Federation of American Hospitals

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President and CEO

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Via electronic submission at http://www.regulations.gov

The Honorable Mehmet Oz, M.D., M.B.A.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1848–P
P.O. Box 8016
Baltimore, MD 21244–8016

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS–1848–P)

Dear Administrator Oz:

As the national representative of more than 1,000 leading tax-paying hospitals and health systems throughout the United States, the Federation of American Hospitals (FAH) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program proposed rule (Proposed Rule). FAH's detailed comments are set forth in Appendix A.

Executive Summary

I. Protect Medicare Access by Avoiding Further Payment Reductions and Ensuring Adequate, Sustainable Physician Payment

FAH appreciates CMS's focus on physician payment and its efforts to identify opportunities to support physicians through strengthened primary and longitudinal care, and to improve the accuracy of payments under the PFS. We reiterate our ongoing concerns, however, about the continued downward trajectory of Medicare physician payment relative to the cost of furnishing care. This threatens the long-term sustainability of the physician workforce and, ultimately, beneficiary access to care.

Although we appreciate that Congress provided a temporary 2.5 percent increase for CY 2026, that adjustment expires at the end of this year, and the Medicare Payment Advisory Commission's estimates that under current law physician payment rates will decline in CY 2027 by approximately 1.7 percent for clinicians participating in advanced Alternative Payment Models (APMs) and 2.2 percent for other clinicians, even as clinicians continue to experience growth in their input costs. MedPAC has cautioned that ongoing cost increases that substantially exceed Medicare payment updates could become difficult for clinicians to absorb and, for 2027, recommended that Congress increase physician payment rates by an additional 0.5 percentage points above current law. In addition, the 2026 Medicare Trustees Report warns that the physician payment updates specified under current law do not vary with economic conditions and are not expected to keep pace with increases in physicians' costs. The Trustees caution that, as the cumulative gap between Medicare payments and the cost of furnishing care grows, the availability and quality of physician services for Medicare beneficiaries could decline relative to that available to privately insured patients.

Against this backdrop, we urge caution in adopting additional payment reductions or policies through the rulemaking process that increase the cost of delivering care, as further downward pressure on physician reimbursement risks undermining the clinical infrastructure and workforce necessary to ensure Medicare beneficiaries' continued access to high-quality care. Examples of these types of potential policies include:

- **Multiple Procedure (Modifier 25) Payment Reduction (MPPR):** CMS should not finalize the proposed 50% MPPR—or a 25% alternative—for separately identifiable E/M visits billed with modifier 25 and should not extend the policy to inpatient or other E/M services. CMS has not demonstrated resource-based overlap sufficient to justify an across-the-board reduction, and concerns about inappropriate modifier 25 billing should instead be addressed through targeted claims edits, audits and medical review of outlier billing.
- **Efficiency Adjustment:** CMS should ensure transparent and non-duplicative application of the efficiency adjustment by publishing the complete list of CY 2027 codes for which RUC-recommended work RVUs were effectively reduced through the efficiency adjustment and confirm that those codes will be exempt from the next scheduled application of the adjustment, preventing the same services from being subject to duplicative reductions.
- **Permanently End Unpaid Postoperative Reporting – CPT 99024 Reporting Pause:** FAH supports CMS's proposed pause of mandatory CPT code 99024 reporting but urges CMS to permanently end, rather than expand, the unpaid reporting requirement and to base any future revaluation of global surgical packages on more reliable data sources that do not depend on potentially incomplete, unpaid self-reporting.

In addition, we urge CMS to support and work with Congress to avert cuts to the conversion factor for CY 2027 and develop a longer-term approach that provides adequate Medicare payment for physicians' services. Our recommendations are outlined below and further discussed in Appendix A.

II. Preserve Access to Remote Care by Replacing Direct-Employment Restrictions with Targeted Program Integrity Safeguards

FAH appreciates CMS's continued focus on improving program integrity and ensuring that Medicare beneficiaries receive high-quality, medically necessary care. We share those objectives with respect to remote patient monitoring and support stronger safeguards against arrangements in which beneficiaries are enrolled without an established clinical relationship, the billing practitioner has little meaningful involvement in the patient's care, or monitoring does not result in meaningful treatment management.

Yet, we believe CMS should take a step back from its proposals in the Proposed Rule so that these legitimate concerns are addressed in a manner that focuses on these types of practices and does not disrupt third-party contractor remote monitoring programs that are clinically integrated with hospitals and health systems, which is a predominant industry model. Remote patient monitoring has become an important way for health systems to extend care beyond the walls of hospitals and physician offices, particularly for older adults, patients with multiple chronic conditions, and beneficiaries in rural and underserved communities.

In well-designed programs, RPM is not simply the provision of a connected device; it is part of a longitudinal model of care in which remotely collected physiologic information is integrated into clinical workflows, reviewed pursuant to established protocols, escalated when appropriate, and used by the patient's care team to intervene before deterioration results in an emergency department visit or hospitalization. These programs can provide beneficiaries with capabilities that many individual practices cannot feasibly build on their own, including dedicated clinical teams, sophisticated technology infrastructure and continuous monitoring and support.

The ability of hospitals and health systems to use contracted clinical staff is an important part of making this model scalable and accessible to Medicare beneficiaries. Health systems have invested in technology-enabled care precisely because it can extend the reach of a limited clinical workforce, improve chronic disease management, reduce travel and other access barriers, and keep patients connected to their care teams between office visits.

Employment status is not a relevant proxy for clinical integration or accountability. Medicare's existing general-supervision framework already permits independent contractors while requiring the billing practitioner to exercise overall direction and control, and CMS has previously used a similar approach for contracted staff furnishing Chronic Care Management services**. FAH therefore urges CMS not to finalize the proposed direct-employment restriction and instead adopt targeted, auditable safeguards—for example, practitioner orders, EHR-integrated documentation, shared clinical protocols, and continued practitioner oversight—that distinguish clinically integrated, accountable care from arrangements that pose genuine program-integrity risks.** Such an approach

would strengthen oversight without reducing beneficiary access to proactive care or pushing patients back toward more costly acute-care settings. Specific recommendations for remote patient monitoring provisions in the Proposed Rule are discussed in detail in Appendix A.

III. Provide a Workable Transition to the Ambulatory Specialty Model

FAH continues to urge CMS to make the Ambulatory Specialty Model (ASM) voluntary, and at a minimum delay mandatory participation to provide for a two-year transition period to allow for many of the operational changes to be implemented before holding physicians accountable. Moreover, FAH urges CMS to minimize any downside risk (and exclude rural clinicians from mandatory participation or downside risk), limit the adjustment to claims included in the targeted heart failure and low back pain episodes (and not all Medicare Part B claims), raise the ASM redistribution percentage from 85 percent to 100 percent so that model savings reflect improved care rather than a withhold, and publish the evaluation criteria that would justify any future escalation of risk.

IV. Strengthen MSSP ACO Assignment, Quality Reporting, and Benchmarking

FAH supports CMS's efforts to improve beneficiary assignment and strongly supports finalizing Medicare electronic clinical quality measures (eCQMs) as a permanent reporting option and using predictable, flat quality benchmarks. We also urge CMS to provide Medicare Shared Savings Program accountable care organizations (ACOs) with advance data identifying beneficiaries affected by the new assignment methodology so they can effectively plan care management and quality improvement activities. Finally, benchmark changes should be applied prospectively rather than retroactively.

V. Maintain Traditional MIPS Until MVPs Are Ready for Full Implementation

FAH urges CMS not to sunset the traditional Merit-based Incentive Payment System (MIPS) in PY 2029 and to maintain the voluntary MIPS Value Pathway (MVP) reporting until CMS demonstrates that all specialties and major subspecialties have appropriate, clinically relevant, and reliably benchmarked MVPs, resolves measure, scoring and implementation gaps, and establishes objective readiness criteria. At a minimum, traditional MIPS should remain available where no sufficiently comprehensive or reportable MVP exists.

Conclusion

FAH appreciates the opportunity to comment on the important provisions in the Proposed Rule. We look forward to working with CMS to ensure appropriate payment and streamlined policies for physician services and welcome the opportunity to discuss our recommendations further. If you have any questions, please do not hesitate to reach out to myself or Katie Tenoever at ktenoever@fah.org or (202) 624-1500.

Sincerely,

/s/
Charlene K. MacDonald
President and CEO

Attachments:
Appendix A: FAH Detailed Comments on CY 2027 PFS Proposed Rule

APPENDIX A
FAH Detailed Comments on CMS CY 2027 PFS Proposed Rule (CMS 1848-P)

I. Rate Setting and Conversion Factor

In 2027, the Centers for Medicare & Medicaid Services (CMS) will continue to use two separate PFS conversion factors (CFs): one for eligible clinicians who are qualifying participants (QPs) in Advanced Alternative Payment Models (APMs), and another for all other clinicians and suppliers paid under the PFS. CMS proposes a 2027 qualifying APM CF of $33.1693 and a non-qualifying APM CF of $32.8409.

Both proposed rates reflect the expiration of the one-year 2.5 percent statutory payment increase that applied in 2026, as well as a 0.53 percent budget neutrality adjustment. The difference between the two rates reflects the statutory update for each group: qualifying APM participants receive a 0.75 percent update, compared with a 0.25 percent update for non-qualifying clinicians. The positive budget neutrality adjustment largely results from CMS's proposed reductions to work relative value units (RVUs) for certain services. Taken together, these changes result in proposed 2027 conversion factors that are 1.19 percent lower for qualifying APM participants and 1.68 percent lower for non-qualifying clinicians compared with their respective 2026 rates.

These payment reductions come at the same time that the cost of practicing medicine continues to rise. CMS projects a 2.5 percent increase in the Medicare Economic Index (MEI) for 2027, underscoring the growing disconnect between Medicare payment rates and physicians' practice costs. Physicians cannot continue to absorb increasing costs while their Medicare payment rates decline. Both the Medicare Payment Advisory Commission (MedPAC) and Medicare Trustees have warned that the growing gap between Medicare physician payment rates and the actual cost of furnishing quality care may result in access to care problems for Medicare beneficiaries.[1] **FAH strongly shares these concerns. Thus, we urge CMS to support and work with Congress to avert cuts to the conversion factor for CY 2027 and develop a longer-term approach that provides adequate Medicare payment for physicians' services.**

II. Determination of PE RVUs (Part II.B)

Updates to PE Methodology – Site of Service Payment Differential and Employed-Physician RFI (II.B.4.d.)

In the CY 2026 PFS final rule, CMS reduced the indirect practice expense (PE) allocated to services furnished in facility settings to half the amount allocated to services furnished in nonfacility settings.[2] The accompanying request for information (RFI) asks:

- How indirect PE costs vary when physicians are employed by hospitals, health systems or other entities;
- Whether the 50 percent facility allocation for hospital-employed physicians is accurate or could "possibly be less than 50 percent, such as 0 percent";
- Whether these costs are "not already accounted for in the existing OPPS payments"; and
- Whether a new HCPCS modifier should identify employed physicians as the mechanism for reducing facility PE on the services they furnish.[3]

FAH urges CMS not to further reduce the 50 percent indirect practice expense allocation for services furnished in facility settings, and not to adopt a lower allocation or an employed-physician modifier, especially without collecting representative cost data, publishing a specialty-level impact analysis, and accounting for the interaction with OPPS site-neutral payment policies.

In its CY 2026 comments, FAH urged CMS not to finalize the 50 percent facility reduction because the percentage was not derived from cost data, CMS had not published a specialty-level impact analysis, and the change compounded other payment reductions affecting the same clinicians. CMS finalized the policy as proposed and committed to further examine the methodology as new data and feedback arrived. The CY 2027 RFI now asks whether this facility reduction could be lower than 50 percent, and even zero, for the subset of physicians employed by hospitals and health systems.

Employed physician practices, however, continue to incur the indirect costs the PE allocation is intended to capture. Coding, billing, scheduling, credentialing, compliance and professional liability functions do not disappear simply because a physician practices within a hospital or health system. These functions shift to the employing organization, which incurs them in support of the physician. CMS recognized this point in the CY 2026 final rule, citing the AMA's statement that practices maintain indirect PE costs (such as coding, billing and scheduling) for physicians who are solely facility-based.[4] Hospitals report the same, they continue to incur significant additional infrastructure costs

supporting employed physicians even when the hospital also furnishes the technical service. These professional-service costs are distinct from the facility costs that OPPS rate setting recognizes. The OPPS payment reflects the hospital resources involved in furnishing the facility service; it does not incorporate the additional practice infrastructure costs associated with the professional claim.

The record summarized in the Proposed Rule also shows the difficulty of building a payment differential on employment status. CMS reports statements from interested parties that independent hospital medicine groups account for approximately one-third to one-half of hospital medicine groups nationwide. These parties state that such groups cannot reduce administrative and overhead costs enough to absorb the CY 2026 facility PE reductions. A reduction keyed to the facility setting reaches these independent groups even though they incur their indirect costs directly. FAH also disagrees with the CMS suggestion to create a new HCPCS modifier to identify employed physicians is a reasonable approach to identify and reduce facility PE. A reduction keyed instead to employment would require CMS to define employment across direct employment, foundation and captive group models, professional services agreements and leased arrangements. Claims data do not capture these distinctions today. The proposed vehicle, a self-applied HCPCS modifier, would ask billing practitioners to make that legal determination claim by claim, with payment consequences attached and no audit standard behind it.

The implementation of such a policy with the cumulative effect of other policies in this proposed rule, including the multiple procedure payment reduction (MPPR) for same day E/M visits with global procedures (Section II.D.3.b(58)) and the indirect PE methodology changes proposed elsewhere in section II.B.4 could also have significant unintended consequences. Payment accuracy across settings serves CMS, practitioners and beneficiaries alike, and it begins with representative cost data. **FAH recommends that CMS collect and publish that data, with a specialty-level impact analysis before consideration of any new proposals and provide an opportunity for stakeholder review and comment.**

Finally, we note that in the CY 2027 OPPS proposed rule, CMS proposes to expand site-neutral payment to imaging without contrast at excepted off-campus provider-based departments, paid at a rate calibrated to the relationship between the PFS facility and non-facility payment.[5] Reducing PFS facility PE on the premise that the hospital's OPPS payment carries the overhead, while OPPS site-neutral policies reduce that same payment toward the PFS-equivalent rate, would remove the same indirect costs from both payment systems. Neither rule models the combined effect on the services and providers subject to both. **FAH urges CMS to analyze the interaction between the two payment systems and publish that analysis before considering further site-of-service PE changes.**

Global Surgical Packages – CPT 99024 Reporting Pause (II.B.4.d.b.)

CMS proposes to pause the postoperative visit data collection required under Section 523(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which is limited to practices of ten or more practitioners in nine states and carries no payment.[6] CMS cites burden reduction for practitioners as the basis for the pause, seeks comment on whether all providers should instead be required to report CPT code 99024 and on other data sources for valuing global surgical packages, and is publishing a public use file displaying imputed RVUs with reported postoperative visits removed. **FAH supports the proposed pause of mandatory CPT code 99024 reporting and urges CMS to end the requirement permanently rather than pause it.**

Reporting CPT code 99024 carries no payment, and CMS itself concludes that the collection is unduly burdensome. A pause, however, leaves practices maintaining reporting infrastructure against the possibility of resumption. Ending the mandate permanently delivers the full burden reduction CMS describes. For the same reason, FAH opposes the alternative of expanding mandatory reporting to all providers, which would extend an unpaid reporting obligation CMS has just found too burdensome for the limited population that carries it today. **FAH urges CMS to permanently end mandatory CPT code 99024 reporting and not to expand it to all providers.**

III. Payment for Medicare Telehealth Services (Part II.C)

FAH supports expanded flexibilities for telehealth services which are critical for increasing access to services for Medicare beneficiaries. Key proposals in the rule would promote this result. For example, the Proposed Rule would continue to implement the statutory extension of telehealth flexibilities enacted under the Consolidated Appropriations Act of 2026, which waived geographic and originating site restrictions for telehealth services through December 31, 2027. It also would remove the existing requirement that teaching physicians, residents, and patients all be in separate locations for virtual supervision in teaching settings. This proposed policy would reduce logistical barriers in teaching settings and provide greater flexibility in structuring telehealth encounters, particularly when the resident or

teaching physician is already physically present with the patient. It also supports continuity of care and physician training while preserving teaching-physician oversight.

IV. Valuation of Specific Codes, Including Potentially Misvalued Services (Part II.D)

Efficiency Adjustment (*II.D.2.b)*

For CY 2027, where the American Medical Association/Specialty Society RVS Update Committee (RUC) recommended work RVUs based on pre-adjustment crosswalk values, CMS treated the recommendation as though the RUC had recommended the efficiency-adjusted valuation. This converts recommendations downward outside the RUC's stated basis, and it creates a risk that the same codes receive the efficiency adjustment again when the next three-year application occurs. **FAH urges CMS to publish the complete list of CY 2027 codes affected by this treatment and confirm that these codes will be exempt from the next scheduled efficiency adjustment application.**

Valuation of Specific Codes for 2027 (II.D.3.c)
Maternity Care Services (II.D.3.c(27))

In response to the AMA RUC restructuring of maternity coding – changes that would include 17 deleted CPT codes, 12 new CPT codes and nine revised codes describing maternity care services – CMS discusses its interest in considering different approaches to how maternity care codes are valued and paid under the PFS. CMS is seeking comments on the creation of 15 HCPCS G-codes for 2027 that would seek to replicate the existing maternity CPT codes that are being deleted or substantially changed. CMS states that it may finalize this policy after consideration of public comments.

FAH appreciates CMS's efforts to ensure appropriate coding and payment for maternity care as the CPT code set undergoes significant changes for CY 2027. However, FAH is concerned that CMS's proposal to establish 15 new Medicare-specific G-codes would introduce substantial administrative complexity at the same time providers are implementing significant changes to the maternity CPT code family. **Rather than establishing a parallel Medicare-specific maternity G-code framework, FAH urges CMS to maintain alignment with the standardized CPT code set and address any concerns regarding valuation or payment through targeted payment policies or other transition mechanisms. A G-code framework would increase administrative complexity and impose unnecessary coding, claims, and implementation burdens on providers, as discussed further below.**

Medicare-Specific G-Codes Would Increase Administrative Complexity: As the maternity code family undergoes a substantial transition for CY 2027, providers will need to make significant operational changes to implement this new coding structure. Establishing an additional 15 Medicare-specific G-codes would require providers to maintain a separate Medicare coding methodology alongside the revised CPT framework used by other payers. This approach could necessitate additional system configuration, claims edits, coding guidance, staff education, reimbursement logic, audit procedures and payer-specific billing workflows.

Parallel Code Sets Would Increase Claims and Revenue-Cycle Burdens: Maintaining parallel coding structures also creates unnecessary claims and revenue-cycle complexity. Providers would need to determine whether substantially similar maternity services should be reported using a CPT code or Medicare-specific G-code depending on the payer. This increases the likelihood that providers could inadvertently submit a CPT code when Medicare requires a G-code, or vice versa, potentially resulting in claim denials or rejections, manual corrections, appeals, provider inquiries and payment delays. Rather than reducing administrative burden, the proposal could shift that burden to providers' coding, billing and revenue-cycle operations.

CMS Should Promote Standardization Across Payers

A common CPT code set promotes consistency across Medicare, Medicaid, and commercial payers and allows providers to develop uniform coding and billing processes. Creating Medicare-specific G-codes at the same time the maternity CPT family is being modernized would introduce payer-specific variation precisely when greater standardization would be beneficial. The administrative burden could increase further if Medicare, Medicaid, and commercial payers ultimately adopt different approaches to the revised maternity codes.

An Interim G-Code Policy Could Require Providers to Implement Two Coding Transitions

FAH is particularly concerned if CMS intends the proposed G-codes to serve as a transitional solution. Under that approach, providers could be required to undertake two significant implementation efforts: first, implementing the new Medicare G-codes while simultaneously implementing the revised CPT structure for other payers and, subsequently, transitioning Medicare to the revised CPT framework. Each transition would require system configuration, testing, training, payment updates, communications and revised billing guidance. A temporary Medicare-specific solution therefore could impose greater cumulative administrative costs than proceeding with a single, coordinated transition to the revised CPT framework.

Remote Monitoring (RPM/RTM) (II.D.3.c(48))

FAH appreciates CMS's attention to concerns regarding the integrity of remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services and shares CMS's goal of ensuring that RPM and RTM services are medically necessary, properly supervised and clinically integrated into the patient's treatment plan, and improve care and outcomes for patients. CMS appropriately seeks to address Office of Inspector General (OIG) concerns regarding program integrity and inappropriate marketing practices associated with remote monitoring. CMS cites OIG reports describing inappropriate practices such as cold-calling beneficiaries, unnecessary enrollment, and inadequate practitioner oversight. However, these reports identify compliance failures among certain suppliers—not systemic deficiencies inherent to outsourced clinical services. CMS has not demonstrated that third-party clinical staffing is itself associated with program integrity risks or poorer outcomes.

FAH's overarching concern is that the proposed policies are substantially broader than necessary and will have significant adverse consequences for patients. CMS should instead implement narrowly tailored, targeted guardrails to address the identified risks while preserving beneficiary access to legitimate RPM and RTM services that have become an important component of care management and post-discharge care. Specifically, rather than targeting bad actors, the proposal would fundamentally alter the existing predominant delivery model for RTM and RPM, which would result in reduced beneficiary access and increased administrative burden, while discouraging innovation – including centralized monitoring models that provide scalable, multilingual, technology-enabled services – without clear evidence that these restrictions improve program integrity. The proposal also departs from longstanding Medicare 'incident to' principles and fails to recognize the established role of contracted clinical service providers in modern value-based care.

Notably, limiting payment solely to RPM and RTM services furnished by clinical staff employed by practices will effectively eliminate a substantial number of RPM and RTM arrangements that have been carefully structured to comply with CMS regulations and that were designed to extend critical patient care beyond the walls of hospitals to prevent readmissions and acute medical events. The existing regulatory framework under 42 CFR § 410.26, general supervision standards, and the established patient requirement for RPM, already provide robust safeguards against the types of program integrity concerns that CMS and the OIG have identified. CMS should implement guardrails and enforce existing policies rather than impose sweeping new restrictions that penalize compliant providers and their patients alike.

For CY 2027, CMS proposes five changes to the RPM and RTM code families in response to OIG reports on remote patient monitoring:[7]

- Require that RTM services, like RPM services today, be furnished only to established patients.
- RPM or RTM services be initiated by the billing practitioner during a separately reportable face-to-face visit, in person or by telehealth, at which remote monitoring is discussed with the patient.
- Pay for RPM and RTM services only when the clinical staff furnishing them are direct employees of the billing practitioner or the practitioner's practice. Beginning January 1, 2027, time spent by contracted or third-party clinical staff could not be counted toward the codes.
- Crosswalk the direct practice expense (PE) inputs for the set-up and device supply codes to CPT codes 99473, 99474 and 93270 and remove all PE inputs from the six treatment management codes (CPT codes 99457, 99458, 99470, 98979, 98980, and 98981).
- CMS seeks comment on replacing the 17 remote monitoring codes with four monthly G-codes (GRPM1, GRPM2, GRTM1 and GRTM2), each of which would require every service element in every calendar month.

Our comments below address each proposal.

Eliminate Proposed Prohibition on Contracted Clinical Staff

FAH strongly opposes the proposal to pay for RPM and RTM services only when the clinical staff furnishing them are direct employees of the billing practitioner or the practitioner's practice. CMS's stated concern is the outsourcing of monitoring to companies whose staff have little or no relationship with the beneficiary or the care team. The proposal, however, does not distinguish those "bad actor" arrangements from the supervised, clinically integrated contracted programs with which hospitals and health systems partner to provide remote monitoring services for chronic disease management. Rather, it instead relies on the employment status of the clinical staff, which does not measure supervision, integration, or medical necessity.

Medicare has long recognized contracted personnel under "incident to" requirements. Specifically, the "incident to" regulations at 42 CFR § 410.26 historically have focused on physician supervision, responsibility, and integration into the treatment plan. These regulations also define "auxiliary personnel" as "…any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician …" CMS now proposes adding a direct employment requirement without demonstrating why general supervision and practitioner accountability are insufficient for remote monitoring while remaining adequate for many other Medicare services. The proposed direct-employment requirement represents a significant and unsupported departure from longstanding policy.

Hospital Systems Have Developed Clinically Integrated Programs To Furnish Remote Monitoring Services

Many hospitals and health systems, including FAH members, have invested substantial resources in developing arrangements in which they contract with a clinical remote monitoring partner. Many of these contracted monitoring organizations employ licensed nurses, physical therapists, occupational therapists, and respiratory therapists with specialized expertise in remote care. Eliminating these models will reduce rather than improve quality, as demonstrated by studies discussed further below. The contracted partner's clinicians are clinically integrated and work under the billing practitioner's general supervision and in full compliance with the incident-to regulations at 42 CFR 410.26. They have access to patients' electronic health records, participate in care team communications, and escalate concerns directly to the billing and supervising practitioner in accordance with established clinical protocols.

For example, for a patient with congestive heart failure, a hospital without a clinically integrated vendor may only have the capacity to assess the patient's vital signs during periodic office visits—perhaps several times a year—and otherwise rely on the patient to recognize worsening symptoms and contact the hospital. A clinically integrated, experienced contracted partner, by contrast, receives and evaluates the patient's vital signs every day and, through its centralized clinical team and medication-titration protocols, can immediately adjust medications in response to changes without routinely sending the patient back to the physician. In addition, if a patient's weight and blood pressure begin to indicate worsening heart failure, the integrated contracted partner can intervene, in conjunction with the hospital and supervising practitioner, before the patient deteriorates to the point of requiring an emergency department visit or hospitalization. The advantage is an entire platform that provides daily data, dedicated clinical staffing, physician oversight, and the ability to act on that information consistently across a large patient population involving thousands of patients across multiple states—an infrastructure that would be difficult, costly, and inefficient for an individual hospital, especially a small rural hospital, to replicate on its own.

The Proposal Should Distinguish Between Bad Actors and Compliant Providers

The proposal is a blunt instrument that does not differentiate between bad actors with no meaningful clinical relationship, no oversight of the patient's treatment plan, and no integration with the billing practitioner's care team, and hospitals and health systems with robust, supervised, clinically integrated monitoring programs that deliver measurable improvements in patient outcomes. By applying a blanket prohibition, CMS would penalize the compliant providers whose programs exemplify the very model of care that CMS should be promoting.

Notably, many hospitals and health systems do not directly employ certain clinical staff, or those clinical staff are employed by a different entity than the physicians who provide services at the hospital and provider-based clinics. Employment versus independent contractor status should not be a proxy for whether services are medically necessary and provided under a plan of care established by a qualified practitioner who provides the services under the appropriate level of supervision.

Clinical integration, supervision, and accountability are not determined by the employment status of clinical staff. The direct employment requirement is both underinclusive and overinclusive. It may permit poorly integrated employed staff arrangements while prohibiting clinically integrated contractor arrangements in which monitoring personnel have access

to the patient's medical record, routinely communicate with the treating practitioner, follow practitioner-established protocols, and function as part of the patient's care team.

Unintended Consequences for Beneficiaries

We are concerned that this proposal would have significant unintended consequences for Medicare beneficiaries. As discussed above, it would be difficult, costly, and inefficient for an individual hospital, especially a small rural hospital, to replicate on its own these contracted, clinically integrated arrangements. Thus, eliminating these arrangements would not cause hospitals to build their own remote monitoring platforms. Rather, it would force them to discontinue RPM and RTM programs entirely. As a result, beneficiaries, especially those in rural areas, those with chronic conditions who benefit most from continuous monitoring, and those recently discharged who are at highest risk of hospital readmission, will lose access to remote monitoring services that have demonstrably improved their health outcomes.

In our members' experience, RPM and RTM services reduce hospital readmissions, improve chronic disease management, enable earlier clinical intervention when patient conditions deteriorate, and reduce unnecessary emergency department visits, leading to a reduction in total annual cost of care per patient. Studies confirm these trends and demonstrate that technology-enabled care can improve outcomes while reducing Medicare spending and utilization. Peer-reviewed research found that Cadence remote monitoring programs for heart failure, hypertension, and type 2 diabetes reduced total annual health care costs by $1,302 per patient, driven by a 27 percent reduction in hospitalizations, with comparable savings among rural and underserved patients.[8] A separate study of more than 23,000 Medicare beneficiaries with hypertension found a 70 percent relative increase in patients achieving guideline-recommended blood pressure control, again with similar results among rural and underserved populations.[9] Among heart failure patients, RPM combined with medication optimization increased use of guideline-directed medical therapy from 7 percent to 23 percent and generated average savings exceeding $1,000 per patient per month.[10]

Cutting off access to these services through an overly broad prohibition would lead to worse patient outcomes, higher costs to the Medicare program, and increased burden on hospital emergency departments. Moreover, patients who have come to rely on remote monitoring as part of their ongoing care management could experience an abrupt disruption in services, with no guarantee that alternative arrangements can be established in a timely manner.

Numerous hospitals and health systems have developed RPM and RTM programs in partnership with well-established third-party partners with the goal of reaching rural, underserved, and medically complex patient populations that otherwise face barriers to continuous care. In fact, such models have been advanced by CMS, state governments and Congress. For example, State Rural Health Transformation Program plans approved by CMS fund remote monitoring as a rural access strategy, and the House Committee on Ways and Means reported the Rural Patient Monitoring Access Act (H.R. 3108) by a unanimous, bipartisan vote of 39 to 0 in July 2026 to expand remote monitoring in rural areas.

Denying payment to all partnerships between providers and third-party partners would be extremely detrimental to standing up new and necessary RPM and RTM services. This seems directly contradictory to numerous other initiatives where CMS has encouraged partnerships and the adoption of technology to reach patient populations in underserved areas in order to promote continuity of care and prevent more acute and costly inpatient admissions. The longstanding support and investment CMS has provided for RPM and RTM services will be significantly undermined if CMS finalizes such a drastic proposal that would upend years of progress toward compliant adoption of these services for the benefit of patients.

The Existing Regulatory Framework Can Provide The Necessary Guardrails For A More Targeted Alternative Approach

The existing regulatory framework already provides the safeguards necessary to address CMS's concerns, without the collateral damage that a blanket prohibition would cause. The incident-to regulations at 42 CFR § 410.26 already require that auxiliary personnel furnishing services be under the appropriate level of supervision by the billing practitioner. General supervision already requires that the service be furnished under the billing practitioner's overall direction and control, even when the practitioner is not physically present. Additionally, the proposed established patient and initiating visit requirements would further ensure meaningful practitioner involvement at the outset of RPM and RTM services. CMS already possesses robust enforcement tools to address noncompliant actors, including claims audits, prepayment reviews, civil monetary penalties, False Claims Act liability, and program exclusion. These targeted enforcement mechanisms can address the identified problems without penalizing compliant providers and their patients.

FAH Recommends Targeted Alternatives

Rather than a blanket prohibition on contracted clinical staff, FAH urges CMS to pursue a more targeted approach that addresses the identified problems without harming beneficiary access:

- **Target Noncompliant Actors Through Audits**. Rather than prohibiting the use of contracted clinical staff, CMS should use targeted audits and investigations to address the specific patterns of abuse identified by OIG without disrupting compliant monitoring arrangements or beneficiary access.
- **Establish Clinical Integration Standards.** CMS could require contracted clinical staff to satisfy specific clinical integration requirements, including regular communication with the billing practitioner, participation in care team activities and adherence to practitioner-established protocols for escalation and intervention.
- **Strengthen Supervision and Documentation.** CMS could require billing practitioners to maintain and document appropriate supervision and clinical integration of contracted clinical staff furnishing remote monitoring services, ensuring practitioner accountability without dictating providers' staffing models.

Established Patient Requirement for RTM Ensures Practitioner-Patient Relationship, But Should Not Result in Duplicate and Unnecessary Visits

FAH supports CMS's proposal to require that RTM services be furnished to established patients. This requirement aligns with sound clinical practice and ensures that a meaningful practitioner-patient relationship exists before remote therapeutic monitoring is initiated. We believe this provision will help ensure that RTM services are furnished in a clinically appropriate context and note that this requirement is consistent with the existing established patient requirement for RPM services. Yet, this requirement should not be overly broad and should not result in duplicate and unnecessary patient visits, especially post-discharge from a hospital.

Initiating Visit Requirement Is Reasonable to the Extent It Does Not Require Duplicative E/M Visits

Requiring an initiating visit, in person or via telehealth, in connection with the start of RPM or RTM services is a reasonable guardrail so long as it does not result in mandating duplicative E/M visits. Through such a visit, the practitioner can assess whether monitoring is clinically appropriate for the patient and obtain the beneficiary's informed consent.

At the same time, as proposed, the requirement would add an unnecessary visit for the patients most likely to benefit from monitoring: those leaving the hospital. Under the proposal, only a visit furnished by the billing practitioner can serve as the initiating visit. Remote monitoring is often ordered as part of a hospital discharge plan, and the practitioner who furnishes the discharge or transitional care visit is not always the practitioner who will bill the monitoring.

FAH urges CMS to clarify that a hospital inpatient or observation care discharge day management service (CPT codes 99238 and 99239) or a transitional care management service (CPT codes 99495 and 99496) satisfies the initiating visit requirement when RPM or RTM is ordered and discussed with the patient as part of the discharge plan. The same clarification should apply to any other separately payable face-to-face post-discharge visit. CMS also should allow the initiating visit to be furnished by another practitioner in the same group practice as the billing practitioner. Without this clarification, recently discharged patients would need a duplicative office visit before monitoring could begin, delaying monitoring during the period of highest readmission risk and adding cost and burden for beneficiaries and practitioners.

Valuation Changes Need to Be Informed Through the Comment Process (PE Crosswalks and Elimination of PE Inputs)

CMS proposes to crosswalk the direct PE inputs for the set-up codes (CPT codes 99453 and 98975) to CPT code 99473. CMS also proposes to crosswalk the RPM device supply codes (CPT codes 99445 and 99454) to CPT code 99474, and the RTM device supply codes (CPT codes 98976 through 98978 and 98984 through 98986) to CPT code 93270. CMS acknowledges that it lacks information on the typical clinical workflows, devices used, and costs associated with RPM and RTM services and that it has received very little invoice or pricing information. The codes CMS selected as crosswalks describe a different type of service entirely. CPT code 99474 assumes a single patient-owned blood pressure cuff and reading that the patient reports. Remote monitoring patients frequently use more than one connected device, and the supply codes cover the device, data transmission, software, and technical and clinical support for the month. Eliminating PE inputs entirely for these codes would result in payment rates that bear no relationship to the actual resources required to furnish these services. It nonetheless concludes that the current values are inflated. This approach is premature absent reliable, provider-reported cost data. **FAH respectfully requests that significant reductions not be finalized until CMS has evaluated comprehensive provider cost and workflow information developed through this comment process.**

FAH is particularly concerned about the proposal to eliminate PE inputs entirely for the treatment management codes (99457, 99458, 98980, 98981). CMS's assumption that no clinical staff time is involved in treatment management does not reflect the reality of how these services are delivered in hospital-based programs. In our members' experience, clinical staff play a significant and indispensable role in reviewing physiologic data, monitoring alerts, communicating with patients and caregivers, coordinating follow-up actions, documenting clinical activity, and escalating clinically significant findings to the supervising practitioner. Eliminating PE inputs entirely for these codes would result in payment rates that bear no relationship to the actual resources required to furnish these services. FAH respectfully disagrees with CMS's assumption that treatment management services generally do not involve clinical staff time. These activities represent real resource costs associated with furnishing RPM and RTM services.

In fact, the descriptors for treatment management CPT codes 99457 and 99458 expressly describe a "clinical staff/physician/other qualified health care professional time." CMS acknowledged this directly in its CY2020 PFS final rule, which designated 99457 and 99458 as care management services, allowing clinical staff to furnish them under general supervision so that providers could be appropriately reimbursed for the staff time and work that is required.

FAH urges CMS not to finalize these valuation changes until it has gathered sufficient cost and workflow data from providers, as CMS itself has requested in this proposed rule.

Comment Solicitation on Bundled G-Codes (GRPM1, GRPM2, GRTM1, GRTM2)

CMS seeks comment on replacing the 17 remote monitoring codes with four G-codes: a set-up code and a monthly monitoring and management code for RPM and for RTM. The monthly codes would require device supply, at least two days of data transmission, and at least 20 minutes of treatment management with at least one real-time interactive communication, in every calendar month. CMS suggests valuing GRPM2 by crosswalking the work RVU of CPT code 99457 (0.61) and the direct PE inputs of CPT code 99474.

FAH appreciates CMS seeking comment on potential bundled G-codes and acknowledges the goal of reducing administrative burden while ensuring that beneficiaries receive all three service components of RPM and RTM. We support simplifying the remote monitoring code set and ensuring that beneficiaries receive all components of the service. FAH is concerned, however, with certain aspects of the proposed G-code structure. Remote monitoring patients represent a clinically heterogeneous population; some may require more intensive monitoring and communication in certain months (e.g., immediately post-discharge or during a disease exacerbation) and less in others (e.g., during periods of clinical stability). A one-size-fits-all monthly bundle may not accommodate the inherent clinical variability in remote monitoring, including the various conditions treated or devices used for remote monitoring services. Bundling codes, establishing uniform direct PE and work RVU inputs, and requiring that all three service elements be provided each time the codes are billed could result in changes to the provision of RPM and RTM services that are not beneficial to patients.

This proposal seems premature without further data on the possible implications of this transition. The creation and required use of these G-codes could result in excluding clinically appropriate patients whose monitoring needs do not neatly fit a monthly cadence for all three components of the service; forcing unnecessary interactions solely to satisfy billing requirements rather than clinical needs; and undervaluing medically necessary remote monitoring services. **FAH urges CMS to retain the existing codes or, at a minimum, ensure that any bundled code structure retains flexibility for clinical judgment and does not inadvertently narrow the patient population that can appropriately receive these services. Payment policy should support individualized patient care rather than impose uniform utilization patterns.**

Accordingly, FAH urges CMS not to require the use of bundled G-codes. However, to the extent that CMS moves forward with bundled codes, CMS should:

- **Value the bundled codes on provider-reported cost and workflow data for all three components; and**
- **Retain a mechanism for additional treatment management time.**

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211) Conversion to MOD1/MOD2 (II.D.3.b(53))

For CY 2027, CMS proposes to delete HCPCS code G2211, the office/outpatient (O/O) (E/M) visit complexity add-on code and replace it with two claim-line modifiers. Proposed modifier MOD1 would be billable under the same circumstances as G2211 today and valued at 16 percent of the base E/M code, a percentage CMS derived from a utilization-weighted average of G2211's share of base-code value, adjusted for budget neutrality. Proposed modifier

MOD2 would be available exclusively to Shared Savings Program for ACO participants, ACO professionals, and ACO providers/suppliers, and to LEAD Model Participant Providers, valued at 32 percent of the base code. MOD2 would be voluntary, self-applied based on visit complexity and billable for all beneficiaries a participating practitioner treats, whether or not the beneficiary is assigned, aligned, or attributed to the ACO. CMS proposes to carry forward the current limitations on billing G2211 with modifier 25 and seeks comment on whether MOD1 or MOD2 should be billable with modifier 25 when the E/M visit occurs on the same day as a global procedure.[11]

FAH does not object to converting HCPCS code G2211 to a proportional payment modifier, but urges CMS to publish the utilization assumptions, budget neutrality impact, and specialty-level redistribution associated with proposed modifier MOD2 before considering a doubled payment rate available only to ACO participants.
This valuation needs support. CMS proposes that MOD2 pay twice the rate of MOD1 "to better account for the inherent complexity of some visits in the ACO context," citing cognitive work, care coordinator follow-up, and expanded beneficiary access.[12] Those services are tangible, but the Proposed Rule offers no resource data distinguishing a MOD2 visit from a MOD1 visit, and CMS acknowledges that ACO participation alone does not make a visit longitudinal. A doubled rate warrants the same evidentiary support CMS requires when it revalues any other service.

On the interaction with modifier 25, FAH urges CMS not to finalize the Section II.D.3.b(58) 50 percent payment reduction (discussed below) as the E/M service is a separate service that utilizes separate resources that do not replicate services provided for the procedure and should not build new MOD1 and MOD2 billing rules on top of it. If CMS nevertheless finalizes that policy, the MOD1 and MOD2 percentages should be calculated on the unreduced value of the base E/M code so that the two policies do not compound.

E/M Resource Overlap with Global Periods – Modifier 25 Payment Reduction (II.D.3.c(58))

For CY 2027, CMS proposes an MPPR for office/outpatient (O/O) E/M visits billed with modifier 25 by the same physician, or a physician in the same group practice, on the same day as a procedure with a 0-, 10-, or 90-day global period. Under the proposal, the most expensive service furnished that day would be paid at 100 percent, and every other service, surgical or E/M, would be paid at 50 percent.

FAH urges CMS not to finalize the proposed MPPR 50 percent payment reduction for separately identifiable E/M visits furnished on the same day as global procedures. The 25 percent alternative should not be substituted in its place, and the policy should not be extended to inpatient or other E/M visits.

CMS proposed a narrower version of this policy in the CY 2019 PFS proposed rule, limited to 0-day global procedures, and did not finalize it.[13] The CY 2019 comment record, which CMS summarizes in this rule, anticipated the problems with the broader CY 2027 version. Commenters explained that modifier 25 may be appended only when the visit is significant and separately identifiable from the procedure, that the AMA RUC review process already adjusts valuations for costs it considers duplicative, and that CMS had provided insufficient rationale for a 50 percent reduction rather than another amount.

The CY 2027 proposal is broader than the CY 2019 version, reaching 10- and 90-day globals and inviting extension to inpatient E/M, but it rests on the same unquantified premise. CMS states that it is "likely duplicating payment" and acknowledges that the RUC already adjusts for overlap, characterizing those adjustments as minor. The rule contains no code-level analysis measuring the residual overlap the 50 percent reduction is meant to capture, and CMS's request for comment on whether 25 percent "would be more appropriate" confirms that neither figure is derived from resource data.[14]

The PFS pays for the relative resources required to furnish each service, and work RVUs reflect the time, technical skill, mental effort, judgment and liability risk associated with furnishing that service. A visit billed with modifier 25 is, by definition, significant and separately identifiable from the procedure. Although clinical staff, equipment and overhead may be shared within an encounter, the physician's professional work for a separately identifiable visit is not. Reducing payment because two distinct services occur on the same-day departs from the resource-based framework unless CMS demonstrates that the underlying resource requirements of the visit itself have not changed.

The surgical MPPR on which CMS relies was grounded in documented pre-service and post-service efficiencies. FAH is concerned that this proposal borrows the surgical MPPR's percentage without its evidentiary basis. Any sameday efficiencies that do exist are concentrated in shared clinical staff, supplies, equipment and overhead, which the PE methodology already recognizes. Applying a 50 percent reduction to the full payment, including physician work,

assumes that cognitive and professional resources decline in the same proportion. Absent evidence, that approach risks counting the same efficiency twice.

CMS should not use Modifier 25, which is reported when billing for a separate E/M visit, as a solution to a program integrity concern. The visit is separately payable only when it is significant and separately identifiable, and claims that misuse the modifier should be addressed through CMS's existing enforcement mechanisms. Specifically, CMS should use its existing tools, which the agency identifies in the Proposed Rules: distinct claims editing, comparative billing reports and medical review. Where CMS believes the modifier is misused, targeted review of outlier billing reaches the problem directly. An across-the-board 50 percent reduction instead cuts payment for every compliant practitioner who furnishes a medically necessary same-day visit.

Finally, this proposal reaches the same clinicians affected by other proposals in this rule, including the practice expense site-of-service differential and employed-physician RFI (Section II.B.4.d), the indirect practice expense methodology revisions (Section II.B) and the efficiency adjustment finalized in CY 2026 on a three-year cycle. Neither this section nor the rule's impact analysis models the combined effect on physicians subject to several of these policies at once. FAH's comments on Section II.B.4.d address this interaction, and the two sections should be read together.

Software as a Medical Service Laboratory Analyses (II.D.3.c(61))

Payment Policy for Software as a Medical Service (SaMS)

FAH recognizes the growing and valuable role that software-based technologies — including artificial intelligence (AI)-enabled clinical decision support, clinical risk modeling, and computer-aided detection — play in hospital outpatient care. These tools can improve diagnostic accuracy and efficiency, support earlier detection of disease, and help address the workforce and administrative pressures confronting hospitals and health systems. FAH appreciates that CMS, after several years of study and two prior comment solicitations, is taking concrete steps toward a consistent and predictable payment approach for these services and offers the following for consideration.

Change in Terminology from "SaaS" to "SaMS"

FAH does not object to CMS's proposal to replace "Software as a Service (SaaS)" with "Software as a Medical Service (SaMS)." We agree that terminology distinguishing these clinical, medical-function services from general commercial cloud-computing offerings will reduce confusion. Because CMS has stated that the two terms are interchangeable and that existing sub-policies (such as the SaaS add-on code policy) will carry forward unchanged, **we urge CMS to confirm that the change is purely terminological and will not disrupt existing coding, billing, or claims processing for these services.**

Payment Must Reflect the Full Cost of Furnishing SaMS

CMS proposes to treat stand-alone algorithmic analyses performed on previously generated laboratory data as "other diagnostic tests" under Section 1861(s)(3) of the Social Security Act, rather than as clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule (CLFS). On that basis, CMS proposes to remove ten HCPCS codes from the CLFS and contractor price under the PFS, and to assign any future codes describing SaMS analyses performed on laboratory tests to contractor pricing by default. CMS seeks comment on an alternative of crosswalking payment directly to the new technology APC amounts proposed for the same codes in the CY 2027 OPPS proposed rule. As FAH commented on the CY 2027 OPPS proposed rule, we ask the agency to ensure that any such shift maintains payment adequacy and does not create billing or operational disruption for hospitals, and to confirm that the list of affected codes is complete and appropriate.

We urge CMS to maintain current payment for SaMS and ensure that any new payment methodology must be grounded in the full and adequate cost of these services. We are concerned that the PFS reassignment proposal moves these services from the CLFS, which is not budget neutral, into the PFS payment system, which is budget neutral. Any "rightsizing" of SaMS payment should not come at the expense of other PFS services. To the extent CMS implements changes within a budget-neutral framework, FAH urges the agency to ensure that appropriate payment for these emerging services does not force offsetting reductions elsewhere in the PFS. CMS should likewise account for geographic and infrastructure differences so that payment policy supports, rather than widens, the "digital divide" facing rural and underserved communities.

Beneficiary Cost-Sharing Concerns

FAH is concerned about the beneficiary cost-sharing consequences of the reassignment of the ten HCPCS codes from the CLFS to the PFS. CLFS services generally carry no beneficiary coinsurance, while PFS services carry 20 percent cost-sharing. Moving these analyses/codes to the PFS therefore attaches new out-of-pocket liability for beneficiaries. The rule cites the absence of cost-sharing under the CLFS as a limitation of that system but does not analyze the beneficiary impact of adding it.

Separate CLIA Request for Information

We also note that CMS is separately seeking comment on the scope of CLIA regulation through the Clinical Laboratory Improvement Amendments of 1988 RFI published separately from this Proposed Rule.[15] **FAH urges CMS to consider comments in response to the RFI before establishing payment policy under the Proposed Rule.**

V. Proposed Changes to the Ambulatory Specialty Model (ASM) (Part III.D)

General Comments

FAH strongly supports CMS's goals of improving quality, strengthening accountability, engaging specialists in value-based care, and advancing interoperable and standardized systems. However, we urge CMS to consider the cumulative impact of its quality, payment, and value-based care programs on the hospitals, health systems, and medical groups responsible for implementing these requirements. Increasingly, these goals are being advanced through separate programs that apply different requirements based on clinician, specialty, condition, patient population, geographic area, or participation cohort.

The physician practice environment has changed substantially since many Medicare programs were first designed. As CMS recognizes elsewhere in the Proposed Rule, physician employment and consolidation have shifted a growing share of specialists into health system-affiliated and other integrated organizational arrangements. As a result, even when a Medicare requirement applies to an individual clinician or subset of clinicians, implementation often falls to a much larger medical group or health system.

This creates a significant scalability challenge. Hospitals, health systems, and large multispecialty groups generally build common EHR workflows, clinical standards, quality infrastructure, data systems, reporting processes, education, and compliance controls across their clinician populations. When Medicare programs impose different requirements based on specialty, condition, patient cohort, geography, or individual clinician participation, organizations must create exceptions to those standardized systems. The resulting burden is not simply an additive. Each new program may require separate workflows, measures, attribution methodologies, reporting processes, technology configurations, education, and compliance controls that must operate alongside existing requirements. This fragmentation can also undermine efforts to standardize care and reduce unwarranted variation. CMS has itself acknowledged concerns that full implementation of Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) and subgroup reporting may increase reporting burden, particularly for multispecialty groups. Policies that may appear reasonable when evaluated individually can therefore become difficult and costly to implement when multiple programs must operate simultaneously across a large, integrated organization.

FAH urges CMS to evaluate administrative and operational burden at the organizational and cross-program level, rather than solely at the level of an individual program or clinician. Before establishing new mandatory clinician-level, specialty-specific, condition-specific, cohort-specific, or geographically targeted requirements, CMS should assess how those requirements interact with MIPS and MVPs, Innovation Center models, the Medicare Shared Savings Program, Promoting Interoperability, and other applicable Medicare programs. This is particularly important as CMS prepares to implement ASM, a mandatory model that will hold participating specialists accountable for the quality and cost of care beginning January 1, 2027.

CMS should also make cross-program alignment and scalability explicit design objectives by aligning measures, data standards, reporting infrastructure, performance periods, attribution methodologies, and technology requirements wherever possible. Reducing administrative burden requires more than simplifying individual requirements; it also requires reducing the infrastructure necessary to manage an increasingly fragmented set of federal programs. Greater alignment would allow hospitals and health systems to devote more resources to patient care and quality improvement rather than maintaining parallel systems to comply with overlapping federal requirements.

Mandatory Participation

FAH supports CMS's goal of expanding meaningful specialist participation in value-based care. Specialists have historically had fewer opportunities than primary care clinicians to participate directly in models that hold them accountable for quality, utilization and cost. ASM represents an important effort to address that gap by engaging specialists in the longitudinal management of heart failure and low back pain and holding them accountable across quality, cost, improvement activities and Promoting Interoperability.

As detailed in prior comments, including comments on ASM as proposed, on the proposed CJR-X Model, and on the Transforming Episode Accountability Model, **FAH continues to strongly oppose mandatory provider participation in Innovation Center model testing and urges HHS to ensure the Innovation Center acts only within its authority to test voluntary alternative payment models.**[16] Section 1115A authorizes the testing of models and the making of recommendations to Congress. Congress reserved for itself the authority to make permanent or mandatory changes to the Medicare program. Mandating participation transforms the statutorily prescribed fee schedule payment into a performance-contingent payment scheme that Congress did not authorize.

These concerns are particularly applicable to ASM. Where prior mandatory episode model participation has been applied at the hospital level, ASM requires participation by individual physicians, selected by TIN and NPI, with no ability to opt out for the duration of the five-year test period. The payment adjustment applies to all of a participant's Medicare Part B payments for covered professional services, not only to payment for the care of the targeted chronic conditions, so a cardiologist's or orthopedic surgeon's entire Medicare practice is placed at risk based on performance measured for a single condition.[17] In its CY 2026 comments, FAH strongly objected to operating the model at the individual clinician level, because many specialists practice in employed settings where reporting, compliance and administrative responsibilities are managed by the employer, and urged CMS to permit assessment through clinicians' existing group and facility arrangements.[18] The data submission flexibilities proposed in this rule acknowledge that problem but reach only a part of it. Because ASM scores each participant against the other specialists in the cohort, the model is designed to produce negative adjustments for a share of participants in every payment year, even where the cohort improves in absolute terms.

The model also produces savings by construction. CMS states in the CY 2026 PFS final rule that "[t]o ensure savings in the financial impacts for the model, ASM will also retain a percentage of the payments rather than distributing all funds as clinicians' payment adjustments."[19] CMS finalized that mechanism at an 85 percent redistribution percentage: only 85 percent of the incentive pool returns to participants as payment adjustments, and the remaining 15 percent is retained in the Medicare Trust Fund, an estimated 1.35 percent of participants' Part B covered professional service payments at the 9 percent risk level (discussed below) growing as the risk level escalates to 12 percent.[20] CMS estimates $177 million in net Medicare savings from ASM from 2029 through 2033.[21] As with the structural savings FAH identified in its CJR-X comments, savings that flow from a withhold and relative scoring are payment cuts, not evidence that the model improves care.

If CMS nevertheless proceeds with a mandatory model, FAH urges CMS to make ASM participation voluntary for the 2027 and 2028 performance years and begin mandatory participation no earlier than 2029. The model introduces new clinical, operational, data submission and performance requirements, and selected specialists will be subject to financial risk beginning with their first year of participation. A two-year voluntary transition would allow CMS and participating organizations to identify implementation challenges, assess the model's measures and attribution methodologies, and develop scalable workflows before clinicians are required to participate.

A transition period would be particularly appropriate given CMS's own recognition elsewhere in the Proposed Rule that participants may need additional time to prepare for new requirements. For example, CMS proposes delaying the Electronic Prior Authorization measure until the 2028 ASM performance year specifically to provide participants with "time and flexibility" to prepare to report the measure successfully.[22] FAH believes the same principle should apply more broadly to implementation of this new mandatory model.

FAH is also concerned about the operational implications of selecting individual clinicians within a larger medical group or health system for mandatory participation. CMS selects ASM participants using a combination of TIN and NPI and evaluates participants individually across the model's performance categories. However, the EHR workflows, clinical standards, quality improvement infrastructure, reporting systems and compliance processes supporting those clinicians are often developed and operated at the practice, medical group, or health system level.

As discussed in our *General Comments*, selecting only a small number of clinicians within a practice can therefore require an organization to create a separate clinical and reporting pathway for those clinicians while maintaining existing workflows for their colleagues. This approach is difficult to scale and may undermine efforts to standardize care and reduce unwarranted variation.

As CMS implements and considers expanding ASM, FAH urges the agency to account for the organizational setting in which selected clinicians practice. **Participation policies should allow hospitals, health systems and medical groups to leverage existing group-level infrastructure wherever possible rather than requiring separate workflows and reporting processes for small subsets of clinicians.** CMS can preserve appropriate individual accountability while designing implementation requirements that are workable within integrated delivery systems.

Participant Exceptions and Termination

CMS proposes to rename the participant "exclusions" as "exceptions," to extend the TIN-change exception to reassignment changes that occur before the start of a performance year (with written notice to CMS within 60 days of the start of that year), to remove the requirement that a participant reassign to a new TIN during the same performance year to qualify, and to except heart failure participants who redesignate their primary specialty to one of five specified cardiac specialty types and demonstrate board certification. CMS also proposes authority to terminate a participant's model participation where grounds for remedial action exist.

FAH supports the proposed revision to the TIN-change exception and the proposed exception for heart failure participants who redesignate to a more specialized cardiac specialty type. These changes acknowledge that a five-year mandatory commitment does not fit the reality of physician practice, in which employment arrangements or group affiliations and clinical focus change.

CMS declines to propose a redesignation exception for the low back pain cohort on the rationale that its specialty types do not have Medicare specialty designations reflecting further specialization. But the mismatch CMS identifies for cardiology exists in the low back pain cohort, as well. An orthopedic surgeon whose practice shifts away from spine care, or an anesthesiologist whose involvement in low back pain care is procedural and who does not manage ongoing care decisions the model's quality measures assess. FAH urged CMS to exclude anesthesiologists from the low back pain cohort before the model was finalized.[23] **FAH renews its request that CMS exclude anesthesiologists from the low back pain cohort and urges CMS to adopt a comparable redesignation off-ramp for other low back pain participants whose practice composition materially changes, along with a general hardship exception available to any ASM participant, with criteria and a notice process specified in the final rule.**

FAH does not oppose the proposed termination authority, but urges CMS to provide written notice, an opportunity to respond, and a reconsideration process before a termination takes effect, and to specify the payment consequences that follow for a terminated participant. FAH also supports CMS' proposal to apply the limits on safe harbor availability prospectively from the date CMS determines an exception applies, so that remuneration properly exchanged under a collaborative care arrangement is not retroactively exposed.

ASM Performance Threshold and Benchmarking

FAH urges CMS to establish a clear performance threshold under ASM below which negative payment adjustments would apply, rather than determining both positive and negative adjustments solely through relative performance within an ASM cohort. Under the finalized ASM methodology, participants are scored on a zero-to-100-point scale, and payment adjustments are based on performance relative to other specialists treating the same targeted condition.
Relative benchmarking can appropriately distinguish performance among participants and determine the magnitude of positive incentives. However, in a mandatory model with substantial downside risk, clinicians should also have a clear and predictable standard that allows them to know whether their performance is sufficient to avoid a penalty. When performance within a cohort is tightly clustered, an intracohort approach can result in a high-performing clinician receiving a negative payment adjustment simply because other clinicians performed slightly better.

FAH, therefore, recommends that CMS establish a 75-point performance threshold for avoiding a negative ASM payment adjustment, consistent with the threshold CMS continues to use under MIPS. Under MIPS, a score of 75 corresponds to a neutral payment adjustment, and CMS proposes no change to that threshold for the CY 2027 performance period. CMS could continue to use intracohort benchmarking above that threshold to differentiate performance and determine positive payment adjustments while ensuring that participants who meet an established performance standard are not penalized solely because of their relative position within a high-performing cohort.

At a minimum, CMS should apply the 75-point threshold during the initial ASM performance years and evaluate actual model performance before determining whether a different methodology is warranted. Doing so would provide greater predictability during implementation without preventing CMS from using relative performance to reward higher-performing participants.

Low Back Pain Quality Measure Set and Scoring

CMS proposes several changes to the ASM low back pain quality measure set. Specifically, CMS proposes to add the Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain (modified for ASM) measure, remove the Functional Status Change for Patients with Low Back Pain Impairments measure (MIPS 220), and replace it with the Functional Outcome Assessment measure (MIPS 182). CMS also proposes to calculate administrative claims-based quality measures at the individual TIN/NPI level and to exclude required quality measures from the quality performance category score when CMS is unable to calculate a benchmark. The ASM quality measure framework is intended to assess individual specialist performance across the model, and CMS proposes individual-level scoring for administrative claims-based measures to preserve that focus.

FAH supports removal of MIPS 220 and its replacement with MIPS 182. We agree with CMS that functional assessment is an important component of patient-centered care for individuals with low back pain. 182 promotes routine assessment of functional status and requires development of a care plan when functional deficiencies are identified, helping incorporate patients' functional limitations and experiences into clinical decision-making.

However, FAH remains concerned about the reporting requirements associated with 182. Like 220, 182 is currently available as a MIPS clinical quality measure (CQM). For hospitals and health systems that rely primarily on electronic quality reporting, requiring a CQM for a small number of clinicians selected for ASM may require establishment of a separate data collection and submission pathway. As discussed in our General Comments, this type of clinician-specific reporting requirement can create a disproportionate operational burden when the supporting EHR, quality and reporting infrastructure is managed at the medical group or health system level. FAH therefore urges CMS to develop an electronic specification for 182 or otherwise provide an electronically reportable option as soon as practicable.

FAH has more significant concerns with CMS's proposal to add the modified MRI Lumbar Spine for Low Back Pain measure. CMS explains that the measure is intended to address excess utilization and efficiency within the low back pain quality measure set. However, the measure specifications and testing results necessary to evaluate its validity, reliability and usability are not readily available.

Throughout its discussion of the measure, CMS describes several methodological modifications intended to increase the number of attributed cases, including changes to exclusions, a longer measurement timeframe, attribution to multiple participants, a 20-case minimum and a 365-day lookback period. While increasing denominator size may improve statistical reliability, FAH is concerned that measure design must also preserve the ability of clinicians to receive timely, actionable information that can be used to improve care. A measure may produce a statistically reliable score while providing little meaningful opportunity for a clinician or organization to identify performance issues and intervene.

FAH, therefore, urges CMS to publish the complete measure specifications, testing results and analyses necessary for clinicians and other interested parties to evaluate whether the revised measure appropriately balances reliability and validity with actionability and opportunities for improvement. Until this information is publicly available and demonstrates that the measure is appropriate for accountability purposes, FAH does not support including the modified MRI Lumbar Spine measure in ASM.

Scoring & Benchmarks for Quality Measures

CMS proposes to specify the level at which it would calculate administrative claims-based quality measures at the individual level to ensure that performance assessment reflects the individual ASM participant performance regardless of eligibility to report quality measures at the group level. CMS also proposes to exclude any required quality measure for which they cannot calculate a benchmark in the determination of an ASM participant's ASM quality performance category score by removing the total measure achievement points and the total available measure achievement points from the quality ASM performance category score calculation.

FAH strongly objects to CMS's proposal to calculate ASM administrative claims-based quality measures at the individual TIN/NPI level. This concern applies both to the Risk-Standardized Acute Unplanned Cardiovascular-Related Admission

Rate for Patients with Heart Failure (MIPS 492) and the newly proposed MRI Lumbar Spine for Low Back Pain measure. CMS states that administrative claims-based measures do not require participants to submit data, and that individual-level calculation would preserve ASM's intended focus on individual specialist accountability. However, individual accountability is appropriate only when the resulting score is sufficiently reliable and valid to distinguish performance among clinicians.

For MIPS 492, the most recent reliability testing conducted for endorsement review was performed at the TIN level in 2021. Even at that more aggregated level, the measure did not produce sufficiently reliable scores for most clinician groups. The analysis produced a median signal-to-noise reliability of 0.183 and indicated that approximately 21 to 32 patients with heart failure were needed simply to achieve reliability between 0.4 and 0.5. At the lower 21-case threshold, only 23.9 percent of TINs had sufficient volume to achieve reliability of at least 0.4. These results fall well below the reliability level of at least 0.7 that FAH believes should be required for quality measures used for accountability and payment purposes. If most TINs could not achieve adequate reliability, scoring the measure at the individual NPI level raises even greater concerns and would likely require substantially higher case minimums than the 20 cases contemplated under ASM.

The concern is even more fundamental for the proposed low back pain imaging measure. CMS has not made available the reliability testing demonstrating that this new measure can produce valid and reliable results at the TIN level, NPI level or another level of analysis. CMS should not hold individual specialists financially accountable for performance on a measure until the agency has demonstrated through publicly available testing that the measure can reliably distinguish performance at the level at which it will be scored.

Individual-level scoring also fails to account for the team-based and employer-administered nature of specialty care. Outcomes such as unplanned cardiovascular admissions among patients with heart failure and appropriate imaging for low back pain are influenced by care provided across multiple clinicians and settings, including primary care practices, hospital-based teams and other members of the care team. Hospitals and health systems often manage the clinical standards, care coordination processes, EHR tools, data analytics and quality improvement infrastructure that support this care. Assigning these outcomes to a single NPI may therefore hold an individual specialist accountable for factors that are substantially outside that clinician's direct control.

This concern is particularly significant in a mandatory model. CMS selects ASM participants at the TIN/NPI level and applies performance assessment and payment adjustments to individual selected clinicians. Applying statistically unstable outcome measures at that same level could also create unintended incentives for clinicians to avoid higher-acuity or medically complex patients when a small number of outcomes can materially affect an individual score.

FAH, therefore, urges CMS to calculate ASM administrative claims-based quality measures at the TIN level and only when the measure achieves reliability of at least 0.7. CMS should not finalize individual NPI-level scoring for MIPS 492 until it has conducted and published NPI-level reliability testing comparable to the prior TIN-level analysis. CMS likewise should not finalize individual-level scoring for the proposed MRI Lumbar Spine for Low Back Pain measure until it has published complete measure specifications and reliability and validity testing demonstrating that the measure is appropriate for accountability at the proposed level of analysis.

Rural Scoring Adjustment

CMS proposes to add five points to the final score of an ASM participant in a rural area, as defined for MIPS at 42 CFR 414.1305, who meets the requirements to receive a final score greater than zero. **FAH supports the proposed rural scoring adjustment.** It is a recognition that rural specialists face structural disadvantages in a cohort-relative scoring model: lower volume, fewer resources, and patient populations that differ from the cohort mean.

Five points on a 100-point scale do not, however, address the underlying exposure. A rural cardiologist or spine surgeon still faces a downward payment adjustment that reaches 12 percent of all Part B revenue, determined by comparison to a national cohort dominated by higher-volume urban practices. In its CY 2026 comments, FAH warned that the model's cost emphasis and financial consequences could push needed specialists away from rural hospitals, critical access hospitals, and rural emergency hospitals, and FAH has consistently urged the exclusion of rural and low-volume providers from mandatory models, most recently in its comments on TEAM and the proposed CJR-X Model.[24] **FAH urges CMS to exclude clinicians in rural areas from mandatory ASM participation or, at minimum, to exempt them from downside risk.**

Collaborative Care Arrangements

CMS proposes to permit multiple ASM participants billing under the same TIN to be parties to a single collaborative care arrangement with a primary care practice, to remove the requirement that the shared patient be an "established" patient, and to clarify the treatment of remuneration exchanged under an arrangement. **FAH supports these changes, which reduce administrative burden for group practices.** They do not, however, cure the underlying concern. In its CY 2026 comments, FAH opposed requiring specialists to enter into collaborative care agreements at all, because a mandate creates an unequal negotiating environment in which primary care practices know specialists are compelled to contract, and recommended that CMS remove the requirement.[25] **FAH renews its recommendation that CMS make collaborative care arrangements voluntary; improvement activities should encourage collaboration without mandating contractual obligations.**

Payment Approach

CMS finalized the overall ASM payment methodology in the CY 2026 PFS final rule. Under that approach, CMS will apply performance-based payment adjustments to all Medicare Part B covered professional services furnished by an ASM participant during the applicable payment year, based on the clinician's performance in the corresponding performance year. CMS will determine the adjustment by comparing final scores among participants within each ASM cohort and applying an ASM payment multiplier derived from the distribution of those scores. The model begins with a two-sided risk of up to 9 percent in the 2027 and 2028 performance years, increasing gradually to 12 percent by the 2031 performance year. In this Proposed Rule, CMS does not propose substantive changes to the level of financial risk but proposes technical clarifications regarding how payment adjustments follow an ASM participant when the clinician changes TIN affiliations.

FAH urges CMS to reconsider the finalized payment approach and adopt a more gradual phase-in of downside risk under ASM. Although the maximum adjustment increases over time, beginning a new mandatory model with potential downside exposure of 9 percent does not provide participants with a meaningful transition period. This concern is heightened because the adjustment applies to all Medicare Part B covered professional services furnished by the participant, not only services related to the heart failure or low back pain condition for which the clinician is participating in ASM.

This level of initial risk is particularly concerning because selected clinicians will have no prior experience with ASM's attribution methodology, quality measures, reporting requirements, scoring methodology or payment calculations before performance begins. Hospitals and health systems may likewise need to make significant investments in clinical workflows, EHR configurations, data collection, and reporting infrastructure to support a relatively small subset of clinicians selected for participation.

FAH, therefore, recommends that CMS begin ASM with a substantially lower maximum negative payment adjustment and phase in downside risk over several performance years as CMS and participants gain experience with the model. At a minimum, CMS should not subject participants to the full 9 percent maximum negative adjustment in the first performance year. A lower initial downside limit would preserve meaningful financial accountability while allowing CMS and participants to identify and address implementation problems before those problems result in significant payment reductions.

A slower transition is particularly important because ASM's reporting requirements can trigger the maximum negative adjustment. CMS finalized a policy under which an ASM participant who fails to satisfy the model's minimum data submission requirements receives a final score of zero, which results in the maximum negative payment adjustment for the corresponding payment year. By contrast, a participant who satisfies the submission requirements but cannot be evaluated on quality and cost receives a neutral adjustment. This creates substantial financial risk during the model's early years, when organizations will be establishing new reporting processes while CMS is simultaneously refining ASM's measures and other model requirements.

The proposed changes to the low back pain quality measure set illustrate this concern. As discussed above, CMS proposes to replace MIPS 220 with MIPS 182 and add a new administrative claims-based MRI Lumbar Spine measure. These changes raise unresolved questions regarding reporting infrastructure, measure reliability and the level at which performance should be assessed. Participants should not face the model's maximum downside adjustment while CMS and participating organizations are still gaining experience with requirements that may materially affect the clinician's final score.

CMS should not pair a new mandatory model and evolving quality and reporting requirements with substantial first-year downside risk. FAH urges CMS to establish a meaningful transition period with lower initial downside exposure and increase financial risk only after CMS has evaluated early model experience, addressed implementation challenges and demonstrated that the measures, attribution and scoring methodologies operate as intended.

If CMS proceeds with this mandatory model, FAH urges CMS to minimize any downside risk, limit the adjustment to claims included in the targeted heart failure and low back pain episodes, raise the ASM redistribution percentage from 85 percent to 100 percent so that model savings reflect improved care rather than a withhold, and publish the evaluation criteria that would justify any future escalation of risk.

VI. Medicare Shared Savings Program (Part III.G)

Beneficiary Assignment Methodology

CMS proposes to revise the Medicare Shared Savings Program (MSSP) claims-based beneficiary assignment methodology beginning in PY 2028. Under the current methodology, CMS considers allowed charges for primary care services furnished by an accountable care organization (ACO) professional whether those services are billed through an ACO participant TIN or a non-ACO TIN when determining which ACO or other entity provided the plurality of a beneficiary's primary care services. CMS proposes to exclude the plurality calculation allowed charges for primary care services furnished by an ACO professional when those services are billed through a non-ACO TIN. CMS states that this change is intended to reduce the potential for differences in an ACO professional's billing patterns inside and outside the ACO to affect assignment outcomes. The revised methodology would apply beginning January 1, 2028, and CMS acknowledges that the change could result in additional beneficiaries being assigned to ACOs.

FAH supports CMS's efforts to improve the accuracy and transparency of beneficiary assignments. However, because the proposed change could materially alter an ACO's assigned population, ACOs need sufficient information before implementation to understand and prepare for its effects.

FAH, therefore, recommends that, no later than the end of the second quarter of 2027, CMS provide ACOs with an impact file or assignment indicator identifying beneficiaries whose assignment would change specifically as a result of the proposed exclusion of non-ACO TIN claims from the plurality calculation. Providing this information prospectively would allow ACOs to assess changes in their assigned populations and understand the potential effects on beneficiary characteristics, illness burden, expenditures and quality improvement opportunities before assuming accountability for those beneficiaries in PY 2028. This advance information would also support a more orderly transition and allow ACOs to appropriately plan their care management and other population health activities.

Quality Performance Standard and Other Quality Reporting Requirements

CMS proposes several changes to quality reporting and scoring for Shared Savings Program ACOs. Most notably, beginning in PY 2027, CMS proposes to establish Medicare electronic clinical quality measures (eCQMs) as a new quality reporting option. Under this approach, ACOs could report the five Medicare eCQMs in the APP Plus quality measure set or use a combination of eCQMs, MIPS CQMs, Medicare CQMs and Medicare eCQMs to satisfy Shared Savings Program quality reporting requirements. Unlike traditional eCQMs, which generally require all-payer/all-patient reporting, Medicare eCQMs would focus on measurement of the Medicare population.

FAH strongly supports establishing Medicare eCQMs as an additional quality reporting option for Shared Savings Program ACOs and urges CMS to finalize this proposal. Aligning the measured population with the Medicare beneficiaries for whom an ACO is accountable preserves the benefits of electronic clinical quality measurement while reducing the significant complexity associated with aggregating and reconciling all-payer, all-patient data across multiple EHRs and TINs. This approach better aligns the reporting burden with the population for which ACOs are financially and clinically accountable. FAH encourages CMS to maintain Medicare eCQMs as a permanent reporting option.

CMS also proposes to use flat benchmarks for Medicare eCQMs beginning in PY 2027 and to extend the use of flat benchmarks for Medicare CQMs beyond their first two performance periods. CMS states that flat benchmarks provide greater predictability, allow high-performing ACOs to earn maximum or near-maximum achievement points, and avoid a "tournament" approach in which ACOs must continually outperform other high-performing ACOs to receive strong quality scores.[26] For Medicare CQMs, CMS further proposes to apply flat benchmarks retroactively in PY 2026, including for Quality IDs 001,134 and 236.

FAH supports the use of flat benchmarks for Medicare CQMs and Medicare eCQMs. Flat benchmarks provide ACOs with a clear and predictable performance target and appropriately reward high-quality performance while preserving opportunities for continued improvement.

However, FAH does not support CMS's proposal to retroactively change the benchmarking methodology for Quality IDs 001,134 and 236 for PY 2026. Regardless of whether CMS anticipates that the change would improve ACO quality scores, changing the methodology after the performance year is already well underway creates an inappropriate precedent. ACOs should know the standards against which their performance will be evaluated before a performance period begins so they can incorporate those standards into their quality improvement strategies and appropriately direct clinical and operational resources.

FAH, therefore, urges CMS to apply the proposed flat benchmark methodology prospectively rather than retroactively for these measures. Going forward, CMS should publish applicable quality benchmarks sufficiently in advance of each performance year and periodically evaluate the effects of those benchmarks on ACO quality scores and eligibility for shared savings. This approach would provide ACOs with greater predictability while allowing CMS to monitor whether its benchmarking policies appropriately distinguish performance and support continued quality improvement.

Financial Methodology

CMS proposes several changes to the Shared Savings Program's benchmarking and financial methodology, applicable to agreement periods beginning on or after January 1, 2027. FAH supports the following proposals:

- **Increasing the shared savings rate under Level E of the BASIC track from 50 percent to 60 percent.** Narrowing the differential between Level E and the ENHANCED track allows ACOs to remain in two-sided risk at a level matched to their readiness, rather than advancing to higher levels of risk prematurely.
- **Increasing the prior savings adjustment scaling factor from 50 percent to 75 percent.** The current 50 percent factor penalizes ACOs at rebasing for their own prior success in reducing expenditures and weakens the incentive to continue participation into subsequent agreement periods.
- **Risk adjusting the 5 percent cap on upward adjustments to the historical benchmark by Medicare enrollment type.** FAH supported the creation of the population adjustment in its comments on the CY 2025 proposed rule. Risk adjusting the caps extends the same principle, allowing adjustments to reflect the severity and case mix of each ACO's assigned population while preserving its function as a safeguard against outlier adjustments.
- **Establishing a growth adjustment to the historical benchmark.** Rewarding ACOs that expand their assigned populations is consistent with CMS's goal of growing participation in accountable care relationships. FAH urges CMS to publish the incentive factor methodology and projected ACO-level impacts in the final rule so that ACOs can evaluate the adjustment before making participation decisions.

VII. Updates to the Quality Payment Program (Part IV)

MIPS Value Pathways

CMS proposes that beginning with the CY 2029 performance period/2031 MIPS payment year, all MIPS eligible clinicians, other than clinicians reporting through the APM Performance Pathway, would be required to report through a MIPS Value Pathway (MVP). CMS estimates that approximately 98 percent of MIPS eligible clinicians would have an MVP available based on specialty designation and MVP topic, while acknowledging that some clinicians may still lack applicable measures or a sufficient number of measures to report successfully. CMS also proposes to permit Virtual Groups to report through MVPs beginning in CY 2029.

FAH strongly opposes finalizing the proposed sunset of traditional MIPS beginning in PY 2029. Before requiring MVP reporting, CMS must demonstrate that clinicians across all specialties have access not merely to an MVP by name, but to an MVP that contains a sufficient number of clinically relevant, reportable and reliably benchmarked measures. FAH urges CMS to maintain traditional MIPS and continue to allow voluntary MVP reporting until the significant gaps and unresolved structural concerns identified below are addressed.

The MVP Portfolio Does Not Yet Provide Complete Specialty Coverage

FAH urges CMS to ensure that 100 percent of specialties have access to an appropriate MVP before mandatory reporting is finalized. Even with the three additional MVPs proposed for CY 2027, important gaps remain. For example, clinicians specializing in allergy and immunology still lack a relevant MVP. We are therefore concerned that CMS's estimate that approximately 98 percent of MIPS eligible clinicians would have access to an MVP overstates the practical readiness of the current portfolio.

To assess the potential effect of eliminating traditional MIPS, FAH compared existing MIPS specialty measure sets with the proposed and finalized MVPs. This analysis identified significant gaps in specialty coverage, measure availability and clinical relevance that should be addressed before CMS establishes a mandatory transition.

Existing MVPs Are Too Narrowly Defined to Support Meaningful Reporting for Many Specialties

Several MVPs are narrowly defined in ways that limit a specialty's ability to identify and report relevant quality measures. For example, the Improving Care for Lower Extremity Joint Repair MVP targets hip and knee replacement surgeries only, which would require orthopedic surgeons who specialize in other areas – such as hand, shoulder, or sports medicine – to identify another applicable MVP. Unfortunately, the alternative, the Surgical Care MVP, includes only three general surgery measures, four cardiothoracic measures, and three lumbar spine measures, leaving these surgeons with extremely limited reporting options.

The Prevention and Treatment of Infectious Disorders including Hepatitis C and HIV MVP presents a similar problem: it includes three measures on HIV, two on Hepatitis C, and one on upper respiratory infection, but no measures addressing other conditions highly relevant to infectious disease practice, such as sepsis or pneumonia. This again demonstrates the lack of a comprehensive measure set through which an infectious disease specialist can meaningfully report.

These examples also illustrate a further challenge: even when an applicable MVP exists, the number of clinically meaningful measures within it is often insufficient. The current minimum number of quality measures that must be reported is four, yet most MVPs do not include four meaningful measures for a given condition or procedure. For example, the Gastroenterology Care MVP would include only two measures related to colonoscopy if measures 320 (Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients) and NHCR4 (Repeat Screening or Surveillance Colonoscopy Recommended Within One Year Due to Inadequate Bowel Preparation) are removed from the program as proposed, along with three measures on Hepatitis C and one on inflammatory bowel disease. The lack of a comprehensive measure set for each condition and procedure will force clinicians to select measures that do not reflect their actual scope of practice, which exacerbates the ongoing challenge with this program: namely, that quality reporting is completed to satisfy reporting requirements rather than to drive quality improvement or provide useful information about the quality of care furnished to patients.

Mandatory MVP Reporting Would Substantially Narrow Clinicians' Measure Selection Compared to Current Specialty Sets

FAH's analysis also demonstrates that mandatory MVP reporting would substantially reduce the number of quality measures available to many clinicians compared with current specialty measure sets. While CMS has described MVPs as a way to make MIPS more clinically meaningful, narrowing the available measure pool may have the opposite effect when clinicians lose access to measures that better reflect their scope of practice.

The current MIPS specialty measure sets provide a considerably wider array of measures from which a clinician can select than the applicable MVP or MVPs for that specialty. For example, internal medicine currently has 52 measures available within its specialty set, compared to the two MVPs identified as most applicable to that specialty – Value in Primary Care (12 measures) and Advancing Care for Heart Disease (18 measures) – combined. Only 17 measures overlap between the specialty set and those two MVPs, meaningfully narrowing the pool of measures from which internal medicine clinicians could select. The table below illustrates this same pattern across several additional specialties.

Specialty	Current Specialty Set	Applicable MVP(s)
Internal Medicine	52 measures	12 (Value in Primary Care) + 18 (Advancing Care for Heart Disease) – 17 overlaps with the specialty set
Family Medicine	59 measures	19 measures across the Value in Primary Care and Advancing Care for Heart Disease MVPs
Orthopedic Surgery	21 measures	7 measures in the Improving Care for Lower Extremity Joint Repair MVP (hip/knee replacement only)
Urology	21 measures	8 measures in the Optimal Care for Patients with Urologic Conditions MVP
Otolaryngology	19 measures	7 measures in the Quality Care for the Treatment of Ear, Nose, and Throat Disorders MVP

These examples demonstrate that the existence of an applicable MVP does not necessarily provide clinicians with equivalent or sufficient measure choice. A mandatory transition would reduce clinicians' flexibility to select measures that reflect their practice and quality improvement priorities. This concern is compounded by the limited number of cost measures available within many MVPs. Before eliminating traditional MIPS, CMS should evaluate not only whether an MVP exists for a specialty, but also whether it provides a sufficient range of clinically relevant, reportable and reliably benchmarked measures for the clinicians expected to use it.

Operational Readiness for Mandatory MVP Reporting

The gaps in specialty coverage and measure choices are compounded by broader implementation concerns. Voluntary MVP participation is inherently self-selecting and may disproportionately reflect clinicians and organizations that already have appropriate measures, technology and reporting infrastructure. CMS should therefore not rely on voluntary MVP adoption as evidence that the broader MIPS population is prepared for mandatory participation.

Before eliminating traditional MIPS, FAH urges CMS to publish actual MVP participation and successful reporting rates by specialty, participation type and practice characteristics and establish objective readiness criteria demonstrating that clinicians across specialties have a reasonable opportunity to participate successfully. CMS should evaluate these criteria annually and allow actual participation and readiness data, rather than a predetermined date, to guide any transition to mandatory MVP reporting.

CMS should also evaluate readiness at the organizational level. Hospitals, health systems and large multispecialty groups may be required to support many MVPs simultaneously, each with different measures, workflows, reporting methods, registries, vendor configurations and audit requirements. Although an individual MVP may appear simpler than traditional MIPS when considered alone, the cumulative burden across a large clinician enterprise can be substantially greater.

FAH is also concerned about reliance on proprietary QCDR measures within MVPs. Specialty-specific QCDR measures can fill meaningful measurement gaps, but they should not become a practical prerequisite for participation in a mandatory federal reporting pathway. Large multispecialty organizations cannot reasonably be expected to contract with numerous specialty-specific QCDRs or incur significant licensing costs solely to ensure that individual clinicians have access to measures necessary for successful MVP reporting.

If proprietary QCDR measures are needed to make an MVP viable, CMS should ensure that those measures are available on reasonable, standardized, and nondiscriminatory terms. CMS should also evaluate whether sufficient nonproprietary reporting options are available before concluding that clinicians have meaningful access to an MVP.

Fundamental Structural Concerns with MVPs Remain Unresolved

As FAH has stated in comments on prior PFS proposed rules, we remain concerned that the current MVP structure has not yet demonstrated that it reduces burden and complexity or allows clinicians to make meaningful connections across quality, cost, improvement activities and population health measures.

Before mandating MVP reporting, CMS should demonstrate how MVP scoring affects clinicians' ability to meet the MIPS performance threshold; evaluate whether the combined quality, cost and population health measures meaningfully

represent value; identify and mitigate circumstances in which the same clinician or group could receive materially different payment outcomes under an MVP than under traditional MIPS; and coordinate the MVP transition with other major reporting changes, including CMS's planned transition to digital quality measurement.

CMS should also continue to evaluate whether MVPs can serve as a meaningful glidepath toward alternative payment models, rather than simply replacing one reporting structure with another.

These concerns are especially important because experience with MVP reporting remains limited. Additional performance years are needed to understand how clinicians select measures, how scoring functions across MVPs and specialties, and whether the program produces consistent and meaningful results before traditional MIPS is eliminated.

MVP Registration and MIPS Eligibility

CMS requires MVP participants to register for the MVP they intend to report prior to data submission. As CMS moves toward mandatory MVP reporting, registration requirements will have greater consequences for clinicians whose MIPS eligibility or organizational affiliation changes after the registration period.

FAH urges CMS to establish a supplemental registration or exception process for clinicians who become MIPS eligible, are newly licensed, or change TIN affiliation after the standard MVP registration deadline. Clinicians should not be prevented from successfully participating in MIPS because their eligibility or organizational affiliation was not established in time to complete registration.

Virtual Groups in MVP Reporting

CMS proposes to permit Virtual Groups to report through MVPs beginning in the CY 2029 performance period, the same year CMS proposes to make MVP reporting mandatory.

FAH urges CMS to provide Virtual Groups with at least one voluntary performance year before requiring MVP reporting. As proposed, Virtual Groups would have no opportunity to test MVP reporting, identify data or workflow problems or correct implementation issues before payment is at risk.
CMS should either make MVP reporting available to Virtual Groups beginning in PY 2028 or delay mandatory MVP reporting for Virtual Groups until they have had at least one full year of voluntary experience.

MIPS Quality Performance Category

CMS proposes several changes to the MIPS quality performance category beginning with the CY 2027 performance period. Among other changes, CMS proposes to establish MIPS Core measures in traditional MIPS and MVPs, replace the current requirement to report an outcome or high-priority measure with a requirement to report at least one applicable Core measure, establish an attestation process when no Core measure is applicable, remove the high-priority measure designation, and make numerous additions, removals and substantive changes to the quality measure inventory.

MIPS Core Measures and Topped-Out Measures

CMS proposes that, beginning with the CY 2027 performance period, clinicians reporting through traditional MIPS or an MVP generally report at least one applicable MIPS Core measure. CMS also proposes additional scoring protection for certain Core measures that have been topped out for two or more consecutive years.

FAH generally supports CMS's efforts to establish a smaller set of meaningful Core measures and supports providing scoring protection when a required or strongly preferred Core measure is topped out. However, FAH urges CMS to clarify that every reported and scored Core measure meeting the applicable topped-out criteria is eligible for the defined topped-out benchmark, including when a clinician or group reports more than one Core measure during the same performance year.

The protection should not be limited to the single measure used to satisfy the minimum Core measure reporting requirement. Measures can remain clinically important even when performance is consistently high, particularly where clinicians within a specialty have few meaningful alternatives.

FAH also urges CMS to continue evaluating clinically important measures affected by limited measure choice for treatment under its topped-out measure policy. Clinicians should not be disadvantaged because the available specialty measure inventory leaves them with a small number of clinically applicable measures that have become topped out.

Quality Measure Inventory Updates and Implementation Time

CMS proposes numerous changes to the MIPS quality measure inventory for CY 2027, including new measures, measure removals, and substantive changes to existing measure specifications.

FAH supports maintaining a clinically meaningful and current quality measure inventory. However, CMS must provide sufficient implementation time when measure specifications require changes to clinical workflows, EHR configuration, data capture or reporting systems. Hospitals, health systems and medical groups frequently depend on EHR vendors, registries and other technology partners to implement and test these changes.

Final specifications are often available too close to the beginning of the performance year to allow adequate development, testing, and validation. FAH urges CMS to work toward providing two years' advance notice for material quality measure changes, including substantial specification changes, additions, removals and changes to MVP measure sets. At a minimum, final specifications requiring meaningful technology or workflow changes should be available sufficiently before the applicable performance period for organizations and their vendors to implement and validate the requirements.

MIPS Improvement Activities Performance Category

CMS proposes to add, modify, and remove improvement activities for the CY 2027 performance period. Among the proposed modifications is IA PSPA16, which would incorporate AI-enabled clinical decision support and related safeguards, monitoring, evaluation, and mitigation activities.

FAH supports CMS's interest in promoting safe and effective clinical decision support. However, CMS should provide greater clarity before clinicians are expected to attest to a quality improvement activity involving AI-enabled functionality.

CMS should clarify whether use of AI-enabled decision support is required to satisfy the revised activity or whether non-AI clinical decision support, standardized protocols, order sets and other established clinical decision-support tools remain sufficient. If CMS intends to require AI-enabled functionality, it should clearly identify what qualifies, the documentation expected, how performance should be monitored, and what safeguards providers must demonstrate.

CMS must also account for circumstances in which AI functionality is embedded in an EHR or another technology platform, and the hospital, health system or physician practice does not control the underlying model, training data or technical modifications. Providers should not be required to attest to safeguards or technical characteristics that are outside of their ability to evaluate or control.

MIPS Promoting Interoperability Performance Category

Certified Electronic Health Record Technology Requirements

CMS proposes several modifications to the definition of certified electronic health record technology (CEHRT) for the MIPS Promoting Interoperability performance category, effective January 1, 2027, to align with changes proposed by ONC. Among other changes, MIPS eligible clinicians would no longer be required to use technology certified to certain criteria, including automated numerator recording and automated measure calculation criteria at 45 CFR 170.315(g)(1) and (g)(2). CMS also proposes modifications involving certification criteria supporting family health history and patient health information capture. Other certification criteria in the CEHRT definition would remain required.

FAH supports CMS's and ONC's efforts to reduce unnecessary certification requirements for mature functionality that is widely embedded in EHRs and no longer supports specific Promoting Interoperability measures. However, FAH strongly opposes removing certification requirements for automated numerator recording and automated measure calculation while continuing to require clinicians to report Promoting Interoperability measures that depend on this functionality.

CMS cannot reasonably maintain mandatory provider reporting requirements while eliminating the corresponding requirement that certified technology supports the functionality necessary to meet them. Measures such as e-

Prescribing and Provide Patients Electronic Access continue to require numerator and denominator reporting. Provider compliance with federal reporting requirements should not depend on whether health IT developers voluntarily continue to support the functionality necessary to calculate those measures accurately.

Moreover, removing these certification requirements would shift, rather than reduce administrative burden. Hospitals, health systems and physician practices would be responsible for determining whether their vendors continue to support the necessary calculation functionality, monitoring changes to that functionality, resolving gaps with developers, and validating the accuracy of measure calculations. Providers should not assume additional compliance risk for technology functionality over which they have limited control.

If CMS and ONC determine that automated numerator recording and measure calculation no longer warrant certification requirements because of the burden imposed on health IT developers, CMS should also remove the associated provider's reporting requirements. Alternatively, if CMS continues to require clinicians to report calculation-based Promoting Interoperability measures, the certification requirements necessary to reliably calculate those measures should remain.

ONC Direct Review and ONC-Authorized Certification Bodies Surveillance Attestations

CMS proposes to remove the ONC Direct Review attestation and optional ONC-Authorized Certification Bodies (ONC-ACB) Surveillance attestation beginning with the CY 2026 performance period/2028 MIPS payment year. CMS states that removing these attestations would reduce the number of discrete manual reporting steps without diminishing the integrity of the Promoting Interoperability performance category.

FAH supports this proposal. Removing these attestations appropriately streamlines Promoting Interoperability reporting while preserving the underlying ONC certification, surveillance, and direct review framework.

Protect Patient Health Information Objective: Security Risk Analysis Measure

Beginning with the CY 2027 performance period/2029 MIPS payment year, CMS proposes to remove the Security Risk Analysis measure from the MIPS Promoting Interoperability performance category. CMS estimates that removing the measure would reduce reporting burden by approximately 2.1 hours per respondent.

FAH supports CMS's proposal to remove the Security Risk Analysis measure from the MIPS Promoting Interoperability performance category. Eliminating a separate MIPS reporting requirement appropriately reduces duplicative administrative burden while leaving intact providers underlying obligations to conduct security risk analyses under HIPAA and other applicable federal requirements.

FAH also urges CMS to maintain alignment between MIPS and the Medicare Promoting Interoperability Program. CMS has historically sought to align with the clinician and hospital programs where appropriate, and several of the Promoting Interoperability changes in the Proposed Rule have corresponding proposals for eligible hospitals and critical access hospitals.

FAH, therefore, urges CMS to apply the same approach to eligible hospitals and critical access hospitals participating in the Medicare Promoting Interoperability Program. Maintaining different reporting requirements where the underlying security obligation remains the same would preserve unnecessary administrative complexity and undermine CMS's broader alignment goals.

Public Health Reporting: Electronic Case Reporting Measure

CMS previously finalized a measure suppression policy for the MIPS Promoting Interoperability performance category that allows the agency to suppress a measure when circumstances outside a clinician's control affect the ability to meet the measure's requirements. In determining whether suppression is appropriate, CMS may consider, among other factors, the technical or operational capacity of entities upon which clinicians depend to successfully report a measure.

FAH urges CMS to apply this measure suppression policy to the Electronic Case Reporting (eCR) measure for the CY 2026 performance period when clinicians are unable to complete required onboarding because of limitations outside their control. Providers continue to experience delays in completing eCR onboarding due to public health agency capacity, registry readiness, and onboarding queues. These challenges can prevent providers from successfully completing the reporting process even when they have taken the necessary steps to participate.

Clinicians should not be penalized when they have made a good-faith effort to meet the eCR requirements but cannot complete onboarding because a public health agency, registry, or other required partner lacks the capacity to move them through the process. These circumstances are precisely the type of external technical and operational limitations that CMS's measure suppression policy is intended to address.

FAH, therefore, urges CMS to suppress the eCR measure for the CY 2026 performance period when these circumstances prevent successful reporting. At a minimum, CMS should make clear that clinicians will not be penalized when they can demonstrate that they took reasonable steps to participate but could not complete onboarding because of public health agency capacity, registry readiness, or other external onboarding limitations.

If CMS determines that broad suppression of the eCR measure is not warranted, the agency should clearly identify which existing exception clinicians should use in these circumstances and provide straightforward guidance regarding the documentation necessary to demonstrate eligibility. Providers should not face uncertainty about whether an exception applies when their inability to complete eCR reporting results from circumstances outside their control.

Electronic Prior Authorization Measure

For the CY 2027 performance period/2029 MIPS payment year, CMS proposes to make the Electronic Prior Authorization measure optional and award 10 bonus points to MIPS eligible clinicians that attest “Yes” to the measure. Beginning with the CY 2028 performance period/2030 MIPS payment year, CMS proposes to make the measure required. To successfully attest to the measure beginning in CY 2028, a MIPS eligible clinician would be required to use CEHRT to electronically request and receive coverage requirements, request and populate prior authorization documentation using templates and rules, submit the prior authorization request, and receive the payer response through a Prior Authorization API for at least one medical item or service, excluding drugs. A clinician who does not attest “Yes” or claim an applicable exclusion would receive a score of zero for the MIPS Promoting Interoperability performance category.

FAH supports CMS’s proposal to make the Electronic Prior Authorization measure optional for CY 2027, which appropriately recognizes that clinicians, health IT developers and other participants need additional time to implement, test and operationalize standards-based electronic prior authorization capabilities. **FAH urges CMS, however, not to finalize the proposed CY 2028 requirement in a manner that requires clinicians to use every certified electronic prior authorization capability for the same prior authorization request when each capability is not necessary to successfully complete the authorization.**

Electronic prior authorization should simplify the authorization process, not require additional transactions solely to satisfy a reporting requirement. In some circumstances, for example, the information exchanged through Coverage Requirements Discovery (CRD) may establish what is needed for an authorization without requiring additional documentation through Documentation Templates and Rules (DTR). Similarly, the particular circumstances of an authorization may not require every available electronic capability to complete the process successfully. Requiring clinicians to initiate unnecessary transactions solely to satisfy the Promoting Interoperability measure would add administrative steps to a workflow that electronic prior authorization is intended to streamline.

CMS should instead encourage clinicians to use the standards-based electronic prior authorization capabilities necessary to complete a particular authorization successfully. The measure should evaluate meaningful use of electronic prior authorization technology rather than require clinicians to perform transactions that do not contribute to the authorization decision.

FAH, therefore, recommends that CMS retain the flexibility proposed for CY 2027 in CY 2028 and subsequent performance periods by allowing a MIPS eligible clinician to attest “Yes” when the clinician successfully completes an electronic prior authorization using one or more of the certified electronic prior authorization capabilities necessary for that particular request.

Third-Party Intermediaries General Requirements

CMS proposes several changes to requirements for third-party intermediaries, including Qualified Clinical Data Registries (QCDRs) and qualified registries. The proposals address conditions for approval, performance feedback, data validation audits, participation plans, remedial action, and termination policies. CMS also proposes to require a QCDR or qualified registry to be able to submit at least six quality measures, including at least one MIPS Core measure, beginning with the CY 2027 performance period. CMS further proposes to require an intermediary that did not submit MIPS data during the preceding year to submit a participation plan, rather than waiting until two consecutive years of non-submission.

Conditions for Approval

As CMS revises these requirements, FAH urges the agency to reduce unnecessary administrative burden associated with clinician authorization for QCDR and qualified registry data submission. For hospitals, health systems and large physician groups that report on behalf of hundreds or thousands of clinicians, obtaining individual clinician authorization each year can require substantial administrative effort without providing a corresponding program integrity benefit.

FAH recommends that CMS allow authorization for QCDR or qualified registry data submission to remain valid for the duration of a clinician's employment, contractual relationship, or participation in the applicable reporting arrangement, unless the clinician revokes the authorization or there is a material change in the reporting relationship. This approach would preserve clear authorization and accountability without requiring organizations to repeat the same administrative process each year.

CMS should also clarify and expand the circumstances in which an authorized representative of a group, subgroup, Virtual Group or APM Entity may provide authorization on behalf of participating clinicians when the organization already has authority to submit data for the applicable reporting arrangement. CMS recognizes these organizational reporting structures throughout MIPS; the authorization framework should similarly recognize the structures through which MIPS reporting is administered.

FAH, therefore, urges CMS to eliminate the annual individual clinician authorization requirement where an ongoing reporting relationship exists and permit appropriate organizational representatives to authorize data submission on behalf of clinicians when they have the legal and organizational authority to do so. These changes would maintain appropriate safeguards while substantially reducing unnecessary burden on clinicians, hospitals and health systems, QCDRs, and qualified registries.

Endnotes

[1] MedPAC, Report to the Congress: Medicare Payment Policy (March 2026), Chapter 4, pp. 138–139; 2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 199–200.
[2]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, Final Rule, 90 Fed. Reg. 49,266, 49,292 – 49,297 (Nov. 5, 2025).
[3] 91 Fed. Reg. 43,842, 43,861 (July 16, 2026).
[4] 90 Fed. Reg. at 49,292 (Nov. 5, 2025).
[5]Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems, Proposed Rule, CMS-1850-P, 91 Fed. Reg. 41,734 (proposed July 7, 2026); see also 81 Fed. Reg. 79,726 and 82 Fed. Reg. 53,028 (PFS relativity adjuster).
[6] 79 Fed. Reg. 67,582 – 67,591 (Nov. 13, 2014); Section 523(a) of the Medicare Access and CHIP Reauthorization Act of 2015.
[7] Office of Inspector General, Additional Oversight of Remote Patient Monitoring in Medicare Is Needed, OEI-02-23-00260 (Sept. 2024); Office of Inspector General, Billing for Remote Patient Monitoring in Medicare, OEI-02-23-00261 (Aug. 2025).
[8] Feldman, D.I., et al., The Impact of a Remote Patient Care Program on Health Care Costs and Utilization Among Medicare Patients With Chronic Disease, Mayo Clinic Proc.: Innovations, Quality & Outcomes (Feb. 2026), https://www.sciencedirect.com/science/article/pii/S2542454825000906.
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[11] 89 Fed. Reg. 97,856 – 97,858 (Dec. 9, 2024).
[12] 91 Fed. Reg. at 43,901 (Jul. 16, 2026).
[13] 83 Fed. Reg. 35,840 – 35,841 (Jul. 27, 2018).

[14] 91 Fed. Reg. at 43,908 –43,909 (Jul. 16, 2026).
[15] 91 Fed. Reg. 43,586 (July 16, 2026).
[16]Comments of the Federation of American Hospitals on the CY 2026 PFS Proposed Rule (CMS-1832-P), September 12, 2025, at 8 through 15, https://fah.org/wp-content/uploads/2025/09/PFS-Comments-Proposed-Rule-91225-FINAL.pdf; Comments of the Federation of American Hospitals on the Proposed Comprehensive Care for Joint Replacement Expanded (CJR-X) Model (CMS-1849-P), June 5, 2026, https://fah.org/wp-content/uploads/2026/06/FAH-FY2027-IPPS-CJRX-Comments-060626-Final.pdf; Comments of the Federation of American Hospitals on the FY 2027 IPPS and LTCH Proposed Rule (CMS-1849-P), June 8, 2026 https://fah.org/wp-content/uploads/2026/06/FAH-FY-2027-IPPS-and-LTCH-Comments-060826-Final-.pdf.
[17] 90 Fed. Reg. at 49,679 – 49,691 (finalized payment adjustment provisions, codified at 42 CFR 512.750).
[18]Comments of the Federation of American Hospitals on the CY 2026 PFS Proposed Rule (CMS-1832-P), September 12, 2025, at 11 through 12, https://fah.org/wp-content/uploads/2025/09/PFS-Comments-Proposed-Rule-91225-FINAL.pdf.
[19] 90 Fed. Reg. at 49,592 (Nov. 5, 2025).
[20] 90 Fed. Reg. at 49,690 (Nov. 5, 2025) (finalizing the ASM redistribution percentage of 85 percent at 42 CFR 512.750(c)(1)(iii) and illustrating that, at the 9 percent risk level, an estimated 1.35 percent of Medicare Part B covered professional service payments is retained by Medicare).
[21] 90 Fed. Reg. at 49,973 (Nov. 5, 2025); (regulatory impact analysis, Table D-B8, estimating $177 million in net Medicare savings from ASM from Jan. 1, 2029 – Dec. 31, 2033).
[22] 91 Fed. Reg. at 43,986 (Jul 16, 2026).
[23] Comments of the Federation of American Hospitals on the CY 2026 PFS Proposed Rule (CMS-1832-P), September 12, 2025, at 11 through 12 (urging the exclusion of anesthesiologists from the low back pain cohort), https://fah.org/wp-content/uploads/2025/09/PFS-Comments-Proposed-Rule-91225-FINAL.pdf.
[24]See supra note on FAH CJR-X and FY 2027 IPPS and LTCH comments.
[25]Comments of the Federation of American Hospitals on the CY 2026 PFS Proposed Rule (CMS-1832-P), September 12, 2025, at 14 (opposing the requirement that specialists enter into collaborative care agreements and recommending its removal), https://fah.org/wp-content/uploads/2025/09/PFS-Comments-Proposed-Rule-91225-FINAL.pdf.
[26] 91 Fed. Reg. at 44,040. (Jul. 16, 2026).