within a single EHR or site, which appears to be 100 percent, while excluding the eligible encounters from other sites of service. We request that CMS validate its assumption that it is possible to keep increasing the percentage when interoperability and seamless transfer of data are not yet universally available. We also request that CMS work with a few registries and practices to compare which patients/data they are able to capture from the practice and/or EHR against what CMS sees for the TIN or NPI in claims. The analysis should also include data from a few specialties such as GI or radiology, as well as internal medicine and family medicine.

We offer the following example to illustrate the issue:

- *Example 1 - Specialty practice with Vendor X as their EHR*

The specialty practice uses the Vendor X EHR to report their quality measures. Several physicians at the practice also provide care at two local skilled nursing facilities (SNFs). Because one of the SNFs also uses Vendor X and has systems set up to enable data sharing with this TIN, Vendor X can include the data in what is reported for MIPS. The other SNF uses Vendor Y and is unable to share data with the practice. Data sharing roadblocks include lack of agreed-upon semantic and syntactic standards (with regard to version misalignment, optionality, local mappings, profile gaps, incomplete conformance, etc.), data privacy concerns, and patient misidentification. Many physician practices also lack knowledge on how to access providers' "digital endpoints" (i.e., FHIR API endpoints) to collect the data needed for aggregation. To be clear, purposeful information blocking is unlikely the cause in this instance. Lack of technical capability and awareness are the main culprits.

As a result, Vendor X is not aware of how many patients from that SNF could be eligible for the measure and they do not include the SNF's data from Vendor Y when aggregating the data for MIPS reporting. In addition, the vendor has interpreted the data completeness requirement to mean that they must report all of the cases that are captured in the EHR system. Because of this misinterpretation of the data completeness requirements, the vendor reports a data completeness rate of 100 percent while unknowingly omitting the cases from the SNF from the denominator.

Furthermore, physicians are being held to a higher bar than any other CMS quality program. For example, health plans report on a sample of patients for each of the measures that require clinical data beyond administrative claims in the Medicare Part C and D Star ratings. Hospitals also abstract clinical data on a sample of patients for the clinical process of care measures. None of these sample sizes, which are based on the number of plan participants or individuals admitted to the hospital for a specific diagnosis or procedure, comes close to the current 75 percent data completeness requirement in MIPS. If CMS determined that smaller sample sizes provide sufficient information on which CMS and others can make

[13] Center for Medicare and Medicaid Services (CMS). Medicare Shared Savings Program Reporting MIPS CQMs and eCQMs in the Alternative Payment Model Performance Pathway (APP) Guidance. PY 2025 APP Quality Requirements (Shared Savings Program ACOs Only) Posted 05/95/2025.

informed decisions on the quality of care delivered for health plans and hospitals, we believe that this same logic should also apply to MIPS.

Alternatively, we recommend CMS consider a modified data completeness requirement similar to what CMS has proposed for SSP quality reporting requirements. CMS proposes that, beginning on or after January 1, 2026, ACOs may exclude one or more ACO participant TINs from an ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM (if finalized) data (as applicable) for each measure if certain exclusions are met, including due to unforeseen circumstance(s) outside the ACO's control (such as the unexpected closure of a group or individual practice that bills under the ACO's participant TIN), an ACO participant TIN having CEHRT that is intended for specialty use and does not support the measure(s) included in the APP Plus quality measure set, or other circumstances as determined by CMS, so long as the ACO can report on ACO participant TINs that represent at least 95 percent of the beneficiaries assigned to the ACO before applying the measure specifications. Under the proposal, ACOs would still be required to meet the MIPS data completeness requirement (that is, the ACO must report on at least 75 percent of the APM Entity's applicable beneficiaries who meet the measure's denominator). Given MIPS/MVP eligible clinicians report under the same TIN, the exclusion policy for traditional MIPS or MVP reporting should allow physicians to exclude a specific site of service if practicing at multiple sites of service.

Until physicians and other eligible clinicians can work within an environment where data and care are integrated seamlessly across settings and providers, it is premature to require mandatory eCQMs or dQMs for MIPS, SSP, or APMs. Current policy levers such as MIPS Promoting Interoperability requirements or Information Blocking regulations cannot alone resolve data completeness issues. Technology, standards, costs, and implementation decisions made by CEHRT developers will continue to impact the completeness of quality reporting. As previously stated, varying interpretations and assumptions about policy play a key role. Therefore, we urge CMS to work with physicians and developers to solve the data completeness challenges that we have outlined.

Factors Affecting Readiness for FHIR-Based Reporting: *We invite comment on existing clinician capabilities to begin the transition to FHIR-based quality reporting, challenges in using these approaches, and insights from early implementation that may inform future FHIR-based quality reporting activities.*

The AMA believes a simplified and more efficient Bulk FHIR process of clinical quality data submission would benefit healthcare organizations broadly and provide significant advantages for resource-limited healthcare organizations, as well as provide general interoperability benefits. Ultimately, the benefits of Bulk FHIR are functionally dependent on its level of maturity, ease of use, and the degree of standardization and mapping of clinical concepts across FHIR resources and EHR endpoints. However, there appears to be an inherent assumption by CMS that if a physician or practice utilizes CEHRT, the EHR can support all quality measures, which is typically not the case. CMS and ONC need a process to ensure when a practice purchases an EHR that it can support the practice's quality reporting needs or a way for the practice to more seamlessly build in the additional capabilities, without the vendor charging an additional cost to the practice. Currently, any additional practice requests of an EHR vendor, including incorporating quality measures, is an additional cost. Therefore, **transition to Bulk FHIR requires CMS and ONC to reevaluate CEHRT and associated requirements so it can better support the needs of quality and provide assurances to practices that their CEHRT can support CMS quality reporting requirements.** To optimally leverage Bulk FHIR as a quality reporting mechanism, population extraction needs to be separate from calculation and result submission. Thus, CMS should select and document the

end-to-end architecture to make Bulk FHIR transmission workable in the current technology environment.

Additionally, CMS should publish a dependency manifest for each performance year and measure. A floating instruction to use "FHIR" or the "latest" IG is not implementable. The manifest should identify exact package versions, canonicals, terminology editions, value-set expansion dates, errata, backward-compatibility rules, and the process for emergency corrections, such as:

- Base FHIR release and required resource maturity assumptions.
- US Core, US Quality Core, and QI-Core package versions and the permitted profile inheritance path.
- Quality Measure IG and DEQM versions, including the required exchange scenario.
- CQL and ELM versions, function libraries, terminology dependencies, and engine conformance rules.
- Bulk Data and SMART/UDAP versions, scopes, trust model, and endpoint-discovery requirements.

Before finalizing a performance year, the AMA recommends that CMS publish a normative dependency manifest that identifies the accepted versions of FHIR, US Core, US Quality Core, QI-Core, the Quality Measure IG, DEQM, CQL/ELM, Bulk Data, SMART authorization, terminology releases, value-set expansions, and all referenced libraries. Implementers should not be required to conform to a moving "latest version" target. Any material change after the standards freeze should restart the implementation runway for the affected measure.

CMS should publish a reference architecture that distinguishes source-data access, bulk extraction, measure calculation, result packaging, submission, validation, acknowledgment, correction, and audit. The architecture should identify the actor responsible for each step: data holder, extractor, aggregator, measure evaluator, submitter, CMS receiver, validator, and auditor. It should specify whether source-level, patient-level, or aggregate data are exchanged; where measure logic executes; how retries and partial failures work; the authoritative submission timestamp; validation error codes; acknowledgments; amendments; and replay. A complete executable measure package is also needed. A human-readable specification and CQL file are insufficient for reproducible implementation. Each final package should contain:

- FHIR Measure and Library resources, human-readable logic, source CQL, compiled ELM, all referenced libraries, and declared engine compatibility.
- Versioned value sets or immutable expansion references, code-system versions, licensing instructions, and dependency checksums.
- Positive, negative, boundary, missing-data, duplicate, conflict, attribution, stratification, and correction cases with expected population and score results.
- A machine-readable changelog that distinguishes logic changes, data-model changes, terminology changes, clarifications, and non-substantive packaging fixes.

Each final measure package should include executable CQL and ELM, complete terminology dependencies, and positive, negative, boundary, missing-data, duplicate, attribution, and correction test cases with expected results. CMS should demonstrate cross-vendor and cross-engine determinism through a production-scale test environment before the measure is used for payment or public reporting.

We also offer the following insights based on our experience utilizing FHIR:

Cross-cutting informatics & data-quality issues: "Clinical only" coding assumptions can break physician workflows and create measure friction. Many physicians, particularly in outpatient and eligible clinician reporting contexts, rely on billing-adjacent artifacts such as Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, claim lines, and encounter-level billed services to operationalize quality reporting, even when clinical intent is documented using SNOMED CT or LOINC.

If the dQM logic assumes that only clinical terminologies such as SNOMED CT or LOINC will be present, the result will be:

- False negatives when EHRs capture the billed service in CPT but not the equivalent SNOMED procedure;
- Site/vendor variability (some store SNOMED in Procedure, others only CPT on charge capture/claim objects); and/or
- Avoidable "documentation for measurement" burden on physicians.

CMS should ensure that dQMs either (a) natively support CPT/HCPCS coding paths where appropriate or (b) formally specify a normative clinical-to-billing mapping approach so the industry does not reinvent mapping differently by vendor/payer/system. CMS should allow direct source codes and explicitly defined alternative-code pathways when both validly establish the measure concept. Where mapping is permitted, CMS should identify the authoritative map, direction, context, version, licensing, maintenance process, provenance requirements, and conformance tests. Context-sensitive SNOMED CT-to-CPT/HCPCS mappings should not be treated as universally lossless or as a substitute for required billing evidence.

Data Provenance & Attribution Gaps: "who did what" matters to physicians. Many physician measures depend on whether the eligible clinician personally performed, ordered, or documented a service, rather than the activity occurring elsewhere within the care team or organization. When attribution is unclear or inaccurate, clinicians may feel they are being evaluated on events outside their control, leading to dissatisfaction and disputes over scoring. Common gaps to flag in dQM implementations:

- insufficient constraints around Performer/Author and organization/practitioner identity;
- ambiguity between "ordered" vs "performed" vs "resulted" events (e.g., orders, referrals, labs); and
- missing expectations for provenance (Provenance resource or clear "source of truth" policy) when combining EHR and other sources.

To address this, provenance, attribution, and deduplication should be treated as separate concepts. Provenance identifies where a fact came from; attribution determines which clinician, TIN, ACO, facility, or organization receives accountability under a program. CMS should specify expected use of Practitioner, PractitionerRole, Organization, Encounter.serviceProvider, performer/author/orderer elements, NPI/TIN/CCN identifiers, Provenance.target and agent, source-system identity, event time, patient/entity matching, duplicate resolution, and the program attribution algorithm.

Measure implement ability: missing "minimum data set" and conformance guidance. A recurring interoperability gap related to measure specifications is the absence of a clear, implementer-friendly minimum required data elements section for each population criterion, including:

- required resources, required elements, and "must support" elements;
- required code systems and value sets, and how they are expected to appear in FHIR; and
- acceptable alternative data pathways (e.g., CPT in Procedure vs Claim).

CPT value sets must be explicitly supported for clinician reporting feasibility. Eligible clinician measures often rely on preventive services, counseling, screenings, procedures, and office visits that are more consistently and reliably captured through CPT codes than through purely clinical terminologies in ambulatory ehr data. For eligible clinician dQMs that require evidence of a service or procedure, explicitly support CPT-coded data by:

- including CPT codes within the relevant value sets, with licensing and access considerations clearly addressed; and/or
- establishing a clearly endorsed and technically supported mapping pathway from clinical concepts to CPT codes to ensure consistent and reliable implementation.

How does readiness for adopting FHIR-based quality measurement and reporting vary across different practice types, organizational settings, and supporting health IT entities (for example, EHR vendors, Qualified Clinical Data Registries (QCDRs), qualified registries, and other intermediaries)? What are the primary barriers and facilitators to adoption (for example, access to technology, workforce capacity, resources)? Specifically, what can be done to support technology readiness, testing needs, and measure availability?

To ensure the transition to FHIR is successful, objective criteria and deliverables must be established to determine whether the field (i.e., providers and technology developers) is ready to progress to the next stage of implementing FHIR dQMs:

- Demonstrated technical capability, such as successful end-to-end testing of FHIR dQM reporting;
- Sufficient adoption rates of FHIR-enabled systems across provider types;
- Training and technical support readiness for provider organizations;
- Access to data from outside the EHR via HINs and other conduits, e.g., wearables;
- Evidence of data quality and completeness in reported dQMs; and
- Stakeholder consensus on burden, feasibility, and patient safety considerations.

By confirming readiness in this way, we can help the healthcare community adopt new standards with confidence, accelerate the availability of more timely and accurate information, and ultimately improve patient experiences of care and outcomes. Therefore, we urge CMS to release a transparent timeline and actively engage with the health care community for feedback (physicians, hospitals, APMs, health plans, patients, and EHR developers).

CMS should announce the gates in rulemaking and require each measure to pass them before mandatory use. A fixed date may remain as a target, but failure of a gate should delay the affected measure without penalizing participants. **Therefore, the AMA recommends requiring at least two complete optional performance cycles after the last material implementation dependency is final. In addition, CMS**

should make the measure-specific go/no-go determination no later than 24 months before the mandatory performance year.

Gate	Minimum evidence
1. Standards freeze	Exact versions and dependency manifest final at least 24 months before the first mandatory performance year; no material changes after the freeze except through a controlled correction process.
2. Complete measure package	Measure/Library, CQL and ELM, terminology, examples, test deck, expected results, changelog, and checksums are publicly available.
3. Conformance and certification	ONC/CMS requirements cover the quality-specific profiles and workflows; production-grade test kits exist and pass across independent vendors.
4. Semantic availability	Required elements are demonstrably available from typical certified systems or an identified alternate source; missingness and conflicting-data rules are specified.
5. End-to-end operations	At least two EHRs, an ACO/registry aggregator, multiple CQL engines, and the CMS receiver complete successful test cycles at realistic scale, including retry, correction, and audit.
6. Parity and scoring	Published thresholds show acceptable cohort and score agreement with the legacy method; transition-year scoring separates collection types and includes hold-harmless protections.
7. Safety-net readiness	Solo, small, rural, specialty, multi-EHR, and multi-TIN participants can implement with supported tools, reasonable cost, and an exception process for unavailable capability.

Again, we recommend a timeline formulation that requires at least two complete optional performance cycles after the last material implementation dependency is final, including the standards baseline, measure packages, certified capabilities, conformance tests, CMS sandbox, and receiver specifications.

At the same time, CMS must build the internal capabilities needed to receive dQM data through FHIR-based application programming interfaces (APIs) and release guidance and education to assist the healthcare ecosystem in this transition. For instance, we recommend CMS build automated validity and reliability check tools for data verification to simplify reporting, but we do not envision the tools ever fully removing the need to have a person manually review the data to ensure accuracy. One such example of a potentially helpful tool CMS developed is the de-duplication tool for ACOs (DeDupliFHIR).

However, we have heard from practices and vendors that they are hesitant to utilize the tool because it is downloadable from GitHub, an insecure public website that puts them at risk of a data breach and exposing identifiable patient information. Subsequently, once CMS determines that developers are ready and certified to support this reporting and CMS can receive the data, a reasonable timeframe during which practices, hospitals, ACOs, and others must begin reporting these measures should be proposed. Public source distribution does not transmit PHI. Instead, the focus needs to be on supported releases, code signing, SBOMs, vulnerability management, approved local/cloud deployment, and prohibiting PHI upload to public repositories.

Security and Permission Set-Up: It should be noted that **security and permission setup is non-trivial and if done incorrectly, may result in vulnerability at either end of the FHIR transaction.** Organizations are becoming more risk averse to moving patient-level data across firewalls. While improved Bulk FHIR implementation makes that movement easier, additional regulatory attention around security and permitted use would be required to gain compliance from EHRs, health systems, and practices. Health systems rely on internal quality teams to implement continuous quality improvement programs and small practices will likely not have the staffing and financial resources to allow them to quickly shift to this standard. Simply changing the reporting mechanism to Bulk FHIR for CMS quality measure reporting would not necessarily provide efficiency benefits or reduction in burdens to health systems and practices working to make quality changes at the point of care. Quality teams would still need to be engaged to determine how the data can be leveraged to improve programs and represent the quality of care provided. Therefore, **we recommend that CMS develop solutions to the downsides of using Bulk FHIR data exports from EHRs to CMS to simplify clinical quality data submissions.**

Additionally, SMART Backend Services provides a concrete starting point for system-to-system OAuth authorization, asymmetric client authentication, short-lived tokens, and system scopes; UDAP can support cross-organization trust and purpose-of-use policy. CMS should profile registration, certificate lifecycle, endpoint discovery, least-privilege scopes, permitted purpose of use, revocation, audit, minimum necessary, breach handling, and BAA/DUA responsibilities.

In addition, how FHIR endpoints are built, maintained, and mapped varies between EHRs, requiring, at minimum, custom setup to connect to each practice or vendor system. The additional work required by the practices should not be minimized as it will take time and resources to ensure that the mapping is valid. Additional setup and complexities can arise depending on who maintains the FHIR endpoint, and how much support is dedicated to maintaining it. EHRs are currently not incentivized to support Bulk FHIR, increasing the prevalence of the issue. We believe that this issue could become even more complex as practices, hospitals, APM entities, and others expand beyond the EHR to other digital data sources and CMS and ONC must be ready to facilitate these exports and endpoints as much as possible.

What strategies, technical assistance, policies, and scoring approaches would be most effective in helping reporting entities transition to FHIR-based reporting? In particular, how do these factors differ for solo practitioners, small practices and provider facilities, and other practices and provider facilities in rural or underserved areas, and what specific types of technical assistance, shared services, or policy flexibilities would be most helpful for these practices to successfully participate in FHIR-based quality reporting?

In order to encourage early adoption of dQMs, CMS must provide assurances that early adopters' scores in CMS quality programs, such as MIPS or MVPs, will not be adversely affected. Therefore, we recommend that CMS provide the maximum number of points for reporting dQMs. This will encourage dQM adoption and provide a safeguard against penalties since physicians are subject to a payment reduction of up to 9 percent. In addition, transitioning to dQMs makes the Promoting Interoperability requirements duplicative and obsolete because the use of technology is inherently built into the quality measures. **Therefore, we also recommend CMS sunset the Promoting Interoperability measures. Alternatively, CMS should design a PI program requirement identical to what has been proposed in the 2027 PFS proposed rule for the 2027 SSP program, which the AMA strongly supports.**

Before CMS compares performance across formats, it should run the same clinical cohorts through the legacy QDM/QRDA and FHIR/QI-Core pathways and publish tolerances for denominator and numerator agreement, exclusions, missingness, score variance, false positives/negatives, and cross-engine determinism. During transition, collection types should remain analytically separate, and organizations should be held harmless for standards-induced score differences outside those tolerances.

We are also very concerned about the impact that the transition to dQMs will have on solo and small practices. As the QPP data continues to show, small practices are less likely to earn positive incentives under MIPS due to the administrative burden and lack of resources. Therefore, small practices should be exempt from having to report dQMs, and we urge CMS to maintain the claims-based reporting option for small practices. The claims-based reporting option is the only one that does not require a physician to contract with a third party or EHR vendor to submit quality measures.

General Solicitation of Comments: *We welcome comments on any additional issues, opportunities, or considerations related to the transition to FHIR-based digital quality measurement for the Quality Payment Program and other CMS clinician and hospital quality programs for topics not specifically addressed earlier in this section.*

There appears to be an inherent assumption by CMS that if a physician or practice utilizes CEHRT, the EHR can support all quality measures, which is typically not the case. The AMA recommends that CMS and ONC develop a process to ensure that when a practice purchases an EHR, it can support the practice's quality reporting needs or have a way for the practice to seamlessly build in the additional capabilities, without the vendor charging an additional fee to the practice. Frequently, when practices request that their EHR vendor make any change, including incorporating quality measures, this results in an additional cost. Therefore, **the transition to Bulk FHIR requires CMS and ONC to reevaluate CEHRT-associated requirements so it can better support the needs of quality and provide assurances to practices that their CEHRT can support CMS quality reporting requirements.** Bulk FHIR should not be described as synonymous with dQM submission. It can move source data to an evaluator; CQL/ELM performs calculation; DEQM and Measure Report can structure results. CMS must decide where calculation occurs, what is transmitted, who is the system of record, how a receiver acknowledges or rejects a submission, and how corrections are replayed and audited.

We believe that clinical data registries will still play a critical role in quality reporting, particularly for MIPS and SSP since they support quality measure reporting along with serving other purposes and also enabling peer-to-peer benchmarking. CMS must ensure that registries are included in the planning and education efforts during this transition.

Additional Considerations for Shared Savings Program transition to FHIR-based quality measurement.

ACOs have the potential to provide real-time input and expertise on this transition to FHIR dQMs. Several are currently in the process of testing reporting of these measures, and a significant amount of work remains before widespread reporting of these dQMs is possible. Their experience affirms many of the comments we highlight above, including that vendor capabilities are still nascent and successfully reporting even one measure takes many hours, resources, and investments both in people and dollars. The early adopters are encountering challenges including crashing systems and inaccurate data. All of these are to be expected during this process, but they should also serve as reminders that it will take time and continued efforts to get this reporting right.

The AMA recommends that CMS provide the final specifications, implementation guides, test cases, and other resources at least two years prior to any transition to FHIR dQM reporting. Several of the public comments submitted during the public comment period on the FHIR dQM specifications demonstrated that there are substantive concerns with the translation of existing eCQM specifications into FHIR dQM specifications. CMS must also include the clinical data registries and other third-party intermediaries in the planning as they serve key roles assisting ACOs in extracting, de-duplicating, aggregating, and reporting the measures.

In addition, as ACOs begin to report these dQMs for SSP, CMS must recognize the resources and time required during this transition and ensure that ACOs do not receive financial penalties because of quality scores that may initially reflect the inaccuracy of the results. Nor should those results be publicly reported.

For ACOs, CMS should not make a dQM mandatory until it has tested patient and provider attribution, TIN and organization identity, endpoint discovery, duplicate and conflict resolution, multi-EHR aggregation, registry/QCDR participation, correction workflows, and receiver acknowledgments across representative multi-TIN environments. The implementation runway should begin only after final measure packages, certification criteria, and CMS testing and submission services are available.

More specifically regarding mandatory dQM reporting, and as outlined above in the chart, CMS should announce the gates in rulemaking and require each measure to pass them before mandatory use. A fixed date may remain as a target, but failure of a gate should delay the affected measure without penalizing participants. As a result, the AMA recommends requiring at least two complete optional performance cycles after the last material implementation dependency is final. In addition, CMS should make the measure-specific go/no-go determination no later than 24 months before the mandatory performance year.

H. Request for Information: Future Potential Performance Measures of Electronic Prior Authorization

The AMA appreciates CMS' interest in improving the prior authorization process and shares the goal of encouraging electronic workflows that meaningfully reduce burden, accelerate access to medically necessary care, and support efficient communication among physicians, payers, and health IT developers. For electronic prior authorization (ePA) to achieve those goals, however, physicians must be able to rely on technology that is readily available, affordable, well integrated into clinical workflows, fully compatible with all payer systems, and demonstrably useful in real-world practice.

CMS states that requiring physicians to complete at least one ePA may not increase ePA use over time and therefore seeks comment on measures that would require use of CEHRT for a more substantial set of prior authorization requests. This premise does not adequately account for the reasons physicians may be unable or unwilling to use the technology. **Low adoption should not be interpreted as physician resistance to ePA.** It indicates that the necessary EHR functionality is unavailable, unaffordable, poorly integrated into clinical workflows, incompatible with payer systems, unreliable, or of insufficient practical value. Physicians are users of ePA systems. They do not design payer APIs, control EHR development decisions, establish network connections, or determine whether payers provide accurate and actionable responses. **CMS should not hold physicians responsible for ePA adoption failures caused by payers and health IT developers, particularly because physicians have no control over these entities' systems and cannot remedy system defects, poor functionality, communication gaps, or inconsistent payer processes that only payers and vendors have the authority and technical capacity to address.**

For these reasons, CMS should not expand the Electronic Prior Authorization measures into performance requirements that measure the number or proportion of prior authorization transactions physicians complete electronically. **Electronic prior authorization measures for medical items and services and prescription drugs should remain voluntary and attestation-based.** Prematurely mandating ePA use could delay medically necessary care if physicians are forced to rely on systems that generate incomplete responses, technical failures, or manual workarounds. CMS should maintain the voluntary 10-point bonus for the existing Electronic Prior Authorization measure through at least the CY 2028 performance period. Thereafter, ePA should remain a voluntary, coequal CEHRT option that physicians may select without penalties for nonparticipation or consequences for their Promoting Interoperability (PI) score.

The AMA therefore opposes any future transaction- or percentage-based ePA measure unless and until CMS first demonstrates that the technology works reliably for physicians and patients in real-world care settings. Future policy should be grounded in evidence that the technology delivers meaningful value to physicians and patients, rather than assuming mandatory physician reporting is needed to drive ePA success.

Federal reporting and scoring requirements are not the only means of encouraging technology adoption. Physicians will voluntarily adopt technology that reliably improves patient care, accelerates access to medically necessary services, and meaningfully reduces administrative burden. **CMS should focus on ensuring that ePA works before attempting to compel its use.** A technical connection alone does not demonstrate that the process is successful. Electronic prior authorization must replace, rather than supplement, payer portals, faxing, telephone calls, and duplicative documentation. It must provide physicians and medical staff with accurate, timely, and useful information within their normal clinical workflows.

Before proposing any additional physician measures, the AMA recommends that CMS evaluate implementation experience during 2027 and 2028. This evaluation should determine whether the relevant EHR capabilities are broadly available, affordable, reliable, conformant to standards, and integrated into physician workflows. It should assess whether the complete process functions end to end across physicians, EHR developers, payers, pharmacy benefit managers, pharmacies, clearinghouses, and other intermediaries. **Connections, certification testing, and demonstrations of technical conformance are important, but they do not establish that ePA functions reliably in real-world care settings.**

CMS' evaluation must examine whether ePA reduces actual physician and medical staff administrative burdens. Relevant measures should include transaction failures, payer response times, incomplete or unusable responses, manual fallback rates, continued reliance on payer portals, duplicative documentation, added EHR or module costs, implementation and training demands, and workflow disruption. CMS should obtain these objective performance data directly from payers, EHR developers, pharmacy benefit managers, and relevant intermediaries rather than requiring physicians to track and report information generated by systems they do not control.

CMS should pay particular attention to small, rural, independent, and low-resource practices. These practices may lack the technical staff, financial resources, purchasing leverage, and vendor support necessary to acquire, configure, maintain, and troubleshoot additional health IT capabilities. They may also face added module fees, payer implementation requirements, limited EHR choices, unreliable connectivity, and greater dependence on manual workarounds. A measure may appear feasible at a large health system while remaining inaccessible or unaffordable for smaller practices. **CMS should not use broad availability claims from payers or EHR developers as a substitute for evaluating whether the technology is practically available to physicians across different practice settings.**

CMS should also obtain voluntary, firsthand feedback from practicing physicians and medical staff during 2027 and 2028. That feedback should address usability, workflow integration, costs, payer responses, technical failures, manual workarounds, administrative burdens, and whether the technology provides meaningful practical value**. CMS should give physicians the option to provide this information through a simple feedback mechanism within the EHR or during MIPS reporting.** Participation must be entirely voluntary and must have no effect on MIPS scoring, audits, eligibility, or meaningful EHR user status. The feedback process must not become another reporting, documentation, or compliance requirement for physicians. The AMA would welcome the opportunity to work with CMS to explore how best to capture representative physician and medical staff perspectives.

CMS should publish the results of its 2027 and 2028 evaluation in aggregate form, without identifying individual physicians or practices. The findings should distinguish barriers controlled by payers, EHR developers, intermediaries, and health systems. CMS should coordinate with ONC to address identified certification, functionality, implementation, and vendor accountability problems. CMS should also publicly report payer and EHR developer performance, including system availability, response timeliness, transaction failures, manual fallback rates, and reliability, and use these findings to support oversight and corrective action.

CMS should not presume that assurances from payers, technology vendors, or public coalitions establish that ePA is operationally ready or delivers meaningful value to practicing physicians. These stakeholders may not fully understand physicians' real-world workflows, costs, constraints, or experiences using ePA technology at the point of care. **Physician and patient choices regarding care processes and technology should be informed by actual utility, reliability, affordability, and patient needs, rather than driven by federal mandates.**

CMS should not propose additional ePA measures until it has completed and published its analysis of 2027 and 2028 implementation, definitively determined that the new ePA technical systems reduce practice burdens, and established transparent readiness criteria. Only then should CMS proceed through additional rulemaking and explain why voluntary physician adoption of ePA systems, combined with stronger accountability measures directed at payers and EHR developers, would be insufficient. **Future policy should begin with evidence that the technology works for physicians and patients, not with a presumption that mandatory physician reporting is necessary to make it work.**

I. Request for Information: MVP Scoring

We commend CMS for examining ways to more fairly compare the performance of physicians in MIPS and MVPs, as it has been a long-standing recommendation of the AMA. The current methodologies CMS uses to score physician performance in MIPS and MVPs do not result in fair or accurate comparisons of performance. The problems with the current approaches result in payment penalties for many physicians that are often not grounded in actions within their ability to control or influence. Importantly, these problems also have the potential to reduce access to care for beneficiaries with complex needs.

In order to ensure fair comparisons of physician performance, the AMA recommends that **the methodologies CMS uses to assign performance scores on individual quality and cost measures and on composites of multiple measures (including both the MIPS category scores and the final score) should adhere to all of the following principles:**

1. To support transparency and predictability, the performance standard or benchmark that physicians are expected to achieve for each measure must be established prior to the beginning of

the performance year. This enables physicians to know the level of performance they will need to meet or exceed before they deliver services to patients during the performance year.

2. In order for the performance standard to be established prior to the performance year, it must be based on data on physician performance on the same measure or composite from a baseline year that are available prior to the beginning of the performance year. A performance standard or benchmark should not be based on performance data from the same performance year nor from the year immediately preceding the performance year, since it would not be possible to calculate a benchmark using those data before the performance year begins. Physician performance from a baseline year should also be used to establish performance standards or benchmarks for cost measures by making adjustments for changes in payment amounts between the baseline year and the performance year. If data on physician performance in a baseline year are not available for a quality measure, then a benchmark for that measure should not be established, and any physician who is being held accountable for the measure should be classified as having met the performance standard for that measure.
3. The performance level necessary for a physician to avoid being classified as providing low quality or high cost care should be no greater than the median level of performance achieved during the baseline year by physicians who treated similar types of patients.
4. If performance levels in the baseline year differ significantly for physicians who treat specific subgroups of patients, separate performance standards should be established for those subgroups, and physician performance should be evaluated separately for each subgroup. This will avoid unfairly penalizing physicians who treat specific types of patients and potentially reducing access to care for those patients.
5. A physician should not receive a payment penalty or be classified as providing low-quality or high-cost care based on a measure or composite unless their performance differs by a statistically significant amount from the performance standard. If a physician has too few patients or services to reliably determine whether or how their performance differs from the performance standard, they should either not be evaluated on the measure or composite at all or they should be classified as having met the performance standard.
6. Differences in payment adjustments or ratings assigned to physicians based on their performance on a measure or composite should be proportional to the normalized difference between their actual performance level and the performance standard, not arbitrarily divided into deciles. Normalization should be performed by dividing the actual difference by the standard deviation of other physicians' performance on the measure during the baseline year. Physicians should not be scored or rated based on deciles or other systems that are based solely on how many other physicians had higher or lower performance levels.
7. When a composite of multiple measures is used to evaluate a physician's performance, such as a MIPS category score or final score, performance on each of the individual measures or scores used in the composite should first be normalized as described above, and then the composite score should be normalized using (1) a performance standard for the composite measure that is established prior to the performance year and that is no higher than the median performance physicians achieved or would have achieved during a baseline year using the same composite measure, and (2) the standard deviation in performance on the composite by other physicians treating similar patients during the baseline year.
8. **Measure performance standards should not be based purely on arbitrary statistical cutoffs; rather, they should take into account evidence-based standards of care.** Physicians should never be penalized according to arbitrary statistical cutoffs when they are delivering clinically appropriate care.
9. **CMS should stop capping "topped out" measures at seven points, especially for specialties that lack other relevant measures to report.** The purpose of quality measurement is to ensure

patient safety and drive quality care. In other words, patient care should be the focus, not the creation of arbitrary performance distinctions among physicians. CMS should approach updates to the quality inventory with this in mind. If a measure has value because it is meaningfully benefiting patient care in some way, it should not be removed from the program just because physicians are "scoring well." Furthermore, CMS should immediately cease its policy of capping so-called "topped out" measures at seven points, which artificially distorts scoring and creates incentives for physicians not to report measures that could be intrinsically valuable to patient health and safety. This is especially damaging for specialties or subspecialties that have a limited number of measures to report outside of topped out measures, which puts them at an automatic disadvantage through no fault of their own but simply due to the quality measures available to them.

10. **CMS must address current gaps in clinically relevant quality and cost measures in MVPs *before* making them mandatory. As part of this effort, CMS should review measures that were previously removed for reasons of being topped out or due to low reporting and consider bringing them back, especially for specialties that lack relevant measures to report.** Any shift to required MVP reporting must include a robust identification of the remaining gaps in measures and a measure development plan, both for those specialties for which no MVP exists and, within each specialty, for the subspecialties, clinical conditions, and procedures not yet adequately addressed. If CMS is considering moving to mandatory MVPs at any point in the future, it should make a concerted effort to reexamine its quality measures inventory and work with the AMA and relevant medical specialty societies to fill any gaps. A critical part of this should be examining measures that were previously supported in the MIPS program but were removed either because they were "topped out" or due to low reporting rates. As noted in bullets three and nine above, CMS should eliminate perverse scoring incentives for new, low reported, and "topped out" measures. Once these policies are removed, CMS should add measures that are deemed clinically relevant back into the program for a fair analysis without these artificial constraints. There should be a concerted effort to include measures that fill current gaps and would support specialists' or subspecialists' abilities to report clinically relevant measures and participate more effectively in MIPS, and eventually MVPs.

Normalization of Scores

Recommendation:

- Performance scores should not be normalized by comparing physicians' performance solely to other physicians in the same MVP.

Most of the questions in the RFI relate to whether and how CMS should normalize scores for physicians in order to ensure fair comparisons of physicians within and across MVPs. As indicated in the principles above, the AMA believes a normalization process should be used for both individual measures and composite scores, but the normalization process must be both fair and methodologically sound, otherwise it could make the current process of scoring and payment adjustments even more problematic and unfair than it is today.

Many MVPs include measures applicable to a wide range of patient conditions, services delivered by multiple types of specialties, or both. For example, the Advancing Care for Heart Disease MVP includes measures specific to heart failure, coronary artery disease, ischemic vascular disease, and atrial fibrillation. The Advancing Cancer Care MVP includes measures for colon cancer, lung cancer, ovarian cancer, and prostate cancer. The Surgical Care MVP includes measures for heart surgery, general surgery,

and lumbar surgery. As a result, two physicians who are each reporting in one of these MVPs may be treating two completely different types of patients, and normalizing scores within the MVP would result in "comparing apples and oranges" both within and across MVPs. This is true regardless of whether the normalization is done at the final score level or the performance category level, because in either case, the scores for the physicians are not based on the same types of patients and the same measures.

Conversely, two physicians who treat similar types of patients could be reporting measures under two different MVPs. For example, many internists and family physicians as well as cardiologists manage the care of chronic heart conditions, and internists and family physicians are able to report either the Value in Primary Care MVP or the Advancing Care for Heart Disease MVP.The Value in Primary Care MVP has quality measures for control of blood pressure and use of statin therapy but no quality measures related to heart failure, whereas the Advancing Care for Heart Disease MVP has quality measures for heart failure but not for blood pressure or statin therapy. It makes no sense to compare physicians who treat chronic heart conditions only to the physicians in the same MVP rather than to all physicians who treat patients with the same conditions.

In addition, many MVPs have quality measures for specific health conditions without corresponding cost measures for those conditions, and some have cost measures without matching quality measures. As a result, some physicians in an MVP can be scored on both quality and cost, some can be scored on quality for some patients and costs for other patients, and others can be scored only on quality. This means that neither the individual performance category scores for cost and quality nor the final MIPS scores based on both categories will be comparable for different physicians in the same MVP.

Performance on individual measures should also not be evaluated only by comparing physicians who are in the same MVP. Many measures appear in multiple MVPs, so comparing performance within MVPs could result in unfair ratings for physicians and misleading information for patients. For example, the measure of poor glycemic control for diabetes (Q001) is included in the Optimal Care for Kidney Health MVP, the Value in Primary Care MVP, the Vascular Surgery MVP, and the proposed Diabetic Disease MVP. If the physicians in each of those MVPs are assessed only in comparison to the other physicians in the same MVP, it would be impossible for patients with diabetes to determine whether a physician who reports in one of the MVPs has better or worse performance than a physician who reports in a different MVP. In fact, a physician in one MVP could receive a low-performance rating even though their performance was better than most of the physicians in other MVPs. Similarly, the episode-based cost measure for heart failure is included in both the Advancing Care for Heart Disease MVP and the Value in Primary Care MVP, so comparing physicians on that measure only within each MVP would not show which physicians overall have the lowest episode costs for the condition.

Any additional scoring methodologies or approaches to ensure fairness within and across MVPs.

Recommendations:

- MVPs must be redesigned to focus on specific health conditions, not physician specialties or large groups of different health conditions.
- Scores for each individual quality and cost measure should be normalized before the measures are used to score physicians' overall performance. Normalization should be based on standard deviations from the performance standard, and the performance standard should be no higher than the median performance level achieved in a baseline year by physicians with similar patients.
- CMS must revise its scoring policy for "Topped Out" measures and eliminate scoring caps.

The current set of MVPs cannot be used to fairly or accurately assess physician performance because CMS has created MVPs primarily based on physician specialties and broad categories of health problems, rather than focusing each MVP on a specific type of health condition.

These problems are also major reasons why so few physicians have been participating in MVPs. The solution is not to mandate that physicians participate in poorly structured MVPs, but to redesign the MVPs so that they enable physicians to be evaluated fairly based on the kinds of patients they treat. If, and only if, this is done, physicians could then be compared to other physicians who are in the same MVP, and overall scores and payment adjustments for each physician could be based on a combination of all of the MVPs that are applicable to the patients they treat.

In addition, the AMA urges CMS to reconsider its policy for capping "topped out" measures at seven points. We support CMS removing the cap for core measures and a select set of MVP measures, but recommend that CMS extend that removal to all topped out measures. Limiting it to a select set of measures is confusing and arbitrary. Because of this policy, physicians are often prevented from achieving the full number of quality category measure points. A physician should not begin the program with a lower maximum possible score solely because of the measures CMS assigned to the applicable MVP. For example, this is the case for the "ENT Disorders MVP" and "Pulmonology MVP". The current variation reflects differences in measure inventory and scoring design, not differences in clinician quality or patient outcomes. Moving to mandatory MVP reporting before addressing these structural disparities risks creating inequitable payment consequences across specialties.

A scoring methodology that would help to ensure appropriate comparisons between clinicians participating in different MVPs

Recommendation:

- Scores for each individual quality and cost measure should be normalized before the measures are used to score physicians' overall performance. Normalization should be based on standard deviations from the performance standard, and the performance standard should be no higher than the median performance level achieved in a baseline year by physicians with similar patients.

CMS currently uses two different methodologies to normalize and score quality and cost measures, each of which has different strengths and weaknesses. The AMA recommends that a common approach be created that combines the strengths of the current approaches while avoiding the weaknesses in both.

- **A physician's score for every measure should be based on the difference between the physician's performance and the performance standard for the measure, normalized by the standard deviation of other physicians' performance on the same measure. If the physician's performance does not differ from the performance standard by a statistically significant amount, the physician should be classified as meeting the performance standard.** Normalization using the number of standard deviations from the median is currently used by CMS for administrative claims-based quality measures and episode-based cost measures. This is a fair way of comparing physicians because it ensures that small differences in performance do not result in large differences in performance scores or payment adjustments unless they represent differences that are truly statistically significant. The same approach can and should be used for physician-reported quality measures, rather than the current approach that unfairly classifies performance into deciles. In addition, however, a physician's performance on a measure should not be classified as being higher or lower than the performance standard unless the number of

patients or services in the denominator for that physician is large enough to show a statistically significant difference.

- **The performance standard or benchmark for every measure should be established prior to the beginning of the performance year, based on the median performance of physicians in a baseline year for which data are available prior to the performance year.** Currently, CMS establishes benchmarks for physician-reported quality measures prior to the beginning of the performance year. Benchmarks can and should also be established prior to the performance year for both claims-based quality measures and cost measures. Establishing benchmarks prior to the beginning of the performance year is essential because it enables physicians to know prior to the beginning of the year what level of performance they need to achieve, and using the median from the baseline year as the performance standard ensures that it is feasible for the majority of physicians to be successful in achieving the standard. CMS has repeatedly endorsed the importance of establishing benchmarks and performance standards prior to the beginning of the performance year; in the 2017 Final Physician Fee Schedule Rule (81 FR 77278), CMS stated that "benchmarks should be made public and should be known in advance when possible so that MIPS eligible clinicians can understand how they will be measured," and in the 2026 Final Physician Fee Schedule Rule (90 FR 49910), CMS stated that "Benchmarks established based on historical data provide MIPS eligible clinicians with helpful performance targets in advance of or during the performance period." Benchmarks for claims-based quality measures can and should be derived from a baseline year, rather than the current approach that unfairly determines benchmarks for the performance year after the year has already ended. This same approach to benchmarking can also be used for EBCMs by adjusting the spending levels in the baseline year to reflect changes Medicare has made in its payment amounts since the baseline year and then calculating the median. The EBCMs already substitute standardized payments for the actual payment amounts in the spending calculations, so the standardized payments simply need to be adjusted to reflect the Medicare payment amounts that will be applicable during the performance year. Adjusting the payment amounts in this way shows what spending would have been in the performance year if utilization of services had remained the same as in the baseline year.

- **Separate benchmarks should be established for different subgroups of patients if the benchmark data for a measure show that performance levels differ significantly for those patients.** Many of the measures used in MIPS are not adequately risk-adjusted. If the same benchmark is used for all patients when performance on the measure differs significantly for different subgroups, physicians will be penalized for treating the patients for whom high performance on the measure is more difficult to achieve, and physicians will be inappropriately rewarded for high performance with patients where those levels are easier to achieve. We urge CMS to analyze the benchmark data for each measure to determine whether there were significant differences in performance levels for different subgroups of patients, and if so, it should define separate benchmarks for those subgroups. CMS currently defines and uses separate benchmarks for the same measure based on different methods of reporting the measure, so a similar approach can be used for patient subgroup-specific benchmarks.

Therefore, physician scores should not be adjusted to produce similar scoring distributions in different MVPs. Scoring is only fair if all physicians who deliver high quality care and who make improvements in care are recognized and rewarded for doing so. Forcing equal proportions of physicians in each MVP to receive penalties is an unfair approach for the physicians and misleading for patients. For instance, if the physicians who treat the health conditions included in one MVP make significant improvements in the

quality or cost of care, and the physicians who treat a different set of conditions in another MVP do not make significant improvements, fairness requires that the physicians in the first MVP should be recognized and rewarded for high performance, and the physicians in the second MVP should not. Adjusting the scores in the two MVPs to produce "similar distributions" would eliminate these actual differences in performance. As a result, some physicians in the first MVP could unfairly receive penalties even though their performance was better than those in the second MVP, and some physicians in the second MVP could unfairly receive bonuses even though their performance was lower than physicians in the first MVP.

Consideration of providing larger positive payment adjustments for high performing clinicians under MVP reporting, including impacts on those receiving negative payment adjustments because of budget-neutrality requirement.

Recommendation:

- Physicians should receive positive payment adjustments for high performance on quality and cost measures, but increases in positive adjustments should not be funded by increasing payment reductions for other physicians, but with savings compared to baseline or anticipated Medicare spending, similar to APMs.

The AMA supports awarding payment increases to physicians who improve the quality and cost of care and to physicians who consistently deliver high-quality, efficient care. However, we strongly oppose obtaining the funds needed to make larger positive payment adjustments by increasing the size of payment reductions for other physicians. Every year, physician payments have fallen farther and farther behind inflation, and higher payment penalties in MIPS, particularly if they are determined using unfair performance evaluation methods, will force more physicians to leave practice and reduce access to care for Medicare beneficiaries.

We understand that the statute requires payment adjustments made under MIPS to be budget-neutral. The physicians who receive high scores in MIPS are presumably delivering measurably higher quality, lower cost care to their patients, and this will, in many cases, result in savings in Part A and other Part B expenditures through reduced avoidable services and complications often treated in higher acuity, more costly settings. If larger payment increases for high-scoring physicians enable and encourage more physicians to improve performance on quality and cost measures, that is likely to reduce Medicare spending, not increase it. Accordingly, we believe that HHS should be able to quantify savings captured compared to target prices for episodes of care, baseline Medicare fee for service spending, or other metrics and use those funds to support payment increases for high performing physicians, similar to how ACOs and other APMs are evaluated in terms of budget neutrality. Importantly, this type of evaluation can identify the types of interventions that are most effective at keeping patients healthy and avoiding potentially expensive complications and serve as evidence to support possible permanent funding for expanding such services, including those offered outside of discrete office visits.

Ways to better support scoring transparency and predictability.

Recommendations:

- CMS should establish all benchmarks and performance standards based on actual physician performance in a baseline year so that physicians know what level of performance they are expected to achieve before the start of the performance year.

- Provide frequent and timely feedback to physicians on their performance during the current performance year and before the next performance year.

Fairness requires that physicians know what level of performance they are expected to achieve before the beginning of the performance year, that they know it is feasible to achieve that level of performance, and that they be able to determine how different levels of performance will affect their payments and performance ratings. Therefore, the AMA recommends that CMS establish all benchmarks and performance standards based on actual physician performance in a baseline year, as it currently does for physician-reported quality measures, not based on the performance of other physicians during the performance year.

As noted earlier, CMS has repeatedly endorsed the importance of establishing benchmarks and performance standards prior to the performance year. Basing benchmarks on the performance of physicians in the same year makes it impossible for physicians to know in advance what level of performance they would need to achieve in order to receive a high score on an individual measure or a composite score. It also means that physicians could be penalized even if they significantly improved quality simply because other physicians had even higher performance. This "tournament" approach will discourage physicians from collaborating on care improvement initiatives and sharing best practices, because the only way that a physician could achieve a high score would be to perform better than other physicians during the same year. It is not sufficient to give physicians "access to the benchmarks used for normalization in the prior year" because those are not the numbers that will be used to determine the physician's scores in the current year and they may bear little relationship to them.

Fairness also requires that physicians receive frequent and timely feedback on their performance during the current performance year and before the next performance year. Therefore, in order to improve care for patients and reduce avoidable costs, physicians need timely data about their performance on quality and cost measures. Currently, CMS only provides physicians with an annual performance report months after the end of each performance year. This means that physicians have already begun delivering services in a new performance year before receiving any feedback on their performance in the previous year.

CMS can and should provide physicians with performance feedback for claims-based quality and cost measures on at least a quarterly basis. Information for services delivered during each calendar quarter should be provided to physicians no later than the end of the following quarter. This would also ensure that physicians have the results for the majority of a performance year before beginning the next performance year.

J. Request for Information: Star Rating Assignment Methodology for Administrative Claims Quality Measures

We commend CMS for examining ways to improve the Star Ratings system used in the CMS Compare tool and appreciate the opportunity to provide input on the best way to do so. Since the inception of Star Ratings, the AMA has been asking for improvements and alignment between the methodologies used for calculating scores between MIPS measures and Star Ratings. Therefore, we recommend that CMS change the methodology used to assign Star Ratings for all quality and cost measures, not just claims-based quality measures and cost measures, and aligned with an improved methodology for performance rating in MIPS.

We believe that it is unfair for physicians and misleading for patients to use a methodology for assigning Star Ratings to a physician that is significantly different from the method used to score performance on

the same measures in MIPS. Currently, a physician who gets a five-star rating on a measure could receive a low MIPS quality score on the same measure, and a physician who gets a high MIPS score on a measure might not receive five stars for that measure, either because the benchmarks are calculated differently for the Star Ratings and MIPS, because the benchmarks are based on data from different years, or both. In addition, physicians may not report the quality measures that would be most important to patients because they could be penalized for doing so under MIPS, and patients may see Star Ratings for measures calculated by CMS that do not accurately reflect differences in quality that are relevant for those patients' care.

When CMS first adopted the current methodology for assigning Star Ratings in 2015, it reported (80 FR 71128) that multiple commenters had urged the use of a consistent approach to benchmarking across different programs "to promote consistency and minimize confusion." CMS stated at the time that it was "continually evaluating ways to align where and as possible, and will take this recommendation into consideration for the future." However, no changes have been made over the past decade to align the Star Ratings methodology with the methodology used for performance evaluation in MIPS. The AMA has repeatedly pointed out this inconsistency and has recommended improvements to the programs that would better represent the care physicians provide.

In our response to the MVP Scoring RFI, we recommend that CMS use the same methodology for normalizing and scoring all quality and cost measures, rather than using different methods for claims-based measures and physician-reported quality measures, as it currently does. Similarly, the AMA urges that changes be made to the star ratings methodology for all quality and cost measures, not just those for claims-based quality measures and cost measures, so that a consistent approach is used for all Star Ratings, and so that the approach is also consistent with the improved approach that we have recommended be used in MIPS. We offer the following feedback and recommendations in response to the questions posed in the RFI:

The current Star Rating assignment methodology and whether the agency should change the process for administrative claims quality measures?

Recommendation:

- Benchmarks for Star Ratings should be based on the median performance of physicians during the baseline year instead of the Achievable Benchmarks of Care methodology that is currently used. Benchmarks should not be based on data from the performance year for any measures.

The Achievable Benchmark of Care (ABC) approach was developed to support quality improvement activities; it was not intended or designed to be used for ranking the performance of physicians. Moreover, it was designed for use with process-based measures, not outcomes or costs. The creators of the ABC approach explicitly stated that it was "a tool to improve performance, rather than a tool for the analysis of whether or not the provider is a statistical outlier" and they cautioned that "we have designed the method for process of care indicators and we urge that it be applied to outcome measures with only extreme caution, if at all." (Weissman NW et al. "Achievable Benchmarks of Care: The ABCTMs of Benchmarking," Journal of Evaluation in Clinical Practice 5(3), 269-281.)

The benchmarks for measures in MIPS are based on the median performance that physicians were able to achieve on the measure, i.e., one half of physicians were able to exceed the benchmark level of performance. In contrast, ABC is based on a small subset of physicians who had the highest performance levels. In calculating the ABCs used in the Star Ratings, nothing is done to ensure that the patients treated

by the physicians with the highest performance levels on the measure are similar to the patients treated by the physicians with lower performance, nor is anything done to ensure that the physicians with lower performance had access to the same kinds of resources as the physicians with the highest scores. The authors of the approach acknowledged that the 10 percent of patients threshold they used to set the ABC benchmark was arbitrary, and CMS has not provided any information to show whether the physicians or patients in that group differ in any way from the remaining 90 percent of patients and the physicians who treat them. As a result, the ABC performance level may only be achievable by a subset of physicians who have greater resources or who treat specific subsets of patients. One of the reasons CMS provides for issuing the RFI is that "virtually all scores result in two, three, or four stars," and since the ABC is the threshold for receiving five stars, this indicates that the ABC level is too high to serve as an appropriate benchmark.

Currently, CMS establishes the benchmarks used for Star Ratings of physician-reported quality measures prior to the beginning of the performance year. Benchmarks can and should also be established prior to the performance year for both claims-based quality measures and cost measures. Establishing benchmarks prior to the beginning of the performance year is essential because (1) it enables physicians to know prior to the beginning of the year what level of performance they need to achieve, and (2) it ensures that the majority of physicians can be successful in achieving that standard. CMS has repeatedly endorsed the importance of establishing benchmarks and performance standards prior to the beginning of the performance year; in the 2017 Final Physician Fee Schedule Rule (81 FR 77278), CMS stated that "benchmarks should be made public and should be known in advance when possible so that MIPS eligible clinicians can understand how they will be measured," and in the 2026 Final Physician Fee Schedule Rule (90 FR 49910), CMS stated that "Benchmarks established based on historical data provide MIPS eligible clinicians with helpful performance targets in advance of or during the performance period." Benchmarks for administrative claims-based measures can and should be derived from a baseline year, rather than determining benchmarks for the performance year after the year has already ended. Benchmarks for episode-based cost measures (EBCMs) can also be defined using data from a baseline year by adjusting the spending levels in that year to reflect changes Medicare has made in its payment amounts in the performance year before calculating the median used for the benchmark. The EBCMs already substitute standardized payments for the actual payment amounts in the spending calculations, so the standardized payments simply need to be adjusted to reflect the Medicare payment amounts that will be applicable during the performance year. Adjusting the payment amounts in this way shows what spending would have been in the performance year if utilization of services had remained the same as in the baseline year, so using the median amount is a fair way to establish a performance standard.

Transitioning the current methodology to a standard deviation-based methodology for administrative claims quality measures? Applying a standard deviation-based methodology to public reporting of cost measures?

Recommendations:

- The number of stars assigned to a physician should be based on the amount by which their performance differs from the performance standard for the measure, normalized by the standard deviation of physician performance during the baseline year, instead of the "equal ranges" method that is currently used. This approach can and should be used for all quality and cost measures.

The thresholds for Star Ratings should be defined so (1) all physicians who meet or exceed the performance standard on a measure receive at least three stars for that measure, and (2) at least 20 percent of the physicians who were evaluated using the measure receive five stars.

CMS indicates that it is considering changing the star rating assignment methodology to a standard deviation-based methodology for administrative claims quality measures and cost measures. We support using a standard deviation-based methodology, **but only if it is used for all quality measures**, not just for claims-based quality measures. **The AMA recommends that the same approach should be used for scoring all quality and cost measures in MIPS and also for assigning Star Ratings to those measures.**

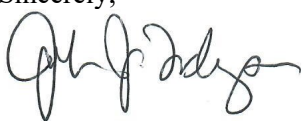
Moreover, **we do not support changing to a standard deviation-based methodology unless the standard deviations are calculated using performance data from a baseline year that were available prior to the start of the performance year.** As discussed above, it is essential that physicians know the performance level they need to achieve before the beginning of the performance year. It is unfair to assign Star Ratings to a physician based on performance standards that were determined after they already delivered services.

Changing to a standard deviation-based methodology for determining Star Ratings also requires deciding what the criteria will be for assigning a specific number of stars to an individual physician. We believe that the meaning conveyed to patients by the number of stars assigned to a physician should be as consistent as possible with the way the physician's performance is evaluated in MIPS. In particular:

- Most patients likely view three stars as reflecting "average" or "adequate" performance. Consequently, any physician who scores at or above the performance threshold for a measure in MIPS should receive at least three stars for the measure.
- Since most patients will want to obtain care from five-star physicians if they can, it does little good to set the threshold for five stars so high that relatively few physicians receive that rating. We suggest that the five-star threshold for each measure be set no higher than the 80th percentile for the normalized scores, in order to ensure that the best 20 percent of physicians receive a five-star rating.

The AMA appreciates this opportunity to share our views and make recommendations on much-needed improvements to the CMS Care Compare tool and welcome the opportunity to have further discussions with CMS. Please do not hesitate to reach out to me directly at John.Whyte@ama-assn.org or 312-464-5288 if you have questions or need further information.

Sincerely,



John Whyte, MD, MPH