September 12, 2025

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

Dear Administrator Oz:

On behalf of 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) 2026 Notice of Proposed Rulemaking (Proposed Rule) on the revisions to Medicare payment policies under the Medicare Physician Payment Schedule (MPFS) and Quality Payment Program (QPP), published in the Federal Register on July 16, 2025.

Medicare Physician Payment

Conversion Factors

The AMA appreciates that Congress provided a one-year 2.5 percent update to 2026 Medicare physician payments and that CMS proposes positive 2026 conversion factor updates. Physicians continue to strongly advocate for permanent updates to the conversion factor that account for the growth in physician practice costs. Despite temporary updates in four of the last five 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 2025, Medicare physician pay remained virtually flat even though the cost of running a medical practice increased 59 percent. Adjusted for inflation in practice costs, Medicare physician pay declined 33 percent from 2001 to 2025.

Inadequate physician payment has real-world consequences, accelerating the trend in consolidation and worsening seniors' access to care. To protect Medicare for the next generation, we urge the Trump Administration to support any congressional action to enact inflation-based updates for physician payments, such as the provision tied to the Medicare Economic Index that was in the House-passed reconciliation bill.

Proposed Efficiency Adjustment

CMS proposes a 2.5 percent decrease in work relative value units (RVUs) and physician intra-service time for most services, affecting more than 7,000 physician services, and additional cuts every three years. The AMA agrees with CMS' goal of ensuring that the time data used in work RVUs is accurate, that high-volume services are frequently reviewed to account for efficiencies, and that primary care

payment is adequate, but recommends alternative approaches to achieve this goal based on data and physician input.

Recently published data indicated there has not been an efficiency gain in procedure times. A new study published in the Journal of the American College of Surgeons found that the proposed efficiency adjustment is not supported by empirical surgical time data, as analysis of intra-service times from 1.7 million surgeries across 249 CPT codes and 11 specialties showed that overall operative times increased by 3.1 percent from 2019 to 2023, with 90 percent of CPT codes having longer or similar operative times in 2023 compared to 2019.

In addition, the Society of Thoracic Surgeons (STS) reviewed the intra-service time data related to arterial and venous (33510-33523, 33533-33536) coronary artery bypass graft (CABG) procedures from the STS National Database from 2012 – 2022. This data compiled from 1,448,393 procedures shows that the intra-service times for arterial or venous CABG codes have substantially increased by 12 percent, not decreased since the codes were last valued by the AMA/Specialty Society Relative Value Scale Update Committee (RUC) and CMS.

The AMA has additional concerns with the proposal, including:

- The -2.5 percent efficiency adjustment assumes the same amount of efficiency gains across a large group of services over a fixed period.
- Applying a broad-based adjustment factor to all work RVUs could have unintended consequences to the budgeting, projecting, resource determination and staffing within physician practices and health systems that rely on stable physician work RVUs to use in their productivity and compensation plans.
- Adjusting physician work RVUs and intra-service time for all codes, while exempting commonly performed services that are often used as key reference services, will create challenges in the processes to update the RBRVS and ensure appropriate relativity of new and revised codes.
- Via the potentially misvalued code project, the RUC has accounted for efficiencies in high-volume codes, and it would be unfair to reduce the services again. For example, 66984 cataract surgery was reviewed and reduced in 2013 and again in 2020. The 2025 work RVU for cataract surgery is nearly 30 percent lower than the 1992 work RVU.
- The exceptions to the efficiency adjustment are inconsistent. Sufficient data and/or studies are not provided to justify why physicians might be able to obtain efficiency in most services yet not others. For example, why would the potential ability to perform a service via telehealth preclude a physician from the ability to achieve efficiency in providing the service?

Combined with the proposed practice expense cuts to services performed in a facility, these proposals will result in widespread impacts on physicians and patients, including:

- 37 percent of oncologists face notable cuts of 10-20 percent.
- More than 56 percent of internists face cuts of 5 percent or more.
- 49 percent of ophthalmologists face cuts.
- 80 percent of infectious disease physicians face cuts of 5 percent or more.
- 37 percent of obstetricians and gynecologists face cuts.

Rather than finalize a -2.5 percent efficiency adjustment applied to nearly all CPT codes, the AMA urges CMS to work with physicians to accomplish its objectives to increase primary care payment and ensure frequent review of codes with empirical data. Regarding primary care payment, in 2021, CMS implemented revised office visits which increased the work valuation of this family of services by 26 percent. The remaining evaluation and management (E/M) code sets were reviewed and implemented in

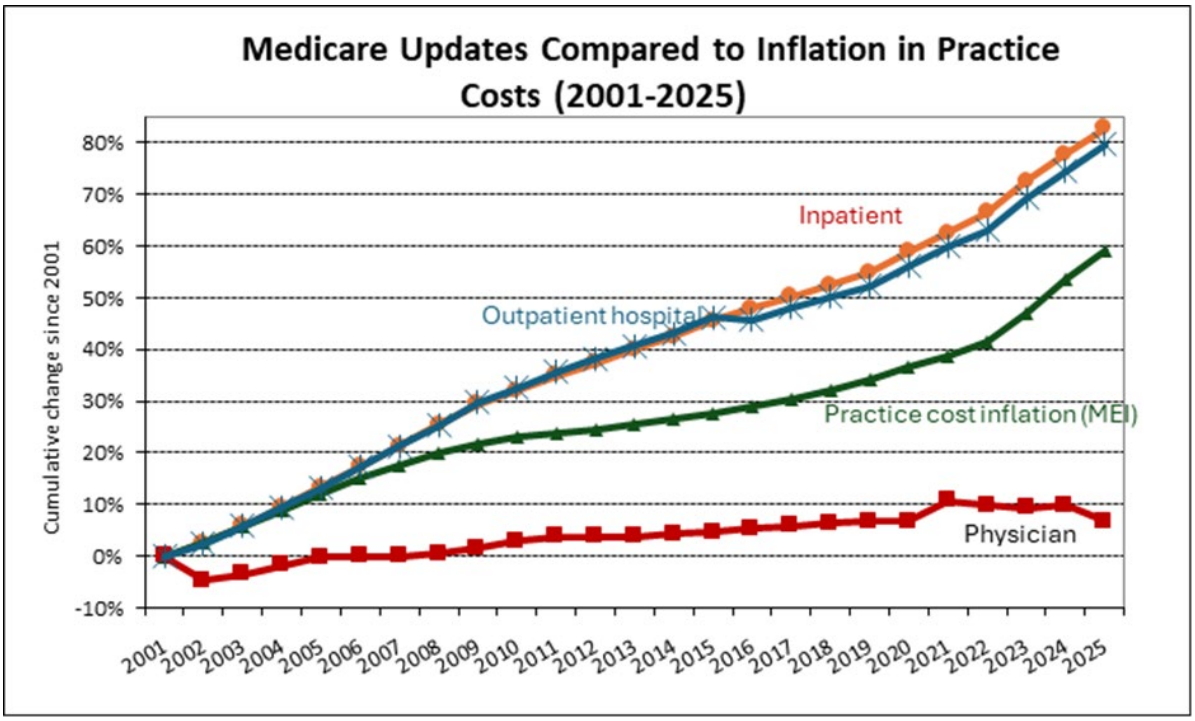
2023. Combined, Medicare redistributed more than $6 billion from other services to E/M. In 2024, CMS followed these E/M increases with implementation of a new add-on code G2211 to further support primary care office visits. Medicare claims data analysis indicates that the previous administration significantly overestimated 2024 utilization of this code, dramatically impacting the Medicare conversion factor via a negative budget neutrality adjustment. The resulting conversion factor reduction hurt payments to primary care physicians more than reporting of G2211 helped them. To provide meaningful support to primary care physicians, CMS should make a prospective increase to the 2026 Medicare conversion factor to prevent this overestimate from continuing to reduce Medicare payment rates year after year, as outlined in our May 2025 letter. This would lead to a more significantly positive impact for primary care than the proposed positive budget neutrality adjustment from the efficiency adjustment.

Finally, CMS should continue to support the use of surveys to ensure the clinical expertise of practice physicians and other health care professionals is appropriately reflected in establishing work RVUs. Furthermore, the RUC will actively seek additional time data to augment its survey data and will ensure that higher volume codes are reviewed on a more frequent basis.

Update to Practice Expense (PE) Methodology – Site of Service Payment Differential

The AMA agrees with CMS that the pay differential between hospital outpatient departments and physician offices for the same services puts independent physician practices at a competitive disadvantage, particularly as practice expenses and administrative burdens climb. We are concerned that the proposed cuts to PE do not address the root cause of this differential, do not reflect resource costs incurred by practices in the facility setting, create significant impacts to many individual physicians and other health care professionals, and could drive consolidation. To achieve CMS' objective to bolster private practice, CMS should work with the AMA to consider the new 2025 AMA Physician Practice Information (PPI) Survey results more fully, including updating the PE/hour groupings.

We are pleased that CMS acknowledges that private physician practices need more money to stay afloat and compete with hospitals and health systems. One major source of the problem is that hospitals receive annual, inflation-based updates while physicians do not. As shown in the chart below, Medicare updates to hospitals totaled roughly 80 percent (or 2.5 percent per year on average) since 2001, while physician payments remained essentially flat. As mentioned above, we would greatly appreciate support from the Trump Administration for congressional efforts to provide annual, inflation-based updates for physicians consistent with hospitals and nearly all other Medicare providers.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

The AMA also wishes to express our concerns that CMS' proposal to reduce indirect practice expense when a service is performed in a facility setting could have the unintended consequence of further incentivizing consolidation by hurting private practice physicians who provide services in hospital outpatient departments or ambulatory surgical centers. The results from the AMA's PPI survey showed $57 in indirect expenses per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery. These are not facility expenses. Respondents were instructed to only include costs related to the physician practice, such as coding and billing. 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. The physicians may have no choice but to sell their practice to a facility or corporate entity that can absorb their unpaid costs.

When physicians are directly employed by the hospital, ultimately the hospital may receive payment for both the professional and facility claims. However, hospitals typically charge back the physician related costs to the department or unit, resulting in reduced compensation. Therefore, the proposal would not account for costs incurred by non-hospital-employed or hospital-employed physicians who provide services in the facility. The AMA strongly urges CMS to reconsider this proposal and to work with physicians on an alternative based on the 2024 PPI Survey data that will support private practice physicians.

Merit-based Incentive Payment System (MIPS)

On January 31, 2025, President Trump issued an EO, titled, "Unleashing Prosperity through Deregulation," to promote prudent financial management and alleviate unnecessary regulatory burden. There is no better way to fulfill this directive than by reducing the morass of complicated rules and requirements that define the ineffective MIPS program as the AMA outlined in a February letter to CMS. Despite being implemented in 2017, MIPS has yet to demonstrate better health outcomes for Americans

or lower avoidable spending. Nevertheless, the program imposes steep compliance costs on physicians. Even worse the program disproportionately hurts small and rural practices, which are small businesses, by cutting their Medicare reimbursement up to 9 percent despite being "approximately as effective as chance in terms of identifying high versus low quality performance," according to a *JAMA* study.

We appreciate that CMS has been responsive to the AMA and proposes the following improvements to MIPS:

- Maintaining the performance threshold at 75 points for the next three performance periods (until the CY 2028 performance period/2030 payment year) to provide continuity and stability to physicians.
- Updating the benchmarking methodology used for calculating administrative claims-based quality measures to align with the benchmarking methodology used for cost measures. The AMA urges CMS to consider applying it to ALL quality measures, not just administrative claims measures.
- Adding the AMA-stewarded electronic clinical quality measure (eCQM), *Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes*, which aligns with the Administration's focus on disease prevention and empowering individuals to engage in lifestyle change behaviors as part of their overall wellness. Under a diabetes prevention cooperative agreement, the Centers for Disease Control and Prevention (CDC) also requires designated grantees to implement the measure as part of their diabetes prevention program.
- Refining the Total Per Capita Cost (TPCC) measure attribution methodology.
- Creating a two-year informational-only period for new cost measures, which the AMA sought to ensure physicians have an opportunity to review and, if necessary, improve their performance on new measures before they are held accountable for them.
- Aligning with the AMA's recommendations on an alternative framework for structuring MIPS Value Pathways (MVP) by proposing "Clinical Groupings" within MVPs. Instead of the current approach of having a long list of quality measures in the MVP ordered by Measure ID, we suggested that CMS organize the quality and cost measures into categories, each of which is relevant to a particular patient condition or an episode of a particular type of treatment.

While CMS put forward several positive changes in the 2026 MPFS proposed rule, there is more red tape to be cut. The AMA makes the following key recommendations:

- While there is no one-size-fits all approach to MVPs that will work for every medical specialty, we believe that MVP clinical groupings MUST 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.
- We urge CMS to incentivize the reporting of MVPs, rather than mandate it, **and do not support sunsetting traditional MIPS.** In 2023, which is the most recent data CMS has shared, only 1.26 percent of MIPS eligible clinicians were scored via MVPs.
- **CMS must maintain a robust portfolio of MVPs and quality measures, including accepting new measures.** Measurement burden is increased when there are too few measures in the program and physicians are forced to report for the sake of reporting and compliance.
- 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 based on the highest volume of service and/or largest number of clinicians.

- CMS should 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.
- Many of the MVPs currently available to physicians do not reflect the input of the physicians. For example, the AMA and impacted surgical groups have repeatedly stated we do not support 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.
- CMS should reduce unnecessary quality measure reporting burden and eliminate arbitrary scoring rules that drive up the cost of compliance with MIPS and disincentivize reporting on new and substantially revised measures.
- Although CMS proposes changing the most egregious attribution problems with TPCC, these changes do not address its fundamental flaw of holding physicians accountable for care outside of their control. The AMA continues to urge CMS to remove TPCC from MIPS or, at a minimum, from any MVP that also includes an episode-based cost measure.
- We urge CMS to maximize usage of electronic health records (EHRs) and other emerging technologies while minimizing wasteful "check the box" reporting exercises. The AMA supports CMS' efforts to transition to digital quality measures (dQMs). 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 recommend CMS sunset PI.

We are also disappointed that the 2026 MPFS does not address MIPS data access issues. Physicians across the country are united in agreement about the need for timely data to improve care for patients and reduce avoidable costs. Unfortunately, CMS provides physicians with an annual Medicare MIPS Feedback Report that includes information about their performance on quality and cost measures six to 18 months after they have provided a service to a Medicare patient. Without this information at any point during the actual performance year, physicians have no way to understand gaps in care and identify opportunities to improve health outcomes, reduce variations in care delivery, or eliminate avoidable services—all steps that can improve quality and lower costs for patients and the Medicare program. CMS must fulfill the requirements in the Medicare Access and CHIP Reauthorization Act (MACRA) statute to provide timely (e.g., quarterly) feedback reports and Medicare claims data to physicians.

Congress also recognized the value in providing continuous feedback and the use of digital tools by physicians and practices by encouraging the use of private sector funded and physician-led qualified clinical data registries (QCDRs) to satisfy MIPS requirements. Utilizing specialty-led QCDRs provides an opportunity to evaluate care across an entire specialty, as well as at the individual physician level. QCDRs also advance quality measurement towards digital sources and move beyond snapshots of care, which focus on disconnected individual measures, to a learning system with a broad focus that can readily adapt and grow over time. The lack of a viable QCDR option due to numerous obstacles erected by CMS is unfortunate because capturing data through a registry allows for its collection and tracking across various settings and disease states including inpatient versus outpatient settings, acute episodes versus chronic disease, surgical versus nonsurgical interventions, and resource-intensive versus relatively inexpensive therapies. Currently, physicians are forced to use less clinically meaningful measures and do not receive appropriate recognition for their registry activities, reducing the opportunity for quality improvement. It is the morass of MIPS regulations and requirements that lead to a burdensome program, not the number of QCDRs and associated measures in the program. CMS must eliminate these barriers and fully recognize the role of specialty-led QCDRs as a cornerstone of meaningful, clinically relevant quality improvement.

Therefore, we urge the Administration to eliminate all bureaucratic barriers and better incorporate the use of private sector funded QCDRs and physician specialty society expertise.

Ambulatory Specialty Model (ASM)

The AMA has been urging Medicare to create alternative payment models for specialists for many years and appreciates that the proposed ASM has several elements that are directly responsive to our recommendations. Although ASM builds upon the MVP program, instead of being designed to apply to all services across a broadly defined specialty, ASM is intended to focus on care of patients with specific conditions that are managed by specialists who provide mainly ambulatory rather than inpatient care: heart failure and low back pain. Another improvement is that ASM uses quality and cost measures applicable to the same health condition. To help support physicians in independent private practices transitioning to value-based care models, ASM allows physicians to participate without having to be part of an accountable care organization, hospital, or large physician group. In addition, unlike other models that require participants to repay Medicare if the total cost of care for a patient population is more than a benchmark set by CMS, ASM does not place physicians at direct financial risk for increases in total Medicare spending on their patients.

ASM also contains several features that the AMA urges CMS to modify. As currently structured, ASM's financial model guarantees that most participating physicians will have their payments cut regardless of how well they perform on the measures. Instead of achieving Medicare savings by reducing physician payment rates, ASM should assist physicians in reducing avoidable Medicare spending on hospitalizations and other services.

ASM would mandate participation by physicians in seven specialties who treat patients in selected geographic areas – the AMA strongly urges CMS to redesign ASM as a voluntary model. CMS should also set a performance standard in advance instead of using a "tournament" approach. As proposed, a physician's payment adjustment will depend on whether their performance exceeds the majority of other ASM participants each year. We are also concerned that physicians treating as few as 20 patients with heart failure or low back pain a year would be required to participate and have their payments reduced or increased based on the ASM required measures even if ASM patients are a small subset of all their patients.

One of the CMS Innovation Center's current aims is designing models to "level the playing field for providers practicing independently and outside of health system or health plan ownership to increase competition in markets." The AMA and CMS are aligned in this goal, but we are concerned that the current model design will not provide better support for independent practices and may lead them to look to help from larger organizations to maintain their financial sustainability. For example, data from the AMA's 2024 Physician Practice Benchmark Survey identified "ease participation in risk-based payment models" as a key reason that physicians left private practice.

We thank you for the opportunity to provide input on this Proposed Rule. Please reach out to me directly at 312-464-5288 or John.Whyte@ama-assn.org if you have questions or need further information.

Sincerely,

John Whyte, MD, MPH

I. UPDATES TO PAYMENT PROVISIONS

A. CY 2026 Medicare Conversion Factors

Recommendation:

- The AMA urges the Trump Administration to work with Congress to enact a permanent, annual inflation-based update to Medicare physician payments.

For the first time this century, CMS proposes four conversion factors. The conversion factors reflect two different, small permanent updates to the baseline beginning January 1, 2026, as required under the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015. Under MACRA, physicians who are qualifying participants (QPs) in advanced alternative payment models (APMs) will receive a higher conversion factor update and, thus, higher Medicare payments in 2026 compared to physicians who are not QPs. Each conversion factor also reflects the temporary, one-year 2.5 percent update enacted in H.R. 1 signed into law by President Trump on July 4, 2025. These conversion factors are outlined in the table below.

Proposed 2026 Medicare Conversion Factors (CFs)							
	2025 CFs	**APM or Non APM Update Factor (1.0075 or 1.0025)**	**CY 2026 RVU Budget Neutrality Adjustment (1.0055)**	**CY 2026 2.50 Percent Increase (1.025)**	**Anes-thesia Only PE and PLI Adjust-ment**	**Proposed 2026 CFs**	**Percentage Changes**
APM QP	$32.3465	$32.5891	$32.7683	$33.5875	N/A	$33.5875	**3.84%**
Non-APM QP	$32.3465	$32.4274	$32.6057	$33.4209	N/A	$33.4209	**3.32%**
Anes-thesia APM QP	$20.3178	$20.4702	$20.5828	$21.0973	$20.6754	$20.6754	**1.76%**
Anes-thesia Non-APM QP	$20.3178	$20.3686	$20.4806	$20.9926	$20.5728	$20.5728	**1.26%**

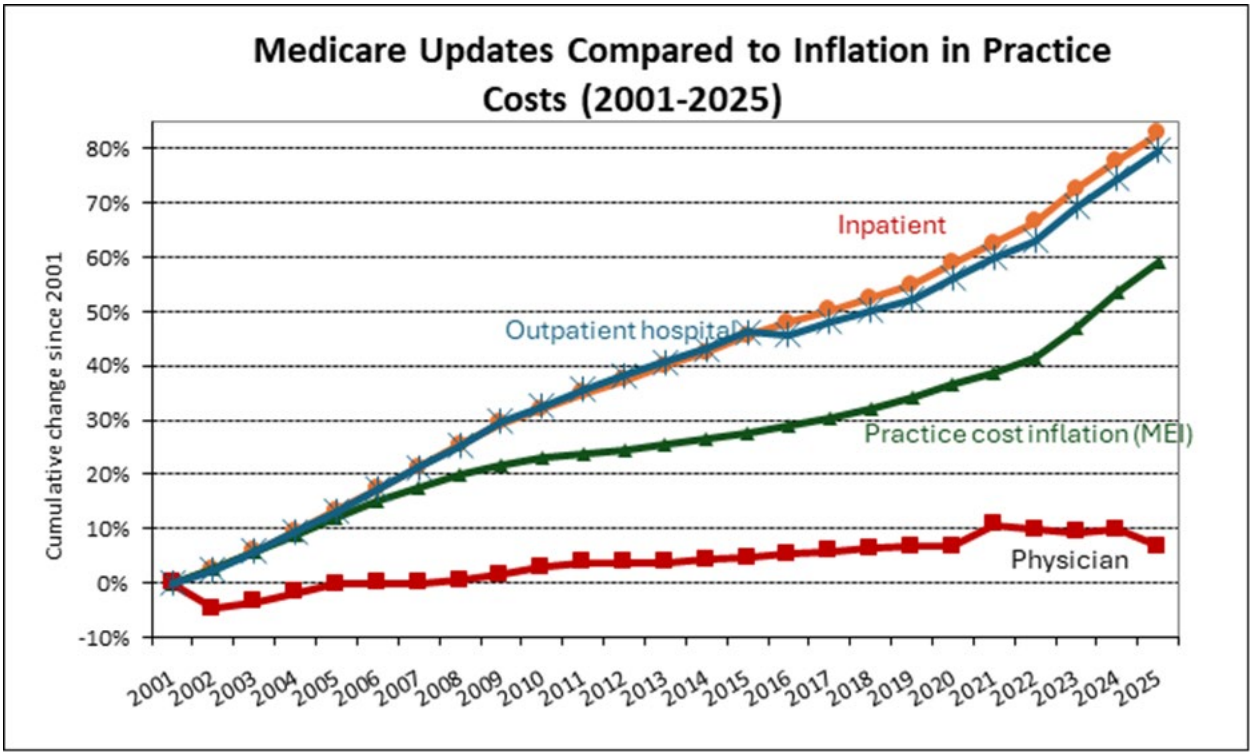
Additionally, the conversion factors are affected by a positive 0.55 percent budget neutrality adjustment resulting from proposed misvalued code changes and a -2.5 percent efficiency adjustment, which CMS proposes to apply to work RVUs and the corresponding intra-service portion of physician time of non-time-based services that CMS believes accrue gains in efficiency over time. This efficiency adjustment impacts most surgical specialties, radiology, and pathology by reducing overall payment by one percent. The AMA addresses this proposal in detail below.

The AMA appreciates that Congress provided a one-year 2.5 percent update to 2026 Medicare physician payments. Physicians continue to strongly advocate for permanent updates to the

conversion factor that account for the growth in physician practice costs. Despite temporary updates in four of the last five 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 2025, Medicare physician pay remained virtually flat even though the cost of running a medical practice increased 59 percent. Adjusted for inflation in practice costs, Medicare physician pay declined 33 percent from 2001 to 2025.

Declining Medicare payment rates accelerate the trend in consolidation. Seventy percent of physicians who have sold their practice to a hospital, private equity firm, or insurer in the last 10 years cited the need to "better negotiate higher payment rates with payers" as very important or important in making their decision. In its June 2025 report to Congress, the Medicare Payment Advisory Commission (MedPAC) also acknowledged that the growth in physicians' input costs is expected to exceed growth in Medicare payment rates, which would create incentives for physicians to vertically consolidate with hospitals, which could increase spending for patients and the Medicare program.

The AMA applauds CMS for acknowledging that private physician practices need more money to stay afloat and compete with hospitals and health systems. We similarly believe that private practice must remain a financially viable option for physicians. This is increasingly difficult as physicians' expenses have risen sharply in recent years, and their payments have not kept pace due to a lack of an automatic, inflation-based update. By contrast, hospitals receive annual, inflation-based updates. As shown in the chart below, Medicare updates to hospitals totaled roughly 80 percent (or 2.5 percent per year on average), while physician payments remained essentially flat.



Sources: Federal Register, Medicare Trustees' Reports, Bureau of Labor Statistics, Congressional Budget Office

Worse, inadequate Medicare physician payment also harms seniors' access to care, increasing their wait times and delaying their care. The Medicare Trustees and MedPAC have issued warnings about beneficiaries losing access to high-quality care due to insufficient Medicare physician payment. In its

June 2025 Report to Congress, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the growing gap between physicians' input costs and Medicare payment, warning: "[t]his larger gap could create incentives for clinicians to reduce the number of Medicare beneficiaries they treat, stop participating in Medicare entirely, or vertically consolidate with hospitals." MedPAC therefore recommended Congress repeal current law updates and replace them with annual updates tied to MEI for all future years. The 2025 Medicare Trustees Report reiterated similar concerns about patient access to care, stating that under current law, "the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."

The impact of inadequate payment on physician practices is being felt across the country as discussed in the quotes below from practicing physicians:

- "What I think is really important for people to know about Medicare costs is they don't just affect our senior patients—they affect all of our patients," said an obstetrics and gynecology (OB/GYN) physician in Texas. "As an OB/GYN, I primarily treat Medicaid patients, but every time there is a cut to Medicare, it impacts my ability to take care of all of my patients."
- A general surgeon from Colorado said, "In my area, we see physicians retire and do not continue to care for patients. We are not able to care for patients as we would like, and physicians cannot afford to keep their offices open. I have not had a raise in over 10 years because practicing medicine has made it cost more to have a practice than the physician is reimbursed."
- A family medicine physician in Oklahoma said, "We are unable to keep our doors open, pay our staff or pay ourselves. And in doing so, that affects patients because we're closing offices all the time. When you don't have a rural physician, then they don't go to the doctor, and health care outcomes become worse."

To fulfill this Administration's goals of increasing competition by leveling the playing field for independent physician practices and ensuring Medicare patients have access to high-quality preventive care, **we strongly urge the Trump Administration to support any congressional action to enact inflation-based updates for physician payments, such as the provision tied to the Medicare Economic Index that was in the House-passed reconciliation bill.**

B. Determination of Practice Expense (PE)

Recommendations:

- The AMA shares CMS' goal of ensuring accurate payment across settings of care based on the costs to deliver care in physician's offices, hospitals, and ambulatory surgical centers and agrees with the Administration's emphasis on independent physician practice as a viable model of care delivery.
- CMS should work with the AMA to consider how the 2024 Physician Practice Information (PPI) Survey and Clinical Practice Information (CPI) Survey data could be used in the future to reflect changes in physician practice cost and physician hours worked.
- CMS should utilize the PPI and CPI to implement new MEI shares of work, PE, and PLI RVUs, which results in the following distribution: work = 54.4 percent; PE = 43.9 percent; and PLI = 1.7 percent. These changes should be implemented in 2026.
- The AMA strongly urges CMS to reconsider its proposal to reduce indirect practice expense when a service is performed in a facility setting using this methodology, as this proposal does not accurately reflect resource costs incurred by practices when performing services in the facility setting and may inadvertently lead to greater consolidation.

- The AMA strongly supports the long-standing RUC recommendation that CMS 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, where items are annually reviewed and updated.

Development of Strategies for Updates to Practice Expense Data Collection and Methodology – Physician Practice Information Survey

The AMA contracted with Mathematica to conduct a technical and comprehensive survey of physician practice costs, termed the Physician Practice Information (PPI) Survey. This project began with interviews and pilot surveys in 2020, leading to a delay in a broader launch until practices had time to recover from the COVID-19 public health emergency. Mathematica pre-tested and piloted the survey again in 2023 before launching in summer 2023. More than 170 organizations signed a letter of support to share with all potential survey respondents, including all state medical associations, more than 100 national medical specialty societies and other health care professional associations, the American Group Medical Association, the Medical Group Management Association and the Association of American Medical Colleges. This letter of support was similar to the specialty society support letters shared with all previous practice cost surveys.

The PPI Survey data collection effort was completed in September 2024 with 380 practices providing usable data for 831 departments, which encompassed 18,086 physicians, resulting in a 6.8 percent response rate. As part of the overall PPI effort, 5,690 physicians responded to a separate survey that collected data on physician hours of direct patient care. In parallel, a non-MD/DO survey concluded with 317 practices providing usable data and included 2,548 other health care professionals. The response rate was 9.1 percent. These data were shared with CMS in January 2025.

CMS discusses the PPI Survey in the Proposed Rule, noting concerns about low response rates, representativeness, and variance in the number of specialties with sufficient responses, as compared to the previous 2007/2008 PPI Survey. CMS also specifically notes that occupational therapy and the independent diagnostic testing facilities (IDTFs) did not share their collected data. CMS states the intention to work with the AMA to understand whether and how such data should be used in rate setting in future rulemaking. CMS shares numerous alternatives, and their specialty impacts, for use of the PPI data in determining the Medicare Economic Index (MEI) weights for physician work, practice expense and professional liability insurance.

The PPI data represents the most recent data on physician practice costs and hours. The following comments address the CMS concerns raised in the Proposed Rule. CMS states 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." **CMS should delay implementation of any modifications to the indirect practice expense methodology until the 2024 PPI data are implemented.**

Low Response Rates and Representativeness

Response Rates

CMS stated that the "2024 PPI Survey had a response rate of 3 to 7 percent, depending on whether practices that did not click through the invitation email link were counted as non-respondents" and contrasts that with the 12 percent response rate of the 2007 PPI Survey. Mathematica, the consultant on the 2024 PPI Survey, indicated in its Methodology Report that the 7 percent response rate "was equivalent to the American Association of Public Opinion Research (AAPOR) standard response rate

calculation." It was the response rate presented as the final response rate in the Report and is the one that best reflects practice responses to the 2024 PPI Survey.

Importantly, while the 2007 Survey was of physicians, the 2024 Survey was of practices. It is not clear that a fair comparison of response rates can be made. The switch to a practice-level survey was motivated by the decreases in the percentage of physicians who are owners and the increase in the percentage of physicians in larger practice size categories and in practices not wholly owned by physicians. The change to practice level was also made to enable better data from physician owned practices. Our 2007 experience confirmed that practice leaders do not always have access to the necessary financial data; therefore, inclusion of non-physician executives is required at the practice level. As employees, often in large and system-owned practices, physicians also do not have direct access to practice financial information and may not even have access to the managers who would approve participation in the survey and provide the requested data for it.

The practice-level focus of the 2024 Survey called for different sampling and weighting methodologies than the 2007 Survey, ones that may have led to better representation and which should ameliorate CMS' concerns about a low response rate. Namely, the 2007 methodologies were based on physician characteristics such as age and gender and had little focus on practice type and none on practice size, ownership, or the setting in which patient care was delivered. In contrast, sampling and weighting in the 2024 Survey focused on those variables—size, ownership, and setting. Through its focus on practice attributes correlated with practice expense per hour of direct patient care (PE/HR), the methodology was explicitly designed toward acquiring data that would be representative of the settings in which physicians provide patient care.

Inclusion of Volunteer Practices

CMS raises concern about the inclusion of volunteer practices from the pilot and full study stating that the "AMA allowed 102 practices to volunteer to participate in the survey." However, these practices had minimal impact on the study as only 36 of those practices completed the survey and had enough data to be included in the final PE/HR and MEI share estimates. The departments in those practices accounted for only 6 percent of the 831 departments whose data were used in the estimates. The physicians in those practices accounted for a similar percentage of the 18,086 physicians in those departments.

Treatment of Observations with Missing Data

CMS stated that "… the 2008 PE/HR estimates were based on the observations (about half of responses) that had no missing expense data, whereas the 2024 PE/HR estimates and the shares are based on observations that had at least some non-missing data where the missing data was imputed as described in the Survey Methods Report…".

While estimates based on the 2007 Survey excluded observations with missing expense data and the 2024 Survey included them and imputed missing values, one approach is not necessarily better than the other. One advantage of the earlier method is that it provided a clean and complete sample with the same number of non-missing values for each expense variable. However, this approach could have introduced bias if practices that were excluded and had at least one missing value differed systematically from practices with no missing values (those that were able to report every expense category). As described in detail in the Methodology Report, the approach used with the 2024 data utilized careful imputation methods to address missing expense data so that the widest set of practices could be included.

CMS stated that, "Nearly 40 percent of the responses used in the calculation of the PE/HR estimates reported that they had nurse practitioners or physician assistants in their practice, but only 27 percent

were able to separately report non-physician compensation expenses." The goal of the PPI Survey was to collect practice expense data for physicians and, only where available, for qualified health care professionals, such as nurse practitioners or physician assistants. That 73 percent of the 40 percent of practices that had NPs or PAs could not separately report expenses for them is not a failure of the survey and does not suggest concerns about the data's representativeness. Rather, this indicates that practices often do not organize their financial data in a way that easily translates to the methodology underlying the physician payment schedule. Further, PAs and NPs are compensated differently depending on the payor or the site of service. In some instances, Advanced Practice Registered Nurses (APRNs) may bill directly with a modifier and 85 percent payment. In others, their services are 'incident to' and billed by the physician. In still others, the facility pays them a salary. As such, the expense incurred by physicians varies, requiring flexibility in data reporting and analysis. As was indicated in the Methodology Report, practices "embed their [nurse practitioner or physician assistant] expenses with the physicians with whom they work." As described, to account for that and to ensure that the PE/HR estimates were not biased upward by the inclusion of expenses related to Qualified Healthcare Professionals (QHPs), expenses were scaled down for the practices that were not able to allocate to QHPs. This was based on the hours allocated to each physician specialty department for each type of QHP. For example, if a specialty had 10,000 annual hours across all its physicians, and the practice allocated 5,000 annual QHP hours to that specialty, the practice expense per hour of patient care provided for that specialty was multiplied by 10,000 / (10,000 + 5,000) = 0.67.

Small Sample Sizes and Sampling Variation

Small Sample Size

CMS stated that "Due in part to the low response rates, the number of respondents was small for many specialties included in the 2024 PPI and Clinical Practice Information (CPI) Survey data. For example, the PE/HR measures for Vascular Surgery are based upon responses from only 20 practices."

While the 2024 Survey had a smaller unweighted sample size compared to the 2007 Survey, this partly reflects that the unit of observation in 2024 was a department within a practice, and not a physician as in the 2007 Survey. Each observation (department) in the 2024 Survey contains expense information for multiple physicians. For example, the PE/HR estimates for Vascular Surgery were reported by 20 departments that consisted of 114 physicians (unweighted). In contrast, the estimates based on the 2007 PPI Survey were based on responses from 74 vascular surgeons. In total, the 2024 PE/HR estimates were based on 18,086 physicians who were members of 831 departments in 380 practices. In contrast, the estimates based on the 2007 PPI Survey were based on responses from 2,795 individual physicians.

Wide Confidence Intervals and Statistical Insignificance

To the point of statistical significance, CMS states that "Therefore, in most cases, the new data are unable to establish statistically significant changes from the status quo …."

While the PE/HR estimates from the 2024 Survey are not always statistically different from those in the 2007 Survey, statistical significance alone is not the only criterion for evaluating data quality or their utility. The AMA's goal for conducting the 2024 Survey was not to test for statistically significant differences in PE/HR compared to estimates from the 2007 Survey, but rather to provide updated PE/HR estimates that reflect the current cost of running a practice, including the significant new cost of information technology. The methods for 2024 are an improvement guided by prior experience.

In addition, even where the 2024 confidence intervals are wide or overlap with the old estimates, the new estimates from the 2024 Survey still provide valuable insights into the magnitude and direction of the

change in PE/HR. This is especially applicable when looking beyond the total PE/HR to more specific components. For instance, while overall direct PE/HR rose by almost 40 percent from 2007, indirect PE/HR only rose by 5 percent. This difference is meaningful and provides valuable insight into changes within specific expense categories.

Potential Measurement Error

CMS stated that "the survey contractor found that practices frequently had challenges reporting the number of physicians working in the practice" and then tied that to a large discrepancy between "their estimate of the total number of physicians" and "the number of physicians in their sampling frame." While there is always the possibility of measurement error in a survey, it is not clear what CMS is referencing with those statements. Regarding "challenges in reporting," yes, as described on page 45 of the Methodology Report, some practices left the numbers of physicians blank or indicated zero. Other respondents put in 40. This is not necessarily best described as challenges that would lead to measurement error, but rather is indicative of unwillingness to participate in the survey (in the case of missing and zero values) or of misreading a question (in the case of the 40 values, for which it is suspected that some practices reported number of hours per week rather than number of physicians). As many of these responses were not considered "completes," they are more relevant to the discussion of low response rate than to that of measurement error.

As further stated by CMS, the "estimate of the total number of physicians was nearly three times as large as the number of physicians in their sampling frame, which "indicated a large potential for measurement error in this estimate."" Yes, it was the case that the numbers of physicians reported by practices, when weighted by a preliminary set of weights, did not always align with external data. However, this speaks to measurement error in that *particular variable* but not to measurement error in the PE/HR estimates themselves. The discrepancy reflects that some practices reported at a different level than that suggested by the external data used to create the sample frame. As discussed in the Methodology Report, although the tax identification numbers (TINs) were used as the practice sampling unit, organizations did not necessarily report expenses at the specialty-TIN level. What is important is that, at the specialty/department level, the reported expenses were generated by the number of physicians reported (even if that number was different than that suggested by the external data).

Missing and Incomplete Data Submission

CMS notes that they had to utilize the old PE/Hour data in analysis for the IDTFs as the IDTFs did not submit the data from their surveys to CMS. Additionally, the American Occupational Therapy Association requested a continued crosswalk of their PE/Hour to physical therapy. The AMA and RUC were not involved in either of these decisions or in the private contract these entities undertook with Mathematica. We urge CMS to work with these two organizations to resolve any underlying concerns but not abandon the implementation of updated cost data for all physicians and other health professionals due to concerns related to these two groups.

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.

<u>Alternatives Considered for Adjusting RVUs To Match PE Share PPI and CPI</u>

CMS states that, "…it seems that the AMA calculated specialty-level shares and averaged these shares across specialties, which is mathematically different than estimating the share of total work, PE, and MP across all specialties" and "That is, the average of shares does not need to equal shares of the total." Yes,

these statements allude to a high-level difference between the 2007 and 2024 calculations. However, the methodology used for the 2024 calculations is superior to that for 2007, as explained below.

With the 2007 data, the MEI shares calculation was based *only* on physician survey responses where the physician reported their own share of practice expense (note that the PE/HR estimates for 2007 were based on a broader set of responses that, when certain conditions were met, also included physicians who reported at the department or practice levels in addition to those who reported at the individual level). Weighted means across physicians were computed for each expense category and the MEI shares were based on those means.

Because the 2024 Survey was of practices, not physicians, the MEI shares had to be calculated differently than in 2007. Because expenses were reported at the department level, they had to be adjusted – divided by the number of physicians – to the physician level. Here, the AMA further adjusted them to the hourly level because the survey separately tracked the numbers of part-time and full-time physicians in a department. Essentially, for each expense category, a PE/HR estimate was created for each department. Next, for each department, MEI shares were created based on the PE/HR estimates. Then, the weighted means of those shares were used to calculate the MEI shares reported to CMS.

Importantly, as methodology was developed for calculating the MEI shares for 2024, it was realized that the 2007 methodology biased the MEI shares toward the expense allocation of practices with higher levels of expenses (even if they had the same number of physicians who worked the same number of hours as in practices with lower levels of expenses). The methodology used for the 2024 data – where the shares are computed at the department level and then averaged – does not include this bias.

The 2024 methodology is superior both because it is based on data for "all" physicians (not just those that reported expenses at the individual level) and because it removes the bias toward the allocation of expenses in departments with higher expense levels. We support the CMS option of incorporating the 2024 PPI and CPI data into the MEI weights.

During review of the MEI weight discussion, it became apparent that the current physician work, PE and PLI cost shares for the MFS no longer appropriately reflect the intended MEI weights which are currently implemented at 50.9 percent physician work, 44.8 percent practice expense and 4.3 percent liability insurance (PLI). When using the 2024 Medicare utilization data and the 2025 work RVUs, the current physician work share is only 49.9 percent, PE is 46.2 percent and professional liability insurance is 3.9 percent.

	2025 MFS Estimated Allowed Charges	**2025 Estimated MEI Share Percentages**	**CMS Implemented and Published MEI Share Percentages**
Physician Work	$45,161,740,903	49.9%	50.9%
Practice Expense	$41,833,791,420	46.2%	44.8%
Professional Liability Insurance	$3,508,860,783	3.9%	4.3%
Total	$90,504,393,106	100%	100%

CMS should utilize the PPI and CPI to implement new MEI shares of work, PE, and PLI RVUs, which results in the following distribution: work = 54.4 percent; PE = 43.9 percent; and PLI = 1.7 percent and implement in 2026.

Updates to Practice Expense Methodology – Site of Service Payment Differential

CMS is concerned that the current indirect practice expense methodology may be incentivizing care in higher-priced settings of care, such as hospitals, rather than lower-cost settings, like physician offices. The agency is also concerned that Medicare is making duplicative payments for physicians' practice expenses when services are performed in a facility setting. Therefore, for 2026, CMS proposes a significant change to the practice expense methodology which will result in a significant reduction to the PE RVUs for all services provided in the facility setting (e.g., hospitals, ambulatory surgical centers). The proposal would reduce a key input for the indirect component of the facility PE RVU formula, the work RVU input, to 50 percent of the amount used for non-facility PE RVU computation. This is a substantial change as the work RVU in the PE formula serves as a proxy for how much time indirect resources are used when providing a service.

This policy change would have a large impact, with total MFS payment in the facility setting decreasing by -7 percent, while non-facility-based payments would increase by 4 percent. Many specialties would receive even more substantial cuts in the facility setting, such as 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.

The AMA shares CMS' goal of ensuring accurate payment across settings of care based on the costs to deliver care in physician's offices, hospitals, and ambulatory surgical centers and agrees with the Administration's desire to ensure that independent physician practice is a viable model of care delivery. **We strongly urge CMS to reconsider its proposal to reduce indirect practice expense when a service is performed in a facility setting using this methodology, as this proposal does not accurately reflect resource costs incurred by practices in the facility setting and creates significant impacts to many individual physicians and other health care professionals.**

The AMA agrees that the site of service payment differential between the non-facility and facility settings is an issue that creates inherent unfairness to office-based physicians trying to compete with higher-paid sites of services, such as the hospital outpatient setting. However, the main driver of this differential has been the lack of inflationary updates to physician payment, unlike facility payment schedules. 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 flawed methodology like square feet allocation over actual costs.

The catalyst for the AMA launching the 2024 PPI survey was the AMA House of Delegates (HOD) approved policy, The Site-of-Service Differential D-330.902, which supports Medicare payment policies for outpatient services that are site-neutral 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 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 to better compensate for those direct costs of operating a private outpatient practice. **In lieu of implementing the proposal, the AMA urges CMS to work with the AMA to consider the new 2024 AMA PPI Survey results more fully, which includes updating the PE/HR groupings and specialty data from the 2024 AMA Physician Practice Information Survey.**

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, relativity similar which speaks 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 would 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).

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 or duplicative payment. 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 for 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. When physicians are directly employed by the hospital, ultimately the hospital may receive payment for both the professional and facility claims. However, hospitals typically charge back the physician related costs to the department or unit, resulting in reduced compensation. Costs related to physician billing and other related costs are reclassified as non-allowable on hospital cost reports. If a hospital is doing Part B billing on behalf of physicians, staff time for that billing is not considered as a hospital cost on the cost report.

There are numerous examples of impacts to individual services and patient care, many of which may have been unintended by CMS in formulating this proposal. Here are just a few of the many examples to 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: For the over 4,220 CPT codes with bundled post-operative office visits in their surgical global period, these codes have bundled office visits that are often performed in a physician office 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 show up in the claims data as it is not being accounted for in CMS' proposed PE methodology change. CMS' proposal negatively impacts the entire surgical global facility PE RVU without accounting for this factor. For example, the highest volume cataract CPT code (66984) was performed 81 percent of the time in the ASC setting for Medicare. However, ophthalmologists also perform the follow up office visits in their offices and are maintaining offices that are open while they are performing surgery at the ASC.

- Direct Costs in Facility RVUs: CMS notes that, "In 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 MFS, 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, this summary does not 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.

- Nursing Facility E/M Visits: Nursing facility visits are reported with CPT Codes 99304-99316, which describe services provided to patients classified to be receiving 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. Currently, the 2025 physician payment rates are appropriately identical. 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* is $104.16, regardless of the patient's status of skilled or non-skilled nursing facility assignment. Under the CMS proposal, the physician visit practice expense payment for CPT code 99309 would be 35 percent less for the skilled nursing facility visit. Most physicians who see patients in the nursing facility have offices and their indirect costs would not vary based on how the patient is classified at the nursing facility.

CMS noted that the purpose of this proposal is to address their concern for the potential for duplicative payment under the current PE methodology for allocating indirect costs for physicians practicing 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 their practice. 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 work for either a hospital-owned practice or are directly employed or contracted by the hospital.

In summary, the application of the indirect practice expense methodology should be reconsidered. CMS should accomplish its goal to better support office-based physicians with alternative proposals that are fair to all physicians and ensure that accurate resource costs are considered.

The AMA recommends that CMS implement the following as an alternative to the indirect practice expense proposal:

- CMS should work with the AMA to consider how the 2024 PPI PE/HR could be utilized in place of data from 2007, including how best to capture better data for certain Medicare specialties, including allergy and immunology; radiation oncology; and independent diagnostic testing facilities.

- The MEI weights should be updated to reflect the data collected in the 2024 PPI and CPI data, which results in the following distribution: work = 54.4 percent; PE = 43.8 percent; and PLI = 1.7 percent.

- The work allocator for the indirect practice expense allocation should be retained as status quo (100 percent) until CMS is able to work with the AMA on incorporating the 2024 PPI PE/Hour data. If CMS pursues a change for 2026, CMS should increase the allocator to recognize at least 75 percent of physician work for services provided in the facility setting, rather than the proposed 50 percent.

- Should CMS finalize this proposal, at a minimum it should phase in the PPI PE/Hour Data and modification to the indirect practice expense methodology 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). In this proposed rule, CMS even proposes a phase in to address the correction to a mathematical error in medical supply packages.

An impact analysis of the new MEI weights based on the 2024 PPI and CPI survey is included in column H of Table 108, page 32837 of the notice of proposed rulemaking (NPRM). An analysis that adds the non-APM 2.75 percent legislative update to the conversion factor and provides these data at a more granular specialty level is attached (See *Attachment 1).*

C. Potentially Misvalued Services

Recommendations:

- The AMA agrees with CMS' goal of ensuring that the time data used in work RVUs is accurate, that high-volume services are frequently reviewed to account for efficiencies, and that primary care payment is adequate and recommends alternative approaches to achieve these goals based on data and physician input.

- Rather than apply a -2.5 percent efficiency adjustment to nearly all CPT codes, even those with low volume, CMS could instead consider ensuring that higher volume codes be reviewed on a more frequent basis.

- CMS should continue to support the use of surveys to ensure the clinical expertise of practice physicians and other health care professionals is respected and utilized in establishing work RVUs. The RUC will actively seek additional time data to support and augment survey data.

- To support primary care, CMS should implement a correction to the utilization assumptions for G2211, leading to a positive $1 billion budget neutrality adjustment to the Medicare conversion factor.

Progress in Identifying and Reviewing Potentially Misvalued Codes

Since the inception of the Relativity Assessment Workgroup (RAW), the RUC and CMS have identified approximately 3,000 services through over 20 different screening criteria for further review by the RUC. Through these screens the RUC examines services such as those with high growth, services that are performed together more than 75 percent to determine if a code bundle solution should occur, services in which the site of service has changed (i.e., inpatient to outpatient) and services that were surveyed by one

specialty but are now performed by a different specialty. Additionally, the RUC charged the Workgroup with maintaining the "new technology" list of services that are re-reviewed by the RUC as reporting and cost data become available.

Through this initiative, the RUC has reviewed services that comprise approximately 95 percent of the Medicare Physician Payment Schedule allowed charges. Codes that have not been reviewed are low volume and represent a minimal amount of allowed charges. The RUC has recommended reductions and deletions to over 1,600 services, more than half of the services identified, redistributing more than $5 billion within the RBRVS. **The AMA supports the ongoing work of the RUC and CMS to address potentially misvalued services.** Please see a detailed report of the RUC's progress on relativity assessment.

Methodology for Establishing Work RVUs – Proposed Efficiency Adjustment

CMS proposes to decrease the work RVUs and/or physician intra-service time for 7,267 physician services by 2.5 percent. CMS would apply additional reductions every three years. The agency states that it will exempt 389 codes, including time-based services, E/M, care management, maternity care, and services on the CMS telehealth list, from this efficiency adjustment. CMS arrives at the -2.5 percent efficiency adjustment by tallying the last five years' private, non-farm, productivity adjustments in the MEI.

The adjustment impacts most specialties by reducing their payment by 1 percent. Per the CMS Table 92 Impact Table, the only specialties or professions projected to gain at least 1 percent from this proposal are: clinical psychology, clinical social work, geriatric medicine, and psychiatry, specialties with individuals who perform a more significant amount of E/M services, behavioral health and telehealth services, which CMS has exempted from efficiency adjustments. This proposal, combined with the RUC's recommendations on individual CPT codes, results in the 0.55 percent budget neutrality adjustment to the conversion factor.

This proposal is based on the CMS desire to address the following issues within RBRVS: 1) a general goal of increasing payments for primary care services; 2) the perception that physician time is inflated, with criticism of utilizing physician surveys to estimate physician time and a call for other time data to augment survey data; and 3) concern about the timeliness of review of individual services, resulting in unaddressed potential efficiencies. The AMA agrees with CMS' goal of ensuring that the time data used in work RVUs is accurate, that high-volume services are frequently reviewed to account for efficiencies, and that primary care payment is adequate and recommends alternative approaches to achieve these goals based on data and physician input. **The AMA recommends that alternative solutions be considered to accomplish these objectives.** Our comments first focus on concerns with the CMS proposal, while later offering information and potential actions addressing the CMS concerns and goals that would produce a more supported long-term policy that is fair to all physicians and the patients they serve.

Concerns with CMS' Proposal

The following arguments should persuade CMS to pivot from implementation of this proposal to other initiatives to achieve our shared objectives.

(1) There is No One-Size-Fits-All Efficiency Adjustment for Physicians' Work

The application of the efficiency adjustment is inconsistent with the approach envisioned by section 1848(c)(2) of the Act. While section 1848(c)(2) may allow for extrapolation in some circumstances, such as where specific data are not available, this would not be the case with the physician work RVUs that have been evaluated by the RUC on an ongoing basis. The across-the-board adjustment is being applied to all codes/services, as opposed to service/code-specific adjustments. CMS has not articulated why this specific adjustment is appropriate and should be applied uniformly to thousands of services. An across-the-board adjustment to all non-timed physician work RVUs is assuming the same amount of physician work efficiency across a large group of services across a fixed period which would be inconsistent with valuing "the service that reflects the physician time and intensity in furnishing the service." CMS itself acknowledges this point indicating that "accruing efficiencies does not apply equally to all services, and that efficiencies gained over time may often apply more to services that take less time to perform." (90 FR 32403). Nevertheless, CMS proposes that there is a base level of efficiency across all physician services based on economy-wide productivity and higher efficiency for the services cited. Again, this is an assumption that deviates from the implication in the statute that the review be of individual services with extrapolation or other techniques being reserved for services for which CMS does not have data.

Section 1848(c)(2)(B)(ii)(I) states:

> The Secretary shall, to the extent the Secretary determines to be necessary,… adjust the number of such units to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary shall publish an explanation of the basis for such adjustments.

The reference to "such units" appears to be to section 1848(c)(2)(B)(i) that states "relative values established under this paragraph for all physicians' services." Again, the implication of the statute is that the adjustments consider the individual circumstances of a procedure and not be applied across the board because of the variety of circumstances that there will be among individual codes or families of similar codes. Making such adjustments across several thousand codes, as being assumed by CMS, does not take into consideration this variety and diversity of circumstances. For instance, efficiencies gained for long duration surgical procedures will be very different than for diagnostic tests or minor surgical procedures that are shorter in duration.

CMS presumes, often citing dated studies, that intra-service physician time is overstated for all physician services. It is hypothesized that physicians can provide services more efficiently, so the physician intra-service time and work should be continuously decreased. CMS itself points to the unfairness in this application, "We recognize that over time, there may be variation in the efficiencies accrued service-by-service...." Recognizing that this is true, it is unfair to propose and inconsistent to propose a broad-based adjustment. CMS goes further in asking for comments on which services may not accrue efficiency but then provides no criteria for which they will consider these comments.

Reviewing the past four years of RUC recommendations for existing codes (CPT codes with work RVUs and existing time), 82/206 codes (40 percent) reflect intra-time decreases. Most re-reviewed codes do not illustrate efficiency or a decrease in time. Of the 82 codes with decreased time, 50 codes (61 percent) had the work decreased by the RUC. CMS concurred with 75 percent of the recommendations related to the 32 codes with decreased intra-time and stable work RVUs. CMS was compelled that code revisions, original time source validity or intensity countered the time decrease. It is particularly important to point out that for many codes original times were based on Harvard extrapolation or by a crosswalk from CMS personnel, rather than from any survey data from practicing physicians. Therefore, comparing a flawed initial time to a recent survey time and assuming efficiency in service is unfair and the RUC will often point this compelling evidence out to CMS in its recommendations.

CMS cites a study[1] that reviews efficiency and time differences between novice and experienced surgeons. The RBRVS and Medicare Physician Payment Schedule pay all physicians the same payment rate, regardless of individual experience. The study is not relevant as it does not relate to new technology or the ability of physicians in general to become more efficient at long-standing medical services. Importantly, the author noted the results varied greatly by procedure, which argues against a uniform reduction. When the RUC reviews new technology and the performance rate is low, the survey responses are segregated between those with low and higher performance rates per year. A low performance rate does not always translate into a higher estimated time or work RVU.

Importantly, a recently released study in the Journal of the American College of Surgeons, found that the proposed efficiency adjustment is not supported by empirical surgical time data. Intra-service time data (ie, skin-to-skin operative time) from 2019 and 2023 were compared for 1.7 million surgeries across 249 CPT codes and 11 surgical specialties from the National Surgical Quality Program registry. The study concluded that "Overall, operative times increased by 3.1 percent (CI 3.0-3.3%, $p<0.001$) in 2023 compared to 2019, or 0.8 percent/year (CI 0.7-0.8%/year, $p<0.001$). At the procedure level, 90 percent of CPT codes had longer or similar operative times in 2023 compared to 2019."[2]

The Society of Thoracic Surgeons (STS) reviewed the intra-service time data related to arterial and venous (33510-33523, 33533-33536) coronary artery bypass graft (CABG) procedures from the STS National Database from 2012 – 2022. This data compiled from 1,448,393 procedures shows that the intra-service times for arterial or venous CABG codes have substantially increased by 12 percent, not decreased since the codes were last valued by the RUC and CMS.

Newer technologies, including artificial intelligence (AI) software, frequently generate substantially more images and sequences than were previously available. A Computed Tomography (CT) study that once consisted of 40 images now frequently contains 400 or more. In addition, AI tools often highlight or flag findings that then require further physician review, confirmation, or correlation with other studies. This process adds uncompensated time and cognitive effort to the physician's workload. Far from creating net efficiencies, these innovations can increase the interpretive and documentation burden.

CMS proposes to also apply the efficiency adjustment to all recently reviewed services. For example, a new code implemented in 2026 and surveyed between March and December 2024 would be arbitrarily reduced by a 2022-2026 productivity adjustment, impacted by years in which the service was not even described by a code and prior to survey. **CMS should not apply efficiency adjustments to any code, especially those reviewed in the last five years.**

(2) Unintended Consequences Result from the Efficiency Adjustment Proposal

Since the inception of the RBRVS in 1992, CMS, the AMA, the RUC, and organized medicine have been united in the desire to retain the relativity in the physician work RVUs, rejecting any rescaling of work RVUs to accommodate budget neutrality, updates to MEI, or other policy changes. Stability in work RVUs is essential to provide a baseline for reviewing codes each year. Importantly, physician practices and health systems rely on stable physician work RVUs to use in their productivity and compensation plans. 56 percent of physicians nationally receive compensation adjusted based on productivity, according to an AMA report reviewing data from the AMA Physician Practice Benchmark Survey (Physician Compensation 2012-2022: Physicians Increasingly Compensated Through Multiple Methods). If implemented, this proposal could have unintended consequences to the budgeting, projecting, resource determination and staffing within physician practices and health systems. **CMS should not apply a broad-based adjustment factor to all work RVUs.**

(3) Difficulty in Maintaining Relativity with RBRVS

Adjusting physician work RVUs and intra-service time for all codes, while exempting commonly performed services that are often used as key reference services, will create challenges in the processes to update the RBRVS and ensure appropriate relativity of new and revised codes. Both the RUC and CMS will be relying on two different datasets to review codes for the 2027 cycle, for example. This would be further complicated if CMS were to apply an efficiency adjustment every three years.

In a relativity scale, the 2.5 percent proposed reduction applied to some codes and not others impact relativity in two ways. Rank-order anomalies will be created within and across families. Further, intensities will be altered as the 2.5 percent changes the work per unit time disproportionally. The RBRVS was developed by Harvard economists to measure physician work based on magnitude estimation, considering not only time but also the intensity of services. It is critical that the fundamental principles of magnitude estimation be upheld for the integrity of this payment system.

CMS applies the adjustment to the total work RVU when the efficiency is assumed to apply to the intra-service time only. In applying the work efficiency adjustment to the work RVU for CPT codes with a 010- or 090-day surgical global period, CMS is also decreasing the work value of the bundled E/M visits by 2.5 percent. CMS would create an even larger discrepancy between the payment level of a stand-alone E/M visit and the E/M visits bundled into surgical global payment. As discussed later in this letter, CMS should establish payment for E/M visits bundled into surgery global payment at the same level as standalone visits, while working with the RUC to ensure the number and level of visits included within the global are accurate.

The RUC, via the potentially misvalued code project, has assessed many high-volume codes in multiple reviews and recommended appropriate reductions in work values. The efficiencies that occurred for these codes have been accounted for. It would be unfair to reduce the services again. For example, 66984 cataract surgery was reviewed and reduced in 2013 and again in 2020. The 2025 work RVU for cataract surgery is nearly 30 percent lower than the 1992 work RVU. Traditional Medicare claims data indicate that the volume of cataract surgeries performed dramatically decreased during the COVID-19 pandemic and has not yet returned to pre-pandemic levels. There is no evidence that this surgery has become more efficient since 2020.

In September 2025, the RUC is reviewing several high-volume codes, including hip, knee, and shoulder replacement surgical procedures, identified due to a change in the site-of-service from inpatient to outpatient. The work RVU recommendations and time data will be submitted to CMS in October 2025 and will be based on physician surveys and other information gathered this summer. CMS should base its review of these services for the 2027 MFS based on these data and not in comparison to an efficiency adjusted 2026 work RVU.

The physician time data proposed by CMS is so granular, it is impossible to maintain in such a precise measure. For example, rather than a 10-minute intra-service time, the proposal would establish a time of 9.75 minutes. This level of precision in the time data is unnecessary, and it is impossible to compare it to survey data or other extant data. Certain elements of clinical staff time and equipment time are also linked to physician intra-time. This proposal destroys that existing link. **CMS should not apply a broad-based adjustment to physician intra-service time.**

(4) Exempted Code List Has Inconsistencies

CMS states that the proposed efficiency adjustment will be applied to the work RVUs for all codes with the following exceptions: time-based services, E/M, care management, maternity care, and services on the

CMS telehealth list from this efficiency adjustment. However, in the CMS list of codes subject to efficiency adjustment, CMS includes several codes that fall under these stated criteria for exemption. In addition, CMS does not explain the rationale regarding why some codes are excluded and others are not. Sufficient data and/or studies are not provided to justify why physicians might be able to obtain efficiency in most services yet exclude others. For example, why would the potential ability to perform a service via telehealth preclude a physician from the ability to achieve efficiency in providing the service? CMS notes a rationale for exclusion of E/M services, arguing that there has been passive devaluation of E/M services due to budget neutrality related to other services. To be entirely fair and accurate, CMS should acknowledge that it was the three major increases to E/M, and implementation of transitional care management, chronic care management, and the G2211 E/M intensity add-on code that resulted in significant budget neutrality redistribution from other physician services. **CMS should not implement the proposed work and time efficiency adjustment because the list of codes applicable and exempted is not well-explained or consistent.**

- Time-Based Services Subject to Efficiency Adjustment in Error - CMS proposes to exempt the efficiency adjustment to the work RVU and corresponding intra-service portion of physician time for time-based services. However, there are 126 CPT time-based codes included on the list, subject to the efficiency adjustment. *Please find the list of 126 CPT codes time-based codes that are subject to the efficiency adjustment in error (See Attachment 2).*

- Telehealth List Services Subject to Efficiency Adjustment in Error - CMS proposes to exempt codes on the Medicare telehealth list from being subject to the efficiency adjustment. However, it appears that two new codes proposed to be added to the telehealth list for 2026, CPT codes 92622 *Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes* and 92623 *Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (List separately in addition to code for primary procedure)* are listed as subject to the efficiency adjustment in error. These two codes are also time-based.

- Care Management Services Subject to Efficiency Adjustment in Error – CMS proposes to exempt care management services from the efficiency adjustment. However, it appears that three new care management codes *GPCM1 Initial psychiatric collaborative care management*, GPCM2 *Subsequent psychiatric collaborative care*, and GPCM3 *Care management services for behavioral health* are listed as subject to the efficiency adjustment in error.

(5) Unsourced and Potentially Inaccurate MEI Productivity Adjustment

CMS proposes implementing a -2.5 percent efficiency adjustment factor to the work relative values and physician intra-service time and explains that the source of this adjustment is the annual private non-farm productivity adjustment used in the MEI. However, these adjustments for 2022 – 2026 are not listed in either of the CMS online tables related to the MEI or in information available from the U.S. Bureau of Labor Statistics (BLS). Although CMS states on page 32402 that these productivity figures reflect "historical data at the time of the CY update," for only two of the past four years shown in the table were we able to find any data source to validate the figures in Table 11. CMS indicates that it applies this productivity adjustment to inpatient and outpatient hospital payment, but those entities receive a market basket update to account for inflation. Physicians do not receive an MEI update, so penalizing them with a productivity adjustment is not comparable to hospital payment. **CMS should not implement an MEI productivity adjustment that has not been well-explained or sourced.**

CMS TABLE 11 PROPOSED EFFICIENCY ADJUSTMENT FOR 2026

Calendar Year	MEI Productivity Adjustment (%)
2022	0.2
2023	0.5
2024	0.4
2025	0.6
2026	0.8*
Efficiency Adjustment	2.5%

**Subject to revision in Final Rule*

CMS explains that they are choosing to implement five years of a productivity adjustment now and then three years of adjustment going forward. In part, CMS seeks to justify this proposal with a statement that "it takes two years to make changes in valuation after we receive recommendations from the RUC." This is not accurate. CMS receives RUC recommendations 10 to 19 months before implementation, due to the CMS imposed requirement that all data and information be submitted by February 10. **While we do not support an efficiency adjustment, if CMS does implement one, the AMA urges you not to implement five years of efficiency adjustments in 2026.**

Additional Information and Alternative Solutions to Address CMS Concerns

Our intention is to ensure that the CMS concerns are addressed. Therefore, we provide additional information and potential solutions to address these concerns. We have a shared interest in ensuring that the RBRVS is accurate and fair to all physicians and other health care professionals.

(1) Primary Care Payment

CMS has ongoing concern that primary care is not being adequately supported in the United States. For decades, the RUC and CMS engaged to support and enhance primary care payment. The RUC led significant initiatives to review E/M office visits, the most frequently reported service by primary care physicians, in 1997, 2007 and 2021. Each review resulted in RUC recommendations to greatly increase office visit valuation. In 2021, the CMS implementation of office visits led to a collective 26 percent increase in work valuation for this family of services. The remaining E/M family of services were reviewed and increases implemented in 2023, combined, more than $6 billion in Medicare payments were redistributed from other services to E/M. The RUC's work to improve primary care valuation and address potentially misvalued services within the RBRVS has led to improvement. The cumulative result of these efforts, the four Five-Year Reviews, and other changes to the RBRVS and practice, are reflected in comparing the portion of allowed charges within the MFS from the inception of the RBRVS to 2024:

Medicare MFS Allowed Charges (Percent of Total)	**1992**	**2024**
Primary Care Specialties	24%	27%
Internal Medicine Specialties	14%	16%
Surgical Specialties	30%	16%
Other Specialties (Radiology, Anesthesiology, etc)	25%	22%
Other Health Care Professionals	7%	19%

In the Proposed Rule, CMS cites a 2018 MedPAC Report to Congress which included a number of potential options to redistribute payments from other services to primary care. CMS uses one of the options to support implementation of the efficiency work adjuster. However, CMS does not acknowledge that one of the other options supported by Medicare Payment Advisory Commission (MedPAC) in this report was already achieved. MedPAC recommended a 10 percent increase in office visit payment, offset by a budget neutrality adjustment to decrease payment for all other services. As noted above, this was achieved with the 2021 office visit increases and $6 billion in redistribution, implemented via a reduction to the Medicare conversion factor. In addition, the MedPAC option presumed efficiency was based on adequate review of new technology after diffusion and addressing services with high volume growth. The RUC has incorporated both reviews within its processes.

In 2024, CMS followed these E/M increases with implementation of a new add-on code G2211 *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)* to add $15.53 to further support primary care office visits. Medicare claims data analysis indicates that the previous administration severely overestimated utilization of this code, dramatically impacting the Medicare conversion factor via a budget neutrality adjustment. Of note, this budget neutrality adjustment negatively impacted the specialties the code was intended to assist. CMS can correct this problem by prospectively increasing the 2026 Medicare conversion factor to prevent this overestimate of budget neutrality from continuing to reduce Medicare payment rates year after year. As discussed later in this comment letter, CMS should review and implement the recommendations from the May 2025 AMA letter. The $1 billion adjustment to the conversion factor to correct this error would have a much greater impact than the $400 million dollar adjustment for the proposed efficiency adjustment. **To support primary care, CMS should implement a correction to the utilization assumptions for G2211, leading to a positive $1 billion budget neutrality adjustment to the Medicare conversion factor.**

(2) Survey Process and Availability of Extant Data

RUC Standardized Survey Process
The RBRVS methodology was established by Harvard economists in the late 1980s and relied heavily on the clinical expertise of practicing physicians and other health care professionals, both in data collection via surveys and in panel discussion to ensure magnitude estimation within and across all specialties and professions. The AMA, national medical specialty societies and other healthcare professional organizations were involved in the Harvard study and initiated a process to ensure that CMS would receive clinical input in updating the RBRVS on an annual basis. The RUC process initiated in 1991 just prior to the implementation of the RBRVS in 1992.

The RUC and the RUC survey process, allowing for maximum participation by all interested national medical specialty societies and other healthcare professional organizations, adheres to all standards and definitions developed by Harvard and updated by CMS via rulemaking. The process has continuously evolved since the inception of the RUC in 1991. In 1992, the threshold of 30 survey respondents was developed with input from consultants and statisticians based on the Central Limit Theorem which states that the sampling distribution of the sample mean will approximate a normal distribution as the sample size increases, typically considered sufficient at n = 30. In 2013, the RUC increased the minimum survey complete requirements. For services performed more than 1 million times per year in the Medicare population, at least 75 physicians must complete the survey. For services performed more than 100,000 annually, at least 50 physicians must complete the survey. On average, the number of responses per surveyed code is 70 physicians or other health care professionals.

The survey is standardized and continuously improved to ease completion, improve response rates and to conform to CMS policy and standard changes developed via rulemaking. Specialties utilize the AMA managed Qualtrics electronic platform to conduct random surveys and a standardized tool to summarize data statistics for RUC review. Data are summarized, reviewed by national medical specialties and other health care professionals, and included in standardized recommendations to the RUC. The RUC reviews the survey data and other information to inform its decisions and recommendations to CMS. For 2026, the RUC accepted 72 percent of the specialty recommendations. For those recommendations based on surveys, only 10 percent were based on the survey medians. The other 90 percent were based on RVUs below the survey median after a rigorous review by the expert panel using CMS approved methodologies. CMS accepted 89 percent of the RUC recommendations.

Clinical vignettes are developed and evaluated by the CPT Editorial Panel. The RUC's Research Subcommittee also reviews vignettes for existing services to specifically ensure that they are typical. Respondents are also queried if the vignette is typical for their practice and the RUC reviews these responses. CMS medical officers also participate in the process of reviewing vignettes. These abbreviated descriptions of the typical patient are brief, and attention is specifically paid to ensure that they are representative. CMS criticism, based on opinion from a ten-year-old report, that the vignettes are not typical does not reflect the current review process.

Several processes are used to ensure the integrity of the RUC survey process, including prohibiting individuals with a financial interest in a vendor related to the code under review from completing the survey. When a specialty must utilize a vendor client list to identify physicians performing new technology, the vendor must sign an attestation statement that they will not contact the clients related to the survey. In addition, the potential survey respondents are asked if anyone other than the specialty society staff has contacted them related to the survey. If there has been any contact, they are precluded from completing the survey. Importantly, the Advisor from each specialty society or health care professional organization is required to sign an attestation statement prior to presentation of the survey data to the RUC that states: ***"As a RUC Advisor, I attest that the integrity of the RUC survey, summary of recommendation forms and practice expense recommendations are based on accurate and complete data to the best of my knowledge."*** The documents and processes utilized by the RUC to ensure integrity of these data are publicly available on the AMA website.

Empirical Data Utilized by the RUC

The RUC has used empirical evidence and data in its process since the inception of the process. For example, in the most recent review of hip and knee replacement codes, orthopaedic surgery has shared peer-reviewed literature that supported the intra-service time. These orthopaedic codes are under re-review at the September 2025 RUC meeting, and it is understood that orthopaedic surgery will share recent literature in support of its recommendations. Literature is also an important component of the RUC's review of specialty compelling evidence arguments regarding budget neutrality within a family of services.

The RUC relies heavily on information from Medicare claims data in evaluating services. The AMA is actively pursuing obtaining Medicare Advantage and Medicaid data through the Research Data Assistance Center (ResDAC). These data are essential in understanding the typical patient, specialties performing the service and site of service. The RUC also uses these data in the identification of potentially misvalued services screens.

Each year, the RUC actively encourages specialty societies to nominate extant data sources for use in the process. For example, the Society of Thoracic Surgeons (STS) National Database™ was utilized to support the intra-service time for coronary artery bypass procedures. In 2007, the RUC and its Research Subcommittee developed the following criteria for submission of an extant data source:

RUC Extant Database Requirements:

- Databases must have data integrity/reliability:
    - Must collect data prospectively,
    - Should have the ability to identify and assess outliers – multiple procedures resulting in greater length of stay (LOS); diseases with high mortality rate (LOS=0) or extended recovery (LOS>90); age variance (bi-modal)
    - Should have the ability to have transparency of data to compare to other databases including the RUC database
    - Should have the ability to audit the database
    - Should have the ability to track the data/changes over time
    - Should have the ability to collect data on all cases done by participants or for large volume procedures or E/M encounters, and should have sampling criteria that are statistically valid to eliminate sampling bias
    - Should have current data, preferably from the last three to five years, although older sets can be used for comparison purposes
- Databases should collect time data for the procedures, at a minimum, the skin-to-skin or intra-service time and length of stay. Additional time elements may include intensive care unit (ICU) LOS, and other specialty specific time factors (i.e., phone calls, ventilator hours)
- Must have the ability to unequivocally map the procedure to a CPT code and isolate the procedure from associated physician work that is otherwise billable in the same setting
- Databases must list their limitations – include what is provided and not provided with respect to the RUC database
- Databases must be representative:
    - The data should be geographically representative eg, regionally and nationally for the specialty
    - The data should have various levels of patient severity
    - The data should have adequate practice site representation and sample size – practice sites and rural and urban representation
    - The data should be from various practice types – representative of the academic, non-academic, and other types of practices for the specialty
    - The data should be collected from the majority of specialties (including subspecialties) that perform the procedure or encounter
    - The data should be collected from either a hospital/institution or an individual physician.

To date, the RUC has approved and utilized the following sources of empirical data:

- Society of Thoracic Surgeons (STS) National Database™
- American College of Cardiology (ACC) CathPCI Registry®
- American College of Cardiology LAAO Registry™
- American College of Cardiology EP Device Implant Registry™
- STS/ACC TVT Registry™
- American Speech Hearing Language Association National Outcomes Measurement System

The RUC continues to explore other potential data sources, for example, any data that may be available from Electronic Health Records (EHR). The AMA engaged with EPIC and Oracle in 2024, and it was determined that specific data to determine intra-service time per CPT code were not available. However, the RUC is interested in learning what level of time data may be validated via EHR data. A researcher from the University of Maryland will join the RUC on September 25, 2025, at the Research Subcommittee meeting to share what time data are available for consideration. We encourage CMS to

attend this session. The RUC would also seek to work with CMS to determine if any of the above extant criteria should be modified.

CMS should continue to support the use of surveys to ensure the clinical expertise of practicing physicians and other health care professionals is respected and utilized in establishing work RVUs. The RUC will actively seek additional time data to support and augment survey data.

(3) Timeliness of Review of Individual Services

CMS expresses concern about the timeliness of review of individual services, with particular attention to efficiencies that may occur in the service between dates of review. The RUC has a number of processes in place to ensure that potential efficiencies and misvaluations are addressed. These processes and data on the RUC's timeliness in reviewing services will be discussed here, along with a suggestion to address the broader CMS concern.

New Technology List
The RUC identifies codes as new technology at the time of initial review based on recommendations from specialty societies and RUC members. The RUC considers several factors to identify new technology services, including recent Food and Drug Administration (FDA) approval; newness or novelty of the service; use of an existing service in a new or novel way; and migration of the service from a Category III to Category I CPT® code. Since 2010, the RAW maintains and develops all standards and procedures associated with the new technology list. The RUC has re-reviewed 60 services with new survey data from this new technology screen. The RAW will analyze claims data to identify other services where technology diffusion implies a re-review is required. Most of the services initially added to the new technology list are rarely performed (i.e., less than 500 times per year in the Medicare population), never really diffuse into a broader population and will not need to be further examined. The Workgroup will continue to review claims data for new technology services every April after three years of Medicare claims data are available for each service. The RUC and CMS could consider a volume threshold to re-review new technology (eg, after volume reaches 10,000 per year), however, for most codes added as new technology, the volume remains very low.

RAW Screens Related to Efficiency
The RUC also includes targeted efforts to address efficiencies that may occur in services via objective screens to identify potentially misvalued services. Prior to the establishment of the RAW to identify services that may be potentially misvalued, there was a Five-Year Review process in which CMS, CMDs, and specialty societies would nominate codes for re-review (1995, 2000, 2005 and 2010) and the RUC would review and provide recommendations. MedPAC and others were critical that these five-year reviews did not sufficiently address potential overvaluations within the RBRVS. The RUC stepped up to take on the responsibility to identify and review potentially misvalued services when no one else had succeeded in this role. For nearly two decades, the RUC has identified and reviewed these services annually. As part of this effort, the RAW has developed screens to account for various efficiencies in providing services. Some examples are:

- *High volume growth screen* – Services with Medicare utilization that have increased over 100 percent over a period of 5 years are identified for further review. These services are examined to determine if the growth has affected the resources required to perform these services and need to be resurveyed.

- *Site of service anomalies screen* - These services show a shift as once provided in the inpatient setting but now provided primarily in the outpatient setting. These services are resurveyed, and inpatient hospital visits are removed.

- *Services originally surveyed by one specialty are now performed by a different specialty* -These services are resurveyed to be sure they are valued accurately based on the typical physician or other health care professional and patient receiving these services.

- *Services performed together 75 Percent of the time or more* - One new code may be created to describe two services for these codes often reported together. This will address efficiencies to eliminate double counting pre-service time, immediate post-service time or post-operative care associated with two individual codes.

- *Harvard-Valued or CMS/Other source data* - The RUC reviews services that were valued over 33 years ago in the Harvard Studies that have Medicare Utilization over 30,000 and CMS/Other codes, which are services that were not reviewed by the Harvard studies or the RUC and were either gap filled, most often via crosswalk by CMS. These services are either revised at CPT if the code descriptors no longer accurately describe a service and then surveyed or surveyed as described and are accurately valued based on valid data from the physicians who are performing these services.

CMS has also developed the High Expenditure Procedural Codes screen on two separate occasions. In the Proposed Rule for 2012, CMS requested that the RUC review a list of 70 high MFS expenditure procedural codes representing services furnished by an array of specialties. CMS selected these codes since they had not been reviewed for at least 6 years, and in many cases, the last review occurred more than 10 years ago. The RUC reviewed the 70 services identified and expanded the list to 145 services to include additional codes as part of the code family. The CPT Editorial Panel deleted 20 codes, and the RUC submitted 125 recommendations to CMS for the 2013-2019 Medicare Physician Payment Schedules.

In the Final Rule for 2016, CMS requested that the RUC review a list of 103 high MFS high expenditure services across specialties with Medicare allowed charges of $10 million or more. CMS identified the top 20 codes by specialty in terms of allowed charges, excluding 010 and 090-day global services, anesthesia and Evaluation and Management services and services reviewed since 2010. The RUC expanded the list of services to 238 services to include additional codes as part of the family. The CPT Editorial Panel deleted 30 codes. The RUC submitted 208 recommendations to CMS for the 2017-2019 Medicare Physician Payment Schedules.

In addition to the review of new and revised codes, the RUC has examined 2,924 potentially misvalued services and has reviewed approximately 95 percent of the Medicare Physician Payment Schedule allowed charges. Codes that have not been reviewed are low volume and represent a minimal amount of allowed charges. The RUC, via its 2006-2025 potentially misvalued services review effort, has recommended reductions and deletions to over 1,600 services, redistributing $5 billion within the RBRVS. These efforts have contributed significantly to addressing any efficiencies associated with services throughout the life of the RBRVS and a separate adjustment is unnecessary.

CMS notes that in the intervening years without revaluation, they are most likely overvaluing codes by not accounting for efficiencies gained in the valuation of work RVUs for non-time-based services. CMS states that when recommendations have been submitted by the RUC to CMS as potentially misvalued codes from 2009 to 2025, the RUC only recommended a decrease in the physician time and resources for the codes 39 percent of the time. CMS neglects to account for over 500 services or approximately 18 percent of codes that have been reviewed as potentially misvalued, that have been deleted in CPT. Only accounting for work RVU decreases in current codes, while excluding deleted codes and bundled codes,

presents an incomplete picture of the total actions taken to accurately assess the value of these services. Omitting these prior deletions and other CPT actions overlooks key historical context and corrective steps already implemented by the RUC, which are essential to understanding the full scope of valuation efforts.

Survey to CMS Implementation Timeframe

CMS states, "even when a code is reviewed by the RUC, two to three years usually pass between when the survey data was collected and its use by CMS in setting rates becomes effective." This statement is inaccurate. The table below illustrates the timeline between specialty society surveys, RUC review and CMS implementation. The number of months between survey and CMS implementation ranges from 13 months to 21 months. The longest period from the time a code is surveyed to the time it is implemented in the MFS is 21 months, which is less than two years (i.e., surveyed in April 2024 and finalized and effective January 1, 2026). The shortest time period from survey to implementation is 13 months. Before 2017, the longest period from survey to implementation was 16 months (i.e., surveyed in August 2014 and implemented January 1, 2016), and the shortest was 9 months. The shift was due to the Agency's call to allow them to respond with proposed values for all services in the July Proposed Rule instead of the November Final Rule as interim values. Therefore, all RUC recommendations for 2026 implementation were due to CMS by February 10, 2025. The RUC must adhere to the due dates that CMS itself has implemented.

Physicians Surveyed	RUC Meeting	RUC Submission to CMS	CMS Implementation	Time Span
Dec 2024	Jan 15-18, 2025	Feb 4, 2025	Jan 1, 2026	13 months
Aug 2024	Sep 25-28, 2024	Oct 15, 2024	Jan 1, 2026	17 months
Apr 2024	Apr 24-27,2024	May 14, 2024	Jan 1, 2026	21 months

Frequency Between RUC Reviews

CMS states, "We would highlight, however, that there are often many years between a code's introduction and revaluation within the RUC process, with only a few hundred out of the more than 9,000 codes paid under the MFS considered for revaluation annually by the RUC. While there is significant variability in how often codes are reviewed by the RUC, on average, CMS estimates that there are 25.49 years since a code valuation has been reviewed by the RUC (this includes 5382 out of 9970 codes which were never reviewed). When we exclude from the average those codes that have never been reviewed, the average is 17.69 years since the last review of a code by the RUC. We note that these numbers weight each code equally and the MFS itself is heavily weighted by utilization towards a much smaller number of often utilized codes." **There are 7,258 CPT Category I codes with a work RVU, not 9,970 codes. Codes with Medicare utilization greater than 10,000 have been reviewed, on average, within 13 years. There are 497 CPT Category I codes with volume greater than 100,000, comprising 88 percent of Medicare spending. The average number of years since the last RUC review for these codes is 11 years.**

Category I CPT Codes with Work RVUs by Medicare 2023 Utilization	Number of Codes	Medicare 2023 Allowed Charges	Percent of Medicare MFS Spending	Average Number of Years Since Last RUC Review
Greater than 10,000	1,356	$82 billion	96%	13 years
Greater than 100,000	**497**	**$75 billion**	**88%**	**11 years (median=10 years)**
Greater than 1,000,000	127	$62 billion	73%	10 years

ALL	7,258	$85 billion	100%	23 years
Less than 1,000 times per year	4,467	$500 million	0.60%	26 years

Rather than an arbitrary efficiency adjustment applied to nearly all CPT codes, even those with low volume, CMS could instead consider ensuring that higher volume codes be reviewed on a more frequent basis (e.g., the RUC could consider reviewing and validating the valuation of codes with more than 100,000 in utilization, which represents nearly 90 percent of Medicare MFS spending, every 10 years). The RUC already reviews these higher volume services, on average, each 11 years, so it is a realistic timeframe, and it provides the opportunity for specialties and the RUC to demonstrate that the relativity for these services is appropriate, without application of arbitrary adjustments. It is likely that most high-volume codes will be identified by the RAW or CMS well within this 10-year timeframe. For example, CMS used a high expenditure screen in 2012 and 2016, and the RUC identified codes through a number of objective screens.

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D. Ambulatory Specialty Model (ASM)

Overview

The CMS Innovation Center (CMMI) proposes ASM as a new alternative payment model for implementation in 2027. Physicians in seven specialties (anesthesiology, cardiology, interventional pain management, pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation) that treat patients with heart failure or low back pain would be required to participate in ASM for up to five years. Specialists who deliver most of their heart failure or low back pain care to patients in 240 geographic areas selected by CMMI would be required to participate in ASM if they are attributed at least 20 episodes of care under the MIPS Heart Failure Episode-Based Cost Measure (HF EBCM) or Low Back Pain Episode-Based Cost Measure (LBP EBCM) based on services they deliver two years before an ASM performance year.

ASM participants would be assigned scores based on comparison to other specialists assigned to ASM for the same condition (heart failure or low back pain). Cost scores would be based on average Medicare spending attributed to them under the HF EBCM or LBP EPCM and quality performance would be measured utilizing five measures selected by CMMI. Participants would also be evaluated on IA measures focusing on their relationships with primary care practices and processes to help patients find a primary care physician if they do not have one and whether they meet PI requirements.

As in MIPS, physicians' performance in ASM during the years 2027-2031 would determine their Medicare payment adjustments two years later, in 2029-2033. Payments for all their services, not just those for heart failure or low back pain patients, could be reduced or increased as much as 9 percent in 2029 and 2030, 10 percent in 2031, 11 percent in 2032, and 12 percent in 2033. These payment

adjustments would be based on participants' overall ASM performance score compared to all other specialists who are in ASM for the same condition (heart failure or low back pain), but not to non-ASM MIPS participants, even if they report or are attributed some of the same measures. The financial model appears to be designed to reduce payment rates for most ASM participants.

Positive Aspects of ASM

The AMA has been urging CMMI to create alternative payment models for specialists for more than a decade and appreciates that ASM has several elements that are responsive to our recommendations. ASM has been designed to focus on care of patients with specific diseases or health problems that are managed by specialists who provide mainly ambulatory rather than inpatient care. It uses quality and cost measures applicable to the same health condition. To help support physicians in independent private practices transitioning to value-based care models, ASM allows physicians to participate without having to be part of an accountable care organization, hospital, or large physician group. In addition, unlike other models that require participants to repay CMS if the total cost of care for a patient population is more than a benchmark set by the agency, it does not place physicians at direct financial risk for increases in total Medicare spending on their patients.

Concerns

ASM also contains several features that the AMA urges CMMI to modify substantially. As proposed, ASM's financial model guarantees that most participating physicians will have their payments cut regardless of how well they perform on the measures. Maximum penalties in 2031-2033 are larger than in MIPS and much larger than hospitals face in the Hospital Value-Based Purchasing program. ASM would mandate participation by specialists in 25 percent of the country. Redesigning ASM as a voluntary model would be more consistent with CMMI's statutory authority to test experimental models. Another concern is that, instead of setting a performance standard in advance, payment adjustments would depend on whether a participant's performance exceeded the majority of other ASM participants each year. This kind of "tournament" model has been discredited and is not used in other payment models. Finally, physicians treating as few as 20 patients with heart failure or low back pain a year would be required to participate and their payments would be reduced or increased based on the ASM required measures, even if ASM patients are a small subset of all their patients.

One of CMMI's current aims is designing models to "level the playing field for providers practicing independently and outside of health system or health plan ownership to increase competition in markets." While the AMA and CMMI are aligned in this goal, we are concerned that the current model design will not provide better support for independent practices and may lead them to look to help from larger organizations to maintain their financial sustainability. For example, data from the AMA's 2024 Physician Practice Benchmark Survey identified "ease participation in risk-based payment models" as a key reason that physicians left private practice.

ASM Payment Methodology

Recommendations:

- The AMA recommends that CMMI make the following changes to the proposed ASM payment methodology: (1) eliminate the use of a "redistribution percentage;" (2) use a performance threshold that is defined in advance; (3) evaluate physicians based on performance improvement as well as absolute performance on quality and cost measures; (4) use a linear exchange function to convert performance scores into payment changes; and (5) reduce the maximum amount that physician payments could be cut.

The AMA is pleased that ASM does not propose to place physicians at direct financial risk for increases in Medicare spending that they cannot control or influence. We are concerned, however, that the proposed ASM payment methodology appears to be designed to achieve Medicare savings by reducing payments for the majority of physicians who participate, and that it uses a "tournament" model that could penalize physicians even if they significantly improve quality or reduce avoidable spending**.** Rather than "incentivizing" physicians to improve care for patients, the proposed payment methodology could instead *penalize* specialists for treating Medicare patients with heart failure or low back pain. This could have the unintended consequence of reducing access to needed care for patients with these conditions and lead to higher spending for Medicare. It could also drive even more physicians out of private practice. For example, the AMA's most recent data show that less than one-third of cardiologists are still in private practice, the smallest percentage of any specialty, and reducing payments to cardiologists under ASM could drive this percentage even lower.

We are concerned that CMS proposes using a "redistribution percentage" of 85 percent in calculating payment changes for physicians, which means that only 85 percent of any payment reductions would be used to increase payments for high-performing physicians. The redistribution percentage would guarantee Medicare savings from ASM by forcing a net reduction in Part B payments to the participating physicians. No such redistribution percentage is used in MIPS, nor is one used in the Hospital Value-Based Purchasing (VBP) program. In those programs, any payment reductions for lower-performing physicians and hospitals are used to fund payment increases for high performers, whereas in ASM, most physicians would receive payment reductions. We strongly oppose the use of a "redistribution percentage" in ASM.

Medicare payment adjustments in ASM would be determined by comparing participant's overall performance score to the median score of the other physicians participating in ASM during the same year. This "tournament" approach means that physicians could be penalized even if they significantly improved quality or reduced avoidable spending, and it also means that physicians would have no way of knowing in advance what level of performance would enable them to avoid a payment reduction. Moreover, it would discourage physicians from collaborating on care improvement initiatives, because the only way that a physician could avoid a payment reduction would be to receive a significantly higher score than most other physicians. This approach is not used in MIPS, in the Hospital VBP program, or in other CMMI alternative payment models, and we oppose the use of a tournament model in ASM.

Both MIPS and the Hospital VBP program evaluate performance using both "improvement scores" and "achievement scores." Also, both programs determine payment adjustments by comparing the overall score to a predefined performance threshold rather than comparing it to the scores other physicians or hospitals receive during the same year. **We recommend that in ASM, physicians be evaluated based on both (a) whether the physician's performance on quality and spending has improved compared to the previous year, and (b) whether the physician's performance exceeds a threshold that is defined in advance and is known to be feasible for physicians to achieve based on the scores physicians have achieved on the same quality and cost measures in previous years.**

CMS proposes to use a "logistic exchange function" in ASM, rather than the "linear exchange function" that is used in MIPS and the Hospital VBP program. Use of a logistic function would cause physicians with performance scores slightly below the median to receive payment reductions that are almost as large as physicians with much lower scores. **We oppose the use of a logistic exchange function in ASM and recommend using a linear exchange function instead.**

CMS proposes that physician payments could be reduced by as much as 9 percent in 2029 and 2030 and increase by one percent each year until reaching 12 percent in 2033. These reductions would be more than

four times as high as the 2 percent maximum penalty for hospitals under the Hospital VBP program, and the maximum payment reductions in 2031-2033 would be higher than the maximum amounts permitted in the MIPS program. **We recommend that physicians not be subject to any payment reductions in the initial two years of the program, so that they can gain experience reporting the measures and receive feedback on their performance before being subject to penalties. Maximum penalties should be reduced to 2 percent, the same as the maximum in the Hospital VBP program.**

Illustrative Payment Scenarios

Two scenarios are shown below to illustrate the problems caused by the proposed ASM payment method. For simplicity, each scenario assumes that there are only 3 physicians (A, B, and C) who are required to participate for a particular health condition (i.e., heart failure or low back pain). However, the same results would occur if there were 10,000 physicians participating, 1/3 of whom have scores and average Part B payment amounts like those shown for each of the hypothetical physicians.

Scenario 1 is based on the example used in the proposed rule at 90 FR 32608. The example in the rule is based on $1 billion in Part B professional services payments to all participants; Scenario 1 is based on $1 million so it makes sense for 3 physicians. Since the total payments for the 3 physicians is $1 million instead of $1 billion in the CMS example, all the dollar numbers in the scenario will be smaller than in the CMS example by a factor of 1,000.

The CMS example uses a physician with a score of 80, and it assumes the median score for all physicians in the ASM cohort is 50. In Scenario 1, the 3 physicians have scores of 80, 50, and 20, which results in a median of 50. After "transforming" those scores using the proposed logistic exchange function, the "denominator" (using the calculation in Step 5 at 90 FR 32608) is calculated as $51,000 (equivalent to the $51 million in the CMS example for $1 billion in payments), and the "scaling factor" is 1.5, the same as in the CMS example. Scenario 1 shows that the physician who scores 80 would get a 3.86 percent payment increase, which is essentially the same as the 3.85 percent adjustment in the CMS example. However, Scenario 1 shows that the physician who is performing at the median would get a payment reduction of 2.25 percent. This is inherent in the proposed model, because it is designed to guarantee a 1.35 percent overall reduction in payments to the participants in the first year.

Scenario 1: Example Based on Proposed Rule Scenario							
ASM Participant	**Part B Payments**	**Final Score**	**Transformed Score**	**Denominator**	**Payment Adjustment Factor**	**Payment**	**Change in Payment**
A	$350,000	80	0.95	$30,006	3.86%	$363,509	$13,509
B	$447,300	50	0.50	$20,129	-2.25%	$437,236	($10,064)
C	$202,700	20	0.05	$865	-8.36%	$185,755	($16,945)
Total	$1,000,000			$51,000		$986,500	($13,500)
Median		50					-1.35%
Risk Level	9%						
Redistribution %	85%						
Incentive Pool	$76,500						
Scaling Factor				1.50			

Scenario 2 shows that if every physician received a perfect score, they would all receive a payment reduction. The current ASM design would always ensure savings for CMS but not always reward good performance.

Scenario 2: All Physicians Perform Perfectly = All Receive Payment Reductions							
ASM Participant	Part B Payments	Final Score	Transformed Score	Denominator	Payment Adjustment Factor	Payment	Change in Payment
A	$350,000	100	0.50	$15,750	-1.35%	$345,275	($4,725)
B	$447,300	100	0.50	$20,129	-1.35%	$441,261	($6,039)
C	$202,700	100	0.50	$9,122	-1.35%	$199,964	($2,736)
Total	$1,000,000			$45,000		$986,500	($13,500)
Median		100					-1.35%
Risk Level	9%						
Redistribution %	85%						
Incentive Pool	$76,500						
Scaling Factor				1.70			

The AMA urges CMS to work collaboratively with physicians who treat patients with low back pain and heart failure to develop an improved payment methodology for ASM that would support higher quality care for patients and lower avoidable spending.

ASM Quality and Cost Measures

Recommendation:

- Physicians should not be required to participate in ASM if there is not an adequate number of measures that are designed to assess the performance of individual physicians on both quality of care and avoidable spending for Medicare patients with heart failure or low back pain. Physicians should not be required to participate in ASM or have their payments reduced based on ASM measures if: (a) they do not have a sufficient number of patients to produce a reliable performance score; (b) the measures do not reflect aspects of quality and spending that physicians can control; and (c) they have not been able to use the measures and receive feedback on their performance for at least two years.

The quality measures proposed for use in ASM would not accurately or adequately assess whether Medicare beneficiaries with heart failure or low back pain had achieved better outcomes nor would they protect patients from underuse caused by efforts to reduce episode spending. Although the proposed rule implies that ASM focuses on use of patient-reported outcome measures, none of the proposed quality measures for heart failure are patient-reported outcome measures, and only one of the five quality measures for low back pain is a patient-reported outcome measure (Functional Status Change for Patients With Low Back Impairments).

Most ASM quality measures are calculated based on patients of all ages, whereas the cost measures focus on Medicare beneficiaries. All the quality measures for heart failure include younger patients except the Hospital Admission Rate for Heart Failure Patients measure, and all the quality measures for low back pain include younger patients except the High Risk Medication measure. As a result, any reductions in quality of care for Medicare patients that result from spending reductions for those patients will not be apparent in the quality measures.

Both “heart failure” and “low back pain” represent a wide range of very different health problems, and the measures proposed for use in ASM do not assess quality and cost for the same group of patients. Two of

the heart failure quality measures (Beta Blocker Therapy for LVSD and ACE/ARB/ARNI for LVSD) apply only to patients with reduced ejection fraction (left ventricular systolic dysfunction), whereas the cost measures include patients with preserved ejection fraction. The Functional Status Change for Patients With Low Back Impairments measure is defined for a different set of diagnosis codes than are used for the Low Back Pain EBCM and the measure, originally developed by Focus on Therapeutic Outcomes (FOTO), was developed to evaluate the quality of care provided by physical therapists. While the use of the measure may be expanded in other programs, it remains primarily focused on rehabilitation services rather than the care provided by other specialties such as neurosurgery or orthopedic surgery. In addition, it is very likely that these other specialties will need to interface with a new system outside of their usual workflows and EHRs to be able to successfully capture and report data on this measure. The MIPS guidance provided by FOTO includes a recommendation that practices must manually record the date of survey completion, the score and predicted change and then use these data to calculate a residual score, creating an unreasonable expectation and burden to report this measure (https://fotoinc.com/science-of-foto/low-back/). This measure uses the FOTO Low Back Patient-Reported Outcome tool, and it is not clear that this survey aligns with the Oswestry Disability Index, which is referenced as a part of the justification for this measure. This measure was last reviewed for endorsement maintenance in 2019 and no recent data on the reliability and validity data are available nor is it clear if any new data would include specialties outside of physical therapy.

Three of the five quality measures that would be used for the low back pain component of ASM (Use of High-Risk Medications, Screening for Depression, and BMI Screening) are based on services to patients who have a wide range of diagnoses, not just low back pain. As a result, spending on patients with heart failure or low back pain could be reduced in a way that would negatively affect outcomes for specific subsets of patients, but the reductions could have little or no impact on the quality measures because those patients are not included in the measures or because they represent only a small subset of the patients in the measure. Also, endorsement was removed from the screening for depression and BMI screening measures in 2020. As a result, there is no recent data demonstrating that the measures are reliable and valid at the individual clinician level. In addition, the Use of High-Risk Medications measure was developed at the health-plan level, not the individual clinician level. Therefore, its reliability and validity at the individual clinician level must be demonstrated.

One of the quality measures that is proposed for use with low back pain (Use of Lumbar Spine MRI for LBP) has not even been developed. It is inappropriate to propose holding physicians accountable for performance on measures that have not been developed or tested at the individual clinician level and that they have no experience using. In addition, this measure was removed from the Hospital Outpatient Quality Reporting program due to overall stable performance and low average volumes. There are also several studies demonstrating that this measure is not correlated to improved outcomes and therefore this measure should not be included in this model.[1,2,3]

The EBCMs include spending on avoidable services as well as necessary services. As a result, a physician could be rewarded for reducing spending on necessary services as well as on avoidable services, and as

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[1] Blackmore CC. (2019). The Relationship Between Medicare Outpatient Efficiency Measure OP8 and Lumbar MRI Utilization, Journal of the American College of Radiology 16(3): 276-281. https://doi.org/10.1016/j.jacr.2018.10.026.

[2] Lind KE and Flug JA. (2019). Sociodemographic Variation in the Use of Conservative Therapy Before MRI of the Lumbar Spine for Low Back Pain in the Era of Public Reporting, Journal of the American College of Radiology 16(4): 560-569. https://doi.org/10.1016/j.jacr.2018.12.047.

[3] Martin BI and Jarvik JG. (2015). The Medicare Outpatient Imaging Efficiency Measure for Low Back Pain ("OP-8"), Radiology 276(1). https://doi.org/10.1148/radiol.2015150648.

explained above, if this causes worse outcomes for patients, it may not be apparent in the quality measures. In addition, average spending on a physician's patients could increase because of factors they cannot control, such as changes in the prices of drugs or spending on services ordered by other physicians that the patient has chosen to see. Physicians should not be penalized for changes in aspects of spending that they cannot control.

In the proposed rule, CMS reports that 43 percent of the cardiologists who would be required to participate in ASM have only 20-29 attributed heart failure episodes, and 35 percent of the other specialists who would be required to participate in ASM have only 20-29 attributed low back pain episodes. The Measure Justification Form for the HF EBCM indicates that when the measure was tested for NPI-TINs with 20 or more attributed patients, reliability of the measure was below 0.7 for 70 percent of the NPI-TINs, and reliability was below 0.4 for 13 percent of NPI-TINs. The Measure Justification Form for the LBP EBCM indicates that when the measure was tested for NPI-TINs with 20 or more attributed patients, reliability of the measure was below 0.7 for 37 percent of the NPI-TINs, and reliability was below 0.4 for over 4 percent of NPI-TINs. This is unacceptably low reliability for measures that would be used for payment penalties. Because of this, a large proportion of the physicians in ASM could be inaccurately labeled as providing "high cost" care and be unfairly penalized as a result.

In addition, the measure of Risk-Standardized Acute Cardiovascular-Related Hospital Admissions for Patients with Heart Failure has been proposed for use in ASM to evaluate the quality of care by individual cardiologists, even though it was not designed to evaluate individual physicians and it has only been used in MIPS for groups, not for individual physicians. The reliability of the measure has only been evaluated for TINs, not individual physicians, and the Measure Testing Form indicates that the reliability scores were less than 0.6 for half of TINs that had at least 21 heart failure patients, and reliability scores were less than 0.6 for more than one-fourth of TINs that had 32 or more heart failure patients. This is unacceptably low reliability for a measure that would be used for adjusting payments for physician groups, much less individual physicians.

Lastly, we agree with CMS' assessment that the following measures should not be included in ASM:

- Patient activation measure (PAM) (MIPS Q503): The measure is not tested at the individual clinician level and requires a minimum of 50 patients to meet the minimum reliability level.
- Advance care plan (MIPS Q047): The measure is extremely burdensome to implement and we agree with CMS' assessment regarding the lack of return on investment to impact change.
- Clinician and clinician group risk-standardized hospital admission rates for patients with multiple chronic conditions (MIPS Q484): The measure is only endorsed at the group level and reliability testing from the first and only review showed results of 0.413 for practices with at least 15 clinicians and 18 patients with multiple chronic conditions.
- Cardiac Rehabilitation Patient Referral from an Outpatient Setting (MIPS Q243): The measure is not specific to heart failure and we support CMS' concern with the regional variation on the availability of cardiac rehabilitation services.
- Falls: Plan of Care: We support CMS' concerns that patients may be at risk of falls or reasons unassociated with the care of the ASM participant.

CMMI should not implement ASM for heart failure, low back pain, or other conditions until it has developed a fully aligned set of measures of the quality and cost of care for the same patients. Physicians should not be required to participate in ASM or have their payments reduced unless they have enough patients to produce reliable scores on ASM quality and spending measures that have been tested at the appropriate level of analysis. In addition, CMS should not adjust physicians' payments based on a measure until the physicians have at least two years' experience receiving information based on the measure and using the information to improve patient care. In general, a physician should not be held

accountable for a measure for the first two years they report on a measure or when an existing measure has been updated and/or undergone substantive changes. The measures should be in the program as informational only or as pay-for-reporting.

Specialists and Geographic Areas Selected for ASM

Recommendation:

- Every physician should have the opportunity to participate in ASM if they believe it will enable them to deliver higher quality patient care. Physicians should not be required to participate in ASM nor precluded from participating based on where their patients receive care or the specialty code assigned to them by a CMS contractor.

The AMA applauds CMMI for working to develop an alternative payment model focused on improving care for patients with specific health problems and improving payment for the specialists who deliver ambulatory care to those patients. However, we have significant concerns with the methodology CMMI has proposed for determining which specialists and geographic areas will be ASM participants.

CMMI proposes limiting participation in the low back pain component of ASM to anesthesiologists, pain medicine and interventional pain medicine physicians, neurosurgeons, orthopedic surgeons, and physiatrists, even though most Medicare patients with low back pain are treated by chiropractors, physical therapists, and primary care physicians, according to data released when the LBP EBCM was being developed. The proposed rule says that ASM was designed to "focus on clinicians who commonly treat patients in the ambulatory setting," but ASM includes surgeons and anesthesiologists while excluding the clinicians who provide most ambulatory care for patients with low back pain. CMS also proposes limiting participation in the heart failure component of ASM to general cardiologists, even though the data released when the HF EBCM was being developed shows that half of patients with heart failure are attributed to other types of physicians and clinicians, including cardiologists with subspecialty designations. These arbitrary rules will result in most beneficiaries with back pain and a large proportion of beneficiaries with heart failure being excluded from ASM. Moreover, the rule states that the "specialty" designation that will be used to include or exclude a physician will be determined by CMS contractors instead of the physicians treating the patients. Physicians who provide the same types of services to similar patients should not be subject to different payment rules simply because of the specialty code CMS has assigned to them.

The geographic limitations that CMS has proposed also have several serious flaws. Most Medicare patients with heart failure or low back pain would be denied the benefits of any quality improvements that result from ASM. Physicians who deliver the same types of services and treat the same types of patients would be paid differently based solely on the locations where their patients with heart failure or low back pain receive services. Many Core Based Statistical Areas (CBSAs) and metropolitan divisions are immediately adjacent to each other, so physicians could be included or excluded from ASM based solely on which side of a county or city boundary their office is located. Physicians practicing at the same location could be paid differently based on where their patients received other services, and physicians whose practices are not located in an ASM region could be included in ASM if their patients received other services from hospitals or physicians located in an ASM region.

CMS has justified mandating participation by physicians in a randomly selected subset of CBSAs and prohibiting participation in other areas to improve its ability to evaluate the impact of the program. The proposed methodology would not ensure that two groups of similar physicians and patients could be compared to each other over multiple years. However, there would likely be significant changes from year to year in which physicians participate because a high percentage of physicians have small numbers

of eligible patients, so many physicians could be included one year and excluded the next if the number of patients attributed to them changes by a small amount. In addition, attribution based on small numbers of patients could easily cause the characteristics of the patients in ASM to change from year to year in non-comparable ways. Forcing all specialists in some regions to participate and preventing those in other regions from participating would also prevent CMMI from evaluating why specialists do or do not choose to participate in ASM. **It would be more consistent with the statutory requirements for evaluation of a Phase I model test for CMMI to allow physicians to voluntarily participate in ASM rather than being required to do so.**

The AMA opposes requiring or prohibiting participation in a payment model based on the specialty code that CMS has assigned to the physician rather than the types of patients they treat. Moreover, if CMMI adopts our recommendations to fix the problems with the ASM methodology so that it can support the delivery of higher quality care for patients, then availability of ASM should not be limited to 240 randomly selected CBSAs and metropolitan divisions as CMMI has proposed. The AMA recommends that physicians who treat patients with heart disease or low back pain should be able to choose whether to participate in a well-designed ASM regardless of where they practice or where their patients receive services, and regardless of what specialty code is assigned to them by CMS. CMMI should evaluate ASM and other new alternative payment models 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 physician participation or implementing models only in randomly selected parts of the country.

Physicians Required to Participate in ASM

Recommendation:

- CMMI should change the ASM participation requirements so that physicians are not required to participate if they are not directing the care of the patients attributed to them. Physicians should also retain the option of participating in MIPS rather than ASM if only a small proportion of their patients are being treated for heart failure or low back pain and they believe the measures available in MIPS would better reflect the quality and cost of services for most of their patients. Alternatively, any payment reductions should only be applied to the services ASM participants deliver to patients with heart failure or low back pain, not the services they deliver to other types of patients.

ASM would require physicians in the designated specialties to participate if 20 or more patients are "attributed" to them under the HF EBCM or LBP EBCM. They would then be held accountable for all spending related to heart failure or low back pain for these patients during the next 12 months. The proposed rule says that ASM was designed "with a focus on clinicians who commonly treat patients in the ambulatory setting, develop longitudinal relationships with patients, and co-manage beneficiaries with primary care clinicians." However, a patient could be attributed to a physician under ASM regardless of whether the physician was managing the care of the patient's heart failure or low back pain. A patient could be attributed to the physician even if the services the physician delivered to the patient were intended to address health problems other than heart failure or low back pain. **We oppose reducing a physician's payments based on how much Medicare is spending for a patient if the physician is not actively managing the care of that patient, and we urge CMS to allow physicians to use Patient Relationship Codes to report the nature of their relationship with attributed patients.**

CMS has proposed that physicians participating in ASM would be precluded from participating in MIPS. Yet physicians in the designated specialties could be required to participate in ASM if they saw as few as 20 patients with heart failure or low back pain during the year, even if most of their patients do not have

those conditions. As a result, the quality and cost measures in ASM could be applicable to only a small proportion of a physician's patients, and the physician would be precluded from using different measures that are more appropriate for the other types of conditions they treat. As a result, patients would be unable to determine the quality of care the physicians in ASM deliver for other health conditions.

Physicians should not be precluded from reporting on different quality measures than are available in MIPS if those measures better reflect the types of services the physicians deliver and the majority of patients they treat than the ASM measures. If a physician is forced to participate in ASM, their performance on measures related to heart failure or low back pain should only affect their payments for services related to those conditions; the amounts the physician is paid for services to patients with other types of conditions should only be adjusted based on measures of quality or resource use that are directly related to those conditions.

Improvement Activity Requirements

Recommendation:

- CMMI should remove the "improvement activity" requirements under ASM. They are impractical, extremely burdensome, will discourage specialists from treating Medicare patients who need their skill and expertise, and will likely force more small practices to close and further increase consolidation in the healthcare industry.

The AMA supports CMMI's aim to address patients' social needs and improve coordination between specialists and primary care. We share the goal of "screen once, share widely" so information follows the patient and informs clinical decision-making. However, as drafted, the 2027 ASM requirement to exchange social-needs screening information is **not implementation-ready**. Mandating compliance before the infrastructure, workflow standards, and financing are in place will drive duplicative screening, increase administrative burden, and push activity into back-office workarounds rather than the point of care. CMS should phase in expectations, align them explicitly to national standards (Gravity/U.S. Core Data for Interoperability (USCDI)), furnish practical tools (including Collaborative Care Agreement templates), and finance the operational lift so practices can succeed.

Why the model is not implementation-ready

In the ambulatory specialty setting, verification of a patient's primary care attribution and prior social determinants of health (SDOH) screening is still largely manual where systems do not share an EHR or health information exchange (HIE). Staff outreach and patient recall are unreliable and will promote repeat screenings "just in case." Interoperability for SDOH data remains uneven: while Gravity and USCDI elements exist, exchange across vendors frequently reverts to scans and faxes, and closed-loop referral tracking across organizations is uncommon. Financing is also misaligned. Practices face staffing, HIE fees, and referral-management tooling costs at the same time reimbursement signals for SDOH screening and exchange are ambiguous—dampening vendor and provider investment. Finally, the proposal presumes that thousands of practices will create their own Collaborative Care Agreements (CCAs) without standard templates or legal/operational guidance, which will widen variation, slow adoption, and invite compliance via portals and manual queues instead of clinician workflow.

Many of the physicians participating in ASM will likely be treating patients who have a wide range of primary care clinicians from many different practices. As a result, it will be impractical to have detailed formal arrangements with all or most of these primary care practices, particularly since there may only be one or a few patients from each practice, and 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 the specialist, and there is no compensation for the time that would be required to do so, making it very difficult for specialists to convince primary care practices to engage in these agreements in order for the specialists to meet this requirement. **This requirement should be eliminated, and specialists should have the flexibility to determine the best way to engage with primary care practices in the communities they serve.**

CMS actions to make this workable (and measurable). AMA urges CMMI to adopt a phased, standards-aligned, and funded approach. First, designate **Performance Years (PY) 2027–2028 as reporting-only**, crediting specialists for documenting (1) a patient's PCP status and (2) whether a **Gravity-conformant SDOH screen** exists within the prior 12 months. Limit early scope to high-yield visits (e.g., new patient or major decision visits) in selected specialties to learn before scaling. Begin performance scoring no earlier than PY2029.

To prevent duplication and back-office drift, CMS should codify "**screen once, share widely**": when a valid screen exists, pulling it into the record satisfies the requirement—no rescreen. Compliance must be achievable **within the EHR visit/inbox/application programing interface (API)** rather than through separate portals or manual lookups.

On standards, CMS should **name the expectations now and measure them later**, explicitly aligning the model to the **HL7 Gravity FHIR Implementation Guide** and relevant **USCDI** SDOH elements, while recognizing multiple exchange rails during the transition (FHIR API, Direct, TEFCA-enabled HIE, or CCD with Gravity-mapped codes). Timelines should be coordinated with ASTP/ONC certification and vendor upgrades to avoid dueling federal clocks.

CMS should supply **model CCA templates** that operationalize roles, minimum data sets, turnaround times, closed-loop expectations, and escalation pathways. During the ramp, track a small set of actionable measures: (a) process—percent of visits with PCP status recorded and percent of patients with a documented SDOH screen within 12 months; (b) closed loop—percent of referrals with notes returned within a defined interval; and (c) exchange—percent of screens received electronically rather than by fax.

Finally, CMS must **finance the lift**. Participating in the model will require additional resources, often not available to medical specialists. The model should provide funding to support staffing, HIE connectivity, and referral-management tooling. CMS should include flexibilities for **unknown or unavailable primary care physicians** (credit documented navigation attempts/community referrals) and **small/solo practices** (technical assistance and lighter reporting in the first two years). It is unsustainable to require physicians to participate in a model or in the required improvement activities without support, thus **if CMS declines to provide a financial lift, CMS should not require participation.** Participation must be matched with support; otherwise, it undermines the very objectives CMS seeks.

Conclusion. Phasing in requirements, standardizing to Gravity/USCDI, providing templates and guardrails, and financing the operational work will deliver real information liquidity, reduce physician burden, and advance CMS's social-needs objectives faster—and more sustainably—than a premature mandate. The AMA stands ready to work with CMS on finalizing these modifications and supporting successful implementation.

Promoting Interoperability (PI)

Recommendation:

- CMMI should not require ASM participants to complete PI requirements.

The MIPS PI category measures are too limiting to benefit ASM participants or their patients. Tying check-the-box performance measures to ASM misses the intent of moving away from the MIPS status quo. Certified EHR Technology (CEHRT) is already widely in use, and we expect that EHRs will play a key role in supporting the care coordination necessary for ASM success. Anchoring ASM to PI requirements may also unintentionally prevent physicians from adopting non-CEHRT like remote patient monitoring or telemedicine tools for fear they will not "count" in PI for ASM. Furthermore, engaging patients and interoperability are already critical to value-based care and there are far greater and more meaningful incentives found in the Information Blocking and HIPAA regulations. If ASM is to have any PI requirement, it should only be for physicians to provide an affirmative "yes/no" attestation that they adopt, implement, and use CEHRT to exchange electronic health information. CMS has already taken a step toward such an approach by allowing eligible clinicians to attest to two measures in the MIPS PI program. Finally, we urge CMMI to take full advantage of the flexibility to demonstrate use of CEHRT (e.g., straightforward attestation) found in The Health Information Technology for Economic and Clinical Health Act.

Patient Engagement

Recommendation:

- ASM should: (1) include new payments to support additional services that would help to support preventive care and patient self-management, facilitate care coordination with primary care and other physicians, improve patient health outcomes, and reduce overall Medicare spending; and (2) ensure that physicians receive timely performance feedback.

It is widely recognized that one of the most serious problems with the current Medicare payment system is that there are no payments for many high-value services. For example, Medicare does not cover validated self-measured blood pressure (SMBP) monitoring devices and cuffs even though there is significant evidence that patients who use SMBP devices achieve better blood pressure control, which clearly could help prevent problems and improve outcomes for heart failure patients in ASM, and CMMI has explicit statutory authority for models to include a focus on patient self-management. Although CMS has adopted several care management services, patient cost-sharing requirements and other restrictions associated with these services have limited physicians' ability to use them to optimally support effective preventive care outreach and care management programs. Payments for telephone or email communications between primary care physicians and specialists also require patient cost-sharing and may not provide the level of support needed for coordination of care and brief consultations to assist primary care physicians in making decisions about diagnosis, treatment, and referral.

As proposed, ASM will not resolve these problems because it does not include any new payments for services or any upfront payments to help engage patients in their own care or help their physicians improve care delivery. Under the proposed ASM payment methodology, most physicians would not receive a payment increase, and those that do would not receive the increase until two years after services have been delivered. In contrast, other CMS alternative payment models for specialists, such as the Oncology Care Model and Enhancing Oncology Model, provide additional payments to physicians that can support enhanced services to payments. In addition, the Making Care Primary model offered participants significant support to improve integration and coordination between specialists and primary care physicians.

We are also concerned that, as proposed, ASM participants will not receive any more timely or actionable data on their patients or their performance in ASM than MIPS participants currently receive. To improve care for patients, reduce avoidable costs, and succeed in ASM, physicians need data about their performance on quality and cost measures. CMS only provides physicians participating in MIPS with an

annual feedback report six to 18 months after they have provided services to Medicare patients. Without this information at any point during the actual performance year, physicians have no way to understand gaps in care and identify opportunities to improve health outcomes, reduce variations in care delivery, or eliminate avoidable services—all steps that can improve quality and lower costs. In ASM, CMMI should do better and provide timely and actionable feedback and Medicare claims data to physicians at regular intervals, at least quarterly.

We recommend that ASM pay for SMBP devices for heart failure patients to help patients self-manage their condition and achieve better outcomes at a lower overall cost. We also recommend that ASM include an option for physicians to bill Medicare for a new monthly payment with no cost-sharing that could be used to support enhanced preventive care, coordination with primary care physicians, care management, and other services that could improve outcomes for patients with low back pain and heart failure. Finally, we recommend that ASM participants receive timely data on their patients' quality, cost, and utilization of services.

E. Medicare Diabetes Prevention Program (MDPP)

New Online Modality

Recommendation:

- CMS should finalize its proposal to allow MDPP suppliers to deliver MDPP services asynchronously through a new online modality.

CMS proposes several changes aimed at increasing beneficiary access and uptake of this program. Most significantly, CMS proposes allowing MDPP suppliers to deliver MDPP services through a new online modality. This would allow suppliers to deliver MDPP services asynchronously online without requiring them to maintain in-person delivery capabilities through CY 2029 provided they meet existing standards including interaction with a live coach, which may be satisfied via email or text messages. CMS would also introduce a separate new G-code and payment for online sessions to collect additional data about the effectiveness of online versus other modalities of delivering MDPP sessions.

The AMA strongly supports CMS' decision to test an online modality through 2029 to increase the number of suppliers as well as enrollee access to the program, especially in rural, underserved, and other areas that may lack access to an in-person supplier. As CMS points out in the rule, participation in MDPP has been low, with less than one percent of eligible beneficiaries participating in the program. The Agency notes that virtual learning sessions have increased in popularity over time and that hybrid attendees have appreciated the flexibility that virtual sessions can offer, especially in rural areas. In terms of effectiveness, enrollees who utilize virtual distance learning sessions also report higher levels of weight loss compared to in-person sessions (5.3 percent of their body weight compared to 4.6 percent). The AMA agrees this data supports CMS' proposal to test an online modality. We further commend CMS for making this option available through 2029, which gives suppliers the predictability they need to invest in participating in the program.

The AMA supports CMS' proposed definitional components for "online" delivery such that sessions can be delivered 100 percent through the internet via smartphone, tablet, or laptop in an asynchronous (non-live) classroom where participants are experiencing the content on their own time without a live (non-AI) coach teaching the content provided these sessions are furnished in a manner consistent with the DPRP Standards for online sessions with e-mails and text messages counting toward the requirement for live Coach interaction if there is bi-directional communication between the coach and participant, whereby both parties engage in the interaction. CMS expressly stipulates that bots and AI forums would not count as live Coach interaction. The AMA supports this proposed definition. We believe it strikes an

appropriate balance between sufficient flexibility to reduce burden on program suppliers and promote more flexibility and access for enrollees, while upholding a high standard for the quality of instruction through a human instructor.

Flexibilities for Satisfying Weight Requirements

Recommendation:

- CMS should finalize proposed new flexibilities for satisfying weight measurement requirements, including allowing weight documented in the beneficiary's medical record to count and allowing beneficiaries to self-report weight from a location outside of their home. CMS should expand on these flexibilities by allowing more flexible rules for maintenance self-reported weigh-ins and clarify that metadata can satisfy time and date stamp requirements on photos or videos.

CMS proposes to allow certain additional flexibilities for satisfying weight measurement requirements, including allowing beneficiaries to self-report weight from a reasonable location outside of an MDPP in-person delivery site or the beneficiary's home, such as a hotel while traveling. The AMA strongly supports increased flexibilities for self-documented weight that also upholds the integrity of the program. We strongly support the proposal to allow self-reported weights taken outside of the home and agree this flexibility will help enrollee's abilities to successfully complete the program while maintaining accountability and ensuring program integrity.

We also appreciate the proposal to allow weight documented in the beneficiary's medical record within two days of completing the MDPP session in the spirit of affording more flexibility, as currently weight must be documented the same day of completing the MDPP session. We believe it is important to acknowledge that allowing weights documented in a patient's medical record would require a physician office visit, which requires a patient copay, so we would not expect this modality to be heavily utilized unless a patient is already seeing their provider for a regular visit. We also believe the 48-hour window is overly restrictive and should be expanded to a week. That said, we appreciate CMS' willingness to consider new and creative ways to allow additional weight measurement options to ease enrollee burden of participating in the program.

To that end, we believe there are additional flexibilities that could further encourage uptake and success of the program while maintaining program integrity. For example, CMS could maintain the more stringent existing requirements for monthly weigh-ins during the first six months and quarterly weigh-ins for the latter six months, while allowing more flexible rules for self-reported weigh-ins in between. To further ensure integrity if it were to adopt these new flexibilities, CMS could stipulate that payments, including weight-loss performance-based payments, must be made on a documented weight or self-reported weight meeting the more stringent requirements. Another simple way CMS could reduce barriers to self-reported weight is to allow metadata to satisfy time and date stamp requirements on photos and videos, which exists in nearly every picture and video taken with a smartphone and would free enrollees of having the technological capability to time and date stamp photos themselves while still meeting CMS' goal of having the time and date of each photo/video verified. We also urge the Agency to consider additional methods that could verify self-reported weight, such as use of a digital scale or applications that automatically send data to MDPP suppliers. We agree with CMS that introducing new flexibilities to overcome barriers to weight collection will become increasingly more relevant as suppliers continue to expand distance learning, especially with the new online modality and urge the Agency to consider adopting these additional recommendations for self-reported weight measurement.

Recommendations to Further Align with the CDC's National Diabetes Prevention Program (DPP) and Improve MDPP Uptake

Recommendation:

- The AMA appreciates CMS' efforts in this rule to expand access to and uptake of MDPP services and to further align the MDDP with CDC's NDPP. In this vein, we reiterate our previous recommendations that CMS should: 1) remove the once per lifetime cap on MDPP services; and 2) classify MDPP suppliers as medium fraud risk.

As of March 2025, there were 331 approved MDPP suppliers compared to 1500 CDC NDPP suppliers.[4] Part of the reason for this discrepancy is the onerous requirements that MDPP suppliers are uniquely expected to meet due to being classified as high risk for fraud. We believe reclassifying MDPP suppliers as medium fraud risk will directly result in several reputable organizations with a national footprint reconsidering participating in the program as suppliers.

We similarly urge CMS to remove the once per lifetime cap on MDPP benefits, which does not exist in the CDC's DPRP and unnecessarily restricts participation in and effectiveness of the MDPP. Losing weight, the core metric of success in the program, often takes several attempts. Medicare beneficiaries should be supported in those efforts. Notably, there is no once-per-lifetime cap on other Medicare lifestyle programs, such as smoking cessation.

F. Valuation of Specific Codes

High-Cost Disposable Supplies

For 2026, the RUC considered numerous high-cost disposable supplies (i.e., priced more than $500) as part of its recommendations for direct PE inputs for physician services. The RUC recommended six new high-cost supply inputs for Lower Extremity Revascularization alone, with cost estimates ranging from $4,700 for a *FemPop IVL Catheter* to $1,900 for a *Drug Eluting Stent*. The RUC also recommended several additional high-cost disposable supply inputs, including an *Optilume BPH Prostatic Dilation Kit* with a cost estimate of $5,900 for Cystourethroscopy, *IB-Stim device kit* with a cost estimate of $1,195 for Percutaneous Electrical Nerve Field Stimulation, and a Scalp Cooling Cap/Kit with a cost estimate of $1,800 for Scalp Cooling Services.

As part of its consideration of the Lower Extremity Revascularization codes, CMS proposes the RUC-recommended PE inputs for all 46 CPT codes, with some refinements, and states, "we are seeking comments on whether we should create 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 (i.e., priced more than $500) using appropriate HCPCS supply codes. To date, CMS has been reluctant to implement this recommendation. It is appreciated that CMS is seeking comment in this Proposed Rule on the creation of G-codes to describe the use of high-cost supplies. Given the significant number of new high-cost disposable supplies that are included as part of the RUC recommendations for direct PE inputs, there is an urgency to support the RUC recommendation to separately code and pay for high-cost disposable supplies.

The 2026 Proposed Medicare Physician Payment Schedule includes 94 medical supply items currently embedded in codes with a purchase price of more than $500. These high-cost medical

[4] Ronald T. Ackermann; The U.S. National Diabetes Prevention Program (NDPP) Shows Promise as a Cost-effective Implementation Strategy. *Diabetes Care* 20 June 2025; 48 (7): 1150–1151. https://doi.org/10.2337/dci24-0100

supplies represent $1.53 billion in direct costs for the 2026 MFS and 21 percent of all direct practice expense medical supply costs in the non-facility setting. ***Please see the analysis of high-cost supplies over $500 (See Attachment 3).***

The AMA urges CMS to address the outsized impact that high-cost disposable supplies have within the current practice expense RVU methodology. The current system not only accounts for a large amount of direct practice expense for these supplies but also allocates a large amount of indirect practice expense into the PE RVU for the procedure codes that include these supplies. The practice expense methodology derives code-level indirect practice expense in part from code-level direct practice expense inputs, including high-cost disposable supplies. When CPT codes include a high-cost disposable supply, a larger portion of indirect practice expense is allocated to the subset of practices performing the service, which is subsidized by the broader specialty and all other physicians and qualified healthcare professionals. If high-cost supplies were paid separately with appropriate HCPCS codes, the disproportionate indirect expense would no longer be associated with that service. The result would be that indirect PE RVUs would be redistributed throughout the specialty practice expense pool and the practice expense for all other services.

CMS further states, "Alternatively, we are seeking comments on whether we could use the OPPS mean unit cost data (MUC) to accurately price these services and their supplies based on how these supplies are paid for in the hospital setting." The RUC emphasizes the importance of accurate pricing of high-cost supplies. The RUC focuses on two principal areas of concern: payment accuracy, as discussed above regarding the PE methodology, and pricing accuracy. The pricing of these supplies should be based on a transparent process, where items are annually reviewed and updated. While the RUC is concerned about pricing accuracy, it does not make recommendations on pricing. Rather, the RUC notes that invoices for high-cost supplies are required at the time of submission but should be reviewed annually to ensure accuracy.

We appreciate the Agency's attention to resolving the high-cost disposable supply issue and ensuring payment and pricing accuracy in the Medicare physician payment system. **The AMA strongly supports the long-standing RUC recommendation that CMS 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, where items are annually reviewed and updated.**

On February 7, 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 MFS. The recommendations reinforce the longstanding RUC recommendation and strongly encourage accurate pricing and review of the high-cost supply items.

G. Medicare Shared Savings Program (MSSP)

Reducing Maximum Allowed Time in Upside-Only Risk from Seven to Five Years

Recommendation:

- Before finalizing the proposal to reduce the time allowed in one-sided risk by two years, the AMA recommends that CMS consider exceptions for certain types of ACOs, including those in rural or underserved areas and those serving medically or socially complex populations, to maintain access to value-based care for these patient communities. CMS should not reduce time in upside risk to any less than five years and should closely monitor for changes in participation and total programmatic savings.

The AMA understands the need to balance program performance and savings with allowing ACOs, particularly rural and other types of ACOs, time to transition to risk. We also appreciate the additional flexibilities and supports CMS has finalized since initially adopting the seven-year transition period to two-sided risk, including advance investment payments for new, low-revenue ACOs and benchmarking methodology changes to support participation by ACOs serving medically complex, high-cost populations.

While we understand that incentivizing savings at the individual ACO level is important to overall program savings, equally important is attracting and retaining more ACOs in the program. CMS says in the rule that it does not find the concern about potential attrition by ACOs unwilling to transition to performance-based risk compelling, however, every ACO that participates in and saves money under the program contributes to the program's overall savings rate and is therefore instrumental to the program's overall success. As noted in the rule, 17.7 percent of ACOs participating in their second or subsequent or subsequent agreement period in 2025 entered the BASIC track at level A, demonstrating ACOs still value retaining one-sided risk options beyond their initial five years in the program. Discontinuing this option risks alienating these ACOs from the program. This would likely disproportionately impact rural, low revenue, safety net, and other types of ACOs serving vulnerable patient populations.

Importantly, higher levels of risk/reward remain an incentive for ACOs to elect to advance to two-sided risk, as demonstrated by the fact that when ACOs do participate under two-sided risk, they tend to opt for higher levels of risk/reward. It makes sense that under current program requirements, ACOs transitioning from one-sided to two-sided risk levels, or remaining under two-sided risk in the BASIC track generate higher levels of average net savings compared to those that remain in one-sided risk, because there is a huge inherent difference in these two populations of ACOs; the ACOs that progress to two-sided risk are confident in their ability to do well in the program. This, if anything, speaks to the fact that the program is currently operating exactly as it should by appropriately incentivizing ACOs that are ready to electively advance to two-sided risk, since it also comes with higher reward. On the other hand, forcing the ACOs that would have remained in one-sided risk to advance to two-sided risk earlier potentially forces ACOs that are typically lower performing and thus less confident in their ability to succeed in the program to make the difficult choice between advancing to risk they are not yet sure they can accept, or resulting in their exodus from the program altogether.

We do not agree with the premise that moving ACOs into two-sided risk earlier will inherently increase their effectiveness make more meaningful changes to healthcare delivery, and in turn cost and quality improvements and result in increased savings earlier than they otherwise would have. Earning savings is a powerful motivator in and of itself and we believe every ACO puts its best foot forward to meaningfully reform care and achieve savings, but these types of major transitions take much investment, training, and technology and clinical workflow changes that do not occur overnight. Even if clinical process improvements themselves are implemented immediately, it often takes years for preventive interventions to yield measurable savings down the road in terms of reduced interventions, acute events and therefore savings. Further, ACOs face a variety of circumstances that make it more challenging for some than others, particularly those with fewer resources, to implement these types of transitions. Those ACOs with fewer resources rely on the performance-based payments to invest in technology and clinical workflow improvements, which are paid out two years into the program. While advance investment payments are helpful in this regard, they are limited to only certain types of ACOs (new, low revenue).

Should CMS move forward with this proposal, we would encourage the agency to consider several exemptions to this requirement for certain types of ACOs that may benefit from more time in one-sided risk including (but not limited to) those located in rural and underserved areas, and those serving socially and/or clinically complex populations before advancing this shorter timeline on all ACOs unilaterally. We believe this would strike a more appropriate balance between advancing CMS' goals to advance to two-sided risk while allowing for considerations for ACOs and retaining access to the vulnerable beneficiary

populations they serve. In addition, we urge CMS not to finalize any length of time lower than five years in the future, and to closely monitor participation levels and its impact on total program savings should it move forward with this proposal.

Proposed New Flexibilities for Requirement to Maintain at Least 5,000 Assigned Beneficiaries

Recommendation:

- CMS should finalize its proposed flexibilities for requiring that ACOs maintain a minimum of 5,000 assigned patients for agreement periods beginning January 1, 2027 or later.

Specifically, CMS proposes to require ACOs applying to enter a new agreement period to have at least 5,000 assigned beneficiaries in base year 3, while allowing the ACO to have under 5,000 assigned beneficiaries in base years 1 or 2 provided they enter the BASIC track. ACOs with fewer than 5,000 assigned beneficiaries in any base year would also be excluded from leveraging increased shared savings opportunities available to low-revenue ACOs and have shared savings and losses capped at a lower rates.

The AMA believes that these proposals appropriately balance the need for integrity and stability of financial performance calculations, while allowing smaller ACOs with fewer than 5,000 beneficiaries to enter the program provided there are additional safeguards in place. We appreciate the agency's efforts to find workable solutions that protect the integrity of the program and Medicare Trust Funds while looking for opportunities to expand participation in the program, particularly amongst smaller ACOs, which disproportionately serve rural and underserved populations.

Expanding Extreme and Uncontrollable Circumstances Policies to Include Cyberattacks

Recommendation:

- CMS should finalize its proposal to expand the extreme and uncontrollable circumstance policies for ACOs to obtain relief from performance requirements to include a cyberattack.

The AMA strongly supports this proposal, which results from AMA advocacy related to the CHANGE cyberattack, including a 2024 survey we conducted on the impacts of such attacks on practices and was directly cited by CMS in this section of the rule. The proposal appropriately recognizes the level of disruption that such attacks can have on ACOs and participating practices which are outside of the ACO's control and can substantially hinder clams processing and practice functions, as well as the ability to accurately and effectively measure and report quality performance. We appreciate CMS' proactivity in this regard and believe knowing this exemption exists upfront to offer protections against potentially similar future events will give ACOs more confidence to participate in the program. We further appreciate the agency making this policy retroactive to the 2025 performance year. We encourage the agency to streamline the process for claiming an extreme and uncontrollable circumstance exemption for a cyberattack by including this as one of the drop-down options that practices can select.

Allowing Mid-Year Participant List Changes in Change-of-Ownership Scenarios

Recommendation:

- The AMA supports CMS' proposal to allow mid-year participant list changes in change-of-ownership scenarios and urges CMS to finalize this proposal.

The AMA believes this approach appropriately balances the need to account for major changes in TIN/NPI restructuring that can occur in today's modern dynamic environment so as not to disrupt ACO, and more importantly, patient care operations, while not opening the flood gates to broader participation list changes that could over-complicate a myriad of programmatic calculations during the performance year and potentially lead to errors.

Proposal to Revise the Definition of Beneficiary Eligible for Medicare CQMs

Recommendation:

- The AMA supports CMS' proposal to revise the definition of beneficiary eligible for Medicare CQMs, as it more closely aligns with the Accountable Care Organization patient eligibility list.

CMS proposes to revise the definition of a "beneficiary eligible for Medicare Clinical Quality Measures for ACO participating in the MSSP Medicare CQMs", for performance year 2025 and subsequent performance years so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the ACO's assignable beneficiary population. A frequent complaint the AMA has heard from ACOs regarding the Medicare CQM reporting option is the lack of alignment between the ACO patient eligibility list and the beneficiary that must be reported on for Medicare CQMs. While there are still some discrepancies between the two lists, CMS' proposal is an improvement over the current approach and the AMA approves of the change. We also support the proposal to make the definition change effective in 2025, as it will hopefully better encourage ACOs to utilize the Medicare CQM reporting option.

Proposal to Remove the Health Equity Adjustment (HEA)

Recommendation:

- The AMA opposes CMS' proposal to remove the Health Equity Adjustment from ACOs quality score and urges CMS to maintain the adjustment in the MSSP program.

The AMA is disappointed with CMS' proposal to remove the Health Equity Adjustment from ACOs quality score and does not support removal from quality calculations. To justify removal, within the rule CMS states that the HEA is duplicative to the complex organizational adjustment, but that is an incorrect assessment. The complex organizational adjustment is to incentivize reporting on electronic clinical quality measures (eCQMs) while the HEA is to incentivize ACOs with a large percentage of poor patients to participate in the program. The HEA is based on dual eligibility for Medicare and Medicaid. At a minimum, we recommend CMS provide ACOs with an option to either utilize the complex organizational adjustment or health equity adjustment applied to their quality scores.

Proposal to Update the APP Plus Quality Measure Set

Recommendation:

- The AMA opposes CMS' proposed changes to the *Breast Cancer Screening measure* and *Colorectal Cancer Screening measure* due to data extraction issues, lack of EHR vendor support and measure reporting option alignment, as well as the potential to lead to overuse and patient harm. We urge CMS to communicate the need to support these eCQMs to EHR vendors and in the interim, identify avenues by which ACOs will not have their potential shared savings at risk (e.g., suppress the measure).

Participating practices within ACOs report that some EHR vendors, particularly those for small practices or specialties, have not maintained the capability to extract the data needed for the *Breast Cancer Screening (BCS) electronic clinical quality measure (eCQM)* and there is potential that it will also occur with the *Colorectal Cancer Screening eCQM*. Vendors believe that they do not need to support them since they were removed as individual measure options from MIPS. As a result, practices with these vendors currently cannot extract the data needed. Depending on the number of practices using these vendors, ACOs that opt to report using eCQMs may be forced to select a different reporting option (MIPS

CQMs or Medicare CQMs) with increased burden of data collection and cost since practices with these vendors will need to identify other avenues by which the data can be obtained (likely through manual data abstraction).

Even if a vendor can produce the QRDA 1 file, it will only include women aged 50-74 years since the eCQM specification was not updated to reflect the USPSTF's most recent recommendation to screen women aged 40-74 years for PY2025. The MIPS CQM and Medicare CQM, however, were updated, leading to several specifications for the same clinical concept to include different age ranges and the associated benchmarking across collection types differ. We believe that CMS must avoid situations where specifications are not clearly supported by vendors and specifications and associated benchmarking are not consistent.

Due to these data collection and extraction challenges, ACOs are at risk of not meeting the 75 percent data completeness requirement for the BCS measure and participating practices within the ACO may be required to collect data manually or through other means, adding undue burden and costs. **We urge CMS to communicate the need to support these eCQMs to EHR vendors and in the interim, identify avenues by which ACOs will not have their potential shared savings at risk (e.g., suppress the measure).**

In addition, **we oppose the proposed changes to the MIPS CQM and Medicare CQM specifications for the BCS and CRC measures, 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. In addition, specifications across reporting options should remain aligned and the eCQM specification does not currently include this requirement nor would we support its addition to this specification in the future. ACOs often work with their participating practices to extract these data from EHRs even when reporting MIPS CQMs or Medicare CQMs and this change will make it even less feasible for them to continue to minimize the data collection burden for practices if they cannot leverage EHR data.

We also believe that this change could lead to a negative unintended consequence of overuse of these procedures since the timeframe for both measures includes data from previous years (for CRC this 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 and not because the patient is due for this screening. **We oppose any change to a measure that could encourage overuse of services, particularly a revision that is not directly tied to improving patient care.**

Furthermore, we are 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 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 across the specifications for all reporting options 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.

H. Payment for Services in Urgent Care Centers

Recommendations:

- CMS should not create a separate add-on code or other G-codes for evaluation and management (E/M) visits furnished at urgent care centers.

- Any proposal to differentiate E/M coding by various sites of service should go through the CPT process, which operates openly and transparently to collect broad input from interested parties across the health care community to ensure CPT codes reflect the current health care system.

CMS seeks comments regarding whether separate coding and payment is needed for E/M visits furnished at urgent care centers, such as an add-on code or a new set of visit codes. The agency also seeks to understand how practice costs, including but not limited to indirect costs, may vary among different non-facility settings of care, including urgent care centers.

On January 1, 2021, landmark changes to office and outpatient E/M services developed by the CPT Editorial Panel and CMS went into effect. These changes modernized how physicians report and document care delivered to patients and shared a goal with CMS to relieve administrative burden. For example, the revisions simplified code selection criteria and created consistency across payers by adding detail within the CPT E/M Guidelines. After these revisions were implemented, the CPT Editorial Panel approved, for 2023, additional revisions to the rest of the E/M code section. These revisions sought to provide continuity across all the E/M sections allowing for the revisions implemented in the E/M office visit section in 2021 to extend to all other E/M sections.

Primary care physicians are reporting that they perceive that the time they spend on E/M documentation tasks is more "clinically meaningful," according to an AMA-funded study published in the *Journal of General Internal Medicine*. The researchers, led by a team at the University of California San Francisco, found that primary care physicians perceived spending less time and effort in documenting review of systems and history of present illness/physical exam after the E/M coding change. They compared survey answers from 87 primary care physicians from before the E/M changes were implemented (February 2020) and after (March 2022). Survey respondents included internists, family physicians, pediatricians and geriatricians.

Based on this proven track record, the CPT Editorial Panel is the appropriate venue to evaluate a potential E/M code set for office visits performed in urgent care centers. CPT brings together experts across medicine and other health care professions, as well as representatives from insurance companies and health systems, to revise existing codes and create new codes based on innovations in the practice of medicine. This expert-driven, deliberative and rigorous process ensures that resulting codes and code changes are vetted and more likely to be adopted by public and private payers.

Furthermore, we question CMS' rationale for creating an add-on code to pay more for E/M services furnished in urgent care centers compared to physician practices or hospital outpatient departments. It appears that urgent care centers are seeking higher payment akin to a facility fee at a time when CMS is otherwise proposing to reduce indirect practice expense for facility-based services. For example, CMS cites the fact that urgent care centers operate on extended hours, but this is not unique to urgent care centers. In fact, CMS' new Advanced Primary Care Management codes include 24/7 access and continuity of care with a patient's primary care physician, thus reducing fragmentation of care and avoiding visits to urgent care centers or emergency departments. Furthermore, the use of telehealth to provide patients with after hours care or night calls also increased during the pandemic from being mentioned by 9.9 percent of physicians in 2018 to 22.4 in 2020, with another small (but statistically significant) increase to 24.4 percent in 2022.

For these reasons, we urge CMS not to propose an add-on G-code or new E/M family of G-codes for E/M visits furnished in the urgent care center. Rather, the AMA encourages interested parties to bring an application to the CPT Editorial Panel to develop appropriate coding for these medical services.

I. Telehealth

Recommendation:

- The AMA recommends that CMS: work with Congress to permanently extend Medicare telehealth policies; finalize its proposals to permanently lift the frequency limits on telehealth hospital and nursing facility visits and allow virtual direct supervision except for services with a 10- or 90-day global period; maintain or expand the ability for teaching physicians to provide virtual supervision of residents in metropolitan as well as non-metropolitan areas; and finalize its proposal to streamline the process for adding services to the Medicare Telehealth List. The AMA also remains concerned about any potential implementation of a requirement for physicians to report their home address and urges CMS to permanently remove this requirement.

Need for a Permanent Extension

In 2020, rapid action by the Trump Administration made telehealth services available to Medicare patients in their homes nationwide for the first time. Its immediate adoption by physicians illustrates the critical role of payment policy as both a barrier and potential catalyst for the uptake of care delivery reforms with known potential to improve value. While many medical specialties had been practicing telemedicine and developing an evidence base to support its use for decades, the 2020 expansion in access was made possible only when long-standing payment barriers were removed. It served as a catalyst for an acceleration in use of digitally enabled medical care combining in-person, virtual, remote monitoring, and other service modalities to deliver care that meets patient needs. It is critically important that patients with Medicare all over the United States be able to continue receiving telehealth services and that they can continue receiving them in their homes. The AMA strongly urges the current Trump Administration to work for passage of legislation to permanently extend these Medicare telehealth policies, including the Acute Hospital Care at Home program.

Frequency Limits and Virtual Direct Supervision

As the AMA has recommended for several years, CMS proposes to: (1) permanently lift the frequency limits on providing subsequent hospital inpatient and nursing facility visits and critical care consultations furnished via telehealth; and (2) permanently allow virtual direct supervision, except for codes that have a 10- or 90-day global surgery indicator. The AMA welcomes these proposals and urges CMS to finalize them. The environment for telehealth services has transformed in the many years since CMS first imposed frequency limits for these services. Digitally enabled services provided by more than 300 hospitals participating in CMS' Acute Hospital Care at Home program allow patients to receive hospital-level care in their own homes, including through virtual visits with their physicians and virtual supervision of other health professionals involved in the patient's care. These programs free up inpatient hospital beds for the patients who really need them and cannot be cared for at home. Limitations on the number of nursing facility visits that can be provided via telehealth are unnecessary as the visits that are required by regulation must already be provided in-person.

Supervision of Residents by Teaching Physicians via Virtual Presence

The AMA supports permanently allowing teaching physicians to provide virtual supervision of residents when they are delivering a service using telecommunications technology for both remote and in-person services provided by residents in non-Metropolitan Statistical Areas (MSA) and MSA areas. However, CMS is proposing to not extend the current policy that allows teaching physicians to have a virtual presence for purposes of supervising residents in all teaching settings. CMS is instead proposing that, for services provided within MSAs, physicians must be physically present during critical portions of all

resident-furnished services to qualify for Medicare payment, not just in-person services. Nevertheless, in non-MSA settings, teaching physicians would still be allowed to continue utilizing audio/video real-time communications technology to fulfill the presence requirement. As such, if finalized as proposed, teaching physicians in MSAs would be required to maintain physical presence during the key and critical portions of all resident-furnished services provided, including for telehealth services. The documentation requirements, which necessitate medical records clearly demonstrating the teaching physician's physical or virtual presence during key portions of the service, would not change.

For approximately the past five years, spurred on by the COVID-19 PHE, CMS has allowed teaching physicians to supervise residents during "the key portion of the service through real-time audio-video technology" when the resident and patient are together in person and for telehealth services in all residency training locations. The AMA appreciates that CMS extended, through CY 2025, the availability of remote resident physician supervision to services furnished at all residency training sites. Thanks to this expansion, virtual supervision of residents has become an important means of maintaining patient access to academic medical care in MSA and non-MSA areas during and after the COVID-19 PHE and it is vital to permanently continue this additional supervision option regardless of location; especially with significant workforce shortages affecting access to care in many regions of the country. For example, 125 million people currently reside in Mental Health Professional Shortage Areas (HPSAs), and at least 6,556 additional practitioners are needed to fill the gap in care. Approximately 31 percent of Mental Health HPSAs are located in non-rural areas while about six percent are located in partially non-rural areas. An additional 82 million people live in Primary Care HPSAs with 14,112 additional practitioners needed to fulfill this shortage. Approximately 29 percent of Primary Care HPSAs are located in non-rural areas while about four percent are located in partially non-rural areas. Unfortunately, these physician shortages negatively impact patient well-being and promote physician burnout. However, allowing for virtual supervision helps residency programs provide care for a diverse pool of patients and access a broader collection of experienced teaching physicians and specialists.

Through virtual supervision, teaching physicians provide personal and identifiable physician services and exercise full personal control over the management of the care for which payment is sought. The teaching physician and the resident interact with the patient virtually, receiving real-time information from the patient simultaneously. This enables the supervising physician to take an active role in patient evaluation and treatment. Moreover, the documentation that CMS requires in the patient's medical record has not changed and clearly reflects how and when the teaching physician was present, or virtually present, during the service, to ensure accurate and reliable accounts of services rendered. Accordingly, allowing residents to provide telehealth services while being supervised virtually not only benefits the patients that can easily access their physicians from the comfort of their homes, but it also expands access and promotes training opportunities for residents since it will be vital for these physicians to be familiar with providing telehealth as it becomes more widely utilized.

Moreover, the Accreditation Council for Graduate Medical Education (ACGME) rules allow for audio-visual supervision of residents and its guidelines state that direct supervision can occur when "the supervising physician and/or patient is not physically present with the resident and the supervising physician is concurrently monitoring the patient care through appropriate telecommunication technology." ACGME also provides more specific guidance for each specialty. In accordance with ACGME guidance, the AMA acknowledges and supports individually tailoring the virtual supervision of each resident according to their level of competency, training, and specialty since this enables residents to provide additional services while still garnering the support needed from their teaching physicians. The AMA also recommends guardrails be included to ensure virtual supervision is efficacious and to mitigate risk:

- Decisions regarding how residents will be supervised via audio-visual real-time communication technology should be implemented, reviewed, and overseen at the program level, in accordance with ACGME policy.
- Training programs should outline audio-visual supervision requirements in advance to promote consistent understanding between the resident and the teaching physician. Each program must define when the physical presence of a supervising physician is required, and each resident must know the limits of their scope of authority.
- Residency programs should encourage Residency Review Committees and ACGME to increase monitoring of clinical and educational work hour standards in the context of the larger issue of patient safety and acknowledge the impact of the changes of the supervision requirements on the residents and their optimal learning environment to ensure that appropriate education and supervision are maintained.
- Advice should be provided on when and how physicians must inform the patient that direct supervision by interactive telecommunication technology is being used.

Teaching physicians are still required to review the resident physician's interpretations and services and ACGME has strict limits concerning supervision via interactive telecommunications technology, so appropriate levels of patient care and teaching physician direction will continue to be maintained. Moreover, the permanent addition of audio-visual supervision would not change the responsibility of the institutions' GME Committees. They would still be required to monitor programs' supervision of residents and ensure that it is consistent with the provision of safe and effective patient care, residents' educational needs, the progressive responsibility appropriate to residents' level of education, competence, and experience, and any other applicable program requirements. In alignment with the Association of American Medical Colleges and the ACGME, the AMA recommends a permanent expansion of supervision of residents via audio-video real-time communications technology, beyond non-MSAs, especially since these methods of supervision have already been successfully employed for more than five years since the start of the COVID-19 PHE and have been proven to support patient safety, meet the clinical needs of patients, and provide burden reduction without creating risks to patient care or increasing fraud.

Telehealth E/M Services

CMS states that it is not proposing to add the Current Procedural Terminology (CPT®) codes for telemedicine E/M services to the Medicare Telehealth List because the codes are not payable by Medicare, as CMS determined during the 2025 rulemaking cycle. The AMA is disappointed in this decision as we outlined numerous reasons to include the telemedicine E/M services on the Medicare Telehealth List in a February 2025 letter to CMS. As a result, both audio-only and audio-video E/M visits will need to continue being reported with the CPT codes for in-person E/M and the appropriate audio-only or audio-video modifier.

Process for Adding Services to Medicare Telehealth List

CMS proposes to simplify the process for requesting additions to the Medicare Telehealth List by reducing it from the current five to a three-step process. Under this proposal, services on the Medicare Telehealth Services List would no longer be designated "permanent" or "provisional." All services listed or added on the Medicare Telehealth Services List would be considered included on a permanent basis. The AMA supports the proposed streamlining of the regulatory framework for adding services to the Medicare Telehealth List.

Potential Requirement to Report Physician's Home Address

Although it is not mentioned in the current proposed rule, the AMA remains concerned about any potential requirement for physicians who provide telehealth services to report their home address. We urge CMS to permanently remove this requirement and allow physicians to render telehealth services from their homes without reporting their home address on their Medicare enrollment form while continuing to bill from their currently enrolled location. Last year's final rule extended the policy that physicians do not have to report their home address only through the end of CY 2025. It is unclear what purpose reporting the home address is intended to support, and we have concerns that reporting could disincentivize telehealth services. This is particularly concerning at a time when remote care is used as one necessary tool to address the nationwide physician shortage.

In previous comments, the AMA expressed concerns related to the public display of a physician's home address on Medicare websites that include a physician lookup feature. Physician privacy and safety are of the utmost concern and we fear the unintended consequences of this personal information becoming publicly available. For example, physicians who provide behavioral health services may conduct telemedicine visits from their home, and the nature of the medical conditions treated by these physicians may introduce heightened safety concerns that outweigh any potential benefit to CMS from having data on physician home addresses. Concerns for privacy and safety are not new, and escalating trends in violence towards physicians and other health professionals demonstrate that they have never been at greater risk of injury due to work-related violence. Any effort towards preserving the privacy and safety of health professionals must be a top priority for CMS. It is imperative that CMS not allow this flexibility to expire and additionally take the necessary step of removing this requirement permanently.

J. E/M Visit Complexity Add-On Code (HCPCS code G2211)

Recommendation:

- The AMA urges CMS to revisit its utilization assumption for HCPCS code G2211, the E/M Office Visit Complexity Add-On code.

In 2024, Medicare began paying for HCPCS code G2211 *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)* (work RVU = 0.33, 11 minutes intra-service and total time), which was developed to be reported along with office visits when there is a longitudinal relationship between the physician and patient, and the physician serves as the continuing focal point for medical services that are part of ongoing care related to a patient's single, serious condition or a complex condition. Under the Medicare statute, CMS must annually adjust the Medicare conversion factor to maintain budget neutrality, meaning that increases in payment for one service must be offset by corresponding decreases elsewhere, so that overall Medicare spending does not rise solely due to changes in RVUs. To determine the budget neutrality adjustment for G2211, the Biden Administration developed an estimate of how frequently G2211 would be billed in 2024. The final estimate that CMS included in the MFS Final Rule for 2024 was that G2211 would be billed with 38 percent of all E/M office visits reported in 2024. However, instead of being reported with 38 percent of all office visits, an AMA analysis of the first three quarters of 2024 Medicare claims data found that G2211 was reported with only 10.5 percent of office visits.

In May 2025, the AMA submitted a letter describing that the first two quarters of 2024 utilization were markedly lower than the 38 percent assumption implemented by CMS under the Biden Administration. Specifically, in 2024, G2211 utilization steadily increased slightly every week but stabilized at 13 percent

in week 24 and continued at that rate through week 39. The AMA anticipated that the utilization of G2211 relative to E/M office visits to be 11.2 percent for 2024. In the AMA letter on G2211, it was explained that CMS overestimated the expected cost of G2211 by $1 billion.

The Proposed Rule for 2026 online materials included 2024 utilization data that further supports the earlier AMA analysis. The exact utilization assumptions used in 2023 rulemaking to make the budget neutrality adjustment for 2024 was 83,353,045. As the table *2024 G2211 Medicare Utilization* demonstrates, the AMA anticipated utilization for G2211 relative Office/Outpatient E/M was correct at 11.2 percent. This is far below the CMS assumption at 38 percent.

2024 G2211 Medicare Utilization

G2211 2024 Medicare Utilization	24,654,894
99202-99215 2024 Medicare Utilization	219,332,635
G2211 Percent in 2024	11.2%
CMS Assumption Used for Budget Neutrality Adjustment	38%

This overestimate is not without consequence. Because G2211 was implemented in a budget neutral manner and was expected to increase Medicare spending significantly, it resulted in a steep, unwarranted cut to the Medicare conversion factor. Specifically, the budget neutrality adjustment in the 2024 Final Rule resulted in a 2.18 percent decline to the 2024 conversion factor, but the actual 2024 claims data suggest this should have been a 0.79 percent decline. Therefore, the 2024 budget neutrality adjustment cut was three times as large as it should have been, unnecessarily removing $1 billion from the MFS.

The AMA strongly urges CMS to correct the utilization estimate for G2211 based on actual claims data from 2024 by making a prospective budget neutrality adjustment to the 2026 conversion factor in the forthcoming MFS Final Rule for 2026.

K. Enhanced Care Management

Recommendation:

- The AMA encourages CMS to work directly with the CPT Editorial Panel on comprehensive coding changes that reduce administrative burden for advanced primary care and behavioral health integration (BHI) services.

CMS proposes to create optional add-on codes for Advanced Primary Care Management (APCM) services (HCPCS codes G0556, G0557, G0558) that would facilitate providing complementary BHI services by removing the time-based requirements of the existing BHI and Collaborative Care Model (CoCM) codes. CMS believes that removing the time-based requirements will reduce burden by reducing the documentation requirements for billing, which CMS expects will make primary care physicians more likely to furnish BHI and CoCM services.

In 2020, the AMA established the BHI Collaborative, which is comprised of eleven physician organizations representing both primary care (e.g., family medicine, internal medicine, and pediatrics) and other specialties (e.g., cardiology, neurology, and psychiatry) with the mission of equipping physicians and their practices with the necessary knowledge to overcome obstacles and sustain integrated care for their patients and families. The AMA has also created numerous free and open-source resources comprised of comprehensive, proven strategies and best practices associated with the spectrum of evidence-based BHI models (e.g., CoCM, PCBH) and modalities (e.g., co-located, virtual).

Through these initiatives, the AMA has heard feedback that the current time-based requirements of CPT codes 99492, 99493, and 99484 can be a barrier to reporting. The AMA has also learned that BHI services are critical in other specialties beyond primary care, including cardiology and oncology. While we appreciate that CMS is exploring ways to increase BHI for Medicare patients, creating new C-codes for services already described in CPT adds confusion for physicians across payers. **Rather than finalize separate G-codes for Medicare patients only, the AMA encourages CMS to work directly with the CPT Editorial Panel on comprehensive coding changes that reduce administrative burden.** The Panel's Value-Based Care Workgroup is already looking at these types of issues around bundling services, and the Panel remains open to dialogue with the agency on how to best reflect emerging models of care in the CPT code set.

L. Policies to Improve Care for Chronic Illness and Behavioral Health Needs

Prevention and Management of Chronic Disease – Request for Information

Preventing and managing chronic disease is a top priority for CMS. The agency notes that six in 10 Americans have at least one chronic disease and 4 in 10 have two or more chronic diseases. CMS seeks feedback about how to better support the prevention and management of chronic disease, including whether to create separate coding and payment for services addressing social isolation and loneliness, intensive lifestyle interventions, medically tailored meals as an incident-to service, FDA-cleared digital therapeutics that treat or manage the symptoms of chronic diseases, and motivational interviewing. CMS also requests ideas to increase the uptake of Annual Wellness Visits (AWVs).

How could we better support prevention and management, including self-management, of chronic disease?

The AMA shares CMS's objectives of improving patient access, strengthening chronic disease management, and advancing value-based care, and we welcome continued dialogue to ensure that patients can receive preventive services when and where they need them. Over the past several decades, the CPT Editorial Panel has demonstrated its leadership by creating foundational coding frameworks, starting with glucose monitoring services and expanding to remote patient monitoring (RPM), remote therapeutic monitoring (RTM), and self-measured blood pressure monitoring (SMBP). These efforts, built in collaboration with CMS, specialty societies, and digital health experts, recognize the clinical value of continuous patient engagement and provide a sustainable pathway for payment of technology-enabled services. The Panel has also advanced preventive care by establishing more than 120 codes across 26 categories, reducing barriers to access and supporting early detection and chronic disease management.

More recently, the Panel established the Value-Based Care Workgroup (VBC) to examine how CPT can be further developed to describe longitudinal, team-based, and bundled models of care, directly aligning with CMS's goals for advancing value-based care delivery. Looking ahead, CPT is positioned to continue supporting CMS in our shared goals. Whether through the incorporation of digital therapeutics, enhancements to care management coding (including activities such as motivational interviewing), or development of new frameworks for AI-enabled services, the Panel remains committed to ensuring that coding evolves alongside innovation while maintaining clinical rigor, transparency, and physician leadership.

As CMS explores opportunities for supporting prevention and management, the AMA wishes to reiterate our position that high-quality care must remain physician-led to ensure services are integrated into the patient's full care plan. Patients with chronic disease require care coordination, not fragmented services. Isolating services outside physician-led teams risks exacerbating long-standing challenges, particularly in rural areas where access is already limited. CPT supports physician leadership by embedding new

services, such as digital monitoring, therapeutics, or behavioral interventions, into the broader framework of coordinated care.

Furthermore, we encourage CMS to work directly with the CPT Editorial Panel to address coding issues comprehensively, rather than relying on temporary G-codes that increase administrative burden and provider confusion. Engaging directly the aforementioned CPT VBC Workgroup can leverage this initiative to align with CMS policy goals in chronic disease prevention, digital health adoption, behavioral health integration, and value-based care.

Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.

Clinical guidelines include lifestyle behavior change as a first line intervention to improving and managing many chronic diseases including diabetes, prediabetes, hypertension, hyperlipidemia, other cardiovascular diseases and orthopedic conditions such as chronic low back pain. Patients expect their physician to bring up health behaviors, and studies consistently demonstrate that when physicians engage in conversations with their patients about lifestyle changes, it generally improves patient uptake and adherence to those changes.

Medicare can better support physicians and care teams by providing opportunities for engaging with community-based lifestyle change programs such as the Medicare Diabetes Prevention Program (DPP). To facilitate this engagement CMS should collaborate with the CDC that have a history of pilot testing, evaluating, and creating standards for evidence-based programs that are already being implemented or can be adopted by organizations in a variety of settings and delivery modalities. These programs are most successful when tested in within real-world settings by practitioners. This scale and spread model can ensure availability and access of programs and organizational suppliers.

Expecting physicians to provide medical and pharmacological interventions while at the same time engaging patients on lifestyle interventions is a tremendous and costly burden. Studies indicate that brief interventions in primary care can be effective in helping patients stop smoking, reduce at-risk alcohol consumption, and improve weight, diet, and physical activity levels. Adapting the 5 As – Ask, Advise, Assess, Assist and Arrange – a framework commonly used for smoking cessation, is a proven technique in primary care practice. CMS can incentivize physicians to provide brief intervention and referral for lifestyle change by paying physicians for the service in addition to the payment for the visit, as smoking and tobacco use cessation counseling (CPT codes 99406 and 99407) are currently paid.

Primary care physicians are qualified to provide brief intervention but need support for identifying community-based programs that have been evaluated and found to be effective. Referring patients to services in their community where patients also have a level of trust can improve overall health outcomes while also potentially addressing upstream drivers of health. The AMA saw this in practice when it partnered with the YMCA on its Center for Medicare and Medicaid Innovation (CMMI) award to develop and test innovative quality improvement strategies to implement routine screening, testing, and referral of Medicare patients with prediabetes to DPPs at local YMCA. Clinical practices were able to use existing technology to identify patients eligible for screening for prediabetes and have a brief conversation about referral to the evidence-based lifestyle change program in the community.

CMS can integrate brief intervention and referral into clinical practice guidance by providing more opportunities like the MDPP in the community and online to meet Medicare beneficiaries where they are. Creating community clinical linkages takes advantage of the trust that patients have in their physicians.

Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, what evidence has supported these services, and what do these services entail? What services have been delivered by Medicare providers or community-based organizations, including area agencies on aging and other local aging and disability organizations? What has been the impact?

Throughout this RFI, CMS expresses a desire to establish payment within the MPFS for a variety of services not traditionally covered by Medicare, such as meals and aging services. CMS acknowledges that federal funding for agencies on aging is not sufficient as the population ages and demand for those services grows. Food insecurity is also growing as federal funding for meal programs is not adequate. **The AMA agrees that these programs need adequate funding from the federal government to meet the growing demand of the expanding Medicare population. To accomplish this goal, we urge the Trump Administration to work with Congress to increase funding for these services outside of the MPFS.** We are concerned that adding these services to the MPFS, which is a budget neutral system, could result in cuts to medical services, including preventive screenings and chronic disease management, as well as treatment services, such as surgery and therapy, and harm Medicare patient access to care.

Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?

Tracking physical activity minutes and steps by wearable devices cannot be directly linked to preventing certain chronic diseases or improvements in disease management that result in preventing negative health consequences. The intensity of physical activity is as critical as its duration, as vigorous-intensity exercise provides greater health benefits in less time. Consumers often overestimate the intensity of exercise or physical activity. Physicians are cautious when relying on data from a device. Many devices have not been validated for clinical accuracy.

While clinical guidelines recommend lifestyle interventions to manage and improve outcomes from many chronic conditions, the guidelines do not provide recommendations on how physicians can interpret data from so many different devices from multiple manufacturers. CMS could improve this gap by testing and evaluating effective clinical practices linking medical and digital interventions. It is imperative that before reimbursing wearable devices, that there is sufficient evidence of improved health outcomes especially for beneficiaries with existing chronic conditions. Medical interventions might be enhanced by a wearable such as with a continuous glucose monitor or blood pressure device but other devices such as one that tracks steps and sleep patterns have less evidence than a physician/medical intervention.

Self-measured blood pressure home devices are an example where the patient is empowered by their physician to track their blood pressure (BP) as part of self-measured BP monitoring. CMS covers the clinical services – training beneficiaries on using a home BP device and physicians' analysis of home readings – but does not cover the device. The AMA has requested coverage for home BP devices since 2019. The AMA has been successful in working with Medicaid on home BP device and BP monitoring clinical services. Currently 22 states cover home BP devices and clinical service codes for their beneficiaries. Eighteen states cover devices only.

Optimizing interoperability and the ability for patients to share their physical activity data seamlessly from wearables or other remote-monitoring platforms with their clinicians is vitally important. CMS

should continue to work with the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT on optimizing interoperability.

Please provide information on whether we should consider creating separate coding and payment for FDA-cleared digital therapeutics that treat or manage the symptoms of chronic diseases an incident-to service performed under the general supervision of a billing practitioner. Please see the CY 2025 PFS final rule (89 FR 97923 through 97928) for reference as to how we created new coding and payment for FDA-cleared digital mental health treatments (DMHTs).

As detailed in response to CMS' comment solicitation on payment policy for software as a medical device, the AMA has grave concerns about the budget neutrality implications of paying for AI-enabled software in the MPFS. We urge the Administration to work with interested parties and Congress to establish payment for AI-enabled technology outside of the MPFS.

Regarding coding for these services, the CPT code set has long served as a reflection of medical innovation, evolving to recognize and support the integration of technology into clinical practice. A prime example is the Remote Therapeutic Monitoring (RTM) code family, which was designed to accommodate therapeutic interventions in areas such as behavioral health and musculoskeletal therapy.

This evolution is part of a broader, longstanding commitment by the CPT Editorial Panel to recognize and codify advances in medical technology, particularly those that enhance the treatment and management of chronic diseases outlined below in the following timeline:

- **Early 2000s**: CPT began by introducing codes for services like blood glucose monitoring, acknowledging the growing need to capture care delivered outside the traditional office visit, especially for patients managing chronic conditions.
- **2019 – Remote Physiologic Monitoring (RPM)**: In response to rapid advancements in connected health technologies, CPT introduced RPM codes. Developed with input from the Digital Medicine Payment Advisory Group (DMPAG), these codes addressed gaps in the code set and described services such as device setup, patient education, and ongoing treatment management by physicians or QHPs. This marked a pivotal shift toward recognizing the clinical value of continuous, remote patient engagement.
- **2021 – Remote Therapeutic Monitoring (RTM)**: Building on the foundation of RPM, RTM codes expanded remote monitoring to include non-physiologic data—such as musculoskeletal function, respiratory status, and cognitive behavioral interventions. These codes also enabled reporting by non-physician providers like physical therapists and respiratory therapists, reflecting the interdisciplinary, team-based nature of modern care.
- **Self-Measured Blood Pressure (SMBP) Monitoring**: Recognizing the unique clinical and public health value of SMBP, CPT created specialized codes to support this evidence-based practice. These codes align with national initiatives aimed at preventing cardiovascular disease and improving population health outcomes.

Overall, remote monitoring codes have improved access for rural patients, reduced unnecessary in-person visits, and empowered patients with chronic conditions to better self-manage. CPT codes for monitoring services provide the flexible but standardized infrastructure necessary to adapt as technology evolves.

In consideration that there are significantly more types of coding and payment that describe procedures in the physician fee schedule, please provide feedback regarding whether this detracts from the codes describing services that address underlying health behaviors, chronic disease management, and prevention.

We do not believe that a tally of codes used to describe the specifics of procedures in different sites of the body using different instruments or methods with varying degrees of complexity and a tally of codes to describe person-centered, holistic, preventive care are comparable. Patient-centered, comprehensive preventive care may be described in fewer codes than specialized procedures but that in no way detracts from those services. Moreover, a greater number of codes does not translate to a greater amount of Medicare spending. Although there are approximately 6,000 CPT codes that are necessary to describe procedures, the total spending for these services only comprises 21 percent of the total allowed Medicare Physician Payment Schedule spending.

CPT includes more than 120 preventive service codes across 26 categories (e.g., immunizations, cancer screenings, counseling, chronic disease detection, preventive exams). These codes reduce barriers to access by:

- Triggering automatic coverage requirements, ensuring many preventive services are available at no cost to patients.
- Enabling consistent claims submission and adjudication across payers, reducing administrative friction.
- Supporting preventive initiatives, registries, and value-based care contracts.

Preventive coding in CPT ensures early detection, better care coordination, and cost-effective population health management. CPT's physician-led governance ensures that preventive codes are evidence-based, clinically precise, and adaptable as new evidence emerges.

Please provide information on whether we should create separate coding and payment for motivational interviewing, or whether the resources involved in furnishing these services are appropriately recognized in current coding and payment.

The CPT Value-Based Care Workgroup is actively exploring how to evolve the code set to reflect modern care team functions. At the September 2025 CPT Editorial Panel meeting, proposed language has been submitted as part of an application, which adds language to existing care management services to reflect activities akin to motivational interviewing, social/emotional support, and addressing social drivers of health. The proposed language states: *facilitating and providing social and emotional support to health the patient cope with the condition, social drivers of health needs and adjust daily routines to better meet diagnosis and treatment goals*.

In addition, the proposed revisions seek to clarify the roles of "clinical staff" and what "directed by" a physician or QHP means in modern team-based care.

Social Determinants of Health (SDOH) Risk Assessment (HCPCS code G0136)

Recommendation:

- The AMA agrees that SDOH risk assessment is already embedded in existing CPT codes, particularly within the E/M services framework, and these services can be appropriately captured and reported without the need for a separate G-code.
- We urge CMS to educate physicians about coding and payment for addressing food, housing, and transportation needs of patients using the revised E/M coding guidelines.

CMS proposes to stop covering and paying separately for an SDOH risk assessment, to delete HCPCS code G0136, and to remove this code from the Medicare Telehealth Services List. CMS believes that the resource costs described by HCPCS code G0136 are already accounted for in existing codes, such as E/M visits.

Studies have found substantial evidence linking social circumstances, including access to healthy food, stable housing, and consistent and reliable transportation, to health and to health outcomes. It is now understood that non-medical factors, such as food security and access to transportation, account for as much as 50 percent of a person's health outcomes. When one or more of these conditions pose challenges, such conditions can become risk factors for poor health outcomes.

The AMA appreciates CMS' recognition that changes to the coding guidelines for E/M visits implemented in 2021 facilitate capturing SDOH data as it relates to the complexity level or length of the office visit. As CMS notes, the CPT Editorial Panel recognized in the revised CPT E/M Guidelines that SDOH needs can increase the complexity of a physician's medical decision-making for an E/M visit and increase risk to the patient, when diagnosis or treatment is significantly limited by SDOH. Specifically, SDOH appear in the Risk of Complications and/or Morbidity or Mortality of Patient Management category, noted as Diagnosis or treatment significantly limited by social determinants of health. For instance, addressing food insecurity for diabetic patients can lead to improved A1C levels.

Because SDOH assessment is already embedded in existing CPT codes, particularly within the E/M services framework, these services can be appropriately captured and reported without the need for a separate G-code. This approach ensures that the collection and consideration of SDOH remains an integral part of patient evaluation, while maintaining coding alignment and avoiding unnecessary duplication. **To ensure that patients continue to receive screenings and interventions about factors that impact their health outcomes, we urge CMS to educate physicians about coding and payment for addressing food, housing, and transportation needs of patients using the revised E/M coding guidelines.**

M. Payment of Skin Substitutes

Recommendation:

- CMS should not separately pay for skin substitutes as incident-to-supplies under the RBRVS in the non-facility setting. CMS should consider a different payment mechanism outside the RBRVS and Medicare Physician Payment Schedule.

CMS proposes to establish a single payment methodology for skin substitute products furnished in both non-facility and hospital outpatient settings, effective January 1, 2026. Under the proposal, skin substitutes would be paid as incident-to supplies and grouped into three payment categories based on their FDA regulatory pathway: Premarket Approval (PMA), 510(k) clearance, and Section 361 HCT/P (Human Cells, Tissues, and Cellular and Tissue-Based Products). Products licensed under section 351 of the Public Health Service Act would remain separately reimbursed under section 1847A. For CY 2026, CMS proposes to calculate a single payment rate across all three categories based on hospital outpatient utilization patterns. CMS would maintain existing HCPCS codes and apply the applicable rate to each.

The proposed 2026 payment rate is $125.38 per square centimeter, geographically adjusted, and is estimated to save $9.4 billion per year. Future payment rates, beginning in 2027, would impact practice expense RVUs for other services. However, CMS anticipates that market pressure will result in price reductions in these skin substitute products. To establish payment rates, CMS proposes to use the volume-weighted Average Sales Price (ASP) for each category, when available. CMS also proposes to update

these rates annually through rulemaking based on the most recent calendar quarter of ASP data and is soliciting comments on whether using a single quarter is advisable. CMS also seeks input on how to incorporate these payment data into future PE RVUs and whether scaling factors should be applied to improve relativity with other services and supplies. The agency will continue reviewing complete HCPCS Level II applications for skin substitutes through its existing biannual process. Finally, CMS proposes to codify the definition of a "biological" for Medicare payment purposes as a product licensed under section 351 of the Public Health Service Act at 42 CFR §§ 414.802 and 414.902.

We applaud CMS objective to accurately price skin substitutes. CMS states that "Part B spending for these products rose from approximately $250 million in 2019 to over $10 billion in 2024" and "One purpose of the new proposed policy is to limit some of the current profiteering practices occurring in this industry." However, the CMS solution to this problem will put the Medicare Physician Payment Schedule and payments for individual physician services at great risk in future years. **We urge CMS to modify their proposal to pay for 235 supply codes (Q4101-Q4382) under the RBRVS and instead implement the payment outside the MFS.**

To determine the payment for the 235 skin substitute supply codes, CMS developed payment rates based on average sales price for the fourth quarter of 2024 and weighting utilization using data from only hospital OPPS data. The dollar payment amount was then converted to a practice expense RVU of 3.70. CMS inappropriately assigns a professional liability insurance (PLI) RVU of .01 to each of these 235 supply codes and we strongly reject this proposal. **The PLI RVU for application of these supplies is adequately captured in the underlying procedure codes 15271-15278. CMS should convert the global period for the supply codes to reflect a ZZZ add-on code and eliminate the PLI RVUs entirely. It is unfair to dilute the distribution of PLI RVUs away from physicians to supply codes.**

In implementing this proposal, CMS includes the utilization of one service for each of the 235 Q supply codes. CMS does add any allowed charges to the MFS, despite the fact that more than $10 billion was spent on these supplies in 2024. When actual claims data are applied to these codes, the impact the PE RVU methodology could be devastating to other physician services PE RVUs and payment. Likewise, any changes to apply a price increase for these supplies (converted to RVUs) would also be budget neutral and impact other physician services. This method is outlined by CMS as follows: *"Because the resources involved in provision of these supplies were not previously incorporated into RVUs under the PFS, the costs are not accounted for when we compare the RVUs for physicians' services from 1 year to the next. In other words, changes in payment rates for these particular codes will be incorporated into PFS relativity once we use claims data from 2026, should the policy be finalized. Under the usual methodology, that means that changes in rates for these services between CY 2027 and CY 2028 would have an impact on the development of PE RVUs for other services. Over time, we anticipate that our proposal will continue to result in significant overall price reductions since grouped valuation instead of product-specific pricing should result in downward pricing pressure in the market."* CMS attempts to reassure physicians that there will be further price reductions in these services. However, industry is already seeking legislative action to increase the payment rates.

CMS should not separately pay for skin substitutes as incident-to-supplies under the RBRVS in the non-facility setting. CMS should consider a different payment mechanism outside the RBRVS and Medicare Physician Payment Schedule.

N. Geographic Practice Cost Indices (GPCIs)

Recommendation:

- For the 2026 MEI and GPCI weights, CMS should utilize the PPI and CPI data to implement updated shares of work, practice expense and PLI, which results in the following distribution: work = 54.4 percent; PE = 43.8 percent; and PLI = 1.7 percent. The updated 2026 GPCIs should be phased in over two years. CMS should also modify its proposed mapping of the PPI and CPI survey data categories for use in updating the PE GPCI.

2026 GPCI Update

As the GPCIs were last updated in 2023, CMS proposes updated GPCIs for 2026 to be phased in over 2026 and 2027. CMS notes that because the most recent extension of the 1.00 work GPCI floor is set to expire on September 30, 2025, under current law, the 2026 proposed GPCIs do not include the 1.00 floor. Payment impacts for most localities from the updated GPCIs are less than one percent, although several localities face negative impacts greater than one percent if the 1.00 work GPCI floor is not extended.

CMS proposes to continue using the current 2006-based MEI cost share weights in the 2026 GPCIs but seeks comments on potential implementation of the 2017-based MEI cost share weights or PPI and CPI survey weights in a future GPCI update. Specifically, CMS seeks comments on updating the GPCI cost share weights in 2027 and whether such an update should be phased in even though only one year would have passed since the previous GPCI update.

As discussed in detail in the Practice Expense section of this letter, the AMA recommends that CMS update the MEI weights using the PPI and CPI data in 2026; it should not wait until a future year. Utilizing the PPI and CPI Survey weights for the MEI will lead to work equaling 54.4 percent, practice expense equaling 43.8 percent, and PLI at 1.7 percent. These same updated MEI weights should be used in the 2026 GPCI update and, as CMS proposes, updated 2026 GPCIs should be phased in over two years.

Mapping PPI and CPI Survey Data Categories to the PE GPCI

CMS presents a "Proposed Mapping for PPI and CPI Survey Data Categories to the PE GPCI Components" (Table 109). In certain cases, their mapping does not align with the expense category definitions (available in the Appendices to the Methodology Report) that were provided to practices invited to participate in the PPI Survey.

CMS suggests that 50 percent of the Administrative category be mapped to Purchased Services and 50 percent to Office Rent. However, as described in the Appendix (page 14), the Administrative category focused on the compensation of employed and contract workers primarily involved in administration. None of that category should be mapped to Office Rent.

CMS suggests that 50 percent of the Other expense category be mapped to Purchased Services and 50 percent to Office Rent. However, the expenses in this category (contracted billing services, office management services, legal expenses, etc) do not relate to Office rent.

In addition, CMS suggests that 50 percent of Overhead be mapped to Purchased Services and 50 percent to Office Rent. As described in the Appendix (page 22), the Overhead category did include a broader set of expenses than just rent, such as janitorial and laundry services, and security. However, while for some practices those services might be considered Purchased Services, we suspect that almost all that category

would map to Office Rent and only a small percentage – well under 50 percent – would map to Purchased Services.

Occupation Codes Used in the Work GPCI

CMS also considered several alternatives related to the list of occupation codes used in the work GPCI calculation. Under the scenarios it considered for using 57 or 31 occupation codes instead of the 160 that are currently used, the work GPCI values were nearly identical. The AMA has longstanding policy supporting the accuracy of the GPCIs and we appreciate that CMS explored these alternatives.

O. Strategies for Improving Global Surgery Payment Accuracy

Recommendation:

- 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 AMA also recommends that the practice expense inputs should be modified for the inpatient hospital and observation care visits and office visits within the global periods.

CMS continues to express concern about the accuracy of global surgery payment. Most recently, in the Final Rule for the 2025 MFS, CMS finalized a proposal to require the use of the appropriate transfer of care modifier (modifier -54, -55, or -56) for all 90-day global surgical packages in any case when a physician plans to furnish only a portion of a global package both when there is a formal, documented transfer of care (current policy) and when there is an informal, non-documented but expected, transfer of care. Separately, CMS also created HCPCS code G0559 to capture the additional time and resources spent in providing follow-up post-operative care by a physician or other qualified health care professional who did not perform the surgical procedure and who has not been involved in a formal transfer of care agreement. CMS has not yet shared collected data from this initiative. In this year's Proposed Rule for 2026, CMS is seeking comments on strategies to improve the accuracy of payment for global surgical packages, specifically related to the updated transfer of care policy. CMS also solicits comments on the best approach to utilize these data going forward.

Since July 1, 2017, Medicare physicians in 9 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 *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*.

RAND Report

RAND prepared analysis and reports related to the availability of 99024 in Medicare claims data. The AMA previously detailed the inaccuracies with RAND's analyses, beginning on page 31 the AMA comment letter on the Proposed Rule for the 2022 MFS. The RUC continues to express concern that the 99024 data in Medicare claims does not accurately capture and under represents 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. According to RAND's most recent report on 99024 from 2021, only 47 percent of the physicians and other health care professionals who were expected to participate in the effort actually submitted tracking code 99024. 53 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. 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.

According to the 2021 RAND Report, participation also varied widely by both specialty and state.[5] Primary care physicians only participated at a rate of 16 percent and Nurse Practitioners (NPs)/Physician Assistants (PAs) only at a rate of 23 percent; these specialties collectively 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 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 (per figure 3.2 in report).

Specific additional flaws in the RAND study are that 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 are dominated by these three services and, therefore, are not representative of the entirety of 010-day (or other) global codes. For 090-day global codes, cataract surgery (codes 66982, 66984) and hip/knee arthroplasty (codes 27130, 27447) collectively account for 28 percent of the volume. However, the cataract codes (66982 and 66984) were reviewed for the 2020 MFS, and the post-operative visits now align with the 99024 Medicare claims data collected. The hip/knee arthroplasty 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 MFS. Additionally, in September 2025, hip, and knee arthroplasty (codes 23472, 27130 and 27447) have been 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 will review and submit recommendations to CMS in October 2025.

Office of Inspector General Report

As part of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015, Congress mandated that CMS gather information from physicians to assist in improving the accuracy of global surgery valuation, and that the Office of Inspector General (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 study audited 103 medical charts. 64 individual CPT codes were examined, with 47 codes having only one medical chart reviewed, 7 codes having two charts reviewed, 4 codes having three charts reviewed, 5 codes having four charts reviewed and 1 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 MFS. Of the 103 cases studied, codes related to 29 medical records have been reviewed by the RUC since 2018, and post-operative visits have already been reduced. Additionally, codes related to 18 medical records will be reviewed at the upcoming September 2025 RUC meeting. Specifically, the RUC reviewed cataract surgery (CPT codes 66984) for 2020, and the 3 post-operative

[5] 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

visits currently align with the audited performed by the OIG. As stated above, in September 2025, shoulder, hip, and knee arthroplasty (codes 23472, 27130 and 27447) have been 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 will review and submit recommendations to CMS in October 2025.

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 MACs, 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 was isolating their study to only codes with at least one 99024, their medical chart review showed that that subset still had large errors in the quality of the 99024 data. Specifically, 45 of the 103 samples studied had 99024 data incorrect compared to their medical chart review.

Under the current paradigm, 99024 reporting data in its current limited state does not have utility and should not be used to determine the accuracy of surgical global payment. One solution CMS may apply would be to use the OIG data analysis and medical chart review of 99024 to identify potentially misvalued services. The Medicare utilization criteria for most screens to identify potentially misvalued services by the RUC and CMS is at least 10,000 claims. Of the codes reviewed in the OIG report, there are 14 codes that have greater than 10,000 Medicare claims and a variance of greater than one post-operative visit. One opportunity for CMS would be to nominate those 14 codes and their associated code family for review as potentially misvalued.

Separately, in this Proposed Rule, CMS modeled alternative methods for determining accuracy in surgical global payment using either the physician time file or the RVU share to determine the procedure share for the transfer of care policy. Physician time alone would not be appropriate, as that would not consider that the procedure is much more intense than the postoperative care for most procedures. Using RVUs would have its own set of challenges and drawbacks. Surgical global RVUs were not assigned via a building block methodology so comparing the RVUs of separately reported visits to the bundled visits to determine the share would not be appropriate. None of the proposed options appear to be an appropriate viable alternative to the status quo legacy procedure share ratios used in the transfer of care policy. Also, the RUC would again like to remind CMS of the RUC's bundled-postoperative visit recommendation to address the misvaluation of bundled post-operative visits relative to analogous stand-alone E/M visits. Failure to adjust for the increase in post-operative visits in the global period fractures relativity and disables accurate comparison among services in the MFS.

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 AMA also recommends that the practice expense inputs should be modified for the inpatient hospital and observation care visits and office visits within the global periods. A detailed spreadsheet of all RUC Recommendations on Modifications to Visits in the Global Period is attached to this letter (*See Attachment 4).*

II. UPDATES TO QUALITY PAYMENT PROGRAM (QPP) AND MEDICARE PROMOTING INTEROPERABILITY PROGRAM - (SECTION IV.)

P. MIPS Value Pathways (MVP)

Transforming the Quality Payment Program (QPP) - MIPS Value Pathways (MVP)

Clinical Groupings

The AMA appreciates the ongoing dialogue with CMS on MIPS Value Pathways (MVP). We are glad to see CMS is receptive to our recommendations on an alternative framework, which we called Condition-Stratified MVP Framework, in its proposed "Clinical Groupings" within MVPs. The clinical groupings are a nice first start to address many of the pitfalls of the finalized MVPs. Instead of the current approach of having a long list of quality measures in the MVP ordered by Measure ID, the AMA specifically suggested that CMS organize the quality measures into categories, each of which is relevant to a particular patient condition or an episode of a particular type of treatment. However, long term the AMA and medical specialty societies continue to believe that the best way to make MVPs clinically relevant to patients and physicians is to create separate MVPs for individual health conditions, episodes of care, and major procedures, specifically for areas that are high volume conditions and procedures—like the current MVP for Lower Extremity Joint Repair.

While we suggested cross-cutting quality measures, such as depression screening or advance care planning, in a separate category if applicable, it is unclear how CMS derived the groupings titled, *general*, *advancing health and wellness*, and *experience of care* and associated measures or whether CMS consulted with the impacted specialties to ensure correct categorization within an MVP. For example, in Complete Ophthalmologic Care MVP, the measures that fall under "general ophthalmology" could also fall under "advancing health and wellness" and "experience of care" and vice versa. There is also inconsistency regarding whether an MVP includes both the "advancing health and wellness" and "experience of care" clinical groupings and no clear explanation in the rule how CMS made that determination or what was taken into consideration when incorporating measures. For more specifics, please see the section on the Core Measures Request For Information.

While there is no one-size-fits all approach to MVPs that will work for every medical specialty, we believe that MVP clinical groupings MUST prioritize alignment of quality and cost measures. 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. Therefore, we request additional clarification on the intent of the revisions to the structure of the MVPs by clinical topic or an episode of care. Specifically, the pairing of quality and cost measures by these episodes implies that if a physician reports the quality measures for a specific clinical area, only the associated cost measure would be attributed to him or her. However, based on the current attribution rules for the cost measures, any measure including the Total Per Capita Cost (TPCC) measure could be applied regardless of which quality measures are selected. These "assignments" of quality and cost measures should be reviewed and approved by the relevant specialties and CMS should consider revising the attribution approach for the cost measures to ensure that it is only attributed to a physician if the corresponding quality measures are reported.

MVP Participation Option

We also continue to urge CMS to incentivize reporting of MVPs, rather than mandate it **and do not support sunsetting traditional MIPS.** In 2023, only 1.26 percent of MIPS eligible clinicians were scored on an MVP. The MIPS program is already overly burdensome, as research shows compliance costs $12,800 per physician per year and physicians spend 53 hours per year on MIPS-related costs, e.g.

the equivalent of a full week of patient visits. We are concerned that requiring group practices, which is how most physicians participate in MIPS, to form subgroups to report MVPs adds significantly to the burden of compliance. 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. Practices should have the option to determine which MVP or MIPS measures are most relevant to the physicians in the practice.

We are also concerned that there are not sufficient MVPs for all physicians, including subspecialists, as well as measures to fill measurement gaps. A transformative MVP program requires more MVPs and measures, not less. Measurement does not increase burden it leads to a more meaningful program for patient and physicians. A smaller and limited set of measures only leads to physicians reporting on less relevant measures and reporting for the sake of reporting and compliance. For example, the Complete Ophthlamologic Care MVP does not include measures that address subspecialties in cornea, reconstructive, pediatric, neuro, immunology or refractive. Worse, many of the MVPs currently available to physicians do not reflect the input of the AMA and national medical specialty societies who have tried countless methods to offer constructive feedback to improve MVPs which have been dismissed by the agency, often without sufficient rationale. For example, we have repeatedly highlighted that we do not support the Surgical Care MVP because it inappropriately lumps multiple surgical specialties (e.g. general surgery, colorectal surgery, neurosurgery, thoracic surgery) into a single MVP without a basis in how care is delivered to patients. Yet, CMS continues to maintain the MVP in the program. Whether ASM or MVP, there appears to be a clear disconnect between CMS' goals of streamlining programs and basing APMs on MVPs, as well as better informing patients where to seek care on a particular condition.

Population Health Measures

While it is important to measure improvements in population health, adding one-size-fits-all requirements without consideration of how they can be integrated into existing criteria and tailored to each MVP introduces unnecessary complexity and is less effective at improving patient outcomes. For example, the population health measures are focused on hospital care that is not clinically relevant to ophthalmologists. While ophthalmologists and other specialists, including primary care, may be exempt from some of the measures, inclusion of these measures as a foundational layer results in confusion and concern about the applicability of those measures and MVP. It also adds an additional category into the program with burdensome and uneven scoring rules that were never intended or required by Congress in the MACRA statute. Because CMS has added this foundational category, we believe it is not accurate to say that MVPs reduce the number of quality measures that a physician or group must report because, although there is no reporting element with population health measure, physicians must try to understand their performance on these claims-based measures without any timely data from CMS. In addition, given the measures are based solely on administrative claims, CMS is potentially introducing the same flaws we have repeatedly highlighted with the global cost measures into this new category. **Therefore, we urge CMS to remove the flawed population health measures as a foundational requirement as it fails to accurately capture quality.**

MVP Scoring Rules

Furthermore, the underlying and ongoing scoring rules for MVPs must be addressed. Modifications to the scoring rules for MVPS would achieve more appropriate scores for MVP participants, including:

<u>Quality Measure Scoring</u>

- *Few relevant measures:* If there are fewer than four quality measures in the MVP clinical grouping for the specific type of condition that a physician manages or the specific procedure the

physician performs (subcategory), then the physician should only be required to report those measures, rather than being forced to use generic measures in the MVP that are not relevant to their care or to not participate in the MVP at all.

- *Topped out measures:* To ensure equitable scoring rules and incentivize participation in MVPs, topped-out measures should not be capped.
- *New or existing measures or measures without a benchmark:* If there are few or no benchmarked outcome measures or high priority measures relevant to the condition(s)/procedures the physician manages/delivers, then the physician should be given maximum credit for submitting the unbenchmarked measures for a longer period to encourage submission of enough cases to develop a benchmark.
- *Measures with substantive changes:* The current approach to truncate the performance period to nine months may not yield sufficient data to establish reliable measure scores and/or benchmarks. Alternatively, if CMS cannot calculate a benchmark from truncated performance data, CMS creates a performance period benchmark. The scoring rule would lead to uncertainty and potential inequities with achieving the performance threshold. To encourage reporting on measures with substantive changes that need a new benchmark, physicians should be given maximum credit for submitting the measures to encourage submission of enough cases to allow CMS to develop a benchmark for future years, just as with the new or existing measure recommendation discussed previously. The current approach to truncate the performance period to nine months may not yield sufficient data to establish reliable measure scores and/or benchmarks.

Cost Measures

- *Total Per Capita Cost (TPCC) Measure*: Although CMS proposes much-needed attribution changes to TPCC, the proposal does not address its fundamental flaw, which is that this measure holds physicians accountable for costs outside of their control. The AMA continues to call on CMS to remove this measure from the program or, at a minimum, to remove TPCC from any MVP that includes an episode-based cost measure. If CMS does not remove it, TPCC should be revised to separate costs related to each disease or condition, so it is clear which costs are related to a physician's services.

Finally, we reiterate that CMS should allow facility-based scoring within MVPs or within subgroups. Facility-based scoring allows for better alignment between the hospital quality programs and MIPS, which promotes team-based care and lowers the administrative burden of MIPS.

Q. MVP Subgroup Reporting

MVP Group Reporting Option for Small Multispecialty Practices

Recommendations:

- The AMA continues to oppose mandatory subgroup reporting for practices of all specialties and sizes and strongly urges CMS to rescind mandatory subgroup reporting for larger multi-specialty practices to participate in MVPs or, at a minimum, postpone this requirement on an interim final basis in the final rule.
- The AMA urges CMS to finalize its proposal to allow multispecialty groups that are small practices (i.e., 15 or fewer clinicians) to report MVPs as a group practice rather than subdividing into subgroups or reporting as individuals.
- CMS should apply the small practice exception at the specialty level within larger multispecialty practices and enact additional regulatory burden reducing changes to incentivize MVP participation among multispecialty groups.

To encourage small multispecialty practices to report MVPs, CMS proposes allowing them to continue to have the option of group reporting. They may still choose to divide and report as subgroups to be scored on MVPs. CMS acknowledges that small practices face resource constraints and requiring them to divide into subgroups would be too onerous. Additionally, subgroups of small multispecialty practices may not meet established case minimums, resulting in lower scores.

The AMA continues to oppose mandatory subgroup reporting. 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 is not homogenous, 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.

Besides, there has been extremely limited uptake of MVPs and subgroup reporting. Although almost 6,000 clinicians received a MIPS score through an MVP, those scores were based on the performance of only 186 separate entities – 98 groups, 5 subgroups, and 83 individuals, according to the 2023 QPP Public Use File. Of the 12 different MVPs available, more than half of the entities participated in two – the Cancer Care MVP and the Anesthesia MVP. Although the Wellness MVP had the third largest number of clinicians involved (902), this was based on the participation of just six groups.

Furthermore, mandatory subgroup reporting is inconsistent with MACRA, which provides that CMS must establish a process to assess group practices on the quality performance category of MIPS and enables the Secretary to establish processes for assessing group practices on the other categories of MIPS (Section 1848(q)(1)(D)). This provision of MACRA cannot reasonably be read as requiring subgroup reporting. Additionally, the statute encourages MIPS participation by groups via combining tax identification numbers (TINS) rather than participation by subgroups, which involves subdividing TINs. Under 1848(q)(5)(I)(iii), the process for creating a virtual group includes combinations of TINs: "provide that a virtual group be a combination of tax identification numbers…."

We strongly urge CMS to rescind mandatory subgroup reporting for larger multi-specialty practices to participate in MVPs or, at a minimum, postpone this requirement on an interim final basis in the final rule. CMS only released the 2023 Experience Report and Public Use File, providing the AMA and other interested parties with insights into MVP and subgroup participation in 2023, on June 30, 2025. At the same time, it is difficult for practices to prepare for next year as 2024 MIPS scores are delayed and not expected to be released until later this fall, followed by the targeted review period.

The AMA agrees with CMS that MIPS is expensive and burdensome to report and research shows it is disconnected from quality of care, leading many small practices to fall out of compliance not due to poor performance but due to a lack of resources. Based on Table 34a in the 2023 QPP Experience Report, eight percent of small practices received the maximum -9 percent penalty and 14 percent received a negative penalty in the 2023 performance period. By comparison, two percent of practices with 16-99 clinicians received the maximum -9 penalty while 17 percent received a negative penalty in the 2023 performance period. Less than one percent of practices with more than 100 clinicians received the maximum -9 percent penalty and 10 percent of the largest practices received a negative penalty in the 2023 performance period. We believe that forcing small multispecialty practices to subdivide into subgroups to report MVPs would needlessly exacerbate the expense and burden of the program, leading to even more penalties on small practices. **Therefore, the AMA urges the agency to finalize its proposal to allow multispecialty subgroups to continue to have the option to report MVPs as group practices rather than subgroups or individuals.**

Furthermore, CMS should extend this exception to the specialty department of larger multispecialty groups that have 15 or fewer eligible clinicians in the specialty. Similar to small practices, small subgroups may not meet established case minimums, resulting in lower scores. For example, some multispecialty groups may have only one or two surgeons who perform lower extremity joint replacements and forming a subgroup of these surgeons to report a separate MVP could lead to unreliable measure scores and reweighting of multiple measures or even entire categories, resulting in little useful information for the surgeon or the patient. Rather than forming small subgroups, we recommend that any specialty with 15 or fewer eligible clinicians within a larger multispecialty group practice retain the option to report as a group.

Finally, 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 service 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.

MVP Group Registration Process

Recommendations:

- CMS should finalize its proposal to allow group practices to attest that they are a single specialty group or a small multi-specialty group when registering to report an MVP.
- CMS should refine the proposed definitions of single and multispecialty group practices and issue subregulatory guidance to assist multispecialty group practices in forming appropriate subgroups for MVPs.

In lieu of using the claims data for designating a group as either a single specialty or a multispecialty group, CMS proposes that to report an MVP, a group practice which is either a single-specialty group or a multispecialty group that meets the requirements of a small practice (i.e., 15 or fewer clinicians), would be required to attest to one of these designations. CMS also proposes revising the definition of a single specialty group to mean a group that consists of clinicians in one specialty type or clinicians involved in a single focus of care. The definition of a multispecialty group would mean a group that consists of clinicians in two or more specialty types or clinicians involved in multiple foci of care.

The AMA supports CMS' proposal to allow qualifying group practices to self-attest to being single specialty or a small multi-specialty group. We appreciate that CMS acknowledges the limitations of using Provider, Enrollment, Chain, and Ownership System (PECOS) and claims data for designating a group as either a single specialty group or a multi-specialty group, including the specialization of QHPs, changes in the composition of a group practice, and different specialists who are providing similar patient care. We agree that it would likely add burden, create confusion, and potentially penalize group practices if

CMS were to assign an incorrect designation to a group practice. For that reason, it is preferential to allow attestation by the group practice of their designation.

The AMA has previously recommended CMS allow physicians and groups to attest to their specialty. Some physicians are highly subspecialized, providing services for a specific subset of diseases or patients with specific characteristics. They are likely to have the same specialty designation as physicians with completely different subspecialties, simply because CMS does not have a specialty code that defines them more precisely. At the other extreme, some physicians, particularly in rural areas and small communities, may provide a range of services that would typically be delivered in larger communities by multiple physicians from different subspecialties or even different specialties. This is a great benefit to the patients in these communities because they can receive services from more types of specialties and subspecialties than there are physicians practicing in the community. However, these physicians are not "single specialty" physicians, and no one specialty code accurately describes what they do.

Regarding the proposed definitions, the AMA has heard from the medical specialty societies that these revisions may cause confusion as clinicians across multiple specialties focused on a single clinical area would fit both definitions. **We recommend clarifying these definitions and emphasizing the difference in the focus of care, not the specialty type, by making changes such as:**

- Single specialty: clinicians in one specialty type or clinicians *in two or more specialties* involved in a single focus of care.
- Multispecialty group: a group that consists of clinicians in two or more specialty types *NOT involved in a single foci of care* or clinicians involved in multiple foci of care.

To assist group practices in understanding the subgroup reporting option, how to form appropriate subgroups around applicable care, and participate in MVPs, we believe there is a pressing need for more subregulatory guidance. This is especially important during the first few years when group practices will be self-attesting during the registration process.

R. Alternative Payment Model Performance Pathway

Proposal to Update the Alternative Payment Model Performance Pathway (APP) Plus Quality Measure Set

Recommendation:

- The AMA opposes CMS' proposed changes to the *Breast Cancer Screening measure* and *Colorectal Cancer Screening measure* due to data extraction issues, lack of EHR vendor support and measure reporting option alignment, as well as the potential to lead to overuse and patient harm. We urge CMS to communicate the need to support these eCQMs to EHRs vendors and in the interim, identify avenues by which ACOs will not have their potential shared savings at risk (e.g., suppress the measure).

Participating practices within ACOs report that some EHRs vendors, particularly those for small practices or specialties, have not maintained the capability to extract the data needed for the *Breast Cancer Screening (BCS) electronic clinical quality measure (eCQM)* and there is potential that it will also occur with the *Colorectal Cancer Screening eCQM*. Vendors believe that they do not need to support them since they were removed as individual measure options from MIPS. As a result, practices with these vendors currently cannot extract the data needed. Depending on the number of practices using these vendors, ACOs that opted to report using eCQMs may be forced to select a different reporting option (MIPS CQMs or Medicare CQMs) with increased burden of data collection and cost since practices with

these vendors will need to identify other avenues by which the data can be obtained (likely through manual data abstraction).

Even if a vendor can produce the QRDA 1 file, it will only include women aged 50-74 years since the eCQM specification was not updated to reflect the USPSTF's most recent recommendation to screen women aged 40-74 years for PY2025. The MIPS CQM and Medicare CQM, however, were updated, leading to several specifications for the same clinical concept to include different age ranges and the associated benchmarking across collection types differ. We believe that CMS must avoid situations where specifications are not clearly supported by vendors and specifications and associated benchmarking are not consistent.

Due to these data collection and extraction challenges, ACOs are at risk of not meeting the 75 percent data completeness requirement for the BCS measure and participating practices within the ACO may be required to collect data manually or through other means, adding undue burden and costs. **We urge CMS to communicate the need to support these eCQMs to EHRs vendors and in the interim, identify avenues by which ACOs will not have their potential shared savings at risk (e.g., suppress the measure).**

In addition, **we oppose the proposed changes to the MIPS CQM and Medicare CQM specifications for the BCS and CRC measures, 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. In addition, specifications across reporting options should remain aligned and the eCQM specification does not currently include this requirement nor would we support its addition to this specification in the future. ACOs often work with their participating practices to extract these data from EHRs even when reporting MIPS CQMs or Medicare CQMs and this change will make it even less feasible for them to continue to minimize the data collection burden for practices if they cannot leverage EHRs data.

We also believe that this change could lead to a negative unintended consequence of overuse of these procedures since the timeframe for both measures includes data from previous years (for CRC this 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 and not because the patient is due for this screening. **We oppose any change to a measure 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 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 across the specifications for all reporting options 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.

S. Merit-based Incentive Payment System (MIPS)

Performance Threshold

Recommendation:

- The AMA supports CMS maintaining the performance threshold at 75 points for the next three performance periods.

The AMA appreciates CMS maintaining stability and continuity with the MIPS program by proposing to maintain the performance threshold at 75 points for the next three performance periods (until the CY 2028 performance period/2030 payment year). By not raising the performance threshold it gives physician practices a greater opportunity to avoid a penalty and earn an incentive, as well as aligns with President Trump's EO, 14192 on Regulatory Burden.

Quality Performance Category - MIPS Final Score Methodology (Scoring the Quality Performance Category)

Topped Out Measures

Recommendation:

- We support CMS' proposal for identifying topped-out measures to include the impact to MVP scoring but urge CMS to apply the policy to ALL topped-out measures.

The AMA supports CMS' proposal to update the approach for identifying topped-out measures to include whether an MVP is impacted by limited measure choice but continues to urge CMS to expand the policy to all topped-out measures. Limiting it to a select set of 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 1st rather than the 9th 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 9th percentile was chosen when finalized in the 2025 Physician Fee Schedule 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. We continue to hear from specialties that they are handicapped from achieving maximum quality points and reaching the performance threshold. For example, the hospitalist specialty measure set includes four measures, and all the measures are topped-out, but none of the measures are on the flat benchmark eligibility list:

- Advance Care Plan (Measure 047)
- Documentation of Current Medication in the Medical Record (Measure 130)
- HF: ACE or ARB or QRNI Therapy for LVSD (Measure 005)
- HR: Beta-blocker Therapy for LVSD (Measure 008)

Therefore, due to the continued scoring cap on the measures they report on they are unable to meet the 2026 performance threshold. A hospitalist along with other specialties can participate in the program and meet the reporting requirements but will automatically be subject to a negative payment adjustment.

Methodology For Scoring the Administrative Claims-based Quality Measures

Recommendation:

- The AMA supports CMS' proposal to update the benchmarking methodology used for calculating administrative claims-based quality measures to align with the benchmarking methodology used for cost measures but urges CMS to consider applying it to ALL quality measures, not just administrative claims measures.

Due to ongoing concerns from the AMA on the need for CMS to re-evaluate the quality measure benchmark, CMS proposes to update the benchmarking methodology for administrative claims quality measures to align with the benchmarking methodology for cost measures beginning with the CY 2025 performance period/2027 MIPS payment year. This means that the median performance rate for a measure would be set at a score derived from the performance threshold. **The AMA is encouraged that CMS is proposing a change and an improvement over the existing decile-based quality measure benchmark methodology. Therefore, we urge CMS to consider applying this methodology to all quality measures in addition to administrative claims quality measures.**

We believe that expanding the methodology to all quality measures will encourage physicians to report more condition-specific measures. It will also reduce the administrative burden physicians currently face in trying to determine why they received a high or low MIPS quality score. Physicians would be scored by a singular methodology in MIPS, not multiple approaches depending on the measure type and data source. (Currently, physicians are scored using three methodologies because Care Compare utilizes a separate methodology from MIPS —the ABC benchmark methodology.) We do not believe that it is necessary to use a different approach to benchmark non-administrative claims-based measures.

The proposed methodology can be used regardless of the time period from which the benchmark data are derived, so there is no reason to treat measures that use data from EHRs or registries from the administrative claims-based measures. Therefore, we also encourage CMS to explore the use of prior year levels of data when benchmarking administrative claims measures, like it does for setting benchmarks for measures derived from EHRs or registries. While we recognize using prior year data cannot be done for cost measures because costs go up each year and good performance this year may still be higher costs than last year. However, quality performance does not have "inflation" and shouldn't preclude CMS from using prior year data for setting administrative claims quality measure benchmarks.

For all quality measures, not just the administrative claims measures, the points assigned to the median performance level from the benchmark period should be 10 percent of the MIPS performance threshold, not 6.0 as it is today. This change could encourage more physicians to report condition-specific measures because it would ensure they are not penalized for good performance. Under the current scoring system, a physician who performs better than the benchmark median on a quality measure and is in the 6th decile would receive 6.0 – 6.9 points. Quality points in that range would result in a quality score that is below the current performance threshold of 75, which could result in a payment penalty, i.e., the physician is penalized for performing better than the majority of physicians, rather than being rewarded. Assigning 7.5 points to the median performance level would prevent that.

In addition, standard deviations from the median should also be used to determine points for all quality measures rather than the current decile-based approach. Physicians should only be penalized if their

performance on a quality measure is significantly below that of other physicians, not because a large number of physicians have a slightly higher score. Under the decile-based methodology, if most physicians' scores differ only slightly from each other, then a small difference in a physician's score could lead to a large penalty. A small difference in a quality measure score is more likely to reflect random variation in patient characteristics, not a true difference in the physician's performance.

The table below shows an example of how the decile-based scoring system could result in very large penalties when there is very little variation in physician scores. Quality Measure A, on the left, has a wide range of scores below the median. Quality Measure B, on the right, has the same median score (90.5) but much less variation just below the median. Under the decile scoring system, if a physician's performance on Quality Measure A was 90, which is only 1/2 percentage point below the median, they would receive 5.33 quality points toward their MIPS quality score. The same performance for Quality Measure B would result in only 4 points toward their MIPS quality score. The only difference is that for Measure B, other physicians had scores between 90 and 90.5, even though this could have been due solely to random variation. The table shows that the 90 score for Quality Measure B is less than one-tenth of a standard deviation below the median, and so it clearly does not warrant such a large penalty. As shown in the example, a standard deviation-based scoring methodology similar to what CMS has proposed for the administrative claims-based measures would result in more points for the 90 score on Quality Measure B, reflecting the fact that the score differed by only a small amount from the median.

IMPACT OF MEASURE PERFORMANCE DISTRIBUTION ON DECILE SCORING METHODOLOGY

	MEASURE A						MEASURE B				
Physician	Measure Performance	Decile Score		Standard Deviations from Median	Standard Deviation-Based Score	Physician	Measure Performance	Decile Score		Standard Deviations from Median	Standard Deviation-Based Score
1	65.00	1.00		-2.83	0.75	1	65.00	1.00		-2.83	0.75
2	70.00	1.50		-2.28	1.50	2	70.00	1.50		-2.28	1.50
3	75.00	2.05		-1.72	2.50	3	75.00	2.05		-1.72	2.50
4	80.00	2.55		-1.17	3.60	4	80.00	2.55		-1.17	3.60
5	85.00	3.15		-0.61	4.80	5	85.00	3.10		-0.61	4.80
6	85.50	3.24		-0.56	4.95	6	90.00	4.00		-0.06	5.90
7	89.00	4.25		-0.17	5.60	7	90.10	4.25		-0.04	5.90
8	89.50	4.75		-0.11	5.80	8	90.20	4.75		-0.03	5.95
9	90.00	5.33		-0.06	5.90	9	90.30	5.20		-0.02	5.95
10	90.40	5.87		-0.01	6.00	10	90.40	5.95		-0.01	6.00
11	90.60	6.10		0.01	6.00	11	90.60	6.10		0.01	6.00
12	91.00	6.50		0.06	6.10	12	91.00	6.50		0.06	6.10
13	92.00	7.25		0.17	6.40	13	92.00	7.25		0.17	6.40
14	93.00	7.75		0.28	6.50	14	93.00	7.75		0.28	6.50
15	94.00	8.25		0.39	6.80	15	94.00	8.25		0.39	6.80
16	95.00	8.75		0.50	7.00	16	95.00	8.75		0.50	7.00
17	96.00	9.49		0.61	7.20	17	96.00	9.49		0.61	7.20
18	97.00	9.75		0.72	7.40	18	97.00	9.75		0.72	7.40
19	98.00	10.00		0.83	7.70	19	98.00	10.00		0.83	7.70
20	99.00	10.00		0.94	7.90	20	99.00	10.00		0.94	7.90
Median	90.50					Median	90.50				
Std Dev	9.00					Std Dev	9.00				
Decile 1	65.00 - 74.99		-2.5 SD	68.00 - 72.49		Decile 1	65.00 - 74.99		-2.5 SD	68.00 - 72.49	
Decile 2	74.50 - 84.49		-2.0 SD	72.50 - 76.99		Decile 2	74.50 - 84.49		-2.0 SD	72.50 - 76.99	
Decile 3	84.50 - 88.74		-1.5 SD	77.00 - 81.49		Decile 3	84.50 - 90.04		-1.5 SD	77.00 - 81.49	
Decile 4	88.75 - 89.74		-1.0 SD	81.50 - 85.59		Decile 4	90.05 - 90.24		-1.0 SD	81.50 - 85.59	
Decile 5	89.75 - 90.49		-0.5 SD	86.00 - 90.49		Decile 5	90.25 - 90.49		-0.5 SD	86.00 - 90.49	
Decile 6	90.50 - 91.49		+0.5 SD	90.50 - 95.00		Decile 6	90.50 - 91.49		+0.5 SD	90.50 - 95.00	
Decile 7	91.50 - 93.49		+1.0 SD	95.01 - 99.50		Decile 7	91.50 - 93.49		+1.0 SD	95.01 - 99.50	
Decile 8	93.50 - 95.49		+1.5 SD	99.51 +		Decile 8	93.50 - 95.49		+1.5 SD	99.51 +	
Decile 9	95.50 - 97.49		+2.0 SD			Decile 9	95.50 - 98.49		+2.0 SD		
Decile 10	97.50+		+2.5 SD			Decile 10	98.50+		+2.5 SD		

In addition, to improve upon the proposed methodology, we urge that CMS establish the specific thresholds in regulation and only change them after soliciting formal comments. We are concerned that since CMS states that "the standard deviations from the median used to determine cutoffs for benchmark ranges for each year would be reviewed for any necessary updates on an annual basis," CMS could adjust the ranges to increase the penalties for low scores without adequately assessing the impact of those changes.

Data Completeness Requirements

Recommendation:

- We continue to strongly urge CMS to reduce the data completeness requirement for satisfactorily reporting on a measure in MIPS, MVP, MSSP and potentially ASM.

The high quality data completeness requirement CMS has set for MIPS, MVP, MSSP and potentially ASM runs counter to CMS' goal of reducing administrative burden within the MIPS program and CMS has not yet adequately addressed our concerns. 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 the data completeness 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 further be exacerbated for participants in the MSSP program since ALL MIPS quality policies now applies to the MSSP quality requirements. ACOs report that they continue to encounter barriers to capturing data from some practices due to issues such as an EHR is unable to produce a QRDA 1 file or a small practices continues to operate with paper medical records. **We urge CMS to work with the physician, ACOs and the EHR vendor communities to find solutions to these data aggregation problems. Until the technology standards are more mature, CMS should reduce the quality measure data completeness requirement within MIPS/MSSP and delay mandatory eCQM or dQM adoption.** For more details on the ongoing problem, please see *Toward Digital Quality Measurement in CMS Quality Programs – Request for Information* comments.

Quality Measures with Substantive Changes, New Measures and Removal

Recommendation:

Substantive Changes

Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC)

The AMA continues to not support the MCC measure and does not support the proposed change to the measure specifications— remove the exclusion for anyone with a QP status from the measure. It is inappropriate to include an admission measure in the MSSP program because the measure encourages ACOs to stint on care and not admit patients when necessary to score well on the measure and earn higher shared savings. We also urge CMS to address the lack of alignment of the attribution models utilized for the various administrative claims population health quality and cost measures used for MIPS or MVP, such as Hospital-wide Readmissions (HWR), Multiple Chronic Conditions and TPCC. Based on the changes to attribution in many of these measures to hold more than one physician accountable and/or leverage different approaches (e.g., plurality of charges vs. plurality of visits), physicians and practices will have different patients assigned to them for different measures. This lack of consistency across measures will further decrease a physician's ability to drive improvements in care. The lack of a cohesive approach on attribution across one program is not sustainable and must be addressed to create a system that promotes and facilitates improvements to patients in a way that is also meaningful and actionable by physicians.

CMS must address the lack of alignment of the attribution models utilized for the various administrative claims measures used for the MIPS population health quality measures and cost measures, such as HWR and TPCC. The changes to attribution over the years continue to hold more than one physician accountable and/or leverage different approaches (e.g., plurality of charges vs. plurality of visits).

Gains in Patient Activation Measure (PAM ®) Scores at 12 Months

The AMA continues to remain concerned with CMS including the PAM measure in MIPS, especially since CMS continues to highlight its desire to transition the program away from MIPS and require reporting through MVPs-only. The measure was not tested at the individual clinician level and requires a 50-patient minimum to meet the reliability standard. While we support the high case minimum standard, it is counter to CMS' general measure scoring policy. CMS only requires 20 patients to be considered as meeting data completeness. This disconnect becomes problematic with MVPs because CMS has included the PAM measure in several MVPs and MVP limits measure choice. Therefore, inclusion of the measure is inappropriate given any case minimum lower than 50 negatively impacts reliability.

The following three MIPS quality measures were retained for utilization in MVPs and APP measure set only while removed from traditional MIPS: Q112**:** Breast Cancer Screening (BCS), Q113: Colorectal Cancer Screening (CRC), and Q128**:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (only available in MVP, not part of APP)

We urge CMS to re-instate the three individual measures in the MIPS program along with the four other measures that make up *Preventive Care and Wellness (composite*). As a result of removal of the individual measures from MIPS and only maintained for select MVPs and the APP measure set for MSSP, we have heard that electronic health record (EHR) vendors are no longer supporting the individual measures. We also remain extremely concerned that the *Preventative Care and Wellness composite*, which consists of the individual screening measures, is overly complex with seven numerators, denominators, and exclusions/exceptions and will directly impact the feasibility of the measure for use in MIPS. Therefore, **we continue to request that CMS reconsider the removal of the individual measures as each address important preventive activities and aligns with the Administration's focus on health and well-being.** The removal also eliminated the ability of some specialties to select a subset of the measures which are relevant to their scope of practice. As a result, the AMA continues to oppose the removal of the measures and inclusion of the Preventative Care and Wellness composite measure in MIPS.

We also oppose the proposed changes to the MIPS CQM and Medicare CQM specifications for the Breast Cancer Screening (BCS) and Colorectal Cancer Screening (CRC) measures, 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. In addition, specifications across reporting options should remain aligned and the eCQM specification does not currently include this requirement nor would we support its addition to this specification in the future. ACOs often work with their participating practices to extract these data from EHRs even when reporting MIPS CQMs or Medicare CQMs and this change will make it even less feasible for them to continue to minimize the data collection burden for practices if they cannot leverage EHRs data.

In addition, the change has the potential to lead to a negative unintended consequence of overuse of these procedures since the timeframe for both measures includes data from previous years (for CRC this 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 and not because the patient is due for this screening. We oppose any change to a measure 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 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 across the specifications for all reporting options 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.

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 is in further jeopardy, specifically the transition and adoption of meaningful (MVPs).

There is a false belief among the Administration, CMS and its contractors that decreasing the number of measures and MVPs will minimize burden and 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 morass of 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.**

<u>Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes</u>
The AMA supports the addition of the *Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes* measure to the program. The AMA has been a recognized leader in diabetes prevention for the past 12 years and has a long history as a measure developer. Through our collaborations with physicians, clinical teams and health systems on implementing best practices, we have identified gaps in diabetes preventive care. Therefore, we viewed the development of measures in this area to be a valuable contribution to the quality measures available to MIPS participants since diabetes prevention is a priority of the AMA, as well as the Trump Administration and the program does not include any relevant measures.

The AMA approached this work holistically as the measure not only satisfies the needs of MIPS but supports our larger quality improvement work in which we engage with physician practices. Furthermore, the measure also aligns with the Administration's focus on disease prevention and empowering individuals to engage in lifestyle change behaviors as part of their overall wellness. Enacting measures that facilitate diabetes screening supports the efforts of the CDC National Diabetes Prevention Program. CDC has been a partner with us on all our diabetes work, including measure development. Under a diabetes prevention cooperative agreement, CDC requires designated grantees to implement the measures as part of their diabetes prevention program to ensure that physicians are screening and referring their patients to community-based lifestyle change. As a result, if finalized for use in MIPS both the CDC and AMA would be aligned when it comes to diabetes prevention quality measurement.

The measure also received unanimous support during the CMS 2024-2025, Pre Measure Rulemaking Review (PRMR) process. Members of the clinician workgroup highlighted that the measure was exemplary and a model for other measure developers to follow regarding the rigorous testing the AMA performed to support the measure.

<u>Prevalent Standardized Kidney Transplant Waitlist Ratio (PSWR)</u>
We oppose the inclusion of this measure in MIPS for several reasons. First, measures should focus on processes or outcomes that are within a physician's control. Waitlisting is a decision made by the

transplant center and is beyond the control of any of the physicians targeted by this measure. Second, many of the measures on waitlisting that are attributed at the individual clinician level have not achieved Consensus Based Entity (CBE) endorsement due to concerns regarding validity, specifically, the need for additional exclusions and the potential for incorrect attribution. The Pre-Rulemaking Measure Review (PRMR) process also did not reach consensus on recommending this measure for MIPS due to these same concerns. Most importantly, we believe that each patient should be given the opportunity to determine whether he or she wants to be added to the waitlist and using a measure within an accountability program increases the potential for negative unintended consequences since patients may feel pressured to enroll so that performance scores will be higher. Because the current benchmarking approach for quality measures in this program assumes that all measures should achieve 100 percent performance, a measure where the goal may be to identify outliers or it is assumed that overall performance will be less than 100 percent should not be considered for inclusion.

Diagnostic Delay of Venous Thromboembolism in Primary Care Brigham and Women's Hospital
We oppose the inclusion of this measure due to several reasons. Specifically, we are extremely concerned to see that the measure is proposed to be used at the clinician: group/practice level in the program given the multiple statements and documentation provided during the Consensus Based Endorsement (CBE) and PRMR review. The measure developer specifically highlighted that the measure would be **better suited for use at the integrated delivery network and for quality improvement uses ONLY.** We believe the following additional questions and concerns must be addressed before CMS moves forward with the measure:

- The lack of evidence to support attributing a delayed diagnosis based only one venous thromboembolism (VTE) symptom.
- The fact that some of the data used for measure testing overlaps with the Covid-19 public health emergency (PHE) leads us to question whether these data are likely representative of typical care outside of a PHE.
- The minimum signal-to-noise ratio at the group level was 0.37512 and the median was 0.5393. We do not believe that the justification provided by the developer is sufficient to apply the measure even at the group level. The AMA believes that measures must meet minimum acceptable thresholds of 0.7 for reliability.
- The data element validity testing was only conducted in one electronic health record system at the time of endorsement review, and the results were aggregated at the numerator, denominator, and exclusions levels, indicating that this information does not meet the requirements of testing in at least two vendor systems with results provided for each individual data element.

Therefore, until these concerns are adequately answered, we do not support its use in MIPS.

Removal

- Screening for Social Drivers of Health measure
- Connection to Community Service Provider measures

While we support the intent of the two health equity measures that were finalized for use in MIPS and MSSP, we support CMS' proposal to remove the measures. Since finalized by CMS, we have flagged concern with the lack of evidence to support the measures, as well as questioned whether the measures would facilitate improvements in patient care. To date, CMS has not provided adequate testing information regarding the measures' reliability and validity since only data for two screening tools (which are not required) were provided. Most of the information outlined was based on CMS Innovation Center's (CMMI) American Health Communities (AHC) project, which involved community health centers/health

systems. Therefore, testing to date has been insufficient and it is unknown how the measure would perform at the individual clinician level.

Furthermore, we are concerned that clinicians will be unable to address their patient needs due to the lack of resources and tools that are widely and readily available to clinicians and practices. The availability of resources is also dependent on the patient's locality and the type of service needed. For example, the second evaluation report of the AHC model found that there were several factors that contribute to whether a community service provider may offer services to individuals, including limited availability of affordable housing and transportation services and whether some patients were able to meet the eligibility requirements for a service. These gaps are not within the clinician's control and contribute to our concerns. These issues were also identified in a recent JAMA article, specifically that the inadequacy of the measure and "well intentioned mandate will impede progress in health equity and have the potential to increase long-standing racial and socioeconomic inequities."[6]

Adult COVID-19 Vaccination Status

The AMA continues to have concerns with this measure and supports CMS' proposal to remove the measure from MIPS. Specifically, there is a lack of clarity regarding the numerator. The numerator defines the vaccination status as whether a patient is up to date on his or her COVID-19 vaccinations as defined by the CDC, but this definition continues to change throughout the performance year. Therefore, it is inappropriate to hold physicians accountable for COVID vaccination rates of their patients when the recommendations keep changing. No other measure within the MIPS program relies on clinical recommendations that are known to change frequently. This vague and variable definition increases its complexity and could negatively impact the reliability and validity of the measure. It is also difficult to track since a large percentage of patients do not receive their COVID vaccinations from their primary care provider.

In addition, this measure has yet to receive support from the committees charged with determining whether a measure is appropriate for MIPS. First, it was not supported by the Measures Application Partnership in 2022 and during the 2022-2023 Pre-Rulemaking Review (PRMR) Clinician Committee the measure did not achieve consensus on a recommendation. Until testing of the measure with precise specifications is completed and consensus is reached by PRMR, we continue to believe that this measure should not be included in the program.

Survey Modes for the Administration of the CAHPS for MIPS Survey Request for Information

Recommendation:

- The AMA supports the addition of web administration of the CAHPS for MIPS survey but must be optional. We are concerned vendors will use it as an opportunity to increase their survey administration fees.

For years organizations have highlighted the need for CMS to allow organizations the option to administer the CAHPS for MIPS surveys via more modern technology, such as email and do not see the downside, if it is an option. Practices should have the ability to determine whether administering via email or postal mail is most appropriate based on their patient population and any increase in cost is worth the return on investment. CMS' field testing demonstrated that allowing email increased response rates. However, we caution CMS on moving too quickly with the expansion because we are concerned that vendors will increase their survey administration fees. We do not believe that practices should be asked to

[6] [1] Garg A, LeBlanc A, Raphael JL. Inadequacy of current screening measures for health-related social needs. *JAMA*. Published online August 21, 2023. DOI:10.1001/jama.2023.13948.

shoulder the additional expense in an already costly and burdensome survey to administer, on top of the cost to participate in the MIPS or MSSP programs.

Third Party Intermediaries, QCDRs: additional flexibilities to allow third party intermediaries additional time to fully support finalized MVPs.

Recommendation:

- The AMA supports CMS' proposal to provide Qualified Clinical Data Registries (QCDRs) more time to fully support finalized MVPs. However, it should be up to the QCDR to determine which MVPs and quality measures they plan to support. We also urge CMS to take into consideration the need for additional time to implement new, revised or adapt existing measures to eCQM or dQMs across MIPS.

We appreciate CMS's recognition that QCDRs and qualified registries may need additional time to implement and fully support new MVPs and agree with the additional flexibility that is proposed. **We urge CMS to consider building in additional lead times for measure implementation across MIPS since it continues to be challenging, costly, and burdensome for practices, qualified registries, QCDRs, electronic health record system (EHRs) vendors, and others to implement new or adapt existing measures within the current timeframe (approximately two months from the time that the final rule is released and the program year reporting begins).** This need has been recognized for eCQMs as those specifications are released several months prior to the start of a program year. Additional time to implement measures (both new and modified) will become increasingly more complex as we move to a greater numbers of electronic clinical quality measures (eCQMs) and in the future digital quality measures (dQMs).

In addition, we remind CMS that Congress specifically referenced and acknowledged the importance of QCDRs in MACRA and specifically allowed for a separate pathway for measure review outside of the formal Measure Under Consideration (MUC) process. However, CMS has been greatly stifling and limiting the number of QCDR measures. Based on feedback we have received from specialty-led QCDRs, CMS now outright rejects QCDR measures for use in the MIPS quality category and MVPs. For example, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS) proposed the addition of an outcome measure that reports the rate of complications after a tonsillectomy. Unfortunately, during initial discussions, CMS and its contractors suggested that the topic would be better suited as an improvement activity (IA). We believe that this is a missed opportunity to recognize efforts to reduce post-operative complications and related spending and demonstrates a lack of understanding about the level of detail and rigor with which specialty society QCDRs collect and continually validate the data. As a result of examples such as this one from AAO-HNS, the number of available QCDRs has greatly dwindled and more QCDRs will stop participating in the program, which is counter to the MACRA statute.

The lack of viable QCDR options is unfortunate because 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 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. **CMS must recognize and prioritize the value of specialty-led QCDRs and actively select QCDR measures for MVPs.**

The AMA has been committed to the successful implementation of MACRA. To our dismay, it has often been a one-sided partnership. The agency must maintain a comprehensive portfolio of measures in its

physician quality programs and move to a participatory measure consideration process to better ensure that physicians will find quality measures to use within MIPS/MVPs and APMs that are clinically relevant and meaningful for their practices and settings of care, as well as administratively actionable and useful in providing better care and value for patients. We urge CMS to evaluate its process for incorporating measures into MIPS/MVPs and APMs and ensure there is a sufficient suite of MVPs by condition.

T. Cost Performance Category

Total Per Capita Cost (TPCC) Measure

Recommendations:

- While the proposed attribution changes would address some of the most egregious errors with the current TPCC, they do not address the foundational flaw that TPCC holds physicians accountable for costs outside of their control. As a result, the AMA continues to urge CMS to remove TPCC or, at a minimum, remove it from any MVP that includes an episode-based cost measure.
- If TPCC continues to be used, 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 creating any incentive for physicians to undertreat patients.
- The revised attribution methodology should exclude multi-specialty group practices where attribution is based on qualified health care professionals (QHPs) who exclusively perform services in an otherwise excluded specialty.
- Finally, CMS should implement the proposed attribution methodology changes starting with the 2025 performance period and seek input from national medical specialty societies about incorporating patient relationship codes into the attribution methodology to improve its accuracy.

CMS proposes two changes to the TPCC attribution methodology that would address documented problems, such as attribution to a group practice that exclusively provides specialty care based on billing by nurse practitioners, physician assistants, and clinical nurse specialists within the group practice. First, CMS proposes to exclude qualified health professionals (QHPs) in group practices composed of only QHPs and excluded specialists. Second, CMS proposes to adjust the candidate event logic to require both the first and second initiating events to be provided by eligible clinicians in the same group who are not excluded from TPCC.

While these proposed changes are a positive step in the right direction, they would not remedy the fundamental flaw in the current version of TPCC, which is that it attempts to hold 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 the TPCC measure includes all Medicare Part A and B spending, not just the portions of spending that physicians can control, the TPCC measure provides physicians with little or no actionable information about how to lower their spending, and it gives patients no useful information about how to lower their out-of-pocket costs or how to select physicians. TPCC does not enable physicians to determine whether they are making referrals to other physicians who order unnecessary tests or procedures or whose treatments result in avoidable complications and adverse events. Nor does the TPCC help a patient determine whether a particular physician will treat that patient's specific health problems more cost-effectively than another physician. **Because of these fundamental flaws, the AMA strongly urges CMS to remove TPCC from MIPS or,**

at a minimum, remove it from any MIPS Value Pathway (MVP) in which there is an episode-based cost measure.

If the TPCC continues to be used, it must 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 creating any incentive for physicians to undertreat patients. 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. By contrast, in the Maryland Total Cost of Care Model, the Center for Medicare & Medicaid Innovation provides credit in its total cost of care calculations for the estimated future savings from reducing diabetes incidence. It would serve CMS well if its measure development contractor, Acumen, LLC, would develop a method for crediting future cost savings in TPCC. In the short term, the most feasible remedy would be to simply remove preventive services from TPCC.

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.

Specific to the CMS proposals, the AMA supports both proposed changes to the TPCC attribution and candidate event methodology. The AMA has previously written to CMS expressing our concerns that TPCC was inappropriately attributed to radiologists and hospitalists due to these flaws in the attribution methodology. The below analysis of the 2023 Public Use File shows the extent to which TPCC is being inappropriately attributed to excluded specialists. For instance, 47 percent of general surgeons and 46 percent of anesthesiologists were attributed the TPCC measure in 2023. These physicians should not have their Medicare physician payment adjusted based on a measure that they are excluded from

because of inaccurate attribution. **We believe CMS should implement these changes starting with the 2025 performance period to limit any unfair Medicare penalties that result from the current flawed attribution methodology.**

Specialty	Total MIPS ECs	Cost Performance Category*			% of MIPS ECs Attributed to TPCC Measure	% of ECs with Cost Category Score Attributed to TPCC Measure
		Total MIPS ECs Receiving Cost Category Score	Total ECs Attributed to TPCC Measure	Average TPCC Score		
General Surgery	10,558	5,691	4,967	5.1	47%	87%
Anesthesiology	17,575	9,402	8,051	4.5	46%	86%
Cardiac Surgery	622	321	274	5.2	44%	85%
Colorectal Surgery (Formerly Proctology)	920	505	412	5.1	45%	82%
Hand Surgery	1,058	449	407	4.4	38%	91%
Maxillofacial Surgery	240	120	118	4.9	49%	98%
Neurosurgery	2,911	1,589	1,403	4.6	48%	88%
Ophthalmology	13,739	7,733	1,708	4.7	12%	22%
Orthopedic Surgery	13,482	7,092	5,699	4.5	42%	80%
Otolaryngology	5,635	2,135	2,069	5.2	37%	97%
Plastic and Reconstructive Surgery	1,669	911	789	4.7	47%	87%
Surgical Oncology	767	360	345	4.5	45%	96%
Thoracic Surgery	1,392	737	663	5.2	48%	90%
Urology	6,113	2,617	2,224	5.0	36%	85%
Vascular Surgery	2,400	1,253	972	5.4	41%	78%

*This analysis excludes MIPS-eligible clinicians whose Cost performance category was reweighted to zero. Common reasons for reweighting include not meeting the established case minimum for available cost measures or reporting MIPS through an APM entity.

CMS must also do more to address the problem of inaccurate attribution due to billing by QHPs. Because the proposed refinement would only prevent inappropriate attribution to QHPs who are part of group practices that consist solely of excluded specialties, it would do nothing to prevent inappropriate attribution to groups that have both included and excluded specialties. In multi-specialty groups that include both primary care physicians and non-primary care specialists, some or all of the QHPs could be supporting the work of the excluded specialists, yet patients could be attributed to the group solely because of the non-primary care services provided by the QHPs. This would also be inappropriate, and

CMS should identify the types and mixes of services that individual QHPs provide to develop additional ways to eliminate as many inappropriate attributions as possible.

Yet even with these proposed attribution improvements in place, physicians would still have no way to indicate that they are the primary source of care for patients who are healthy and who may not need to be seen for another billable service within the next three months. These patients would still not be attributed to the physician under the proposed changes. Conversely, there is no way to indicate that the relationship between a patient and physician has ended, and that is also important to address since costs beyond that endpoint would no longer be within the control of the physician. Because all attribution remains retrospective, no physicians would have any certainty as to whether they would or would not be attributed patients until after the performance period ends.

For these reasons, it is essential to modify the attribution rules to include a mechanism for using patient relationship codes and to seek input from physician specialty societies about how to make this new attribution method work effectively. Primary care physicians and specialists, as well as QHPs, should be able to inform accurate attribution of patients and cost measures by including the applicable patient relationship code on their claims. The Medicare Access and CHIP Reauthorization Act provides that "[i]n order to evaluate the resources used to treat patients (with respect to care episode and patient condition groups), the Secretary shall, as the Secretary determines appropriate–(i) use the patient relationship codes reported on claims pursuant to paragraph (4) to attribute patients (in whole or in part) to one or more physicians and applicable practitioners" (42 U.S.C. 1395w–4(r)(5)(A)(i)). The statute clearly envisioned that the patient relationship codes would be used for patient attribution of cost measures, and this is particularly important for a cost measure as broad as the TPCC. The current attribution rules merely make guesses, and often inaccurate guesses, about whether a patient's care is being managed by a particular physician. A far more accurate method would be to allow physicians to explicitly describe the nature of their relationship with a patient.

Allowing physicians and other eligible clinicians to prospectively identify their relationship with a patient would provide several benefits, including: (1) improving accuracy of attribution by better distinguishing the relationship between the patient and the physician at the time of the service, (2) remedying flaws in the TPCC attribution methodology by allowing physicians to indicate when their relationship with a patient has changed, and (3) providing physicians greater certainty about which patients will be attributed to them for the MIPS cost measures. For example, a physician could be actively managing the care of a patient through patient portal message exchanges and prescription refills that are not captured in claims data, so the only way to know about the actual relationship between the physician and patient would be through the use of patient relationship codes.

CMS and its contractor, Acumen, LLC, have stated that the reason for not using the patient relationship codes in the cost measure attribution methodology is that very few physicians and other eligible clinicians report these codes. But this is circular logic. The lack of reporting is due at least in part to the fact that the codes are not currently used in cost measure attribution and do not result in any additional payment or other resources. It is not surprising that busy physicians do not take the extra time to record a code when they know it will have no impact on anything. If physicians knew that their MIPS cost measure attribution would be more accurate and better reflect their clinical practice if they reported the patient relationship codes, the AMA believes many more physicians would report the codes, particularly as the cost measures account for 30 percent of MIPS final scores and MIPS penalties can be as large as -9 percent.

While we recommend that CMS examine approaches to promote and incentivize the use of the patient relationship codes, it is neither necessary nor desirable to mandate the use of patient relationship codes on all claims to utilize them to improve attribution. Using the patient relationship codes will require additional time by physicians and changes in their billing systems, and that may not be

feasible today for many physicians, particularly those in small and under-resourced practices. If a physician does not report a patient relationship code for a particular patient, the current attribution rules can continue to be used to determine what portion of costs associated with that patient's overall care, if any, should be attributed to that physician.

Two-Year Informational-Only Feedback Period

Recommendation:

- The AMA strongly supports CMS' proposal to adopt a two-year informational-only feedback period for new cost measures and urges CMS to reserve flexibility to extend the informational-only feedback period on a case-by-case basis.
- CMS should provide a two-year informational-only feedback period for substantially revised cost measures, including the revised TPCC.

Although the agency proposes no new cost measures for 2026, it proposes that in the future there would be a two-year informational-only feedback period when new cost measures are introduced into MIPS. During this feedback period, if a physician is attributed a new cost measure, CMS would calculate a score and confidentially provide the score, as well as MIPS performance feedback, to the physician. However, the score would not be included in the physician's cost performance category score or MIPS final score and would not affect the physician's MIPS payment adjustment. In the third year that the measure is in the program, CMS would incorporate the score for the cost measure into physicians' cost performance scores, MIPS final scores, and payment adjustments.

The AMA strongly supports this proposal. The AMA previously recommended that CMS adopt a minimum of a two-year informational-only feedback period in our comments on the 2025 MPFS proposed rule. The AMA raised concerns about the lack of timely and actionable feedback to physicians about their cost measures, particularly new cost measures. For example, physicians do not know in real time which cost measures they will be assessed on, which episodes and patients will be attributed to them, and what costs outside of their practice they are held accountable for until after the performance period is over. As a result, they cannot make changes to their patient's care to reduce avoidable costs for the Medicare program and for the patient. While we continue to encourage CMS to share more frequent (e.g., quarterly) MIPS and claims based data with physicians, we believe this two-year informational-only feedback period will assist physicians in understanding how they will be scored and evaluated on new measures while they still have time to make adjustments to their practice to improve their performance on the measure and ultimately save Medicare and patients from avoidable costs.

We also urge CMS to reserve regulatory flexibility to extend the minimum two-year informational-only feedback period on an as-needed basis. There may be instances where the informational-only feedback period reveals anomalies with the cost measure as applied in MIPS or MVPs, which require changes to the measure methodology and warrant an additional year of the informational-only feedback period. Additionally, we have seen multiple events outside of the control of physicians, such as the Change Healthcare Cyberattack and COVID-19 public health emergency, that have significantly impacted the MIPS cost measures. In these instances, CMS should have regulatory authority to extend the informational-only feedback period.

Additionally, CMS should provide a two-year informational-only feedback period for substantially revised cost measures, including the revised TPCC. Similar to new cost measures, substantially revised measures introduce significant uncertainty for MIPS eligible clinicians. It is impossible to know based on revised measure specifications alone how changes, such as changes to attribution, will affect physicians and group practices. As the AMA recommends with substantially revised quality measures, we urge CMS

to reevaluate reliability for substantially revised cost measures and to utilize a two-year informational-only period to conduct that analysis, while also giving physicians sufficient time to familiarize themselves with the substantial measure changes before they can negatively affect their Medicare payment. Applying scoring flexibilities to substantively revised cost measures also aligns with CMS' policy for handling substantively revised quality measures.

U. Improvement Activities (IAs) Performance Category

New IA Subcategory on Advancing Health and Wellness (AHW)

Recommendation:

- The AMA strongly supports CMS' proposal to add a new subcategory on advancing health and wellness and urges the agency to finalize this proposal.

The AMA agrees promoting superior mental health and chronic disease management and prevention should be a top priority, strongly supports the addition of this subcategory, and looks forward to additional IAs being developed and added to this category in future years.

Addition of New Improvement Activities

Recommendation:

- The AMA generally supports the addition of new IA options in improvement detection of cognitive impairment in primary care and integrating oral health care in primary care.

The AMA agrees that the new activity entitled "improvement detection of cognitive impairment in primary care" would allow cognitive decline to improve detection of cognitive impairment in earlier stages, and connect patients to treatment options earlier, which will lead to better outcomes. This aligns with this administration's commitment to improving chronic disease management.

The AMA also agrees that oral health care is closely tied to a patient's overall health and supports the addition of a measure on integrating oral health care into primary care by including an oral health risk assessment and screening in primary care, along with counseling on the impact of oral health on other diseases and referrals to dental health providers.

New IA Subcategory on Patient Safety in Use of Artificial Intelligence (AI)

Recommendation:

- The AMA asks for modifications of this new activity to better capture the functions of physicians rather than health IT developers.

The AMA supports the idea of adding a new activity related to the use of AI and how it could be used to improve the health and safety of patients. However, the proposed activity description raises several questions, including where it is focused. We encourage CMS to shift the emphasis from "develop a new data-collection field" to "develop an organizational policy to mitigate AI-attributable events." Developing a new data field is not necessarily a function that physicians perform, given the IT expertise required; generally speaking, that is done by health IT developers. Physicians do develop organizational policies for their practices and teams to follow. This revised activity maintains a patient safety improvement focus

and would help practices by creating organizational policies on how they would address and document harmful and near-miss AI events, as well as how they could identify the causes of these events.

According to recent research from the AMA, physicians are enthusiastic about AI and its assistive role in the practice of medicine. However, our survey findings show we are at a critical juncture with an equal number of physicians excited and concerned about the potential for AI. One of physicians' most significant concerns is about potential liability for the use of AI that ultimately performs poorly in clinical practice. Questions around the liability for the use of AI are novel and complex, and we encourage CMS to work with other HHS agencies to establish effective standards and safeguards that ensures AI used in patient care is of high quality, consistently reliable, and prioritizes patient well-being.

Removal of Achieving Health Equity (AHE) Subcategory and IAs

Recommendation:

- The AMA has general concerns with CMS' proposal to remove the AHE subcategory and proposed removal of multiple IAs that the AMA believes advance important outcomes that align with the administration's goals to close known gaps and improve the health of Americans. Instead of removing all 8 activities, we urge the administration to work with interested parties to make changes as needed to retain certain measures.

CMS proposes to remove the current subcategory entitled "Achieving Health Equity" on the basis that it wants to focus on outcomes-based results. The AMA disagrees with this assumption because the MACRA statute never required IAs to focus on outcomes. The intent was to give physicians and practices credit for quality improvement work. Furthermore, we have concerns about multiple measures proposed for removal on the basis that the agency deems them obsolete. While the AMA understands the need to update the IA inventory over time and remove obsolete measures, multiple measures proposed for removal advance critical evidence-based approaches to improving health outcomes that we disagree are obsolete. In fact, we believe several of the activities proposed for removal align with this Administration's goals to keep Americans healthier through lifestyle interventions and would assimilate well within the proposed new Advancing Health and Wellness subcategory. For this reason, we urge the Administration to reconsider removing activities, especially given the fact that the administration proposes to remove eight activities, but only proposes to add three new activities, leading to an overall reduction in the number of IAs available for physicians to report.

In particular, the AMA is concerned by the proposed removal of "MIPS Eligible Clinician Leadership in Clinical Trials or Community-Based Participatory Research," which focuses on minimizing disparities in healthcare access, care quality, affordability, or outcomes. We believe these types of activities hold merit in developing targeted approaches to improving health outcomes for various subpopulations, including those living in rural areas. It will be difficult to move the needle on improving care coordination and quality of care without a targeted approach that focuses on addressing specific gaps.

The AMA also is concerned by the proposed removal of "Practice Improvements that Engage Community Resources to Address Drivers of Health" for similar reasons. Screening for drivers of health, a known contributor to health outcomes, and connecting patients to resources as appropriate, is a clinically and cost-effective way to better manage care and mitigate poor downstream health outcomes, which aligns with this administration's goals and would align within the new AHW subcategory. Lastly, with regards to the proposed removal of "Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols," food insecurity is a significant contributor to poor health outcomes and removing this activity undermines this administration's focus on nutrition as a key component of health. We believe this activity would also fit within the AHW subcategory. In lieu of removing these IAs altogether, we would advocate

that the agency retain these activities and work with interested parties to make any changes as appropriate.

Expanded Scope of Diabetes Screening for Individuals using Antipsychotic Medications IA

Recommendation:

- The AMA requests clarification and potential modifications regarding CMS' proposal to expand the scope of the Diabetes screening for people with schizophrenia or bipolar disease who are using antipsychotic mediation IA to encompass a broader range of health conditions with modifications. Specifically, CMS should consider modifications to mitigate potential increases in administrative burden that may result from increasing the relevant patient panel size and consider further modifications or clarifications regarding potential discrepancies between the stated proposed rationale and revised description.

The AMA understands the logic behind expanding this Diabetes screening IA to a broader range of health conditions given that antipsychotic use is increasing and that there are a broader range of health conditions that may be impacted by antipsychotic medications beyond Diabetes, including adverse metabolic conditions. However, we have some confusion with regard to the extent of the changes proposed. CMS states that it proposes to "broaden the relevant patient population... [to] encompass a broader range of health conditions that may be impacted by antipsychotic medications, beyond just diabetes."

First, we have concerns about the impact that increasing the patient panel size may have on physicians, particularly primary care physicians, to satisfy the IA, which could lead to a drop in the number of physicians reporting this important activity. On the other hand, we appreciate that expanding the scope of the measure to other conditions could potentially broaden this activity's applicability to other specialties. With this in mind, we encourage the agency to consider modifications to the measure that could achieve the intended effect of expanding the scope of the measure to other conditions while mitigating the potential increase in administrative burden for primary care physicians, such as awarding full credit towards the activity for reporting the activity for any eligible disease subpopulation, and/or allowing physicians to report the activity multiple times for multiple disease subpopulations.

Furthermore, while CMS states in the proposed change and rationale section that it proposes to "modify this activity to broaden the relevant patient population by requiring a comprehensive physical health screening on all patients taking antipsychotic medications. However, the subsequent proposed revised activity description section states, "MIPS eligible clinicians must implement at least one process improvement during treatment of patients taking anti-psychotic medication related to one or more component(s) of appropriate antipsychotic medication assessment and monitoring" before listing seven components, none of which include a comprehensive screening. Then the agency goes on to denote three acceptable forms of process improvements. This both seems to be a departure from the agency's description in its proposed change and rationale section, as well as a potentially greater departure from the original activity. The AMA seeks further clarity on these discrepancies and the true extent of the changes CMS is seeking with updating this measure.

V. Promoting Interoperability (PI) Performance Category

Modify the Security Risk Analysis Measure to Include a Second Component Requiring an Affirmative Attestation of Having Conducted Security Risk Management

Recommendation:

- The AMA opposes this modification of the Security Risk Analysis Measure that adds duplicative reporting requirements for MIPS eligible clinicians to attest to having conducted security risk management activities.

MIPS eligible clinicians firmly believe that ensuring the privacy and security of electronic protected health information (ePHI) is an essential part of practicing medicine. Cybersecurity is a priority for all physicians and a critical patient safety issue. However, as included in previous comments, we question the need to require eligible clinicians to attest "yes" to having conducted a security risk analysis in the MIPS Promoting Interoperability (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. Moreover, CMS's proposal to include an additional measure for eligible clinicians focused on conducting security risk management activities, in addition to what is already required for conducting a security risk analysis, is misplaced.

Adding a security risk "management" measure to what is already required for conducting a security risk "analysis" adds complexity as well as another redundant reporting requirement for eligible clinicians to be considered a meaningful EHR user. Again, the AMA questions why either measure is necessary, given that they are based directly on HIPAA Security Rule safeguards and are already required for HIPAA compliance. We are concerned that CMS views PI as a "catchall" program and believes it is necessary to "dump" all of its health information technology (IT) policies in the program regardless of their impact, clinician burden, or usefulness in achieving programmatic goals.

Physicians take their responsibilities under HIPAA very seriously. MIPS eligible clinicians and other HIPAA regulated entities must comply with the HIPAA Rules' requirements to protect the privacy and security of health information. The Administrative Safeguards provisions in the HIPAA Security Rule require regulated entities to perform an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI held by the regulated entity as part of their security management processes. In addition, the HIPAA Security Rule implementation specification for risk management requires the implementation of security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level. The MIPS PI Security Risk Analysis measure and the proposal to conduct security risk management activities are both already incorporated in HIPAA Security Rule compliance and do not need to be included as a reporting requirement in the MIPS PI performance category.

Physicians strive to appropriately secure patient data and want very much to do their part to ensure that their IT systems deliver proper protections. HIPAA Regulations already require appropriate administrative, physical, and technical safeguards to be in place. These regulations are also critically important to physicians from both a legal and professional standpoint. Maintaining compliance with HIPAA is fundamental for physician practices, as it impacts patient privacy, data security, and the practice's legal and financial well-being.

In addition, the distinction that CMS is making between security risk "management" and a security risk "analysis" will only add to the reporting complexities that physicians face. The MIPS PI reporting burden is real, and the AMA looks for any opportunity to minimize this burden. We urge CMS to remove the

MIPS PI requirements that call for eligible clinicians to conduct or review a security risk analysis and conduct security risk management activities. CMS should instead rely on eligible clinicians' compliance with the HIPAA Rules to hold them accountable for ensuring the privacy and security of ePHI.

Modify the Safety Assurance Factors for EHR Resilience (SAFER) Guides Measure

Recommendation:

- The AMA opposes this modification of the SAFER Guides Measure to Require a "Yes" Attestation to earn a score for the Promoting Interoperability performance category.

The AMA appreciates the updated set of SAFER Guides that were released earlier this year. The streamlined set of guides provides a valuable resource that promotes the adoption of best safety practices for health IT. For CY 2026, this regulation proposes to require MIPS eligible clinicians attest "yes" to completing an annual self-assessment using all eight 2025 SAFER Guides to be considered a meaningful EHR user. However, we ask CMS to make the reporting on the SAFER Guides a voluntary measure instead of a requirement to earn a score for the Promoting Interoperability performance category.

As we have previously discussed, PI reporting burden is real, and the AMA looks for any opportunity to minimize this burden. CMS appears to consider PI as a central hub for required reporting of all health IT-related polices irrespective of their impact, clinician burden, or usefulness in achieving goals. With this new set of guides, we recommend that CMS take this opportunity to conduct a study that reviews the SAFER Guides and determines their impact on improving EHR safety in care delivery across providers. Until we have data demonstrating their efficacy for MIPS eligible clinicians, we recommend that they remain a voluntary measure that is another tool for providers to use to help build system resilience.

The AMA appreciates the new set of guides and the focus on the highest risk, most commonly occurring issues that can be addressed through technology or practice changes. Still, with PI reporting burden a true concern, the SAFER Guides should be a voluntary part of the program as data is collected to validate their contribution in optimizing the safety and safe use of EHRs.

Adopt the Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) Measure as an Optional Bonus Measure

Recommendation:

- The AMA supports the addition of this optional bonus measure to the Public Health and Clinical Data Exchange Objective.

The AMA appreciates the work underway to promote the seamless and secure flow of health information between patients, providers, payers, and public health agencies (PHAs). We see TEFCA as a means to enable enhanced information exchange that should remain as an option on the data exchange landscape. We support CMS's proposal to add the Public Health Reporting Using TEFCA Measure as an optional bonus measure under the Public Health and Clinical Data Exchange Objective. In addition, the AMA encourages CMS, CDC, and ASTP/ONC to continue working closely with PHAs and other interested parties to expand the use of TEFCA for sharing health information for public health purposes.

By standardizing health information exchange across many different networks, TEFCA helps to ensure nationwide network-to-network exchange of health information and simplifies the work of MIPS eligible clinicians by reducing the number of connections needed to send and receive health information. Although TEFCA is a viable tool for exchanging data, we do not want TEFCA participation to become a

requirement for physicians; rather, it should remain as an option among the many means of data exchange currently available. We have moved well past the belief that physicians cannot or will not adopt or use health IT unless forced or prodded. In contrast, from the AMA's experience, and that of hundreds of thousands of physician members, physicians will voluntarily adopt health IT if provided a clear return on their investment, that it serves their needs to care for patients, and benefits public health.

We support the proposal from CMS to offer the Public Health Reporting Using TEFCA Measure as an additional optional bonus measure under the Public Health and Clinical Data Exchange Objective. MIPS eligible clinicians should be able to claim five bonus points under this objective if they are actively engaged with a PHA to submit data for one or more of this objective's four optional measures, including the Public Health Reporting Using TEFCA Measure.

Adopt Measure Suppression Policies

Recommendations:

- CMS should finalize its proposal to adopt a measure suppression policy for the MIPS PI Performance Category beginning with the CY 2026 Performance Period and for the Medicare PI Program for Eligible Hospitals and CAHs beginning in CY 2026.
- CMS should finalize its proposal to suppress the Electronic Case Reporting (eCR) Measure for the MIPS PI Performance Category for the CY 2025 Performance Period/2027 MIPS Payment Year and the Medicare Promoting Interoperability Program for the EHR Reporting Period in CY 2025.

The AMA appreciates CMS formalizing its measure suppression policy for the PI performance category and Medicare PI Program. We agree with the plan to provide CMS with flexibility to not score PI measures for circumstances outside the control of eligible clinicians, eligible hospitals, or CAHs that otherwise intended to meet reporting requirements. This policy should also allow CMS to exclude a measure from scoring due to circumstances that impede its effective measurement or to exclude a measure from the determination of a meaningful EHR user.

In addition, the AMA supports the temporary pause proposed by CMS to suppress the eCR measure for MIPS eligible clinicians, eligible hospitals, and CAHs and exclude it from any scoring calculations in CY 2025. With the CDC pausing eCR registration and onboarding of new health care organizations, suppressing this measure is the appropriate step for CMS to implement. Until the CDC has fully established a more efficient and automated process for the onboarding of health care organizations and their EHR developers, this measure suppression policy should remain in place. We support the development of a long-term, sustainable strategy for the widespread adoption and integration of healthcare and eCR data.

W. Advanced APM Proposals

Adding an Individual Level Qualified APM Participant (QP) Calculation

Recommendation:

- CMS should finalize its proposal to add an individual level calculation *in addition to* APM Entity-level calculations for purposes of making QP and Partial QP determinations. CMS should apply this new policy starting with the 2025 performance year, rather than the 2026 performance year.

CMS proposes adding an individual level calculation to Qualifying APM Participant (QP) determinations such that each eligible clinician would receive *both* an APM Entity-level calculation *and* an individual-level calculation under certain circumstances, including those who appear on participation lists for multiple APM Entities or who appear on an Affiliated Practitioner list for at least one APM Entity and do not otherwise qualify under an APM-Entity. The AMA strongly supports this proposed change as it reflects what the AMA recommended when CMS initially proposed making QP determinations at the individual level *in lieu of* the APM Entity level in the 2024 MPFS, which it ultimately did not finalize. We continue to believe this solution is the best way to appropriately recognize all physicians that meaningfully participate in APMs, both individuals who may participate in multiple APMs, as well as individuals who qualify through participation in an APM Entity that itself meets the threshold.

We strongly urge CMS to consider making this proposal retroactive to the 2025 performance period, which is important as QP thresholds have increased significantly this year from 50 to 75 percent of payments and 35 to 50 percent of patients. Advanced APM lump sum bonuses also expired at the end of the 2026 payment year (which is based on participation in 2024). While the AMA and other stakeholders will continue to press Congress to extend the Advanced APM bonus and allow more flexibility in setting QP payment thresholds, applying this policy to the 2025 performance year would help to mitigate the likely cliff of physicians suddenly not qualifying for QP status despite participating in advanced APMs. Non-primary specialists are at a higher risk of failing to achieve QP status as specialty models inherently have a more challenging time meeting QP thresholds based on model design. Therefore, finalizing this policy for 2025 and closing this gap is critical to achieving AMA and CMS' shared goal of getting more specialists into APMs. We also encourage HHS, to the extent it can, to underscore the importance of increased Secretary discretion when it comes to setting QP thresholds in the future as AMA continues its advocacy with Congress.

Basing Attribution on All Medicare Covered Professional Services

Recommendation:

- The AMA continues to generally support the intent of this proposal to broaden the definition of "attribution-eligible beneficiary" to be based on all covered professional services, not only E/M services, but continues to seek more information about its estimated impact across models and other variables.

CMS proposes to expand the scope of the services used for attribution to all Medicare covered professional services (rather than E/M services with exceptions for certain APMs that focus on specific episodes of care). This change was initially proposed, but not finalized, in the 2025 MPFS rule. The AMA previously supported the spirit of this proposal because we agreed with the agency's reasoning that it affords a more consistent, predictable, and accurate methodology across models moving forward and could help counter perverse incentives for APM Entities to drop specialists from their participation lists. However, we also sought more information concerning the unintended consequences before such a policy was finalized. In response, CMS opted not to finalize the proposal last year and reintroduces the concept in this year's proposed rule.

While the AMA continues to be supportive of the spirit of this proposal for the same reasons, CMS does not provide the additional information we previously requested, which makes it difficult to fully ascertain the impact this proposal will have on attribution, including any disparate impacts across models, patient populations, geographic areas, or specialties. We appreciate the agency's point that it can be difficult to project impacts with so many other changes occurring simultaneously including the afore-mentioned 2025 increase in QP thresholds, it is well within the agency's abilities, and we believe responsibilities, to model the impact this proposal would have based on current or previous data holding other variables constant.

This type of information is vital to stakeholders' abilities to meaningfully assess this proposal and the impact it will have on Advanced APM participants.

The following sentence from the 2025 MPFS rule gives us particular concern: "There still may be situations in which the proposed change in attribution policy would limit QP determinations in certain Advanced APMs, particularly in situations where an Advanced APM is focused on a limited set of services." In last year's rule, CMS also noted that "while this proposal would represent significant progress toward rationalizing attribution for the broader range of Advanced APMs, our continued analysis suggests there may be more work to be done in this area" and that the agency "will continue to analyze these developments and issues with the goal to provide for an equitable, rational, transparent, and meaningful methodology for QP determinations across the full range of Advanced APMs." Indeed, in this proposed rulemaking, CMS states that it "has further explored this issue and has determined that [it] could appropriately address the challenges …described in this and prior rulemaking by allowing for the overall expansion of the QP determinations, in terms of both the level of the determination …and the services included in the QP determinations." Yet, the agency does not present any of its ongoing analysis or additional work in this year's rule. We appreciate the agency looking for ways to more meaningfully engage specialists in APMs. However, it is incumbent on the agency and in line with its commitment to transparency to make this type of analysis available to permit better understanding of the full impact of the proposal before it is finalized.

Removing the 50-Clinician Cap on Medical Home Model Participants

Recommendation:

- **CMS should finalize its proposal to no longer limit Medical Home Model participants to 50 clinicians.**

The AMA strongly supports CMS' proposal to no longer limit Medical Home Model participants to 50 clinicians, which was made in response to previous AMA advocacy. Lifting this unnecessary restriction will allow more physicians to participate in Advanced APMs.

X. QPP Requests for Information (RFIs)

- *Core Elements in an MVP RFI*

One of the key goals of Core Elements is to provide patients with enough information across different clinicians to compare specialist performance on foundational measures within a clinical area. Are there other ways to ensure MVP reporting results provide comparative performance data for patients on critical measures?

As we have indicated in the past, the AMA believes that the best way to provide meaningful performance information for both patients and physicians is to create separate MVPs for individual health conditions, episodes of care, and major procedures. The reason why current MVPs include so many different quality measures is that almost all of them encompass a wide range of different types of patient conditions and services. For example, CMS says that the Surgical Care MVP can be used by general surgeons, neurosurgeons, and cardiothoracic surgeons, and it includes cost and quality measures for procedures ranging from hernia repair to spinal fusion to mastectomy. The Advancing Care for Heart Disease MVP is the only MVP that can be used by cardiologists, even though cardiologists treat a wide range of different problems, including coronary artery disease, heart failure, atrial fibrillation, and myocardial infarction. It is simply not possible to identify a few "Core Elements" which would appropriately represent the wide range of conditions and procedures in these and other MVPs.

Last year, the AMA proposed a condition-*stratified* approach as an alternative to creating condition-*specific* MVPs. We recommended that quality measures in each MVP be organized into categories, each of which is relevant to a particular patient condition or an episode of a particular type of treatment. We are pleased to see that CMS has proposed to at least partially adopt the condition-stratified approach beginning in 2026.

Under this improved approach, physicians whose services are focused on patients with a particular condition could choose the measures specifically identified for that condition, and patients with that condition could look for physician performance information relevant to those measures. There is no need to try and also define "Core Elements." For example, in the Advancing Care for Heart Disease MVP, there are 18 total quality measures, but there are only 4 measures specific to heart failure. These 4 measures are the "core elements" for patients with heart failure and for physicians who treat them, whereas they are not relevant for patients with other types of heart conditions.

Core Elements will be selected based on clinical relevance, but for consistency across MVPs, we are considering a set number of Core Elements for all MVPs. We are also considering setting the number of Core Elements in an MVP based on a percentage of the total number of quality measures in an MVP. For example, we may consider a policy that identifies 25 percent of an MVP's quality measures as Core Elements, such that an MVP with 12 quality measures would have three Core Elements measures to choose from. We request feedback on the ideal number or percentage of Core Elements in MVPs.

We do not believe it is either feasible or desirable to define a fixed number or percentage of measures that would be required for all MVPs. For some types of patient conditions, many different quality measures are available, whereas for others, there are only a few quality measures, and there are no measures at all for some health conditions. As a result, any set number or percentage that CMS chooses would be too small for some conditions and too large for others. The requirement to report multiple measures in MIPS has forced many physicians to report measures that are of limited relevance to them or their patients, rather than enabling them to focus on measures that matter. The smaller number of measures required for MVPs has reduced but not eliminated this problem; adding a requirement to report "Core Elements" without taking steps to ensure that more condition-specific quality measures are available will make the problem worse.

Instead, if CMS defines condition-specific MVPs for specific health conditions or stratifies the measures by condition in broader MVPs, there would automatically be an appropriate number of quality measures for each MVP based on the number of measures that are applicable to the corresponding health condition(s) in the MVP.

One of our concerns is that Core Elements specified for a few collection types, such as electronic clinical quality measures (eCQMs) or Qualified Clinical Data Registry (QCDR) measures, would limit clinician choice and may unintentionally force clinicians to report via intermediaries. One possible solution would be to include Core Elements with several different collection types, when possible, to provide clinicians with some choice of collection type. Are there other flexibilities or options that could reduce this limitation?

We agree that nothing should be done that would inappropriately limit physician choice or force physicians to report measures using intermediaries. However, since not all current measures can be reported in all ways, requiring physicians to report "Core Elements" and only including measures as Core Elements if they have multiple collection types would inappropriately limit physicians' ability to choose the most relevant measures for their patients and services. We recommend that CMS solicit input from physicians regarding the measures they believe are most important to use and whether current reporting

options are too limited and then take steps to ensure there are an adequate number of reporting options for the measures that physicians feel are most appropriate to report.

We are considering policies to increase the likelihood that clinicians have an applicable and available Core Element. We request feedback on ways to include measures that are applicable for more clinicians, such as including cross-cutting and broadly applicable measures. We also request feedback on ways to avoid disadvantaging clinicians without an applicable Core Element, such as attesting to no applicable and available Core Element.

If an MVP is going to use an episode-based cost measure to assess a physician's performance on spending for a specific health condition or procedure, then the MVP has to have an appropriate set of quality measures for that condition or procedure in order to determine whether reductions in spending have been made at the expense of quality and to determine whether higher spending has resulted in better quality. If there are condition-specific quality measures relevant to the types of conditions that physicians treat and the kinds of services they deliver, then those measures should be considered the "Core Elements" for those physicians. "Cross-cutting and broadly applicable measures" would not be an adequate substitute. CMS has devoted extensive resources to developing over 30 episode-based cost measures, and it needs to devote a comparable level of resources to developing complementary quality measures. This would help to ensure that every physician had appropriate quality measures that they could report.

As we consider which measures should be used as Core Elements, we are interested in receiving feedback on specific measures that should or should not be considered for the Core Elements requirement, including measures in the proposed Advancing Health and Wellness quality measures clinical grouping, as discussed in section IV.A.4.a.(2) of this proposed rule, or Adult Universal Foundation quality measures.

No measure should be designated as a "Core Element" that is required for all physicians participating in an MVP unless it is a quality measure specific to a health condition that all the physicians treat or a type of services that all the physicians deliver. In order to designate a group of measures as "Core Elements" and require that physicians use one of those measures, the group of measures would need to have at least one measure applicable to the type(s) of condition(s) that each subgroup of physicians treats or the type(s) of service(s) they deliver.

We request feedback on our goal to consider the Core Elements policy for proposal in the CY 2027 PFS proposed rule.

We believe that the focus for the CY 2027 PFS proposed rule should be revising MVPs so they have quality measures that better align with the types of conditions that physicians treat and the services they deliver.

We understand the Core Elements requirement places a new restriction on MVP reporting. We request feedback on whether the Core Elements reporting requirement would impact your decision to report an MVP while traditional MIPS remains a reporting option.

If Core Elements are not relevant to the types of health conditions that a physician treats or the types of services they deliver, then requiring a physician or subgroup to report them as part of an MVP would likely discourage the physician from using the MVP and encourage the physician to report through traditional MIPS instead.

If CMS moves forward with a proposal to include Core Elements within an MVP, CMS must take into consideration how measures are scored. If there is a core element within a specific MVP and also in

another MVP, physicians should only be scored and compared against physicians reported on the measure within the same MVP. Continuing to score measures the same across specialties does not make clinical sense. While a measure might be relevant across various specialties, the severity of disease and how it is treated often various and illogical to compare a primary care physician against an orthopedic surgeon on the same measure.

Medicare Procedural Codes Request for Information (RFI)

CMS seeks feedback on identifying Medicare Part B procedural billing codes that align with each MVP and to encourage, or potentially require, specialists to report the relevant MVP based on their use of procedural billing codes. The AMA reiterates our position that MVPs should remain voluntary, and physicians should retain the option to select the MIPS measures and MVPs that most appropriately reflect their patient population and care. **Furthermore, we outline numerous concerns with this concept below, and therefore, the AMA opposes an MVP assignment requirement.**

If the agency wishes to provide information to assist physicians and group practices in selecting an MVP, the use of CPT codes may be appropriate for some MVPs, with specialty-focused MVPs more amenable to this method than those that are designed for primary care physicians. Any list of CPT codes that is aligned to an MVP should be vetted by the relevant specialty societies to ensure that they accurately represent the MVP and will also need to be updated yearly to reflect any changes.

Below are several areas of concern with respect to assignment methodology that represent challenges in terms of reporting clarity and appropriate attribution.

1. **Measure definition: is an appropriately differentiated case selection possible?**

   The CPT codes most likely to be utilized in MVPs involving primary care physicians are Evaluation and Management (E/M) codes, some of the most widely utilized codes in the 11,000+ CPT code set for both primary care and specialty care physicians. CPT reporting guidelines do not limit reporting of these codes based on patient diagnosis; as such, effective use of these codes with MVPs focused on primary care will require additional criteria, such as incorporating diagnosis code information that focuses on the condition being treated at a given encounter, to effectively identify cases for review.

2. **MVP assignment and appeals process.**

   For a physician that has already been reporting an MVP and has established all the systems in place for effective patient care and metric performance, it is not known what will occur if CMS assigns them to a different MVP based solely on claims data, and they do not have the infrastructure in place to participate. Would there be an appeals process for a physician if they feel they are not assigned to the correct MVP?

   The potential attribution of physicians who may be assigned to a different MVP than that with which they self-identify is likely to increase, as selection is currently performed at the group level or via APM. Moving to a finer, physician-level attribution process will magnify variations seen in this realm, and the need for an effective and efficient method for physician assignment appeals would be essential.

3. **Measure code selection: Utilization of optional and/or recently introduced (or re-introduced) codes may skew patient populations selected for evaluation.**

As the use of APCM codes has recently been implemented, there is currently no quantitative or qualitative data available to inform about their utilization and uptake. As with many medical coding sets, it is not uncommon for a new/unproven code to progress though a 'settling period,', with inconsistent reporting patterns while physicians become familiar with the codes' intended use. Selecting patient populations reported during this period runs a notable risk of an inaccurate patient pool, skewed towards higher proportions of patients included for whom code reporting may not be appropriate.

4. **Volume thresholds – Twenty is not sufficient to assess performance and accurately assign some physicians.**

   For the majority of MVPs noted, a case threshold of 20 cases is mentioned, which may be influenced by the MIPS eligibility period of reviewing the previous 2 years before the measurement year. It is not clear whether the 20-case minimum would need to be achieved over the 2-year period overall, or if it needs to be met in each of the measurement years.

   We question whether a 20-case minimum represents a clinically valid sample for assignment to a MVP across all specialties. Specialty societies need to be involved not only with vetting any set of CPT codes to represent but also providing guidance on what constitutes an appropriate case volume for a specialty-defined MVP.

   We believe it will be more challenging to identify primary care providers through claims than it would be to identify specialty providers, especially if there is no way to self-identify. The variety of patients that some primary care physicians care for may be quite diverse, resulting in their utilization patterns meeting a 20-case threshold in numerous MVP categories. In these instances, it is imperative for physicians to have a process that permits them to self-identify with an MVP when the available data does not determine a clear lead.

- *Well-being and Nutrition Measures RFI*

We support the development and implementation of measures on health and well-being that are patient-centered, evidence-based, and demonstrated to be reliable and valid. However, these measures must also be clinically appropriate and directly attributed to the quality of care provided to the intended medical specialty. For example, the two preventive care and screening measures that are proposed for inclusion in the Low Back Pain episodes for the ASM model were originally developed to be applicable to primary care physicians and do not necessarily function as key drivers of quality improvement when applied to a different specialty such as neurosurgery or orthopedic surgery. CMS must ensure that any measure on health and well-being will result in incentivizing quality improvement and be clinically appropriate.

In addition, given the Administration's focus on disease prevention and health promotion, **we urge CMS to remove the Preventative Care and Wellness (composite) from MIPS and the Primary Care MVP and re-instate the individual preventative screening measures.** The Preventative Care and Wellness composite is made up of individual preventative screening measures that were developed as individual measures and originally part of MIPS:

1. Percentage of patients who received an influenza immunization or who reported previous receipt of an influenza immunization.
2. Percentage of patients 65 years of age or older who received a pneumococcal vaccination on or after their 19th birthday.

3. Percentage of patients with a mammogram during the 27 months prior to the end of the measurement period.
4. Percentage of patients with one or more appropriate colorectal cancer screenings.
5. Percentage of patients with a documented Body Mass Index (BMI), with follow-up plan if applicable, during the encounter or during the previous 12 months.
6. Percentage of patients screened for tobacco use and, if identified as a tobacco user, received cessation intervention during the encounter or within the previous six months.
7. Percentage of visits where patients were screened for high blood pressure with a documented follow-up plan, as indicated.

As a result of removal of the individual measures from MIPS and only maintained for select MVPs and the APP measure set for MSSP, we have heard that electronic health record (EHR) vendors are no longer supporting the individual measures. We also remain extremely concerned that the Preventative Care and Wellness composite, which consists of the individual screening measures, is overly complex with seven numerators, denominators, and exclusions/exceptions and will directly impact the feasibility of the measure for use in MIPS. Therefore, we continue to request that CMS reconsider the removal of the individual measures as each address important preventive activities and aligns with the Administration's focus on health and well-being. The removal also eliminated the ability of some specialties to select a subset of the measures which are relevant to their scope of practice. As a result, **the AMA continues to oppose the removal of the measures and inclusion of the Preventative Care and Wellness composite measure in MIPS.**

- *Query of Prescription Drug Monitoring Program (PDMP) Measure RFI*

The AMA does not support changing the Query of PDMP measure from an attestation-based measure to a performance-based measure. Shifting to a performance construct will not yield meaningful improvements in patient outcomes or tangible benefits for physicians and other health care professionals. PDMPs can be useful sources of information, but they are not diagnostic or clinical instruments; they present prescription history and do not link patients to treatment. Moreover, while PDMP technology and usability have improved markedly over the past decade, tying PDMP use to performance would disproportionately disadvantage physician practices—particularly those that have not been able to invest millions of dollars to integrate PDMP functionality into their EHRs.

Several overarching principles inform the AMA's position. First, the AMA has long supported PDMPs as informational tools that can help inform clinical decision-making. This support does not equate PDMPs with validated clinical or diagnostic tools such as EKGs, blood tests, or x-rays. Second, PDMPs are now ubiquitous; however, ubiquity has not translated into demonstrated improvements in outcomes. The AMA's 2024 Overdose Epidemic Report shows that physicians and other authorized users queried state PDMPs more than 1.4 billion times in 2023 and more than 5.3 billion times over the past five years. There remains no credible evidence that this substantial usage is associated with reduced drug-related mortality, improved patient outcomes, or increased linkages to treatment for substance use disorder, mental illness, or other chronic conditions. Third, while PDMPs have shown some positive effects in curbing "doctor shopping," they have also been associated with negative consequences, including restricted access to care and abrupt tapering or discontinuation of treatment.

When used appropriately, PDMPs can provide detailed prescription histories that help physicians identify potentially concerning drug combinations, detect uncoordinated care, or recognize when an individual has received multiple prescriptions from different providers. In these circumstances, PDMPs can facilitate discussions about medication safety and support more coordinated treatment plans among physicians. However, PDMP data have also been used to deny prescriptions and to abruptly taper or discontinue care. These actions are often driven by fear of law enforcement and other entities that use PDMP data to flag patients receiving high opioid dosages. Some state licensing boards likewise use PDMP data to identify

"high prescribers," which can include physicians treating cancer, providing hospice and palliative care, or practicing addiction medicine. Without clinical context, PDMP data are raw information; changing the measure from attestation to a performance metric based on total usage will not change that reality.

PDMP technology has evolved from the clunky, multi–sign-on databases of a decade ago—systems that struggled with data exchange and real-time access—to platforms that now generally provide reliable controlled-substance prescription histories. Like a medical history, PDMP information can augment a physician's clinical understanding of a patient. Yet, contrary to the narrative advanced by CMS, the AMA is not aware of evidence that PDMPs "promote the overall effective prevention and treatment of opioid use disorders," reduce "opioid-related overdose rates," or increase "admissions to treatment facilities for prescription drug misuse." The AMA supports appropriate PDMP use but urges CMS to rely on evidence rather than assertion before altering this measure.

The cautions above are consistent with CDC's 2022 Clinical Practice Guideline for Prescribing Opioids for Pain, which emphasizes: (1) PDMP-generated risk scores have not been validated against clinical outcomes such as overdose and should not supplant clinical judgment; a clinical evidence review did not identify studies demonstrating PDMP effectiveness for risk mitigation; (2) clinicians should not dismiss patients from their practice based solely on PDMP information, as doing so can jeopardize patient safety and forfeit opportunities to provide potentially lifesaving education and interventions; and (3) PDMP information has been used to dismiss patients from care, which can result in untreated or undertreated pain.

The nation's overdose epidemic has for years been driven primarily by illicitly manufactured fentanyl, methamphetamine, cocaine, and counterfeit drugs produced outside the United States. Although recent reductions in drug-related mortality are welcome, more than 75,000 people continue to die each year—largely due to these illicit and illegal substances. Increased PDMP usage will not alter this fundamental driver. By contrast, a performance-based PDMP requirement would predictably: (1) prompt more PDMP checks even when clinically unnecessary; (2) increase administrative burden as practices strive to satisfy the metric; and (3) improve apparent performance on paper without providing CMS a meaningful indicator of clinical value. **The AMA supports performance measures that offer valid, outcome-relevant benchmarks. The proposed change does not meet that threshold, and the AMA therefore cannot support its adoption.**

- *Performance-Based Measures in the Public Health and Clinical Data Exchange Objective RFI*

The AMA appreciates the opportunity to respond to the RFI on performance-based measures. Physicians understand and appreciate the importance of public health and the critical role that they play in communicating this information to public health agencies (PHAs) and contributing to improved public health outcomes. Being on the front lines of patient care delivery, physicians are integral in public health surveillance through reporting diseases and conditions to PHAs. Physicians similarly expect that PHAs will communicate with health professionals in their jurisdiction about the status of the population's health and the health needs of the community based on this data. The AMA is uniquely positioned to comment on the advancements needed in public health reporting infrastructure across the nation to drive improvements in the quality and consistency of reporting to PHAs and associated public health outcomes.

The AMA recommends that CMS pursue an HHS-wide approach that aligns across agencies to realize these goals. CMS, CDC, the National Institutes of Health, and the Assistant Secretary for Technology Policy/Office of the National Coordinator for Health IT (ASTP/ONC) need to collaborate to ensure that positive financial incentives for physician practices are in place to adopt technology for public health reporting and help ensure bidirectional information sharing. We advocate for positive incentives for physicians to upgrade their electronic health record (EHR) and other health IT systems to support

immunization registry, electronic case, syndromic surveillance, and electronic laboratory case reports that are timely and complete. This upgraded technology will also help to ensure that physicians can access the most critical public health information that they need, including on emerging infections, to deliver the highest quality care and achieve better outcomes for their patients. Currently, we do not believe that the appropriate infrastructure or alignment across the Department is in place to consider alternatives to the current attestation-based measures and reporting requirements under the Public Health and Clinical Data Exchange objective.

As previously discussed, with the Trump Administration pursuing a deregulatory agenda across government to alleviate unnecessary regulatory burden, the complex rules and requirements for compliance with the ineffective MIPS Program should be a top priority for elimination. As we have emphasized throughout this letter, the MIPS Program has yet to demonstrate better health outcomes for Americans or lower avoidable spending, and it imposes steep compliance costs on physicians while disproportionately hurting small and rural practices by cutting their Medicare reimbursement up to 9 percent. Consequently, replacing current attestation-based measures with measures that would require reporting of a numerator and denominator to better assess performance on measures included under the Public Health and Clinical Data Exchange objective should not be given further consideration.

We encourage HHS to spur the development of public health infrastructure through collaborations across the Department to put us on a path to better capture health information shared with PHAs and improve comprehensiveness, quality, and timeliness. Further developing public health infrastructure for physicians can occur by providing positive financial incentives to physicians that allow them to upgrade their technology. The AMA works from the perspective that financial incentives are most effective when framed as a positive stimulus, as opposed to a penalty. Incentives implemented with the goal of enhancing public health information sharing by physicians should ensure that physicians receive a meaningful positive stimulus to support the necessary practical technology enhancements required to bring about desired improvements.

Moreover, the AMA recognizes the need for increased federal, state, and local funding to modernize our nation's public health data systems to improve the quality and timeliness of data. Positive financial incentives for physician practices should be coordinated with other financial investments in public health data systems for PHAs at the federal, state, and local levels. Aligned investments for all parts of the public health infrastructure ensure that the capabilities to transmit electronic case reporting (eCR) and other data streams are supported along with the capabilities of public health partners to receive that data electronically and return the necessary data to physicians and other providers on the front lines of delivering patient care. Without these investments at the physician practice and PHA levels, CMS should not consider adding new burdensome reporting requirements under the Public Health and Clinical Data Exchange objective.

In terms of new measure concepts, the AMA supports CMS' goal of harnessing modern Health Level 7 (HL7®) Fast Healthcare Interoperability Resources (FHIR) APIs to drive public health reporting, as well as other functionalities, including longitudinal care coordination, quality measurement, and AI-enabled clinical decision support. The ASTP/ONC Health IT Certification Program's emphasis on structured data and standardized APIs, including the FHIR specification, is a positive step toward enabling more seamless data sharing. Yet, implementation variability and usability challenges continue to burden physicians and limit the full potential of certified tools, especially in small and medium-sized practices that lack health IT expertise and extensive technical infrastructure.

From the physician's viewpoint, the most persistent barriers originate with some health-IT developers: five- and six-figure "custom interface" fees to enable certified FHIR APIs, refusal to activate those APIs absent broad data-use waivers, PDF "data dumps" instead of discrete data, sluggish HL7 v2 feeds that

stall connections to specialty registries, and months-long delays in turning on certain interfaces. These nonresponsive or unusable responses leave clinicians—and often their patients—without timely, structured information, illustrating that technology-vendor conduct, not provider reluctance, often drives real-world data bottlenecks.

CMS should address these challenges by further standardizing data-sharing protocols and promoting the use of APIs and FHIR-based solutions to facilitate real-time, patient-centered data exchange. As previously discussed, we recommend that CMS, CDC, and other HHS partners provide positive funding and technical assistance to help smaller and rural physician practices implement and sustain their IT infrastructure and optimize the capabilities of these products to benefit patient care, along with a longer glidepath to meeting the full implementation requirements.

CMS should also coordinate with CDC to create and release a detailed timeline with milestones that indicates when critical steps and activities have been achieved and what factors and deliverables must be met to indicate that the field is sufficiently ready to move to the next step. This process and timeline needs to incorporate an outline of when the technical requirements for FHIR-based reporting will be made available with adequate time for health IT developers to integrate them into their products and when these requirements will be incorporated into certification requirements.

Concurrently, CDC should build and make the necessary investments in the internal capabilities that PHAs need to receive this data through FHIR-based APIs and release guidance and education to assist practices in this transition. By using a stepwise approach with initial activities focused on building the required infrastructure, followed by data collection and reporting by the practices, physicians, PHAs, and CDC can be successful. It will be essential that for each step, there is adequate time and resources provided, and a critical component will be an evaluation of when physician practices and PHAs are ready to move from one step to the next, with input from the community a required element.

In addition, the benefits of Bulk FHIR are limited due to the well-documented barriers in its implementation. There are known performance limitations, inconsistencies in support across developer implementation and technical barriers that CMS, CDC, PHAs, HL7, and other entities must address to allow this standard to work as intended. Processing large datasets with Bulk FHIR can be slow, and the infrastructure required to mitigate this issue can be costly to set up and maintain—a general issue with FHIR. When a Bulk FHIR query fails, the required restart can add additional time and validation complexity, exacerbating the performance issues.

A simplified and more efficient Bulk FHIR process would benefit health care organizations broadly and provide significant advantages for resource-limited physician practices, as well as provide general interoperability benefits. However, there appears to be an inherent assumption by CMS that if a physician or practice utilizes CEHRT, the EHR can support reporting on all required measures, which is typically not the case. CMS and ASTP/ONC need a process to ensure that when a practice purchases an EHR, either that EHR can support the practice's reporting needs, or it provides a way for the practice or the EHR developer to seamlessly build in the additional need, without the developer charging an additional cost to the practice.

Without an EHR certification requirement, many physicians, especially those in small, under-resourced, and/or rural practices, will not be able to access new FHIR APIs or take advantage of their promising capabilities. Establishing a process to evaluate, test, and certify this new technology will create standard APIs, promote end-to-end interoperability, and allow for an electronic process that is meaningfully integrated within the EHR workflow.

Another challenge that surfaces because of complex administrative burdens and technological challenges centers on data completeness requirements. Similar to quality measure reporting, high data completeness thresholds in public health reporting are also particularly problematic for physicians who practice at multiple sites of services or as a part of an ACO 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, data privacy concerns, and patient misidentification. Many physician practices also lack knowledge on how to access providers' "digital endpoints" to collect the data needed for aggregation.

As we have stated in previous public comments, data completeness reporting requirements run counter to CMS' goal of reducing administrative burden within the MIPS program, and our concerns have not been adequately addressed. CMS needs to work with the physician, ACO, and EHR developer communities to find solutions to these data aggregation problems. Until the technology standards are more mature, CMS should not consider any data completeness requirements under this objective.

Rather than consider alternatives to the current attestation-based measures and reporting requirements under the Public Health and Clinical Data Exchange objective, CMS needs to pursue an HHS-wide approach that aligns across agencies to ensure that the appropriate infrastructure is in place to support additional reporting requirements. CMS should be partnering across the Department to put positive financial incentives in place for physician practices, and work with the community to further support standardizing FHIR APIs to drive more robust public health reporting.

Data Quality RFI

- *What data quality challenges does your health care organization experience (for example, discrepancies in data accuracy, completeness, reliability, and consistency)? How are you working to address data quality challenges? What data quality challenges persist longitudinally across your patient population(s)?*

Physicians are routinely asked to make high-stakes decisions with data that are fragmented, stale, or missing context. Problem lists are split across systems; medication histories lack indications and start/stop dates; and essential clinical details are often absent, raising the risk of duplicative or unsafe orders and reducing efficiency at the point of care. Compounding this, unstructured notes and scanned documents block computable reuse; orders/results are inconsistently coded; interface noise generates duplicates; and patient-matching errors split a single record across identities. In quality reporting, measure logic often assumes data elements that are not reliably available, leading to denominator misclassification when encounters are incomplete; key demographic fields, particularly SDOH, are sparsely or inconsistently populated, undermining validity analyses. Administratively, eligibility, benefits, and prior authorization (PA) data are frequently incomplete or out-of-date at the point of care; payer adjudication codes lack clinical specificity; and physician rosters/directories are inconsistent. Finally, inadequate provenance and versioning—and inconsistent timestamps and source tagging—limit auditability, trust, and reconciliation.

Physicians are addressing these issues through physician-led governance, technical hygiene, documentation support, and developer collaboration. CMS should ensure physician-led data stewardship remains central to improving data utility, and that any new policies support these efforts

Despite these controls, longitudinal gaps persist: cross-system reconciliation is fragile because outside data often arrive late, unstructured, or without provenance; SDOH and device data remain under-captured; standard terminology use is inconsistent across payers and developers; and directory, eligibility,

and PA information are not reliably computable and real-time at ordering—undermining point-of-care decisions and related measures.

To close these gaps, CMS should prioritize near-term actions that keep information in the physician workflow and make it computable and trustworthy end-to-end: (1) require real-time, computable coverage, eligibility, and PA information at ordering via standardized, validated payer and EHR APIs, with clear decision rationales and clinically specific adjudication codes; (2) align measurement with data reality by requiring feasibility and realistic data-completeness expectations and avoiding use of sparsely populated fields until capture improves; (3) strengthen EHR data-stewardship requirements by mandating standardized provenance, versioning, consistent timestamps, and source identifiers; (4) raise the floor on patient matching and de-duplication through standardized demographics, normalization practices, and transparent matching performance metrics; (5) drive consistent, trusted coding and terminology use across payers and developers, with industry-led mapping maintenance to prevent drift; (6) improve physician directory and roster accuracy through authoritative, computable sources with attestation timelines and service-level expectations; and (7) require EHR certification and payer operations to support discrete capture and post-encounter validation without shifting work to the back office—keeping coverage and PA information in the clinical workflow at the moment of care.

- *What are the primary barriers to collecting high-quality data? What resources do you believe could help your organization address these challenges?*

Small and mid-size specialty practices want high-quality data but face barriers they cannot solve alone. EHRs vary widely and rarely ship turnkey utilities for provenance capture, duplicate detection, or list reconciliation; practices with limited purchasing power struggle to secure fixes, leaving data quality dependent on local workarounds. Workflow realities compound this: excess clicks, free-text, and scanned documents persist when discrete fields are not prompted in-workflow, and reconciliation (problem/med lists) often falls to physicians after visits. At ordering, eligibility, benefits, coverage rules, and PA status/artifacts are not reliably real-time or FHIR-native, forcing back-office calls and portal re-keying that add latency and error and prevent informed point-of-care decisions. Identity and provenance gaps, e.g., patient-matching errors, missing timestamps, absent source tags, further erode trust. Measurement is misaligned with routine capture: many eCQMs expect discrete elements that are sparse in practice, driving denominator drift, unreliable results, and disproportionate penalties for smaller practices without data-stewardship staff. SDOH fields are inconsistently populated. Finally, resource constraints are decisive: few small practices can fund a data steward, and competing demands crowd out data-quality improvement.

CMS can materially change this trajectory. Update certification so certified EHRs ship out-of-the-box data-quality utilities—standards-based provenance and timestamps, duplicate detection, list-reconciliation workflows, and role-appropriate dashboards (completeness, timeliness, validity). Require standards-based, in-workflow payer APIs for eligibility/benefits, coverage rules, and PA status/documentation (using national standards, not proprietary companion guides) with public conformance testing; real-time, computable signals at ordering eliminate re-keying, reduce denials, and improve accuracy and measure reliability. Publish EHR and payer scorecards on data-quality capabilities (provenance support, reconciliation user experience, real-time coverage APIs) and tie CMS program participation to minimum performance. Advance modernized identity and directory must be usable by small practices without new overhead; authoritative physician data and better matching are prerequisites for clean exchange and reconciliation.

- *What solutions have MIPS eligible clinicians found most effective to address data quality?*

For small, rural, and independent practices, the most effective data-quality solutions are low-cost, EHR-native, and workflow-embedded, shifting effort away from physicians' after-hours work. Add-on apps and bespoke integrations are rarely feasible given thin staff, limited information technology support, and existing MIPS burden. Clinicians therefore rely on the following approaches and need CMS support to use them at scale.

Need 1: In-workflow list hygiene (staff-led).
Embed medication/problem-list reconciliation in intake and pre-visit planning using native EHR tools, with required indication and start/stop dates and "last-touched" timestamps to prompt review only when stale.
CMS should: Require usable reconciliation tools in EHR certification; award Improvement Activity (IA) credit for documented staff-run workflows; provide technical assistance/playbooks.

Need 2: Structured capture where it matters.
Turn on clinician-friendly defaults/templates for discrete vitals, immunizations, and common labs; minimize free text in fields feeding orders, eCQMs, registries, and referrals.
CMS should: Require turnkey templates in EHR certification; align MIPS measures to those fields; grant credit for documented use of native templates (no add-ons).

Need 3: Native duplicate control and provenance display.
Enable EHR-level deduplication and visible source/timestamp badges so external data can be trusted and reused.
CMS should: Add EHR certification criteria for configurable deduplication and human-readable provenance; align MIPS data-completeness expectations with provenance availability; provide physician safe harbors when external data lack provenance.

Need 4: Identity basics at check-in (patient matching).
Standardize two-identifier verification and address normalization using native registration tools; train front-desk staff to correct errors upstream.
CMS should: Require address normalization and configurable identifier prompts in EHR certification; recognize standardized check-in protocols as an IA; avoid penalizing practices for mismatches originating externally; do not mandate untested digital identification systems that lack meaningful patient control.

Need 5: "Measure-ready" documentation tools.
Map common MIPS measures to the exact EHR fields; deploy one-click smart phrases/macros to capture required discrete elements during routine documentation.
CMS should: Require EHRs to publish field maps and ship clinician-friendly shortcuts/macros; offer MIPS credit for use of these native tools; provide sample phrase libraries to reduce local build effort.

- *What steps should CMS consider to drive further improvement in the quality and usability of health information being exchanged? How can CMS partner with MIPS eligible clinicians, industry, and Federal agencies to drive further improvements in the quality and usability of health information being exchanged?*

CMS should center accountability on entities that control data and technology, e.g., EHR developers, payers, and intermediaries, not on frontline physicians. Physicians cannot improve data quality when eligibility, benefit design, PA artifacts, directories, and external clinical data are incomplete, stale, or non-computable. CMS should refrain from new physician penalties and instead require real-time, provenance-rich, standards-based data usable at the point of care.

- Through ASPT/ONC certification, require EHRs to ship baseline data-quality capabilities out-of-the-box: provenance/timestamps and source tagging on exchanged data; native duplicate detection and reconciliation workflows; identity-hygiene supports; and lightweight, practice-facing dashboards (completeness, timeliness, error rates). Include conformance testing and public scorecards to inform product selection.
- Obligate MA plans, Medicaid managed care, and commercial issuers in federal programs to expose and maintain FHIR-based APIs for eligibility/benefits, coverage rules, formularies, PA status and documentation, and physician directories—with service level agreements, public test suites, and audits. Prohibit proprietary companion guides; make coverage/PA determinations returned at ordering binding to prevent back-office denials that undercut clinical decisions and quality measurement.
- Partner practically and physician-led: fund small-practice technical assistance and vendor-agnostic playbooks; convene EHRs, HIEs, and payers with physician users to fix high-friction workflows (problem/med list reconciliation, external results ingestion, point-of-care coverage checks). Coordinate with ASPT/ONC, OCR, FTC, and OIG to align privacy, transparency, and enforcement—especially around payer automation and AI in utilization management.
- In QPP, recognize verified data-quality improvements without punishing clinicians for upstream failures: establish physician safe harbors and attribution rules so missing/inaccurate external data do not depress MIPS scores; allow attestation-based substitutes where payers/EHRs have not met CMS and ASPT/ONC obligations.
- Publish plan and developer scorecards to create market pressure and sustain improvements.

    - *What methods should CMS and other partners explore to further rectify data quality issues in the health care community?*

CMS should focus accountability on entities that control data capture, transport, and display, e.g., EHR developers, payers, and intermediaries, rather than imposing new penalties on physicians. Small and independent practices operate within systems they do not control. Rectifying data quality requires enforceable obligations on platforms and payers, paired with practical assistance for practices.

Near-term (12–24 months):

1. **ASTP/ONC certification:** Require EHRs to ship baseline data-quality utilities out-of-the-box—provenance/timestamps and source tagging on all exchanged data; native duplicate detection and reconciliation workflows; identity-hygiene supports; and lightweight, practice-facing dashboards (completeness, timeliness, error rates). Include conformance testing and public scorecards to guide product selection.
2. **Payer APIs:** Obligate MA plans, Medicaid managed care, and commercial issuers in federal programs to expose real-time, standards-based FHIR APIs for eligibility/benefits, coverage rules, formularies, PA status/documentation, and physician directories, with service level agreements, standardized test suites, and audits. Prohibit proprietary companion guides; make determinations returned at ordering binding to prevent after-the-fact denials that erode clinical decisions and distort quality measurement.
3. **Protect clinicians and support adoption:** Recognize verified improvements without tying scores to non-computable elements; create physician safe harbors and attribution logic so missing external data do not depress performance; fund developer-agnostic technical assistance and playbooks tailored to small practices.

Longer-term structural reforms:

4. **Modernized national physician directory:** Build a trusted, authoritative, de-duplicated clinician/location directory with strict update service level agreements and a transparent validation pipeline that EHRs and payers must consume.
5. **TEFCA evolution:** Add payer endpoints and event notifications; require robust provenance labeling; publish exchange-level data-quality metrics to drive accountability across networks and intermediaries. Above all else, retain voluntary TEFCA participation for physicians and providers.
6. **Measure alignment:** Align eCQM logic with fields routinely and reliably captured in certified EHRs; reduce reliance on rarely populated elements; adopt computable value-set distribution to minimize version drift.

- *Transition Toward Digital Quality Measurement RFI*

The AMA commends the Administration for focusing resources on interoperability and advancing quality measurement. Moving to a standard based on Fast Healthcare Interoperability Resources (FHIR) will allow physicians, hospitals, and alternative payment model (APM) entities to incorporate alternative sources of data into quality reporting and should ease reporting burden. **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:

- *Are there specific eCQMs or components of existing eCQMs that you anticipate presenting particular challenges in specifying in FHIR?*

Anything that may not be mapped to a FHIR resource, or unclean and non-normalized data will cause issues with creating and reporting eCQMs, including medications, genomic data, and uncommon/unusual results from within a patient's notes or lab results. We encourage CMS to complete a comprehensive analysis of every existing eCQM to determine whether specifying all required data elements in FHIR can be achieved. It is critical that any potential challenges or barriers to implementation are identified and resolved before practices are required to capture and report data that cannot currently be represented correctly in FHIR.

- *Can you share any experiences or challenges reviewing, implementing, or testing the QI-Core, DEQM, or Bulk FHIR standards, including any experiences or challenges unique to Bulk FHIR Import versus Bulk FHIR Export?*

Based on the current state of Bulk FHIR, the benefits are limited due to the well-documented barriers in its implementation. There are known performance limitations, inconsistencies in support across vendor implementation, and technical barriers that CMS, HL7, and others must address to allow this standard to work as intended. Processing large datasets with Bulk FHIR can be slow, and the infrastructure required to mitigate this issue can be costly to setup and maintain— a general issue with FHIR. For instance, the AMA has heard that it can take days and sometimes weeks to extract data with BULK FHIR. When a bulk FHIR query fails, the required restart can add additional time and validation complexity, exacerbating the performance issues. The inability to change existing export groups results creates even more challenges when a bulk FHIR query fails, requiring either sophisticated code to ensure non-duplicative results or a complete re-run of the query.

It should also 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 adverse to moving patient level data across firewalls. While improved Bulk FHIR implementation makes that movement easier, additional regulatory attention around security and proper use would be required to gain

compliance from EHRs and health systems and practices. Health systems rely on internal quality teams to implement continuous quality improvement programs and small practices will likely not have many 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 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 CMS develop solutions to the downsides of using Bulk FHIR data exports from EHRs to CMS to simplify clinical quality data submissions.

Furthermore, how FHIR endpoints are built, maintained and mapped vary between EHRs, requiring, at minimum, custom setup to connect to each practice or vendor system. The additional work required by the practices shouldn't 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.

- *Are there any deficiencies or gaps in the DEQM IG that must be addressed before it can potentially be used for reporting to CMS on eCQMs using FHIR APIs?*

Any additional resources that simplify the DEQM Implementation Guide (IG) would be extremely helpful. While the IG is thorough and detailed—providing much of the "why" behind DEQM—it lacks accessible, practical examples that explain the "how," particularly for those who are newer to FHIR or implementing eCQM reporting. A clearer bridge between conceptual documentation and real-world implementation is needed to make the guide more usable, especially for smaller or less technically resourced organizations.

- *Are there additional baseline requirements or capabilities that need to be considered before FHIR-based eCQMs could be reported to CMS using Bulk FHIR*

Yes, the capabilities of the measure stewards and the ongoing expense of working with measure developers must be considered. Successful FHIR-based eCQM development requires not only technical infrastructure but also sustained access to expertise in measure specification, maintenance, and testing—resources that can be costly and are not uniformly available across all organizations.

One significant challenge is the MADiE tool, which is used for building and testing CMS eCQMs. It is often buggy and difficult to use, with much of its functionality not yet fully operational for QI-Core-based eCQMs. While alternatives for testing exist, they typically require additional setup and technical resources that may not be readily available to all implementers. Ultimately, a complete and user-friendly suite of tools for translating and testing FHIR-based eCQMs will be essential—especially for organizations without the infrastructure or capacity to support complex FHIR export and reporting workflows.

- *Are there additional supports or enhancements that CMS should consider for the QI Core, DEQM, or Bulk FHIR IGs that would support quality measurement and reporting beyond the CMS eCQMs or potential dQMs?*

(c) Timeline Under Consideration for FHIR-Based eCQM Reporting

Would a minimum of 24 months from the effective date of a FHIR-based eCQM reporting option using ONC Health IT Certification Program criteria to support quality program submission provide sufficient time for implementation (including measure specification review, certified health IT updates, workflow changes, training, and testing)?

We commend the Administration for focusing resources on interoperability and advancing quality measurement. Moving to a standard based on Fast Healthcare Interoperability Resources (FHIR) will allow physicians, hospitals, and alternative payment model (APM) entities to incorporate alternative sources of data into quality reporting and should ease reporting burden. Specifically, it will allow specialties such as radiology and gastroenterology to use their digital data sources, as well as other physician specialties, providers, and APM entities, to seamlessly incorporate novel sources of information and data. Therefore, to best utilize government, provider, and physician practice resources, **we recommend that CMS focus its efforts on FHIR-based dQMs rather than the interim step of FHIR specifying electronic clinical quality measures (eCQMs). Our organizations are eager to assist CMS in this move, and we welcome the opportunity to participate in its planning and execution.**

The direct transition to dQMs will meaningfully reduce data collection, reporting burdens, and deliver far greater efficiency than a phased approach. Developing FHIR-based eCQMs requires multiple complex, costly steps that disproportionately impact smaller hospitals and medical practices, many of which lack the needed infrastructure and resources. Unlike eCQMs, adopting FHIR dQMs will enable all entities to use electronic health record (EHR) data while, at the same time, allow organizations with broader capabilities, such as Accountable Care Organizations (ACOs) and health plans, to incorporate additional sources, including administrative claims, patient reported information, and health information exchange data. Broadening adoption of FHIR dQMs not only positions the health care system to achieve a modern, efficient standard for data exchange and interoperability but also directly supports the Administration's goals of advancing health innovation, reducing unnecessary burden, and addressing the chronic disease epidemic.

To ensure this transition 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.
- Evidence of data quality and completeness in reported dQMs.
- Stakeholder consensus on burden, feasibility, and patient safety considerations.

By confirming readiness in this way, we can help the health care 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)**. Specifically, the process and timeline must outline when the technical requirements for FHIR-based reporting will be available with adequate time for developers

to integrate them into their products, and when these requirements will be incorporated into federal certification requirements.

At the same time, **CMS should build the internal capabilities needed to receive dQM data through FHIR-based application programing interfaces and release guidance and education to assist the health care ecosystem in this transition.** 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.

The glidepath must also include appropriate positive incentives to support providers and physician practices, particularly those that are small and rural, through each step of the transition in a thoughtful way. By using a stepwise approach with initial activities focused on building the required infrastructure, followed by data collection and reporting by practices, CMS can achieve its goals. It will be essential for each step to include adequate time and resources. A critical component is a transparent process to assess readiness before progressing from one stage to the next. Evaluation also must incorporate input from the provider and developer community to confirm that there is broad consensus that most participants, particularly those that are small and/or in rural settings, are equipped to successfully report FHIR dQMs.

- *What resources or guidance could CMS provide to assist with the transition to submission of FHIR-based eCQM data?*

We recommend CMS build automated validity and reliability check tools for data verification to simplify reporting, but we don't 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 unsecure public website that puts them at risk of a data breach and exposing identifiable patient information.

- *What challenges, if any, do you anticipate with the reporting timeline of FHIR-based eCQMs (beginning with at least a 2-year reporting options period before any future proposal to require FHIR-based reporting)?*

What resources, guidance, or other support could we provide to encourage and facilitate the early adoption and reporting of FHIR-based eCQMs during the data submission period?

The high data completeness requirement CMS has set for MIPS, MVP, MSSP and potentially ASM quality reporting runs counter to CMS' goal of reducing administrative burden within the MIPS program and CMS has not yet adequately addressed our concerns. 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 further be exacerbated for participants in the MSSP program since ALL MIPS quality policies now apply to the MSSP quality requirements. ACOs report that they continue to encounter barriers to capturing data from some practices due to issues such as an EHR is unable to produce a QRDA 1 file or a small practice continues to operate with paper medical records. **We urge CMS to work with the physician, ACOs and the 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 within MIPS/MSSP and delay mandatory eCQM or dQM adoption.**

To justify the increased requirement, it is our understanding that there is a perception within CMS that the reporting rates received for many of the eCQMs within MIPS are 100 percent.[7] 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 (including across sites of service) may participate in MIPS, the registry, or EHR that the physician opts to use for MIPS reporting. Therefore, vendors or practices are just capturing the cases within a single EHR/site, which appears to be 100 percent, but excluding the eligible encounters from other sites of service. Therefore, 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 physicians.

We offer the following examples 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, data privacy concerns, and patient misidentification. Many physician practices also lack knowledge on how to access providers' "digital 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.

- *Example 2 - MSSP Participants Interpretation of Guidance - ACO A*

An ACO has one CEHRT system (Vendor A) used across most participating TINs; however, a small number of the participating TINs are specialty practices and Federally Qualified Health Centers FQHCs, which use different CEHRT systems (Vendors B-D). The ACO is able to collect data from all participant TINs on Vendor A so the ACO can aggregate the data and complete patient de-duplication before submitting a file to CMS. The ACO was unable to successfully extract and aggregate the data from the other TINs using Vendor B due to data privacy concerns. In addition, although the ACO practices are using CEHRT (Vendors C and D), some of the systems were only able to produce Quality Reporting Document Architecture (QRDA) III files so they are unable to de-duplicate patients. The ACO is also

[7] 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.

attempting to use billing claims for those practices that are still on paper. Using all these various methods, the ACO estimates a data completeness rate of at least 75 percent, based on the patient volumes. Here again, unaligned implementation of standards and unique customization choices made by CEHRT impact data completeness.

- *Example 3 - Interpretation of Guidance - ACO B*

An ACO has 10 CEHRT EHR systems used across all participating TINs, including several small practices. The ACO is using an external vendor to assist with the data aggregation. The ACO can collect data from most of the participant TINs. The small practices are unable to submit data to the ACO in the format needed to enable the de-duplication and aggregation steps that ACOs must complete before submitting a file to CMS, because the vendor system used by them will charge an additional fee to support the eCQMs on which the ACO must report that they cannot afford. In addition, one practice changed vendors midyear and as a result is unable to produce the needed files for the reporting year. The ACO is not able to determine the number of individuals who could be included in the eCQMs' eligible populations, so the ACO can either estimate the data completeness and report the measure without data from these practices or remove them from the ACO.

Furthermore, physicians and ACOs 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 informed decisions on the quality of care delivered for health plans and hospitals, we believe that this same logic should also apply to MIPS.**

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 solely mandatory eCQMs for MSSP. 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.

(d) Measure Development and Reporting Tools

- *What capabilities would be most useful for CMS to support in a FHIR-based eCQM reporting model?*
- *What additional concerns, if any, should CMS take into consideration when developing FHIR-based reporting requirements for systems receiving quality data?*

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 health care organizations, as well as provide general interoperability benefits. Employing an exchange of patient-level information from an EHR to CMS could simplify data submissions by minimizing the analytics requirement on reporting departments and health systems. In addition to simplifying quality measure reporting, a well-established and reliable deployment of Bulk FHIR has value across population health, clinical research and public health surveillance. 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 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 addition a practice requests of an EHR vendor, including incorporating quality measures, is an additional cost. Therefore, **transition to Bulk FHIR requires CMS and ASTP/ONC to re-look at 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.**

(e) FHIR Reporting and Data Aggregation for ACOs

What types of technical support, guidance, and resources would be most beneficial for ACOs in the implementation of FHIR-based eCQMs?

It is imperative that CMS ensure that measure specifications are aligned and vendors are supporting the measures for CMS quality programs. Recently, ACOs identified that some EHRs vendors, particularly those for small practices or specialties, were not supporting the Breast Cancer Screening eCQM since it had previously been removed as an individual measure option from MIPS. Because of this, practices cannot produce the data needed for this eCQM, impacting not only reporting for MSSP but also for any physician or practice that elects to report this measure for the Focus on Women's Health MVP. Even if a vendor can produce the QRDA 1 file, it will only include women aged 50-74 years since the eCQM specification was not updated to reflect the USPSTF's most recent recommendation to screen women aged 40-74 years of age. The MIPS CQM, however, was updated, leading to two specifications for the same clinical concept to include different age ranges and the associated benchmarking across collection types differ. We believe that CMS must avoid situations where specifications are not clearly supported by vendors and specifications and associated benchmarking are not consistent. Alignment of each data element within and across eCQMs and ultimately FHIR dQMs is imperative; otherwise, there is great risk that practices and ACOs must map the same clinical concept to multiple FHIR standards, significantly increasing reporting burden.

Y. Payment for Software as a Medical Device and Advanced Digital Health Technologies

The AMA commends CMS on its increasing focus on developing pathways to payment for emerging digital health technologies. Digital health technologies, ranging from digital therapeutics to AI-enabled diagnostics and from augmentative to fully autonomous systems are evolving at a rapid pace, with increasing interest from physicians in integrating these technologies into their practice. However, for these tools to ultimately become available for patient care, they need a clear, consistent pathway to payment.

First, the AMA continues to have concerns over the terminology employed by CMS to describe technologies otherwise classified as "software as a medical device" (SaMD). Using the term "software as a service" (SaaS) promotes confusion, as the term is used broadly outside of the healthcare industry to describe services vastly different than those contemplated by CMS. Additionally, the terminology is not consistent with terminology used by other government agencies, in particular the terminology used by the Food and Drug Administration (FDA) to describe these same technologies. The AMA strongly recommends that CMS align with other federal agencies and discontinue the use of "SaaS" to describe technologies contemplated for payment by the agency and instead describe these services as SaMD, in alignment with FDA.

Where payment is concerned, given the continued rise in healthcare costs in the United States and the significant potential costs of new SaMD technologies, CMS should only consider paying for SaMD, including AI-enabled SaMD technologies, that are safe, effective, and bring significant value to the healthcare system. The AMA has long held that any digital health technology proposed for payment

should meet the goals of the quadruple aim: improving the patient experience, lowering health care costs, improving physician wellbeing, and improving health outcomes.

The AMA is pleased to see CMS's focus on ensuring that patient safety is a significant priority regarding use of emerging technologies in patient care. The AMA generally supports requirements that SaMD paid by CMS be authorized for marketing by the Food and Drug Administration (FDA) and that these technologies have clinical validation data to help ensure their performance. Regulatory systems for SaMD and other digital health technologies are still in flux and are facing a significant push towards deregulation, which can contribute to physician and patient concerns regarding safety and efficacy. Given the regulatory lag, ensuring that payment systems prioritize safe and effective SaMD and AI-enabled systems can play a key role in helping enhance patient and provider trust while encouraging broader adoption of emerging and innovative technologies.

While the AMA strongly supports efforts to develop pathways to payment for high-quality, high-value emerging technologies, the costs of these technologies does raise concern over the potential negative impact to the physician fee schedule. SaMD technologies can be expensive and as an increasing number of new systems come to market, the costs to the Medicare systems could prove to be very significant. Due to budget neutrality rules impacting the physician fee schedule, paying for these technologies on the PFS would likely be unsustainable over the long term. Because of this, the AMA strongly recommends that payment for digital health and AI-enabled technologies be paid outside of the physician fee schedule. A new benefit category or other alternative approach whereby SaMD and other AI-enabled technologies are paid separately from the physician fee schedule would preserve payment for physician services while seeking to provide a clear, consistent pathway to payment for SaMD and potentially other technologies. The unique nature of these technologies would appear to warrant a new payment system tailored specifically to the needs of developers, physicians, and patients when considering integration of these tools into clinical practice. This would be analogous to CMS's approaches to physician-administered drugs paid under Part B and to payment of durable medical equipment. While the AMA recognizes the limitations on CMS's authority to create new benefit categories, we urge the agency to carefully consider how broad payment of increasing numbers of SaMD technologies may impact payment for physician services on the PFS.

Unfortunately, physicians have seen the unintended consequences of paying for high-cost disposable supplies in the practice expense methodology as these services have grown in price and in number. Currently, there are 94 medical supply items embedded in codes with a purchase price of more than $500. These high-cost medical supplies represent $1.53 billion in direct costs and 21 percent of all direct practice expense medical supply costs in the non-facility setting. These supplies are paid for at the expense of other specialties, and we appreciate that CMS is seeking input on how to price and pay for these services. The AMA is reiterating that they should be priced annually and paid outside of the MPFS. We have concerns that the same redistributive trend could emerge if digital health technologies are paid within the MPFS.

Coding for Software as a Medical Device and Other Digital Health Technologies

As discussed above, the AMA is encouraged by the Agency's recognition of the value that advanced digital technologies, such as software as a medical device (SaMD), bring to healthcare. However, the current practice of crosswalking AI devices to the Physician Fee Schedule (PFS) or Outpatient Prospective Payment System (OPPS) established payment amounts, may not be a sustainable method especially given the rapid proliferation of the technology across the health care landscape.

To address this and other challenges, the CPT Editorial Panel recognizes the need for a distinct coding structure and nomenclature that accurately reflects the augmentative or autonomous work a machine performs, separate from the traditional interpretative work a physician or other qualified health care

professional performs. In response, the Panel's Digital Medicine Coding Committee (DMCC) puts forward the proposed guidelines for a new category of CPT codes called Clinically Meaningful Algorithmic Analyses (CMAA). CMAA codes will describe complete, codifiable medical services that deliver clinically meaningful output, and apply directly to the patient care pathway. Establishing such a framework will also support the development of a more sustainable payment pathway for these algorithmic services.

The CPT Editorial Panel will begin discussing the foundational concepts of this framework at its September 2025 meeting. During this session, the Panel will continue to gather input from a broad range of stakeholders involved in the CPT process. The AMA views Panel meetings as a galvanizing force to engage diverse perspectives and foster the kind of dialogue necessary to build consensus around complex coding issues. Following the meeting the Panel plans to continue working collaboratively with stakeholders to refine the framework, ensuring it promotes innovation, supports patient access, and maintains the integrity of the CPT code set.

In addition to coding for algorithmic clinical services, the Panel recognizes that the rise of augmented intelligence in healthcare will impact other aspects of coding. The Panel has prioritized evaluating the implications of algorithmic services on physician work and identifying potential coding gaps. These considerations will inform future discussions and guide the next steps in adapting the CPT code set to evolving clinical practices.

While the CPT Editorial Panel has taken a leadership position in developing a reporting framework for describing algorithmic only clinical services, we understand the importance that the agency plays in ensuring not only the meaningful codification of these services, but establishing sustainable pathways for coverage and payment so that physicians and their patients may benefit from the advances in these technologies. We look forward to enhancing our collaboration on these matters directly with CMS.

Despite CMS seeking feedback on payment and coding for SaMD and AI-enabled systems numerous times, meaningful progress towards development of payment solutions has been very slow. A lack of consistent, predictable pathways to payment for emerging technologies will undoubtedly have a chilling effect on the overall market for these technologies. The healthcare industry has already witnessed the loss of some promising technologies due to a lack of a payment pathway. Continued inability to make progress on this pressing issue will eventually stall development, as investment in these technologies will slow if integration into clinical practice is hampered by a lack of reimbursement. While we recognize that payment for these technologies presents many challenges, such as limitations on the physician fee schedule due to budget neutrality rules, we must make meaningful progress towards solutions if we want adoption of these technologies to increase.