September 9, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Dr. Oz:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 128,300 family physicians and medical students nationwide, we appreciate the opportunity to comment on the CY 2026 Medicare Physician Fee Schedule (MPFS) proposed rule. We commend CMS for its commitment to advancing high-quality, affordable care and maximizing the return on taxpayer investment. We are pleased to see CMS acknowledging the important link between community-based physicians and the health of that community. The AAFP believes this year's rule represents a significant step forward towards several goals we share with CMS but especially that of improving care for patients while "protecting the future of hometown doctors."

Family physicians are the quintessential hometown doctors:

- Family physicians represent the largest share of the primary care workforce;
- Family physicians conduct more visits than any other specialty;
- Family physicians offer the most comprehensive care amongst all specialties;
- Family physicians are more likely to provide care in rural and remote areas than any other specialty.

As the only medical specialty providing whole-person primary care across all ages and geographies, family physicians are essential partners in meeting CMS' goals for prevention, chronic disease management, and accountable care. In fact, the primary care provided by family physicians and similar specialties is the only part of the health care system where an increased supply is associated with improved health outcomes and lower overall spending.[1, 2] **Accordingly, we applaud CMS for taking a bold approach to addressing many of the long-standing barriers that have hindered family physicians from doing what they do best: making and keeping Americans healthy.**

[1] National Academies of Sciences, Engineering, and Medicine. 2021. *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983.
[2] https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/primary-care-the-mvp-of-mssp-2024-evidence-report.pdf

Preserving and strengthening independent practices is essential to ensuring that the best care reaches every corner of the country, especially rural and underserved areas where family physicians are often the only source of comprehensive care. The primary care that family physicians deliver is longitudinal, whole person care that spans prevention, early detection, and chronic disease management. Many family physicians incorporate integrative approaches, including nutrition counseling, physical activity planning, and behavioral health support into their daily practice. This proactive, relationship-based model empowers patients to take control of their health and make informed decisions, which leads to better outcomes and lower costs. The benefits are not limited to health outcomes: primary care physicians, when empowered to practice in rural areas serve as economic catalysts that can benefit the entire community: studies have shown that a single rural primary care physician generates an estimated $1.4 million in annual economic activity for the community and over 26 local jobs.[3]

However, as CMS well knows, accelerating consolidation of health care delivery threatens the accessibility, affordability, and personalization of care for millions of Americans. When independent, physician-led practices are absorbed into larger corporate entities, patients often lose the trusted relationships they've built with the hometown doctors who know their histories, families and communities. Consolidation can lead to reduced care continuity, higher costs, and diminished patient choice. It also undermines CMS' work to modernize Medicare, so Americans get the care that they want, need, and deserve.[4]

The AAFP appreciates that many of the drivers of consolidation are outside of CMS' control and will require congressional intervention to address. Arbitrary cost-containment measures like inequitable budget neutrality rules which disproportionately constrain spending on physician services while other health care spending goes unchecked; the lack of inflationary adjustments to the fee schedule while other payment mechanisms under Medicare receive those updates; limitations on CMS' ability to waive cost sharing to incentivize the use of high value services; and statutory requirements that have limited annual updates to the conversion factor, increased performance thresholds, and eliminated incentives to transition to value-based payments.

Despite these statutory limitations, we are heartened by the leadership demonstrated in this year's rule to address what CMS can control to level the playing field for independent, physician-owned practices and to strengthen primary care. Proposed policies that better recognize the expense of maintaining an independent practice compared with facility-based practice and updates to more accurately account for gained-efficiencies

[3] Eilrich, Fred C.; Doeksen, Gerald A.; St. Clair, Cheryl F. Estimate the Economic Impact of a Rural Primary Care Physician – National Center for Rural Health Works Research Study. October 2016. https://ruralhealthworks.org/wp-content/uploads/2018/04/Physician-Impact-Study-Final-100416.pdf
[4] https://www.cms.gov/newsroom/press-releases/dr-mehmet-oz-shares-vision-cms

over time represent potential solutions to long-standing flaws in the process that have disincentivized physician practice ownership and undervalued primary care. Further, attempts to recognize primary care as the preventive foundation it truly is through the Advanced Primary Care Management (APCM) codes hold promise for making a meaningful difference for primary care physicians – and their patients - across the country on the first day they are implemented. While we recognize that these policies are not perfect, we thank CMS for undertaking this important work and we look forward to offering some additional recommendations throughout our response.

In response to the specific proposals CMS presents in the 2026 proposed rule, we provide our thoughts and detailed recommendations throughout the balance of this letter. For CMS proposals of particular significance to family physicians and primary care, our high-level recommendations are noted here:

- Finalize the proposed efficiency adjustment while making additional corresponding updates to the direct practice expense (PE) inputs for clinical labor and equipment costs.
- Proceed with policy development to utilize more empiric data in the valuation of physician services while preserving direct physician involvement in the process.
- Finalize the proposal to update the PE methodology with modifications to ensure rural physicians and those that split time between facility and non-facility settings are not inadvertently penalized due to their unique practice patterns or geographic location.
- Continue to pursue options for ensuring APCM services have their intended effect of strengthening primary care for Medicare beneficiaries by addressing the valuation of these new codes and patient cost-sharing

Determination of PE RVUs (section II.B.)

In early 2025, the American Medical Association (AMA) submitted data from its Physician Practice Information (PPI) and Clinician Practice Information (CPI) Surveys to CMS for consideration in implementing the PE/HR data and cost shares in PFS rate setting for CY 2026. CMS has substantive concerns about the accuracy and suitability of the PPI and CPI Survey data as an immediate replacement for the current PE/HR data and cost shares for use in CY 2026 PFS rate setting. Specifically, CMS is concerned about the small sample sizes, sampling variation, low response rates, representativeness of the data, lack of comparability to previous survey data, potential measurement error, and missing or incomplete submission of data to CMS. Consequently, CMS is not proposing to implement the PE/HR or cost shares from the AMA's survey data. Instead, CMS proposes to maintain the current PE/HR and 2006-based MEI cost shares for CY 2026 PFS rate setting.

CMS proposes a series of technical corrections and updates to the pricing of equipment and supplies under its PE RVU methodology. For instance, CMS proposes to continue implementing the supply pack pricing update and associated revisions as previously recommended by the Relative Value Scale Update Committee (RUC) by updating the price of 15 supply packs. For three of the packs, the proposed pricing update is modest enough that CMS proposes these supplies move immediately to their final prices for CY 2026. CMS proposes the 12 other supply packs be incorporated into the muti-year supply pack pricing transition finalized in CY 2025 rulemaking, with the final price fully implemented for CY 2028.

One technical change CMS does not propose to make is removing 11 equipment items that fall under the $500 threshold from the CMS rate setting database. CMS solicits comments on whether to maintain or remove these equipment items.

A potentially major change that CMS proposes in its methodology is, for each service valued in the facility setting under the PFS, to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. To better inform its consideration of how to account for indirect PE costs in the PE RVU methodology, CMS seeks comment on the specific types and magnitude of indirect PE costs incurred that are attributable to physicians who practice in part or exclusively in a facility setting, and any variables that affect whether and to what extent a practice would incur them. CMS also seeks comments on whether one half the amount allocated to non-facility PE RVUs is an appropriate reduction or whether it should consider a different percentage reduction for CY 2026 or in future years. Related to this proposal, CMS also seeks comments on whether there are additional data sources that might help identify a more precise site of service difference in the allocation of indirect PE RVUs; whether and how this proposed policy should apply to codes for maternity services and how it could specifically impact access to maternity services; and alternative approaches to improving the allocation of indirect PE as outlined in Chapter 1 of MedPAC's June 2025 Report to the Congress.

Finally, CMS seeks comments from the public regarding whether separate coding and payment is needed for evaluation and management visits furnished at urgent care centers, including whether an add-on code would be appropriate or if a new set of visit codes would be more practical. CMS notes it is also interested in understanding how practice costs, including but not limited to indirect costs, may vary among different non-facility settings of care and in receiving feedback regarding how either the code set, or the PE methodology might be improved to better recognize the relative resources involved in furnishing services across these kinds of settings.

AAFP Comments:

Supply Pack Pricing

The AAFP supports CMS' proposal to update the price of the 15 supply packs identified in Table 5 to bring the prices of the packs into alignment with the sum of the prices of the individual items in each pack. We further support CMS' proposal to move the prices of the surgical instruments cleaning pack (SA043), the moderate sedation pack (SA044), and the small ortho drapes pack (SA081) to their final prices for CY 2026 since, as noted in the rule, the proposed pricing update is modest in each case. Lastly, we support CMS' proposal that the 12 other supply packs be incorporated into the muti-year supply pack pricing transition finalized in CY 2025 rulemaking, with the final price fully implemented for CY 2028, which will be less confusing than having different packs on different transition schedules.

Removal of Equipment Items Under $500

The AAFP is disappointed that CMS is not removing the 11 equipment items that fall under the $500 threshold from the CMS rate setting database. For its rationale, CMS states that these equipment items have historically been included as direct PE inputs in their respective HCPCS codes for the last two decades. Given the very small valuation associated with their use, CMS does not believe it is necessary to remove them from the database and, instead, believes relativity is better served by continuing to maintain these equipment items rather than removing them and potentially causing unnecessary confusion and concern that the valuation of these services would be negatively impacted.

As noted in section II.C of this proposed rule, CMS has a statutory mandate to periodically identify potentially misvalued services using certain criteria and to review and make appropriate adjustments to the relative values for those services. In that section, CMS observes, "We believe services can also become overvalued when PE costs decline. This can happen when the costs of equipment and supplies fall…." Consistent with this mandate, the RUC has identified 11 pieces of equipment whose cost now falls below the threshold CMS otherwise requires for inclusion as direct PE inputs. CMS routinely adjusts the longstanding PE inputs of specific codes, so we fail to understand why these 11 pieces of equipment should be treated differently simply because the equipment items have historically included as direct PE inputs. The very small valuation associated with their use should only facilitate their removal, since the impact will be negligible. Unlike CMS, we believe relativity is best served by applying a consistent standard for the inclusion of equipment as direct PE inputs. Thus, we encourage CMS to accept the RUC's recommendation to remove the 11 pieces of equipment in question from the direct PE inputs and treat them as indirect practice expense, just as it does with all other equipment that costs less than $500.

Physician Practice Information (PPI) and Clinician Practice Information (CPI) Survey Data

The AAFP is disappointed that CMS did not find the PPI and CPI survey data satisfactory for purposes of updating the PE/hour and cost shares for rate setting in 2026 because it means CMS will continue to rely on data that is approaching 20-years old for these purposes. We agree with CMS' acknowledgement that the practice and cost of medicine have changed substantially during the past two decades. We appreciate that CMS explained its concerns with the PPI and CPI survey data in detail in the proposed rule. We are heartened to read that CMS believes the following:

a more efficient and transparent system that could be updated on a regular basis may be possible using available administrative data (such as Medicare claims; hospital cost reports; publicly-reported tax information such as from IRS Form 990; and data collected by other agencies, such as the Census Bureau's Service Annual Survey (SAS)) to the fullest extent possible and relying on survey data only to fill gaps only where available data do not exist. An alternative to collecting any survey data would be to modify the PE allocation system so that it only relies only on data that can be measured accurately and on an on-going basis. For example, if there are components of indirect PE that are not captured in administrative data, those expense categories could potentially be re-classified as direct costs and accounted for in a manner similar to how direct costs are currently considered.

We are also heartened to read that CMS intends "to work with interested parties, including the AMA, to understand whether and how such data should be used in PFS rate setting in future rulemaking." **We strongly encourage CMS to work with the AMA, the AAFP, and other national medical specialty societies to identify and collect the necessary data in time for rate setting in 2027.**

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

The AAFP agrees with CMS that, in the decades since implementing the PE methodology, "there have been significant transformations to the landscape of the healthcare delivery system in the United States, particularly regarding physician practice patterns." As CMS observes, trends indicate a steady decline in the percentage of physicians owning or working in independent, physician-owned practices, with a corresponding rise in physician employment by hospitals. Those trends also indicate growth in the percentage of physicians who practice exclusively, or almost exclusively, in the facility setting. Unfortunately, as it did when the PFS was established, the methodology for allocating indirect practice expense is based in part on an assumption that the physician maintains an office-based practice even when also practicing in a facility setting, such that the PE methodology allocates the same amount of indirect costs per work RVU, without regard to setting of care.

The AAFP supports CMS's intent to question the assumptions underlying this aspect of its PE RVU methodology and to update the methodology accordingly for all the reasons CMS gives in the proposed rule. The proposal to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026 is a policy the AAFP can support because it is consistent with our long-standing advocacy around site neutrality. Lack of payment parity for services across sites of care has helped drive the consolidation to which CMS alludes and helped fuel increases in the prices paid for care.

While the AAFP is supportive of the proposed policy, we are unclear how CMS arrived at a figure of one half the amount allocated to non-facility PE RVUs as an appropriate reduction. The proposed rule does not give any indication of how CMS determined this figure. Until the AAFP can understand CMS's rationale for one half, we cannot comment on whether that is an appropriate reduction or whether CMS should consider a different percentage reduction for CY 2026 or in future years.

As the AMA's comment letter on the CY 2023 PFS proposed rule noted, even physicians who practice exclusively in a facility setting may have some indirect practice expenses (e.g., for coding/billing) if their practice is not owned by a hospital or health system. Physicians who practice in part in a facility setting may have more extensive indirect practice expenses that approximate those of physicians who practice exclusively in the non-facility setting. For instance, a rural family physician still must pay rent, utilities, and other indirect practice expenses associated with the practice's office and exam rooms even if he or she provides services at the local hospital part of the time.

With that in mind, we urge CMS to exempt rural based physicians from the policy, as they are more likely to split their time between the office and facility settings, such as the hospital and skilled nursing facilities. We also ask CMS to investigate just how many physicians are splitting time between the facility and non-facility settings, especially those who own their own practice (or are employed by a physician owned practice) and consider steps to mitigate the harm that such physicians may feel from the policy, including but not limited to alternatives described by MedPAC in Chapter 1 of its June 2025 report to Congress.

The AAFP does not have any information or data on the specific types and magnitude of indirect PE costs incurred that are attributable to physicians who practice in part or exclusively in a facility setting. The AAFP also does not have and is not aware of any data sources that might help identify a more precise site of service difference in the allocation of indirect PE RVUs. The preceding discussion suggests that variables that affect whether and to what extent a practice would incur them may include such things as whether the practice is exclusively in the facility setting, geography of the practice (i.e., rural versus urban/suburban), and practice ownership (e.g., hospital or health-system owned versus physician-owned).

To CMS' questions of whether and how this proposed policy should apply to codes with MMM global periods (i.e., maternity services) and how it could specifically impact access to maternity services, the AAFP echoes CMS's observation that such services include patient encounters and other services done in the office setting. As suggested above, physicians who practice in both the non-facility and facility settings may have the same indirect practice expenses as those who practice exclusively in the non-facility setting. Until CMS can better delineate the specific types of indirect practice expenses in question and the extent to which those are incurred by site of service, the AAFP would encourage CMS to not apply the proposed policy to codes with MMM global periods, lest the agency negatively impact access to maternity care services, which is already under duress in many parts of the country.

In sum, like CMS and MedPAC, the AAFP agrees that the assumptions underlying the current allocation of indirect PE RVUs is flawed and that change is needed. The AAFP supports CMS's proposal as directionally appropriate of the needed change and would appreciate more discussion from CMS on how it arrived at the recommended one-half figure and how applying such a reduction across the board to services provided in the facility setting is preferable to the alternatives described by MedPAC in Chapter 1 of its June 2025 report to Congress, which would otherwise target such reductions to, for example, services predominantly performed in the facility setting. The AAFP encourages CMS to work further on this concept and finalize a better elucidated version as part of rate setting for 2026. Such a version would, at a minimum:

- Identify all the elements (e.g., rent, utilities, administrative staff and equipment) of indirect practice expense under CMS's PE RVU methodology
- Specify which elements of indirect practice expense the agency believes are either not incurred or incurred to a lesser degree when a service is provided in the facility setting compared to the non-facility setting
- Target resulting reductions to a defined set of services to which CMS believes the reductions apply based on MedPAC recommendations and the foregoing points above

Coding and Payment for Services in Urgent Care Centers

The AAFP appreciates CMS' questions regarding coding and payment for E/M services in urgent care centers and how practice costs may vary among different non-facility settings of care. As with a similar request for comments included in the proposed rule on the 2025 Medicare physician fee schedule, the current questions appear driven by concerns about system capacity and workforce issues more broadly, including how entities such as urgent care centers can play a role in addressing some of the capacity issues in emergency departments.

As we noted in response to last year's proposed rule, this issue is particularly important in rural and underserved communities, as rural residents are more likely to be uninsured and are more likely to report difficulty obtaining needed health care than their urban counterparts, largely due to the limited number of clinicians and facilities in their area.[5] Rural hospitals have closed at an alarming rate over the last ten years, and many rural populations face long travel times for primary and emergency care. As a result, family physicians are an essential source of emergency services, maternity care, hospital outpatient services, and primary care in rural areas.

Family physicians are well-trained, versatile physicians who provide highly competent emergency and acute medical care for patients of all ages in emergency department and urgent care settings due to their broad scope of training, particularly in small and rural communities. Meanwhile, urgent care centers are increasingly staffed by mid-level non-physician clinicians who have a severely limited scope of practice as compared to family physicians. Patients are often referred to emergency departments for simple procedures routinely managed by family physicians in an outpatient setting. **To maximize effectiveness and safety, the AAFP strongly believes all urgent care centers should utilize a physician-led health care team**.

Across all settings, including emergency departments and urgent care centers, the U.S. also faces a critical family physician workforce shortage, compounded by misalignment of resources in medical education, which has led to disparate care access for patients nationwide. **The AAFP encourages CMS to work with Congress to consider ways to reimagine our country's GME system so that it better supports and invests in family physicians as the backbone of primary care deliver in the U.S. – especially in rural settings**. Though the current system excels at educating skilled physicians and physician researchers, the primary care physician shortage prevents the U.S. from taking advantage of the better outcomes and lower per capita costs associated with robust primary care systems in other countries. This evidence is borne out by the strong differential shared savings performance of Medicare Shared Savings Plan ACO's that rely more heavily on primary care.[6]

Given the evidence that most physicians are trained at large academic medical centers in urban areas and that physicians tend to practice within 100 miles of their residency program, the current distribution of trainees leads to physician shortages that are particularly dire in medically underserved and rural areas. While 20 percent of the U.S. population lives in rural communities, only 12 percent of primary care physicians and eight percent of subspecialists practice in these areas. **We support consistent funding for GME for family medicine to**

[5] https://www.ahrq.gov/news/newsletters/e-newsletter/970.html
[6] https://www.graham-center.org/content/dam/rgc/documents/publications-reports/reports/primary-care-the-mvp-of-mssp-2024-evidence-report.pdf

ensure that new residency slots are allocated to address rural and urban imbalances, reduce physician shortages, and focus on medically underserved areas, all of which will help prevent rural urgent care centers and emergency departments from being overburdened.

Transparency and data are necessary to ensure that GME slots are being allocated appropriately and most effectively for the communities they serve. The AAFP supports policies that would provide authority to the Secretary of HHS to utilize existing data and to collect any additional data necessary to enable tracking, research, and analysis on the impact of federal GME funding on the geographic and specialty distribution of the physician workforce. Having this data will help address our nation's current maldistribution of physicians and allow us to target the allocation of GME slots toward hospitals and programs in areas and specialties of need, including by considering which ones have a proven track record of training physicians who ultimately practice in physician shortage areas.

Additionally, collecting more detailed, comprehensive data on the amounts of Direct Graduate Medical Education (DGME) vs. Indirect Medical Education (IME) payments would improve transparency and increase understanding of how these payments can be used most effectively. Further details about the utilization of IME should also be considered; transparency of how IME dollars are spent could illustrate the need for increased IME in some locations but may also show if these funds being used in unintended ways in other locations. If a program is not utilizing IME funds in the way they are intended, those funds could be shifted elsewhere to support the creation of additional GME slots.

In sum, although many family physicians practice in urgent care centers, the AAFP does not believe that separate coding and payment is needed for E/M services in such centers nor that CMS should devote more attention to how practice costs vary among different non-facility practice settings. Instead, we urge CMS to focus on better ensuring that coding and payment supports primary care physicians in their practices and that the country's GME system, for which CMS and Medicare are largely responsible, better supports and invests in primary care.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act (section II.D.)

b. Proposal to Modify the Medicare Telehealth Services List and Review Process

CMS proposes to simplify the Medicare Telehealth Services List review process from its current five steps and to instead have a three-step review process by eliminating Step 4 and Step 5. The proposed simplified process would be:

1. Determine whether the service is separately payable under the PFS;
2. Determine whether the service is subject to the provisions of section 1834(m) of the Act; and

3. Review the elements of the service as described by the HCPCS code and determine whether each of them is capable of being furnished using an interactive telecommunications system.

CMS believes Step 4 (Consider whether the service elements of the requested service map to the service elements of a service on the list that has a permanent status described in previous final rulemaking) and Step 5 (Consider whether there is evidence of clinical benefit analogous to the clinical benefit of the in-person service) are unnecessary because Steps 1 through 3 provide appropriate guardrails. The agency states that a physician's "complex professional judgment" can successfully determine if a service can be safely provided via telehealth and will be clinically helpful to the patient.

CMS also proposes to remove the distinction of "provisional" and "permanent" status from the Medicare Telehealth Services List; all services on both lists would be permanently included going forward.

AAFP Comments:

The AAFP appreciates CMS' proposal to simplify the categorization of services on the telehealth list and supports this proposal being finalized. When the current five-step review process and introduction of "provisional" and "permanent" statuses were proposed in the CY 2024 Medicare Physician Fee Schedule proposed rule, we shared concerns that the process may slow down the addition of new codes. We encouraged CMS to thoughtfully consider implementation processes that could increase transparency for submitters and reduce or eliminate lag time between steps. Also, in our CY24 MPFS comments, the AAFP suggested Step 4 be removed from the proposed review process to reduce inefficiency, given that CMS had not (at that time) found a single instance where service elements for a proposed code mapped onto service elements for a service already on the list. As such, the AAFP supports the simplification of the review process to the three-step method proposed here. We also agree with the elimination of "provisional" and "permanent" statuses, given that all services currently on the Medicare Telehealth Services List meet the criteria of Steps 1 through 3.

Additionally, we strongly support CMS' reasoning for these proposed changes. The AAFP agrees that – thanks to their extensive training and well-developed, professional judgment – physicians can best determine if a telehealth service is appropriate for a given patient in a specific clinical scenario, including for the most complex patients. We appreciate CMS recognizing and prioritizing that the appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies.

c. Requests to Add Services to the Medicare Telehealth Services List for CY 2026; (7) Telemedicine E/M Services

CMS' long-standing interpretation of section 1834(m) allows Medicare to pay for services that would otherwise be furnished in person but instead are furnished via telecommunications technology. The Act expressly requires payment to the distant site physician or practitioner of an amount equal to the amount they would have been paid had the service been provided without the use of a telecommunications system. Services that are not ordinarily furnished in person, such as remote patient monitoring and communication technology-based services, are not considered Medicare telehealth services and not subject to geographic, site of service, and practitioner restrictions. Under current statute, beginning October 1, 2026, the geographic and site of service restrictions for Medicare telehealth services will return, except for certain circumstances.

CMS is not proposing to add the telemedicine E/M services (CPT codes 98000-98015) to the Medicare Telehealth Services List. The agency states that since these services are not considered separately payable under MPFS when rendered in person – having an assigned status indicator I ("Not valid for Medicare purposes") – they also would not be separately payable when rendered via telehealth.

AAFP Comments:

The AAFP continues to believe CMS has fairly and reasonably interpreted the applicability of section 1834(m) of the Social Security Act regarding the 16 new telemedicine E/M codes that went into effect as of the 2025 CPT code set. Accordingly, we do not object to CMS assigning the status indicator of "I" to these codes.

Per the AAFP's "Telehealth and Telemedicine" policy, we believe payment models, including the Medicare physician fee schedule, should support the physician's ability to direct the patient toward the appropriate service modality (i.e., provide adequate reimbursement) in accordance with the current standard of care. In general, telemedicine visits require the same level of work by the physician and incur the same level of liability as in-person visits; therefore, those telemedicine services should be reimbursed at parity with the corresponding in-person visit, consistent with CMS' interpretation of section 1834(m).

For administrative simplicity and other reasons, the AAFP has historically encouraged physicians and health plans to abide by the principles of CPT, especially in a fee-for-service payment system like the Medicare physician fee schedule. In this case, the current CPT principles and code structures are working. The greater good of administrative simplicity supports maintaining the existing CPT principles, rather than requiring physicians to use 16 additional codes for services already adequately captured elsewhere.

Regrettably, whether CMS finalizes its proposal or not is unlikely to mitigate the negative impact from the expiring telehealth flexibilities related to geographic location or site of service restrictions. In case there is not a legislative extension beyond Sept. 30, 2025, we urge CMS to clarify in the final rule how the agency intends to identify services for the diagnosis and treatment of mental health and substance use disorder.

d. Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS is proposing to permanently remove frequency limitations for Subsequent Inpatient Visits (CPT codes 99231-99233), Subsequent Nursing Facility Visits (CPT codes 99307-99310), and Critical Care Consultation Services (HCPCS codes G0508 and G0509).

AAFP Comments:

The AAFP has long been supportive of CMS removing telehealth frequency limits for Subsequent Inpatient Visits, Subsequent Nursing Facility Visits, and Critical Care Consultation Services for CY 2025. We appreciate this proposal and urge CMS to finalize it as proposed.

2. Other Non-face-to-face Services Involving Communications Technology Under the PFS

a. Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS is proposing to permanently adopt a definition of "direct supervision" that permits the immediate availability of a supervising physician to include using audio/video real-time communications technology (excluding audio-only) for the subset of services described under §410.26, except for services that have a global surgery indicator of 010 or 090: (1) services provided incident-to a physician or other practitioner's service when provided by auxiliary personnel employed by the billing practitioner and working under their direct supervision, and for which the code has been assigned a PC/TC indicator of '5', and (2) services described by CPT code 99211. Additionally, the agency is seeking comment on if services with a 000 global surgery indicator should also be excepted alongside indicators 010 and 090.

CMS is not proposing to extend current policy that permits a distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. This policy will expire on January 1, 2026, at which time distant site practitioners will be required to use their home address when providing telehealth services from that location.

AAFP Comments:

The AAFP supports CMS' proposal to permanently adopt a definition of direct supervision that permits the virtual presence of a supervising physician to include using audio/video real-time communications technology — though not audio-only — for all services described under §410.26, except for services that have a global surgery indicator of 010 or 090. Additionally, we agree with CMS that it is unnecessary to add services that have a 000 global surgery indicator to the list of exceptions, given the lack of a minimum postoperative period assigned to the 000 indicator.

The AAFP strongly believes in the value of physician-led, team-based care and that health professionals should work collaboratively as clinically integrated teams in the best interest of patients, which can be accomplished via real-time audio/video technology. This virtual capability continues to promote patient access, continuity, convenience, and choice, decreasing the spread of communicable diseases and providing critical support to patients and physicians in rural and other areas dealing with health professional shortages.

With an abundance of concern for the safety of all health practitioners delivering telehealth services, the AAFP has significant concerns regarding the expiring flexibility for telehealth practitioners to bill from their currently enrolled location instead of their home address when providing telehealth services from their home. We urge CMS to continue – and make permanent – its current policy that permits the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services.

The digitization of health data has produced many benefits, including easing patients' access to their own health information. The ubiquity of health data has also elevated the risk of misuse, including cyberattacks against all health care organizations. Additionally, it is important to minimize situations in which individuals' personal identifiable information could be inappropriately accessed and used in ways that could be harmful to them. The AAFP stands with family physicians and their patients in support of the confidential patient-physician relationship, and we urge CMS to not require physicians include their home address on Medicare enrollment paperwork related to rendering telehealth or any other service in 2026 and beyond.

b. Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence

In the 2021 PFS final rule, CMS established a policy allowing teaching physicians to meet the requirements to be present for the key or critical portions via audio/video real-time communications technology for services furnished by residents when the services are furnished in residency training sites located in rural areas – defined as residency training sites located outside of an OMB-defined MSA. In response to feedback, CMS modified its policy to

allow teaching physicians to have a virtual presence in all teaching settings in clinical instances when the service is furnished virtually (e.g., a 3-way telehealth visit, with all parties in separate locations). The policy originally applied to all residency training locations through December 31, 2024, and CMS subsequently extended it in the 2025 PFS to apply to all residency training locations through December 31, 2025.

In this year's proposed rule, CMS is proposing not to extend the current policy that allows teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings through December 31, 2025. Instead, the agency is proposing to transition back to pre-PHE policy, which would require teaching physicians to be in-person with their residents in all teaching settings. CMS does propose to maintain the rural exception established in the CY 2021 PFS final rule, which permits teaching physicians to continue utilizing audio/video real-time communications technology to fulfill the presence requirement, so long as they maintain active, real-time observation and participation in the service.

AAFP Comments

The AAFP disagrees with this proposal not to extend the current policy, and we strongly urge CMS to reconsider. We continue to encourage CMS to allow a teaching physician to have a virtual presence, regardless of whether the service is provided in-person or via telehealth. The virtual presence promotes patient access, continuity, convenience, and choice, and decreases the spread of communicable diseases. A virtual presence does not preclude a teaching physician from providing a greater degree of involvement in services furnished with the resident. The teaching physician would still have discretion to determine the appropriateness of a virtual presence rather than in-person, depending on the services furnished and the resident's experience. The teaching physician can also review the service with the resident during or immediately after the visit to exercise full and personal control over the service. The AAFP continues to believe that surgical, high-risk, interventional, endoscopic, or other complex procedures under anesthesia should remain excluded from this policy.

Primary Care Exception

The AAFP continues to strongly support the primary care exception (PCE), which permits a teaching physician to bill for certain lower and mid-level evaluation and management (E/M) services furnished by residents in certain types of residency training settings, even when the teaching physician is not present with the resident, if certain conditions are met. The PCE provides invaluable experience for applicable medical residents, expands patient access to primary care, and improves relational continuity of the patient and primary care physician in teaching centers. The AAFP also supports including additional preventive services and all

levels of office/outpatient E/M services to the list of services allowed under the PCE. This would direct needed resources to family medicine residency programs and support programs' ability to hire more preceptors or improve compensation for current preceptors. The AAFP highly values family medicine preceptors and the mentorship they offer, which evidence shows increases students' likelihood of choosing a family medicine career path.

In previous recommendations, we noted comments in the final CY1996 MPFS rule that suggest the PCE was established out of concern that physical presence requirements for Part B payment would "unfairly deny reimbursement for the activities of teaching physicians in these programs and endanger the financial viability of these programs."[i] Expanding services allowed under the PCE would help family medicine resident training programs remain financially stable—which ultimately supports primary care workforce development. Teaching physicians would also have more availability to residents who need their assistance if their physical presence is no longer required for additional services and more complex E/M visits the resident physician is able to furnish.

Including additional services under the PCE would not impede the teaching physician's ability to remain available for up to four residents and direct care. If a resident reviews the patient's visit with the teaching physician before, during, or after a visit, it does not reduce the availability of the teaching physician or impose additional time burdens. Without the requirement to be physically present during a visit, the teaching physician has more time available to other residents. This level of involvement allows teaching physicians to focus with residents on medical decision-making without the necessity of direct supervision, assuring appropriate care.

Valuation of Specific Codes (section II.E.)

Per CMS, research over time has demonstrated that the time assumptions built into the valuation of many PFS services are very likely overinflated. To mitigate these effects and account for changes in medical practice, CMS proposes to apply an efficiency adjustment to the work RVU and corresponding intraservice portion of physician time of non-time-based services that CMS expects to accrue gains in efficiency over time. This would periodically apply to all codes except time-based codes, such as evaluation and management (E/M) services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period of MMM.

Specifically, CMS proposes to use a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage to calculate this efficiency adjustment. This would result in a proposed efficiency adjustment of -2.5% for CY 2026. CMS also proposes that, going forward, it may give preference to empiric studies of time to incorporate into

service valuation, compared to low-response rate survey data. CMS solicits comments on the types of empiric data that CMS should consider. CMS expects that moving away from survey data would lead to more accurate valuation of services over time and help address some of the distortions that have occurred in the PFS historically. If finalized for CY 2026, CMS proposes to apply the efficiency adjustment to the intraservice portion of physician time and work RVUs every 3 years.

CMS seeks comments on whether adjustments should be made in future rulemaking to also adjust the direct PE inputs for clinical labor and equipment time that correspond with the physician time inputs. CMS also seeks comments as to whether efficiencies stop accruing for services after a predefined number of years. Finally, CMS seeks comments on whether and how it should consider additional efficiencies for services that require less time to perform and on whether the introduction of new artificial intelligence has or will lead to otherwise unaccounted for efficiencies gained in specific services.

Among the many codes for which CMS proposes specific valuations and valuation refinements are the following of interest to family physicians:

- Combination COVID-19 vaccine administration
- Immunization counseling (without vaccine administration)
- RSV monoclonal antibody administration
- Remote physiologic monitoring services

AAFP Comments:

Efficiency Adjustment

The AAFP agrees with CMS that many of the codes paid under the Medicare physician fee schedule have times in the CMS time files that do not accurately represent time spent in providing the service. We endorse CMS's efforts to correct this problem, as it has implications for both physician work and practice expense RVUs. We also endorse CMS's desire to get more empiric time data to inform its valuation of services under the fee schedule.

The proposal to address this issue by applying a 2.5% efficiency adjustment to work RVUs and physician service time for most services is directionally appropriate and will help to correct some of the distortions in physician time that have significantly overvalued many procedures and tests while undervaluing other services, such as evaluation and management. However, we encourage CMS to consider beginning by applying any such adjustment to a narrower range of codes. The AAFP agrees that time-based codes such as E&M, care management, and maternity care are properly excluded from such an adjustment. While some E&M codes may be chosen based on time or medical decision making, they all heavily depend on time spent with the patient and thus are not amenable to efficiencies that otherwise apply to

procedural or technology-oriented services. The fact any given E&M code may be selected based on time also makes them akin to other time-based services and thus properly excluded from the efficiency adjustment proposed by CMS. There may be reasons to exclude other services, too. For instance, new services, such as those valued within the past five years, likely do not merit an efficiency adjustment, especially if the values are based on empiric data. As CMS notes, gains in efficiency seem unlikely to occur over a short time. Instead, CMS may want to exempt non-time-based services valued at least five years ago or those that have been valued based on empiric data. However, we note that exempting recently valued codes without including an additional data requirement may lessen the incentives for interested parties to present empiric data.

Another refinement CMS may want to consider before finalizing its proposal concerns the length of the look-back period. Instead of 5 years, CMS may want to increase the look-back period to 10 years, for example. As CMS notes in the proposed rule, many codes have often gone more than 17 years since their last revaluation. In the intervening time, efficiencies have accrued, such as technological advancements, workflow improvements, and development of expertise. Application of five years of productivity adjustment captures less than half that time. A 10-year look-back period, while still less than a 17-year look-back period, would come closer to correcting for the distortions that have occurred over time. It would also create additional incentives for interested parties to empirically examine the intraservice time of the services in question and submit that data to CMS if they felt the efficiency adjustment was inappropriately applied.

To the extent CMS finalizes its proposal to apply the efficiency adjustment to the intraservice times and work RVUs of procedures, diagnostic tests, and other services, the AAFP would also strongly recommend making additional corresponding updates to the direct PE inputs for clinical labor and equipment costs and to factor all those changes into CMS's indirect PE methodology where appropriate. The AAFP recommends that CMS include these changes to be finalized in 2026. Failing that, CMS should make these changes in the 2027 physician fee schedule at the latest. Since the direct PE inputs for clinical labor and equipment costs are often impacted by the physician time, not making these changes creates a distortion in which CMS is not fully accounting for the efficiencies garnered over time as technology advances, workflows improve, and expertise develops. Procedures that become more efficient, for example, also reduce clinical labor time and costs and equipment costs (e.g., since the equipment is being used for less time).

The AAFP agrees that CMS should continue to seek and use empiric, accurate time data sources. Doing so will obviate the need for application of a makeshift efficiency adjustment based on the MEI productivity adjustment, especially when physicians do not otherwise receive an MEI-based update as part of the fee schedule. In the meantime, applying an

efficiency adjustment to the intraservice portion of the physician time and work RVUs every three years, concurrent with updates to the geographic practice cost indices and malpractice RVUs, is a reasonable proposal, especially for minor procedures that are typically performed many times per day and thus ripe for efficiency gains.

Lastly, the AAFP urges CMS to maintain physician involvement in the valuation of physician services. For instance, use of more empiric, accurate time data will not address the element of physician work known as "intensity." Physician input will continue to be needed for that and other aspects of CMS's RVU methodologies.

Valuation of Combination COVID-19 Vaccine Administration (CPT codes 90480 and 9X16X)

In September 2024, the CPT Editorial Panel created a new add-on code, 9X16X (each additional component administered (List separately in addition to code for primary procedure)), to report when each additional non-COVID vaccine component is administered with the COVID-19 vaccine. CPT revised code 90480 (Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SAR CoV2)(coronavirus disease [COVID19]) vaccine; first or only component of each vaccine administered) as part of this family of services.

CMS received RUC recommendations for CPT code 90480 that affirmed the September 2023 work and PE RUC recommendations. CMS previously established CPT code 90480 with a procedure status of "X" on the PFS and the code is therefore not payable under the PFS. Payment for this CPT code is also addressed under previously finalized policies associated with the emergency use authorization declaration. The Medicare national payment allowance effective for code 90480 for claims with dates of service on or after March 15, 2021, is $44.95.

CMS also received RUC recommendations for add-on CPT code 9X16X. The RUC recommendations for this CPT code do not include work or PE inputs as the recommendations suggest that the work and PE is already included in the administration base code and this add-on code is intended for tracking purposes of the second vaccine. Accordingly, CMS proposes to maintain procedure status "X" for CPT code 90480 and assign procedure status "X" to CPT code 9X16X.

The AAFP supports CMS's proposal to maintain procedure status "X" for CPT code 90480 since it is paid outside of the Medicare physician fee schedule. The AAFP also supports CMS's proposal to assign procedure status "X" to CPT code 9X16X. Like CMS, the AAFP understands new code 9X16X as intended for tracking rather than payment purposes.

Immunization Counseling (without vaccine administration) (CPT codes 90XX1, 90XX2, and 90XX3)

In 2022, CMS created six new HCPCS codes so that Medicaid providers could bill for stand-alone vaccine counseling, "State Health Official Letter #22-002 "Medicaid and CHIP Coverage of Standalone Vaccine Counseling"53. The six HCPCS codes are G0310-G0315. In May 2024, the CPT Editorial Panel created three new time-based CPT codes 90XX1, 90XX2, and 90XX3 to report vaccine counseling performed where a vaccine is not administered. The RUC requested that CMS delete HCPCS codes G0310-G0313, and replace them with the new CPT codes 90XX1, 90XX2, and 90XX3. However, CMS proposes to assign status indicator ("I") to each of these three services, as not valid for Medicare purposes. According to CMS, Medicare uses other coding for reporting of, and payment for immunization counseling, although CMS does not say what those other codes are apart from G0310-G0315, all of which are also status indicator "I" (i.e., not valid for Medicare purposes). CMS is not proposing any work RVUs or PE RVUs for any of the three new CPT codes.

The AAFP is discouraged by CMS's proposal in this regard. CMS's rationale for assigning status "I" to new codes 90XX1, 90XX2, and 90XX3 on the basis that Medicare uses other coding for reporting of, and payment for immunization counseling seems flawed from our perspective. We are not aware what other codes are available to report immunization counseling without administration under Medicare. As noted, the codes that CMS references, G0310-G0315, are active for Medicaid but not Medicare. The creation of those latter codes by CMS in 2022 suggests CMS understands the rationale and implications for the national urgency on this topic. Why CMS is unwilling to extend the same benefit to Medicare beneficiaries is unclear.

The AAFP urges CMS to assign new codes 90XX1, 90XX2, and 90XX3 status indicator "A" (i.e., active for Medicare payment) and accept the work RVUs and direct practice expense inputs recommended by the RUC in valuing the codes under the Medicare physician fee schedule. If CMS otherwise finalizes its proposal to assign status indicator "I" to these codes, then the AAFP respectfully requests CMS to at least publish the RUC recommended values, so they are available to other payers who choose to cover and pay for the codes.

RSV Monoclonal Antibody Administration

In September 2023, CPT created two Category I codes, 96380 and 96381 to report administration of respiratory syncytial virus (RSV), monoclonal antibody and seasonal dose, with and without counseling. These codes were effective October 6, 2023, for immediate use. CMS proposes the RUC-recommended work RVU of 0.28 for CPT code 96380 and 0.17 for CPT code 96381. CMS proposes the RUC-recommended direct PE inputs without refinement. The AAFP appreciates CMS' acceptance of the RUC's recommendations for these codes and supports CMS's proposals in this regard.

Remote Physiologic Monitoring Services

Remote physiologic monitoring (RPM) represents the remote monitoring of parameters such as weight, blood pressure, and pulse oximetry to monitor a patient's condition and inform their management. For CY 2026, the CPT Editorial Panel revised and expanded the RPM code set. None of the RPM codes (CPT codes 99091, 99474, 99XX5, 99457, and 99458) met the minimum survey requirements established by the RUC when they were considered at the January 2025 RUC meeting. As a result, the RUC-recommended that CPT codes 99091, 99474, 99XX5, 99457, and 99458 be resurveyed after 1 year of utilization data is available for this CPT 2026 code structure. All RPM codes are expected to be reviewed at the January 2028 RUC meeting.

CMS proposes the following for these codes:

For CPT code 99091, CMS disagrees with the RUC's recommendation of 0.70 work RVUs and proposes to maintain the current work RVU of 1.10 and the corresponding physician time inputs. The RUC did not recommend, and CMS is not proposing any direct PE inputs for CPT code 99091.

For CPT code 99XX5, CMS disagrees with the RUC's recommendation of 0.39 work RVUs and proposes a work RVU of 0.31, with 10 minutes or intra-service/total time, based on the total time ratio between the 20 minutes of total time assigned to CPT code 99457 and the 10 minutes of total time assigned to CPT code 99XX5. This ratio equals 50 percent, and 50 percent of the current work RVU of 0.61 assigned to code 99457 rounds to a work RVU of 0.31. CMS also proposes using this time ratio with the current PE inputs for CPT code 99457 for clinical staff time. Specifically, CMS proposes 5 minutes of CA021 intra-service clinical labor time and 15 minutes of CA037 post-service clinical labor time for CPT code 99XX5.

For CPT code 99453, which is a PE-only code, CMS proposes the RUC-recommended PE inputs without refinement.

For the PE-only CPT codes 99XX4 and 99454, the RUC's recommendations include a "digital remote physiologic monitoring device app," which is a per-click vendor fee that has not traditionally been included as a form of direct PE. CMS expresses concern with the RUC-recommended PE inputs for device supply and equipment based on CMS's perception that these inputs are difficult to accurately account for due to lack of substantive invoices and other types of supportive data. Given its concerns with the RUC-recommended PE inputs and its inability to verify the pricing for these inputs, CMS proposes to use Hospital Outpatient Prospective Payment System (OPPS) cost data to value CPT codes 99XX4 and 99454. CMS assumes the costs incurred in furnishing these PE-only codes would be the same across settings of care (physician office and hospital outpatient), since these codes do not have any physician work and only account for PE associated with device supply and data

transmission. Specifically, CMS proposes to divide the OPPS Geometric Mean Cost (GMC) for CPT code 99454, which is represented in a dollar amount, by the estimated CY 2026 PFS conversion factor (CF), which represents the dollar value of an RVU, to convert the GMC dollar amount into RVUs. The resulting value is the proposed PE RVU for CPT codes 99XX4 and 99454. CMS proposes the same valuation for both CPT codes 99XX4 and 99454 since the device is supplied to the beneficiary for the full 30-day period, regardless of the number of days that data is transmitted.

For CPT code 99457, CMS disagrees with the RUC's recommendation of 0.45 work RVUs and proposes to maintain the current work RVU of 0.61, the current work time of 20 minutes, and the current direct PE inputs.

For CPT code 99458, CMS disagrees with the RUC's recommended direct PE inputs and proposes to maintain the current inputs. Also, CMS proposes the RUC-recommended work RVU of 0.61 for CPT code 99458, which is also the current work RVU for this service.

For CPT code 99473, which is a PE-only code, CMS proposes the RUC-recommended direct PE inputs without refinement, as this code was reviewed by the RUC and resulted in no recommended changes for CY 2026.

For CPT code 99474, CMS proposes the RUC-recommended work RVU of 0.18 and direct PE inputs without refinement, as this code was reviewed by the RUC and resulted in no recommended changes for CY 2026.

In general, the AAFP supports CMS' proposals to maintain the current work RVUs and direct PE inputs for the existing RPM codes and to assign the work RVUs and clinical staff time for new code 99XX5 relative to 99457 based on a time comparison between the two codes. As CMS notes, despite the best efforts of the specialty societies involved, the RUC surveys for these codes did not generate the minimum number of responses typically required of RUC surveys when the RUC considered the codes in January 2025. As CMS also notes, all the RPM codes are scheduled to be reviewed again at the January 2028 RUC meeting. Given these facts, we think CMS' proposals related to the RPM codes are reasonable.

Regarding the proposed PE RVUs for PE-only CPT codes 99XX4 and 99454, the AAFP again thinks that CMS's proposal to use OPPS cost data for code 99454 as a basis for the PE RVUs under the MPFS is reasonable, pending further RUC review of the codes in January 2028.

That said, unlike CMS, we are not convinced of the validity of CMS' underlying assumption that the costs incurred in furnishing these PE-only codes would be the same across settings of care (physician office and hospital outpatient). The AAFP is inclined to believe that hospitals and health systems' bargaining and purchasing power may allow them to purchase equipment at a different cost than that incurred by physician practices, which extends to the

"digital remote physiologic monitoring device app," (i.e., per-click vendor fee) referenced by CMS. We do agree with CMS that it is reasonable to have the same valuation for both CPT codes 99XX4 and 99454 since the device is supplied to the beneficiary for the full 30-day period, regardless of the number of days that data is transmitted.

Lastly, we appreciate CMS' recognition that the technologies involved in providing RPM services continue to evolve and that, as a result, the issues involving the use of software and other forms of digital tools are becoming increasingly difficult to account for accurately in CMS's standard PE methodology. We strongly encourage CMS to work with the RUC's Practice Expense Subcommittee and the specialty societies to sort through these issues and develop appropriate changes to CMS's standard PE methodology in this regard before the RPM codes are reviewed again by the RUC in January 2028.

As we discuss in our response to CMS' comment solicitation on payment policy for software as a service, the AAFP recommends that CMS pilot temporary G-codes for remote monitoring that capture an expanded range of SaaS-generated data analysis. This would more accurately reflect the intensity and clinical value of the cognitive work that physicians perform to interpret and act on SaaS data. Piloting G-codes for SaaS-related remote monitoring tasks, including the review of predictive analytics, algorithm-generated alerts, and other non-face-to-face data analysis will allow CMS to evaluate feasibility, utilization, and impact across varied practice settings. These pilots would generate valuable data to inform future refinements to existing RPM codes, ensuring that asynchronous clinical decision-making is appropriately recognized and paid for. This is especially critical for physicians managing complex chronic and behavioral health conditions, where timely data interpretation can improve outcomes, reduce hospitalizations, and enhance quality of life. Supporting this work not only strengthens primary care but also advances the administration's broader goals of making America healthy again.

The AAFP welcomes the opportunity to serve as a collaborative partner to CMS in this effort. We stand ready to contribute clinical expertise and policy insight to support the development or refinement of CPT codes for remote monitoring and to ensure that valuation for SaaS-related work is both clinically meaningful and operationally feasible.

<u>Evaluation and Management (E/M) Visits (section II.F.)</u>

In 2024, CMS finalized the G2211 add-on HCPCS code that "reflects the time, intensity, and PE resources involved" in furnishing certain E/M services, specifically office/outpatient E/M services (CPT codes 99202-99215). Since then, stakeholders have recommended that CMS either establish a separate add-on code specific to home-based visits or expand the use of G2211 to be reported alongside home and residence E/M visits. CMS believes home and residence E/M services involve similar resource costs involved in building trust in a long-term

patient-physician relationship. Therefore, CMS is proposing to allow HCPCS code G2211 to be reported as an add-on code with home or residence E/M services (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350). The descriptor would be updated as follows:

> *"(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to home or residence or office/outpatient evaluation and management service, new or established))."*

AAFP Comments:

The AAFP strongly supports this proposal and urges CMS to finalize it as written. For many Medicare beneficiaries, especially the most vulnerable, home-based medical care serves as the continuing focal point for most, and sometimes all needed health care services. Family physicians who do home-based primary care maintain the relationship and continuity that G2211 is meant to value but have been prohibited from reporting it when their care for patients occurs in the home rather than the office. We thank CMS for making this update to ensure physicians providing this essential care in the home can be appropriately compensated and continue doing so.

Enhanced Care Management (section II.G.)

Integrating Behavioral Health into Advanced Primary Care Management (APCM)

In finalizing APCM services in the CY 2025 final rule, CMS noted that they viewed behavioral health integration (BHI) services as complementary to APCM services but continued to have interest in the use of BHI as they relate to APCM. In this year's proposed rule, CMS states that they believe those providing APCM services should be able to provide BHI and collaborative care management (CoCM) services without needing to document their time. CMS believes this will help facilitate a more holistic, team-based approach. They point out that a practice would need to establish a workflow to track time for BHI and CoCM but not APCM. CMS believes many practices that develop interdisciplinary teams to provide APCM are also the ones most likely to provide BHI and CoCM services.

For CY 2026, CMS is proposing to create optional add-on codes for APCM services that would facilitate providing complementary BHI services by removing the time-based requirements of the existing BHI and CoCM codes. By reducing the burden, CMS believes primary care practitioners may be more likely to offer and furnish BHI and CoCM services, therefore improving access to those services for primary care patients. The proposed codes

would be considered a "designated care management service" that could be provided by auxiliary personnel under the general supervision of the billing practitioner.

The BHI add-on codes could be reported when the APCM base code is reported by the same practitioner in the same month. GPCM1 would be based on CPT code 99492, GPCM2 would be based on CPT code 99493, and GPCM3 would be based on CPT code 99484. They are not proposing to create an add-on code for CPT code 99494, as it describes additional time and the proposed codes do not have a time threshold.

CMS proposes to crosswalk to the corresponding work RVU values. They also propose a direct crosswalk to the current PE amounts. CMS welcomes comments on this approach.

AAFP Comments:

The AAFP is encouraged by CMS' continued efforts to reduce the burden associated with care management services, including behavioral health integration and collaborative care management services. And we support CMS' proposal to establish add-on codes for behavioral health integration and collaborative care management that may be reported with APCM services. Primary care physicians are often the first point of contact for patients needing mental health care. Studies[7] have shown that BHI can improve depression severity and enhance patient experience of care. Patients receiving CoCM are less likely to go to the emergency room and less likely to require inpatient psychiatric care.[8] The AAFP strongly supports policies like this that further promote the provision of integrated behavioral health along with a comprehensive and longitudinal primary care relationship. **To further increase access and eliminate barriers, we urge CMS to remove patient cost-sharing for the add-on codes.**

The AAFP supports CMS' proposal to base the new add-on codes on the BHI and CoCM CPT codes. We also support the proposals to crosswalk the work RVUs and use a direct crosswalk to the current PE amounts.

If finalized, the AAFP asks CMS to issue guidance on any consent requirements. For example, would there need to be separate consent for the new BHI Add-on codes, or would practices need to amend their APCM consent to include the new codes? We also encourage CMS to clarify whether there are any new or different documentation requirements for the add-on codes compared to the CPT codes.

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[7] https://www.jabfm.org/content/30/2/130.long
[8] https://www.healthymindspolicy.org/research/understanding-integrated-behavioral-health-care-and-the-collaborative-care-model

Request for Information related to APCM and Prevention

In response to the CY 2025 MPFS, commenters raised concerns that cost sharing could be a barrier for many beneficiaries and may limit uptake of the codes. Many commenters recommended that CMS eliminate cost-sharing for APCM services while others suggested that APCM services are preventive and should therefore be exempt from cost-sharing. CMS responded that they did not see how APCM fits within the preventive services benefit categories. Upon further review and analysis, CMS now believes that there are some service elements of APCM that are substantively similar to certain aspects of the "personalized prevention plan services" described under section 1861(hhh)(1) of the Act. Since APCM is a bundle of different care management and communication technology-based services (CTBS), there are other service elements that may be covered under Medicare Part B and carry cost sharing obligations.

CMS notes that the blending and balancing of preventive and treatment services are inherent to advanced primary care practices and effective care management. Given these factors, CMS seeks comments on how they should consider the application of cost-sharing for APCM services, particularly if they were to include preventive services within the APCM bundles.

AAFP Comments:

As we expressed in our comments in response to the CY 2025 MPFS NPRM, we are grateful for CMS' work to improve payment for primary care services through the creation of the APCM code set and also commend CMS for its comprehensive approach to improving physician payment in this year's proposed rule. The delivery of comprehensive primary care services under Medicare Part B is challenging due to a number of interconnected barriers: budget neutrality, the lack of an inflationary update, cost-sharing limitations, and numerous challenges related to the transition to meaningful value-based care models. However, perhaps the greatest challenge primary care faces under Medicare Part B is that the very nature of fee-for-service (FFS) code-based reimbursement is incompatible with the comprehensive, continuous, and relationship-based nature of primary care. Despite this, we again commend CMS for using its authority to address issues like gained efficiencies and practice expense to improve payment accuracy under the MPFS and provide some marginal relief for primary care providers, in addition to the introduction of APCM.

The AAFP greatly appreciates that CMS has taken the feedback of AAFP and others into consideration and is seeking further input on potential avenues to waive patient cost-sharing and further refine the APCM services to reflect the comprehensive nature of

primary care. We recommend that CMS waive cost-sharing for APCM services in 2026 and provide our rationale for doing so.

As CMS points out, prevention and treatment must be simultaneously balanced in the provision of advanced primary care. This principle is foundational to the AAFP's definition of comprehensive care, which emphasizes the **concurrent prevention and management** of multiple physical and emotional health problems over time, in the context of family, life events, and environment. We appreciate CMS' acknowledgement that prevention and treatment are not competing priorities, but complementary pillars of primary care.

We also appreciate that CMS is approaching APCM as a solution to address the structural mismatch between FFS payment and primary care that has resulted in the absence of payment for many essential primary care service capabilities and tasks. For those services that are eligible for payment, billing requirements are often administratively burdensome and undervalued. Addressing these payment challenges is central to improving the level of primary care workforce dissatisfaction and dissipation we are currently witnessing.[9] We appreciate that CMS is taking steps to address these critical problems with APCM and other proposed rules noted above.

As we stated in our comments last year, embedding a population-based payment in the MPFS runs the risk of codifying years of underinvestment in primary care. The AAFP supports APCM and its evolution as an important step toward improving payment for advanced primary care while also encouraging CMS to not lose sight of the need for more significant primary care payment reform. In addition to encouraging CMS to use data and seek feedback from physicians and patients, **the AAFP offers these recommendations and stands ready to collaborate with CMS and other stakeholders to ensure primary care payment reform is comprehensive and sufficient to secure the stability of the current and future workforce.**

- FFS, code-based reimbursement is unlikely on its own to accomplish the necessary level of primary care payment reform. CMS will need to continue to be creative in its more comprehensive health care payment and financing strategies to achieve its goal of strengthening primary care.
- Ensure APCM and other new primary care codes are valued appropriately which will require seeking information and other empiric data sources beyond what is represented in historically undervalued primary care MPFS payment.
- Eliminate patient cost-sharing that inhibits access to much needed high-value care for patients, especially those most in need of this care.

[9] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-primary-care-workforce-2023.pdf

- Ensure important patient interactions, like the annual wellness visit, continue to be incentivized for both patients and their primary care physicians.
- Address data and other systemic issues that make measuring progress challenging, including the Value in Primary Care MVP required for APCM implementation, to ensure it does not create impediments to the adoption of this new payment opportunity.
- Primary care has proven to be essential to the success of accountable care organizations. We encourage CMS to continue to seek creative ways to ensure primary care is recognized and well-funded within accountable care models, including support and expansion of Primary Care ACO Flex and incentivizing APCM implementation in MSSP models.

We offer the following comments in response to CMS' RFI related to APCM and Prevention:

How should CMS account for cost sharing if APCM includes both preventive and other Part B services?

The AAFP believes there is sufficient and meaningful alignment between APCM and prevention for CMS to waive cost-sharing and recommends that CMS eliminate cost-sharing in full for APCM services starting in 2026. We do not recommend a partial reduction in cost-sharing that is likely to be impractical to implement and confusing to practices and patients.

The AAFP believes the majority of services provided by a patient's primary care physician should not be subject to cost-sharing. We agree with CMS that there is a strong degree of alignment between elements of APCM and the "personalized prevention plan services" included in the Annual Wellness Visit (AWV) and that this should qualify APCM services for waived cost-sharing. We appreciate that CMS took initial steps in the 2025 MPFS final rule to recognize this rationale by allowing the care plan developed as part of the AWV to satisfy the patient-centered comprehensive care plan element of APCM and believe this strong link between the AWV and APCM provide strong rationale for cost-sharing waiver.

As CMS notes, there are many aspects of the AWV and APCM that complement each other. For example, the health risk assessment of the AWV can be used as a starting point to identify which additional care management activities of APCM may be most beneficial and applicable to the patient. Moreover, APCM includes "system-based approaches to ensure receipt of preventive services." This ensures that patients actually receive the crucial preventive services that are included in the screening schedule established as part of the personalized prevention plan under 1861(hhh)(2)(E) of the Act.

The AAFP is greatly appreciative of CMS' expressed commitment and ongoing support for preventive services and effective management of chronic disease. Family physicians are the first point of contact for patients and provide comprehensive, continuous care that spans primary care prevention, early detection/secondary prevention, and long-term management/tertiary prevention of chronic conditions. **Eliminating patient cost-sharing for these services through APCM is an important step toward realizing this level of care by family physicians and we stand ready to support our members in its implementation.**

Should CMS consider including the Annual Wellness Visit, depression screening, or other preventive services in the APCM bundle, and if so, which services and why?

The AAFP strongly believes that APCM in its current form is sufficiently aligned with preventive services for CMS to waive cost-sharing. Only if CMS is unable to identify an alternative mechanism to waive cost-sharing, would the AAFP agree with exploring the inclusion of either the depression screening or the AWV in the APCM bundle. We stand ready to collaborate with CMS and other stakeholders to address the implementation of this approach to ensure success for physicians and their patients.

If CMS believes it must include additional services in APCM to waive cost-sharing, the AAFP strongly urges CMS to account for valuation of those services with a corresponding and adequate increase in the valuation of each APCM service level. Further, AAFP recommends that the inclusion of these services in the APCM should be framed as service capabilities like current APCM billing guidance that states: *To bill for APCM services, you must complete these elements when they're clinically appropriate for the individual patient (you don't have to provide all of these services every month).*

In this vein, the AAFP would be supportive of a new APCM service element focused on outreach to ensure the beneficiary receives the specified preventive service from their primary care physician or care team. We believe the depression screening is better suited than the AWV for such an approach. Like the other services already included in APCM, the time requirements of the depression screening are unnecessary and burdensome for many family physicians. For inclusion of depression screening in APCM, the element could be for practices to conduct outreach to patients to encourage that screenings be conducted at the appropriate time (e.g., based on the screening schedule developed during their AWV).

While we discourage CMS from including the AWV in the same way due to its value to patients and physicians as a focused service that is foundational to a longitudinal primary care relationship. If included, the APCM requirement could similarly reflect conducting outreach to patients to schedule the AWV with the patient's PCP. Framing a new requirement related to AWV in this way would support the existing element "System-based approaches to ensure receipt of preventive services." Since consent requires informing patients that they

should only receive APCM from one physician or clinician, we feel this approach would also help reinforce the importance of the PCP relationship and reduce instances of beneficiaries receiving the AWV or depression screening from a third-party vendor thereby protecting CMS from potentially paying for duplicative services.

As noted in our comments on the 2025 MPFS proposed rule, the AAFP discourages establishing prerequisites to billing APCM services, as it would introduce unnecessary complexities and cause confusion for practices and beneficiaries. Similarly, **we do not recommend that CMS make billing for depression screening or AWV (if either service is included) a prerequisite for reporting APCM services for the following reasons:**

- APCM services currently require a patient to have an established relationship or an initiating visit. Altering this would put pressure on practices to perform an AWV and introduce new tracking requirements for APCM billing eligibility.
- In addition to being an operational challenge, it could cause confusion among beneficiaries who are used to receiving these services during a specific month and may not understand why they are suddenly receiving them at a different time (especially if they had a recent AWV or are already enrolled in APCM).
- If a beneficiary receives an AWV or depression screening from someone other than their PCP, their PCP would be ineligible to report APCM services when they are otherwise providing the remaining components of APCM to the beneficiary. This could even include instances where the beneficiary received the service from a different physician within the same practice.

If CMS believes it must pursue an approach that includes requirements related to the depression screening or the AWV within the APCM bundle, the AAFP recommends that CMS provide additional resources and guidance on the following implementation issues and offers its support in helping CMS to understand the physician and practice perspective.

- Establishing processes with the MACs to allow practices to submit ghost claims for the included depression screening or AWV. CMMI has already established similar processes in their models. For example, MACs zero-pay claims submitted for services covered by the prospective payments in Making Care Primary. Allowing ghost claims would ease the operational burden for practices since they would not need to make significant changes to their billing processes. It would also ensure the practice still receives credit for any performance measures that rely on HCPCS codes for depression screenings or the AWV to calculate a numerator or denominator (e.g., Quality ID 134: Screening for Depression and Follow-up Plan).

- Whether consent needs to be re-obtained for patients already enrolled in APCM and/or any new elements that must be communicated as part of the consent process.
- Any changes to documentation requirements. We would also recommend CMS expand on its existing documentation guidance, as the AAFP has received questions from our members who are unsure what needs to be reflected in the patient record. CMS stated that practices were essentially attesting to their ability to meet the APCM requirements when they reported the service. However, it is unclear how CMS would determine that during a medical record review. Without clear and detailed guidance, they are hesitant to bill for APCM because they are concerned about audits.
- Tools to help practices better understand how APCM would impact their revenue compared to billing each service individually, as it may help practices feel more comfortable with implementing APCM. The AAFP has heard from members that they are reticent to transition from billing individual services to APCM because they are unsure of the financial impact and how to adjust their billing processes. Unlike CMMI models, where payments are truly prospective and for an assigned population, the nature of APCM introduces unique challenges for practices to fully understand the impact it may have on their revenue. This will be particularly helpful for practices that are less familiar with bundled payments as well as if CMS adds services to the APCM bundle.

Should CMS consider other changes to APCM or additional coding to further recognize the work of advanced primary care practices in preventing and managing chronic disease?

The AAFP is encouraged by the introduction of APCM but reiterates our concern that the discrete coding structure and budget-neutral valuation constraints of the MPFS represent inherent challenges. To achieve primary care payment that fully recognizes the work of advanced primary care practices in preventing and managing chronic disease requires broader payment reforms that go beyond the creation of new codes. New billing codes will provide an impactful solution only when they truly reduce administrative burdens associated with getting paid and increase payment levels to a degree that rectifies the long-term under-investment in primary care ensuring that we retain and grow the workforce needed to meet the needs of an increasingly aging and unhealthy population.

The AAFP again cautions CMS on the use of the MVP as a requirement to bill APCM. Our primary concern is that making a practice's ability to bill specific services contingent on performance measurement reporting is unprecedented and could lead to an uneven playing field across practices with different data and reporting capabilities, thus hindering CMS' primary goal of strengthening primary care for all of its beneficiaries.

We agree with CMS that the Value in Primary Care MVP aligns with the service requirements and practice capabilities outlined in the Advanced Primary Care Management (APCM) codes. However, we remain concerned that several MVP measures—while conceptually aligned with primary care—are difficult to implement in practice due to persistent health data silos and interoperability challenges. Measures like Adult Immunization Status impose ongoing administrative burden on primary care practices due to persistent data silos and systems that make reporting challenging. Tying the ability to bill APCM codes to these reporting requirements risks creating an uneven playing field between well-resourced practices able to address these challenges and smaller resource-constrained practices,

While the APCM proposal is designed to be cost-neutral relative to existing care management codes, it introduces more extensive operational and reporting requirements—some of which are duplicative of other QPP policies and more burdensome than any previously imposed through rulemaking. **To support widespread adoption of APCM codes, CMS should address systemic issues related to data and measurement reporting to ensure use of the MVP is not a deterrent to adoption of APCM, regardless of a practice's size or sophistication. While it works toward systemic solutions, CMS should consider eliminating the requirement to report through the Value in Primary Care MVP as a condition of billing these services.**

As with all new HCPCS or CPT codes, implementation and uptake of APCM will increase gradually as more practices become aware of the service and patients recognize its benefits providing consent for billing. APCM is still in the early stages of adoption and **the AAFP recommends that CMS continue gathering data and feedback on APCM from physicians and other clinicians, as well as patients.**

Should CMS consider new payments to SSP ACOs for prospective monthly APCM payments to be delivered to primary care practices that satisfy APCM billing requirements, with the payments reconciled under the ACO benchmark?

As reflected in our support for the Primary Care Flex model, the AAFP believes prospective monthly APCM payments to SSP ACOs that are delivered to primary care practices that satisfy the billing requirements could be beneficial as a mechanism for strengthening upfront and more predictable revenue to practices – a payment consideration especially important for smaller, independent practices. Prospective APCM payments would expand the opportunity for more primary care practices in SSP ACOs to transition toward a more predictable revenue model and begin shifting away from sole reliance on FFS. If CMS pursues a new prospective monthly APCM payment option, we strongly recommend that CMS make it available to all primary care practices in an SSP ACO, regardless of track.

As with other advanced or capitated payments made to ACOs, it is important that funds are appropriately allocatebd and distributed to the practices delivering the care. Understanding that ACOs have varying organizational structures, the AAFP recommends CMS allow the ACO to decide whether the payments would go to the ACO or directly to the primary care practices. When payments are provided to the ACO, we recommend that CMS stipulate a maximum level of retention by the ACO (for delivery of specific qualified services) and/or a minimum percentage that must flow to primary care practices.

The AAFP asks CMS to explore policies that would exclude ACPM from year-end reconciliation for ACOs that elect to receive a prospective monthly APCM payment.

Should CMS consider other updates to APCM services or SSP policies that would drive increased participation of primary care practitioners in ACOs

The AAFP is supportive of optional prospective monthly APCM payments for SSP ACOs as an incremental step toward a more robust payment option for primary care. In 2023, SSP ACOs yielded more than $2.1B in net savings, representing the largest savings in the program's history. ACOs led by primary care clinicians consistently generate higher net per capita savings than ACOs with a smaller proportion of primary care clinicians. These results once again reinforce the importance of primary care in ACOs.[10]

The AAFP believes to adequately support primary care's unique role in caring for the whole person, payments need to shift away from the predominant reliance on FFS toward prospective payment sufficient to support a comprehensive array of primary care services delivered by physicians and care teams. One study estimated that more than 60% of a primary care practice's revenue needs to be prospective, non-FFS to sustainably support comprehensive, team-based primary care. Making a hybrid payment option that includes non-FFS primary care payment (e.g., capitation, population-based payment) available to all risk tracks in MSSP is a necessary step for CMS to fully realize the benefits of the program and achieve its beneficiary goals – particularly for those with high needs or in underserved areas.

When designing the non-FFS components of primary care payment, ACOs and their primary care practices should have flexibility to select a level of payment that corresponds to their practice capabilities. This flexibility will allow smaller, independent, and new entrant practices to participate in alternative payment approaches. Ideally, ACOs could gradually increase to higher levels of non-FFS payment as they gain more experience and take on more risk.

As noted above, ACOs and their participating practices should have a choice as to how non-FFS payments are delivered. Whether the payment goes to the ACO with some minimum

[10] https://www.cms.gov/newsroom/press-releases/medicare-shared-savings-program-continues-deliver-meaningful-savings-and-high-quality-health-care

level of distribution to practices or goes directly to the primary care practices, will vary based on many factors, including the degree of centralized practice support provided by the ACO.

Finally, we recommend CMS consider additional ways to support independent practice participation in MSSP including:

- Ensure independent practices are represented in ACO governance.
    - Establish clear guidelines for maximum revenue retention by ACOs, including the maximum percentage that can be used to fund a clearly defined list of ACO primary care support services.
    - Require ACOs receiving non-FFS primary care payments to help participating practices build the capacity to independently receive and effectively support the provision of comprehensive primary care.
    - Provide the ability to gradually increase to higher levels of non-FFS payment.
    - Provide an entry point at a lower beneficiary alignment threshold.

Advancing Access to Behavioral Health Services (section II.I.)

1a. Updates to Payment for Digital Mental Health Treatment (DMHT)

CMS proposes expanding coverage under HCPCS codes G0552, G0553, and G0554 to include FDA-authorized DMHT devices for ADHD cleared under section 510(k) of the FD&C Act or granted De Novo authorization by FDA and in each instance classified at §882.5803, in addition to mental health conditions already covered for conditions under 21 CFR 882.5801, including depression, anxiety, and substance use disorders. This expansion allows additional reimbursement opportunities for FDA-approved DMHT devices used to treat ADHD or its symptoms, provided they meet CY25 MPFS billing requirements. CMS also clarifies that the billing practitioner no longer needs to be the one who diagnosed the patient's mental health condition.

CMS is soliciting public input on whether to establish new codes and payment structures for digital tools/apps used in behavioral health care that do not require FDA authorization. These tools may support treatment adherence, monitor progress, or promote healthy behaviors. CMS seeks data on clinical use, effectiveness, and payment benchmarks, especially in cases where clinicians incorporate these tools without incurring device costs.

AAFP Comments:

DMHT code expansion to ADHD devices

While the AAFP supports CMS's proposal to expand payment for FDA-authorized, clinically validated DMHT devices for ADHD, we caution that the policy may fall short of its intended impact unless technological access barriers, clinical integration, and provider support are adequately addressed.

This expansion represents a meaningful step toward improving access to behavioral health services, particularly for patients in communities where provider shortages persist. Further, we appreciate CMS removing the requirement for the billing practitioner to be the diagnosing practitioner for DMHT devices. That said, we encourage CMS to ensure these tools are accessible to all Medicare beneficiaries who need them, particularly older adults and low-income individuals who are less likely to have access to broadband or the digital literacy needed to benefit from these technologies. We encourage CMS to explore incorporating targeted mechanisms within the CY26 MPFS to support the use of digital mental health tools among Medicare beneficiaries who face barriers to technology access. These mechanisms may include, but are not limited to, providing add-on payments for providers who assist patients with DMHT onboarding, and collaborating with existing CMS programs to subsidize broadband access for rural beneficiaries.

Additionally, to maximize the benefits of reimbursement for DMHTs, we encourage CMS to ensure they are properly integrated into clinical workflows. Many DMHTs are designed for self-guided use, which can be especially challenging for individuals with ADHD who may struggle to stay engaged with treatment. This also makes it harder for clinicians to track patient progress and ensure consistent adherence. A 2024 feasibility study found that digital tools implemented without structured integration into clinical workflows led to fragmented treatment and limited follow-up.[11] Given that primary care physicians are often the first point of contact with the health care system for most patients, it is essential that CMS support both EHR integration of DMHTs and reimbursement for clinician training. Without these supports, newly covered devices risk being used inconsistently or outside recommended treatment plans. To ensure safe and effective implementation, AAFP urges CMS to reimburse these foundational elements. Further, given CMS's own acknowledgment of low uptake of these codes, investing in physician education and infrastructure will not only improve care quality but also increase utilization of the services these codes are designed to encourage.

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[11] Carpenter-Song E, Acquilano SC, Noel V, Al-Abdulmunem M, Torous J, Drake RE. Individualized Intervention to Support Mental Health Recovery Through Implementation of Digital Tools into Clinical Care: Feasibility Study. Community Ment Health J. 2022 Jan;58(1):99-110. doi: 10.1007/s10597-021-00798-6. Epub 2021 Feb 21. PMID: 33611684; PMCID: PMC7897361.

Reimbursing non-FDA approved DMHT tools/apps

The AAFP encourages CMS to delay reimbursement for non-FDA authorized tools until sufficient clinical effectiveness data is available to secure FDA authorization and avoid adding codes that increase billing complexity without clear and proven benefit.

The landscape of behavioral health tools grows highly variable and largely unregulated. Reimbursing non-FDA approved digital tools introduces products with unproven clinical efficacy, potentially risking taxpayer dollars and compromising patient safety. As noted above, the AAFP supports reimbursement for FDA-authorized DMHT devices, as FDA authorization ensures a minimum threshold of safety and effectiveness. We strongly urge CMS to apply these same standards consistently across all DMHT tools considered for coverage to safeguard quality and patient outcomes.

We strongly advise against the creation of new CPT codes for digital tools that do not meet FDA authorization criteria. According to the Substance Abuse and Mental Health Services Administration, while some digital therapeutics have demonstrated effectiveness, many other digital platforms marketed for behavioral health lack robust clinical evidence and may exacerbate poor health outcomes for users, particularly among rural, minority, and vulnerable populations.[12] Moreover, expanding CPT codes for unvalidated tools will also increase the administrative burden on overburdened physicians. Behavioral health coding is already complex, and additional codes may lead to more clinician confusion, billing errors, and documentation challenges. Thus, we encourage CMS to delay reimbursement to ensure any reimbursed tools are clinically validated, FDA-authorized, and therefore more likely to be accessible across rural, minority, and vulnerable populations, accounting for differences in digital literacy and broadband access.

1b. Comment Solicitation on Payment Policy for Software as a Service (SaaS)

CMS claims that the data used in their PE methodology has aged and does not account for modern software tools. SaaS tools often involve licensing and analysis fees outside of traditional costs like equipment and supplies that the PE methodology does include. CMS cites historically assessing SaaS software on a case-by-case basis but now proposes a standardized approach and issued an RFI with the following questions:

1. What factors should we consider when paying for SaaS?
2. What has the experience been of risk-based payment arrangement participants with incorporating SaaS under their payment arrangements?
3. Have risk-based payment arrangements reflected the underlying value of SaaS to the practice of medicine?

[12] Digital Therapeutics for Management and Treatment in Behavioral Health

4. Given the limitations of the PE methodology to account for this kind of technology, what alternative pricing strategies should CMS use to accurately pay for SaaS and AI devices under the PFS?
5. How should CMS value the physician work associated with utilizing and interpreting the clinical outputs associated with SaaS and AI devices?
6. Is there an alternative data source outside Medicare claims data currently available and hospital invoices provided by manufacturers which may not fully depict total hospital acquisition costs that can accurately reflect the total costs of the SaaS?
7. How are these technologies used in the treatment of chronic disease?
8. How may CMS best evaluate the quality and efficacy of SaaS and AI technologies?

AAFP Comments:

1. *What factors should we consider when paying for SaaS?*

Family physicians are the cornerstone of whole-person care, particularly in managing behavioral health and chronic conditions. As the first point of contact for many patients and the primary coordinators of longitudinal care, family physicians are increasingly relying on SaaS tools to deliver timely, data-driven, and patient-centered care. Recent findings from a joint survey conducted by the AAFP and Rock Health, a digital health strategy group, underscore the growing role of digital tools in primary care. Notably, 23% of respondents reported using AI-enabled technologies for clinical purposes, including diagnostic support, treatment recommendations, and patient monitoring - functions commonly embedded within SaaS platforms. This reflects a broader shift toward digitally enabled care models that demand thoughtful reimbursement strategies.

To ensure SaaS tools enhance rather than hinder care delivery, we encourage CMS to consider the following key operational and clinical considerations in future payment policy:

a. **Mitigate cost and implementation barriers for small and independent practices adopting SaaS.** Nearly one-third of family physicians practice in independently owned settings.[13] These practices often lack capital, IT infrastructure, and administrative support to absorb the costs of SaaS tools. Further, existing SaaS pricing models, whether subscription-based, tiered, or per-user, can be prohibitively expensive. Without adequate reimbursement for implementation, maintenance, and staff training, adoption will be uneven and may widen gaps in access for the practices most in need of these tools. We encourage CMS to consider providing direct

[13] One-Third of Family Physicians Remain in Independently Owned Practice, 2017–2019 | American Board of Family Medicine

reimbursement mechanisms for SaaS-related costs, add-on codes or modifiers to reflect the operational burden of deploying SaaS, and payment adjustments for practices serving rural and under-resourced populations.

b. **Reimburse the clinical effort required to use and act on SaaS-generated data.** SaaS platforms generate a continuous stream of clinical data that demands meaningful physician engagement ranging from interpretation and decision-making to treatment planning and patient follow-up. These activities require time, cognitive effort, and clinical judgment - yet much of this work occurs outside of billable encounters. The burden is especially pronounced in small and independent practices, where limited staffing and financial margins make it difficult to absorb non-reimbursed tasks. Reducing this burden is imperative as the value of SaaS tools is particularly evident in caring for patients with multiple chronic or behavioral health conditions, where these platforms enable more proactive and coordinated care.[14] We elaborate on this topic below under our response on "How to value physician work related to interpreting SaaS outputs."

c. **Enforce EHR integration and interoperability of SaaS.** Family physicians rely on streamlined clinical workflows to efficiently manage the complex needs of their patients. SaaS tools that do not integrate with certified EHRs can create duplicative documentation burdens, data silos, and clinician frustration. In paying for SaaS, CMS must prioritize adherence to FHIR interoperability standards and incentivize vendors to meet these requirements to ensure seamless data exchange and workflow alignment. **Strengthen data privacy, security, and ownership protections.** Finally, it is imperative that CMS address data privacy, security, and ownership. Family physicians are stewards of sensitive patient information and must be confident that SaaS vendors meet HIPAA and cybersecurity standards. We urge CMS to clarify data ownership policies and ensure that patients and providers retain control over health data generated by third-party tools. While we are strongly supportive of making data reliably interoperable along with maintaining patient confidentiality, we also acknowledge that ensuring health data privacy long-term is going to require a federal citizen data privacy law and regulatory framework. We urge CMS to work with Congress to develop a national data privacy law that would adequately safeguard patients' health data that flows within the health care ecosystem, yet outside of HIPAA's protections

[14] Endalamaw, A., Zewdie, A., Wolka, E. *et al.* A scoping review of digital health technologies in multimorbidity management: mechanisms, outcomes, challenges, and strategies. *BMC Health Serv Res* **25**, 382 (2025). https://doi.org/10.1186/s12913-025-12548-5

5. *How should CMS value the physician work associated with utilizing and interpreting the clinical outputs associated with SaaS and AI devices?*

To appropriately value physician work in interpreting SaaS outputs, CMS must account for the full scope of clinical and cognitive effort involved in using these tools to deliver high-quality care. SaaS platforms increasingly produce large volumes of patient data from symptom tracking and behavioral health assessments to predictive analytics and algorithm-generated alerts. For family physicians, especially those managing patients with multiple chronic or behavioral health conditions, interpreting this data is not a passive task. It requires careful analysis, nuanced clinical judgment, and coordinated follow-up, often outside of traditional, billable encounters. The Office of the National Coordinator for Health IT recognized as early as 2017 that interpreting patient-generated data is a distinct and resource-intensive clinical activity.[15] Since then, the complexity and volume of SaaS tools have grown substantially, yet the time and cognitive effort physicians invest in applying this data remain undervalued in current payment structures. **As primary care physicians face growing demands and persistent workforce shortages, it is critical that any valuation framework for SaaS-related work addresses cognitive work and avoids adding administrative burdens that detract from patient care. Instead, CMS should pursue streamlined, clinically relevant approaches that reflect the realities of asynchronous, data-driven decision-making**.

While we recognize and appreciate CMS's improvements to E/M codes and the availability of CCM CPT codes to support care delivered outside of traditional visits, we agree with CMS, that there remains a gap in how physician cognitive work related to SaaS platforms is valued. E/M codes, despite improvements in accounting for physician time, continue to primarily apply to discrete, face-to-face encounters and do not fully reflect the asynchronous, longitudinal decision-making that SaaS output analysis often requires. Similarly, while CCM codes appropriately support time-tracked care coordination outside of traditional visits, they fall short of reflecting the clinical judgment and cognitive effort required to interpret real-time data, evaluate algorithmic risk scores, and make treatment decisions based on predictive analytics generated by SaaS.

RPM codes (e.g., 99457 and 99458), however, offer a promising pathway for payment innovation. These codes could be expanded to recognize the cognitive work physicians perform when analyzing complex, asynchronous data generated by SaaS platforms. While these codes currently support billing for certain types of patient-generated data, they don't fully capture the cognitive work required to review real-time SaaS data, assess algorithmic risk scores, and synthesize predictive analytics. Expanding these codes could help ensure that

[15] onc_pghd_practical_guide.pdf

the full scope of physician effort in SaaS-enabled care is appropriately recognized and paid for.

The AAFP recommends that CMS pilot temporary G-codes for remote monitoring that capture an expanded range of SaaS-generated data analysis. This would better reflect the intensity and clinical value of the cognitive work that physicians perform to interpret and act on SaaS data. Piloting G-codes for SaaS-related remote monitoring tasks, including the review of predictive analytics, algorithm-generated alerts, and other non-face-to-face data analysis will allow CMS to evaluate feasibility, utilization, and impact across varied practice settings. These pilots would generate valuable data to inform future refinements to existing RPM codes, ensuring that asynchronous clinical decision-making is appropriately recognized and paid for. This is especially critical for physicians managing complex chronic and behavioral health conditions, where timely data interpretation can improve outcomes, reduce hospitalizations, and enhance quality of life. Supporting this work not only strengthens primary care but also advances the administration's broader goals of making America healthy again.

The AAFP welcomes the opportunity to serve as a collaborative partner to CMS in this effort. We stand ready to contribute clinical expertise and policy insight to support the development or refinement of CPT codes for remote monitoring and to ensure that valuation for SaaS-related work is both clinically meaningful and operationally feasible.

6. *Is there an alternative data source outside of the limited Medicare claims data currently available and hospital invoices provided by manufacturers, which may not fully depict total hospital acquisition costs, that can accurately reflect the costs of the SaaS?*

Current data sources, such as Medicare claims and manufacturer-provided hospital invoices, offer only a partial view of SaaS costs and do not reflect the full financial and operational realities of implementation across care settings. This is particularly concerning for small, independent, and rural practices, which often lack the negotiating leverage of large health systems and face greater cost burdens. Nearly one-third of Medicare beneficiaries in the most rural areas are managing five or more chronic conditions, compared to 25% in urban areas, and frequently rely on these practices for ongoing care.[16]

Commercial claims databases like MarketScan and HCCI, and state-level All-Payer Claims Databases (APCDs), provide useful service-level utilization data but are limited in scope. They often lack visibility into acquisition costs, vendor contracts, and clinical integration, nor are they designed to capture the complex pricing models of SaaS, including licensing, cloud

[16] Key Facts About Medicare Beneficiaries in Rural Areas | KFF

hosting, cybersecurity, change management costs, and ongoing updates. The proprietary nature of commercial claims databases and variability across states in APCDs further constrain their utility for comprehensive cost evaluation.

To supplement the limited data available, CMS can consider engaging with federal entities that may hold relevant SaaS procurement data. The Department of Veterans Affairs maintains a catalog of over 200 approved SaaS products and tracks procurement data, offering a potential source of real-world pricing data.[17] Similarly, the General Services Administration, which oversees federal SaaS procurement, may also provide aggregated pricing data through its supply schedules or cloud acquisition programs.[18] While these data sources are likely to also underestimate true market costs for small, independent, and rural practices, their data can support CMS to build a broader picture of SaaS pricing trends.

Ultimately, a core barrier to accurate SaaS cost evaluation is the persistent lack of price transparency across vendors and practice types. Current statutory limitations prevent CMS from explicitly mandating disclosures from private health IT vendors, leaving a critical blind spot in federal payment and policy design. **To close this gap, the AAFP encourages CMS to work with Congress to establish authority to incentivize standardized vendor disclosures, stratified by practice size and geography.** These disclosures are essential for meaningful data collection, cost comparison, and accurate SaaS payment. In the interim, we also encourage CMS to engage directly with small and rural practices to collect real-world cost data through targeted, low-burden surveys to better understand their unique cost pressures and implementation challenges.

7. *How are these technologies used in the treatment of chronic disease?*

SaaS can be critically important in enabling and supporting primary care physicians and their clinical teams in effectively and efficiently managing the health of various populations of patients, as well as individual health. In the management of various patient populations, SaaS aids in identifying, managing, and engaging patients with specific chronic conditions and varying levels of risk. SaaS capabilities may include algorithms and logic to assist with risk stratification of a patient panel; additionally, these capabilities may be especially useful in identifying patients with rising risk, enabling timely and impactful outreach and care interventions, and decreasing disease burden. Empowered with actionable information, primary care physicians and their care teams can more effectively manage patients and populations with chronic conditions. Effective management of patients with chronic disease

[17] https://digital.va.gov/marketplace/
[18] https://www.gsa.gov/policy-regulations/policy/acquisition-policy/acquisition-policy-library-and-resources/mv202401

often results in lower acuity and less costly care encounters, fostering trust in care providers and treatment compliance.

8. *How may CMS best evaluate the quality and efficacy of SaaS and AI technologies?*

Today, CMS evaluates quality and efficacy through an evidence base, examining quality measures data toward identification of outcomes and net results. As the AAFP recently recommended to HHS, an overhaul of how the U.S. pays for and covers chronic care management services is a first step toward changing our health system from one that treats illness to one that prevents it. **The AAFP does not recommend CMS attempt to evaluate the quality and efficacy of a specific product, or of a spectrum of technology as broad as SaaS, but rather we recommend CMS recognize and support a physician or practice's need to leverage technology capabilities to identify, manage, and engage patients and populations with chronic disease**. Physicians and practices should retain the autonomy to select, implement, and use the technology tools felt to be the most appropriate fit for use within their unique practice setting. Quality software or technology tools should employ the applicable standards specified within the certified health IT program, not only to support interoperability, but also to leverage standardized APIs that enable use with certified EHR systems with minimal cost or effort to integrate. The recent requirement that AI technologies must provide any algorithm decision support transparency is also of critical importance and should continue to be supported. Transparency in disclosures regarding a technology's intended use, its limitations, and any algorithm logic leveraged by the technology are essential components of safe and effective systems.

2a. Prevention and Management of Chronic Disease—Request for Information

CMS is broadly soliciting feedback to better support prevention and management of chronic disease, with the following questions:

1. How can CMS better support prevention and management, including self-management, of chronic disease?
2. Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set?
3. Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set?

4. Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set?
5. Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set, and how should these interventions be prioritized?
6. Should CMS consider creating separate coding and payment for medically-tailored meals, as an incident-to service performed under general supervision of a billing practitioner?
7. Please provide information on whether we should consider creating separate coding and payment for FDA-cleared digital therapeutics that treat or manage the symptoms of chronic diseases an incident-to service performed under the general supervision of a billing practitioner.
8. Are there technical solutions that would enhance the uptake of the annual wellness visit (AWV), or the improving accessibility, impact, and usefulness of the AWV? How can CMS better support practitioners and beneficiaries related to the AWV?
9. Are there certain existing or new Physician Fee Schedule codes and payment, or Innovation Center Models, that could better support practitioner provision of successful interventions through partnerships between health care entities, AAAs, community care hubs, and other local aging and disability organizations?

AAFP Comments:

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

The AAFP commends CMS for its continued leadership in advancing chronic disease prevention and management. We urge CMS to build on the strong foundation already established in primary care, where family physicians consistently deliver high-value, patient-centered preventive services, often under significant resource constraints. To scale these proven models, targeted investment and strategic incentives are essential.

To better support chronic disease prevention and self-management, the AAFP recommends CMS explore the following actions:

a. **Increase payment for high-value, patient centered chronic disease management and prevention care.** CMS's reimbursement for Chronic Care Management (CCM)

and Principal Care Management (PCM) services is a critical foundation. However, current rates often fall short of covering the true cost of care coordination, particularly for practices serving high-risk populations living with multiple chronic conditions. Increasing reimbursement for CCM/PCM would better reflect the time, staffing, and clinical expertise required to engage patients meaningfully and prevent downstream costs for the entire health care system.

However, the success of any payment increase, whether for CCM, PCM, or other care management services, will be limited unless CMS concurrently strengthens the APCM framework. As we state earlier in our response to Section II.G, and our previous comments in response to the CY25 MPFS, we urge CMS to reassess the valuation of APCM services, as current proposed rates may not reflect the true costs of delivering these capabilities. Relying on historically undervalued MPFS payment structures risks perpetuating underinvestment in comprehensive primary care. Instead, CMS should collaborate with CMMI to better understand operational costs and adjust APCM values accordingly.

b. **Expand hybrid payment models to chronic disease management services.** We are encouraged by CMS's proposed updates to the Medicare Diabetes Prevention Program (MDPP), including the shift toward outcomes-based delivery. Extending this hybrid payment model, which combines encounter-based and outcomes-based payments, to other chronic disease management services would be a strategic move. It aligns incentives with measurable improvements in the health of patients living with chronic conditions and supports CMS's broader goals of value-based care and making America healthy again.

c. **Reduce administrative burdens**. Administrative complexity remains a persistent barrier, particularly for small and independent practices. Small and independent practices often lack the administrative capacity to navigate complex coding and reporting rules, which discourages participation in new codes. CMS must continue to prioritize simplifying billing and documentation requirements for preventive and chronic disease management services. Any new codes or models should be minimally disruptive to clinical workflows. Payment mechanisms should support, not hinder, the delivery of high-quality care.

d. **Improve reimbursement for care coordination to unlock effective self-management for chronic diseases.** As CMS explores reimbursement for services like nutrition counseling, digital health coaching, and remote monitoring, we urge consideration of the care coordination required to integrate these tools into treatment plans. These services must be accessible to diverse populations, including rural, elderly, and low-income patients, and the associated coordination activities

(e.g., patient education, team-based care coordination, follow-up) should be appropriately valued.

e. **Strengthen payment for integrating upstream drivers of health into treatment plans.** To truly support prevention and chronic disease management, CMS must expand payment for screening and referral services related to upstream drivers of health, including food insecurity, housing instability, and transportation barriers. A study published in JAMA found that addressing social determinants of health is associated with lower health care expenditures across all major insurance types, suggesting that integrating these drivers into care planning can help control costs and reduce unnecessary utilization, including costly, downstream emergency department visits.[19] With chronic diseases accounting for 90% of the nation's $4.5 trillion in annual health care expenditures, addressing upstream drivers of health is essential to bending the cost curve.[20] We elaborate on the importance of integrating upstream drivers in primary care in the following section I.4. Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health.

By enhancing existing programs, reducing barriers to primary care access, and investing in evidence-based solutions, CMS can more effectively support the prevention and self-management of chronic disease. The AAFP stands ready to collaborate with CMS to ensure these strategies are practical, and impactful for all patients and the family physicians who care for them.

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

Yes, services that address the root causes of disease, chronic disease management, and prevention are inadequately captured by current PFS codes. Many of these essential services, routinely delivered in primary care, are undervalued due to the limitations of a fee-for-service structure that fragments care into discrete codes and is further constrained due to outdated budget neutrality requirements. As we elaborate on in our comments to Section II.G above, the AAFP urges CMS to recognize the comprehensive, continuous, and relationship-based nature of primary care. As we state above, we believe the introduction of APCM is a promising step forward, however, embedding it within the FFS framework risks adding

[19] Social Determinants of Health and US Health Care Expenditures by Insurer | Equity, Diversity, and Inclusion | JAMA Network Open | JAMA Network
[20] The Growing Burden of Chronic Diseases

administrative burden without meaningful investment. Broader payment reform is needed to fully support the preventive and chronic care services family physicians already provide.

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

We appreciate CMS's commitment to improving physical activity among Medicare beneficiaries. However, as CMS considers future investments, we urge a focus on strengthening primary care, where physical activity interventions are already being delivered as part of whole-person care, before expanding reimbursement for wearable technologies, which remain limited in clinical impact and accessibility make them an insufficient solution for a population facing complex health needs. Only 12% of older adults with cardiovascular disease, who represent a large share of the Medicare population, use wearable devices.[21] **Instead, we urge CMS to strengthen reimbursement for comprehensive primary care services, including physical activity interventions, that are both clinically effective and accessible to all beneficiaries.** Primary care physicians routinely assess physical activity, provide counseling, prescribe exercise, and refer patients to community-based or supervised programs, all within the context of whole-person care. A meta-analysis in 2022 found that primary care-based physical activity interventions increased moderate to vigorous activity by 14 minutes per week and improved adherence to activity guidelines by 33%.[22] Importantly, primary care doesn't stop at physical activity, but supports whole-person preventive care, addressing nutrition, behavioral health, and other upstream drivers of chronic disease. These interventions are delivered through trusted relationships and continuity of care, and they deserve to be reimbursed accordingly.

4. *Should CMS consider creating separate coding and payment for medically tailored meals, as an incident-to service performed under general supervision of a billing practitioner?*

The AAFP commends CMS for its growing recognition of the role nutrition plays in chronic disease management and enthusiastically supports the proposal to create dedicated codes that support the delivery of medically tailored meals (MTMs) under the

[21] Study finds people who need wearable health devices the most use them the least | American Heart Association
[22] Effectiveness of physical activity interventions delivered or prompted by health professionals in primary care settings: systematic review and meta-analysis of randomised controlled trials | The BMJ

general supervision of the billing practitioner. MTMs are not simply food assistance - they are prescribed, condition-specific meals designed by registered dietitians to meet the specific medical and nutritional needs of patients with serious illnesses including diabetes, heart failure, and cancer.[23] The Food is Medicine Coalitions 2023 study shows that MTMs can reduce hospitalizations, improve medication adherence, and lower total cost of care by up to 16% in high-risk populations.[24] Further, national implementation of MTMs alone has the potential to prevent 1.6 million hospitalizations and save $13.6 billion annually in health care costs.[25] CMS has already laid the groundwork for reimbursing community-based services under general supervision through the Community Health Integration (CHI) and Principal Illness Navigation (PIN) codes. These models allow billing practitioners to contract with community-based organizations to deliver services under general supervision. Extending this precedent to MTMs would leverage existing infrastructure and enable family physicians to prescribe nutrition interventions that are clinically appropriate, cost-effective, and deeply impactful for patients.

5. *Please provide information on whether we should consider creating separate coding and payment for FDA-cleared digital therapeutics that treat or manage the symptoms of chronic diseases an incident-to service performed under the general supervision of a billing practitioner.*

The AAFP appreciates CMS's proposal to reimburse FDA-authorized digital therapeutics for chronic disease management. This is a forward-looking step that can expand access to innovative, evidence-based tools. However, **as CMS advances this work, we urge you to uphold evidence-based clinical standards and ensure equal access particularly for rural and low-income beneficiaries**. While self-evident, it is worth underscoring that the success of new reimbursement models depends on their practical feasibility. CMS's continued prioritization of minimizing administrative burden is essential to enabling billing practitioners to adopt and integrate digital therapeutics effectively, ultimately improving patient outcomes.

6. *Are there technical solutions to enhance the uptake/accessibility/impact of the AWV? How can CMS better support practitioners and beneficiaries related to the AWV? Should CMS consider moving some of the required components of the AWV to optional add-on codes of the AWV instead, with the intent of decreasing burden,*

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[23] FIMC-Tufts-FollowUpCMS-CMMI-Final.pdf
[24] FIMC-Tufts-FollowUpCMS-CMMI-Final.pdf
[25] Deuman KA, Callahan EA, Wang L, Mozaffarian D. True Cost of Food: Food is Medicine Case Study. Food is Medicine Institute, Friedman School, Tufts University: Boston, MA; 2023. https://tuftsfoodismedicine.org/wp-content/uploads/2023/10/Tufts_True_Cost_of_FIM_Case_Study_Oct_2023.pdf

improving uptake, and allowing practitioners to select additional AWV elements that may be more relevant to particular patients?

The AAFP appreciates CMS's continued commitment to preventive care through the AWV. AWVs offer a critical opportunity to strengthen longitudinal patient relationships while engaging patients in preventive care, closing care gaps, and supporting population health goals. They enable family physicians to develop personalized prevention plans, assess risk factors, and close care gaps. Despite its potential to improve health outcomes and its coverage without cost-sharing, AWV utilization remains modest with only about 45% of beneficiaries accessing the service in 2024.[26]

CMS's proposal to shift components of the AWV into optional add-on codes raises concerns. As noted earlier in this letter, the AAFP agrees with CMS' assertion that "blending and balancing of preventive and treatment services are inherent to advanced primary care practices." However, we are concerned that fragmenting the annual wellness visit into individual components could undermine its clinical utility, and lead to inconsistent delivery of essential services and complicated care planning and documentation – especially when the annual wellness visit, or one of its component parts, is delivered outside of the patient's longitudinal primary care relationship. In addition to potentially reducing the impact of this high value care, optional coding for AWV components may also increase administrative burden, particularly for small or resource-constrained practices, by creating confusion around what is required versus optional. Practices serving vulnerable populations may be more likely to omit components due to staffing or time constraints, resulting in uneven access to preventive services. **Rather than restructuring the AWV, the AAFP strongly urges CMS to preserve the integrity of the AWV and invest in strategies that enhance its delivery, accessibility, and impact, especially when delivered in the context of the patient's usual source of primary care and for populations with the greatest need**.

Specifically, we recommend CMS prioritize receipt of the AWV from the patient's usual source of primary care and to consider the following strategies to facilitate AWV delivery:

- Continue streamlining documentation and billing requirements for AWVs.
- Continue supporting audio-only AWVs and ensure they are reimbursed at parity with video visits.

[26] https://pmc.ncbi.nlm.nih.gov/articles/PMC11520687/

- Support team-based care models, allowing non-physician staff to complete AWVs under supervision, as evidence continues to show that team-based AWVs improve completion rates and achieve high patient satisfaction.[27]
- Incentivize practices to work with EHR vendors to embed AWV tracking tools directly into patient records.
- Incentivize health systems to adopt AWV tracking dashboards to improve visibility into AWV performance across provider networks.
- Leverage claims data to generate sortable lists of AWV-eligible patients, organized by last visit date or eligibility status.

Again, we strongly urge CMS to continue paying for the AWV as a vital preventive health service and exploring the technical solutions above to increase its uptake. If CMS decides to move forward with fragmenting the AWV into optional components despite the associated clinical and operational drawbacks, the AAFP urges CMS to ensure that any add-on codes maintain zero cost-sharing, consistent with their preventive nature.

2b. Prevention and Management of Chronic Disease—Request for Information – Motivational Interviewing and Health Coaches

CMS is exploring the development of new coding and payment mechanisms for motivational interviewing. Given its demonstrated effectiveness across diverse settings and its potential to be delivered by health coaches under general supervision, CMS is seeking public feedback on how best to support and reimburse this service within Medicare with the following questions:

- Should CMS create separate coding and payment for motivational interviewing and are those services appropriately recognized in current coding and payment?
    - What is the best definition and description of motivational interviewing?
    - What types of clinical staff should be able to perform motivational interviewing under the general supervision of a billing practitioner?
    - How long does a session of motivational interviewing typically last? If we were to create coding and payment for motivational interviewing, what should the time-based requirements of the code be?
    - We heard from interested parties that in many clinics, health coaches perform services under general supervision, and that there may be substantive overlap

[27] https://pmc.ncbi.nlm.nih.gov/articles/PMC11067673/

with motivational interviewing. To what extent are the services performed by health coaches encompassed by motivational interviewing?

- What training is required to effectively perform motivational interviewing? Are there agreed upon national training or certification standards for health coaches? If so, what are they? Do states have separate training or certification standards for health coaches?
- To what extent would health coaches be able to perform motivational interviewing incident-to billing practitioners under general supervision?
- In what clinical situations are motivational interviewing and health coaching most commonly performed? What are the clinical characteristics of a patient where motivational interviewing and health coaching would be medically reasonable and necessary?
- Can motivational interviewing and health coaching appropriately be performed via audiovisual or audio-only synchronous telecommunication?
- What has been the experience of providers and payers utilizing the codes 0591T (Health and well-being coaching: face-to-face, individual initial assessment), 0592T (Individual follow-up session, at least 30 minutes), and 0593T (Group session, two or more individuals, at least 30 minutes)? If the CPT committee were to create permanent codes with staff able to operate under the general supervision of a billing practitioner, would this capture the time and resources to perform health coaching?
- To what extent would new coding for motivational interviewing or health coaching better support some of the evidence-based programs funded and overseen by ACL that effectively manage or prevent chronic disease?

AAFP Comments:

Motivational Interviewing (MI) is a structured, patient-centered communication technique that has consistently demonstrated its effectiveness in enhancing patient engagement, improving self-management behaviors, and driving better health outcomes. Studies reinforce MI's utility in primary care settings, where it has been shown to activate and engage patients in managing long-term chronic conditions.[28] Additionally, MI has demonstrated strong

[28] 10880_2009_9155_Article 1..7

efficacy in patients living with addiction and in promoting physical activity among individuals with chronic diseases across diverse demographic groups. [29]

While MI is currently embedded within broader care management codes such as BHI and CoCM, this bundling fails to fully recognize its unique clinical value, and the skill required to implement it. This can be frustrating for physicians and care teams who have invested in MI training but receive no additional recognition or reimbursement for using it. Further, a 2021 study identified time as the most influential barrier to MI implementation at both staff and management levels in behavioral health clinics. Clinical leaders ranked time constraints above other barriers like staff resistance and turnover.[30]

Thus, to ensure appropriate tracking, reimbursement, and incentivization of MI as a standalone clinical intervention, the AAFP recommends that CMS collaborate with the AMA CPT Editorial Panel to establish a dedicated time-based CPT code for Motivational Interviewing, supported by utilization data, clinical evidence, and implementation guidance for primary care teams.

To avoid redundancy with existing codes and reduce documentation burden, the new MI-specific CPT code should be clearly defined for use when MI is delivered as a discrete, intentional intervention, distinct from general counseling or care coordination within care management. Further, we recommend CMS provide clear guidance on when and how the MI code should be used. By establishing a dedicated payment for MI, CMS would not only recognize the clinical and operational value of this evidence-based approach but also incentivize its broader adoption in primary care.

AAFP has previously published guidance on integrating MI into primary care workflows and stands ready to collaborate with CMS and other stakeholders to ensure successful adoption and implementation of MI-specific payment.

3. Community Health Integration and Principal Illness Navigation for Behavioral Health

CMS clarifies billing and supervision policies for Community Health Integration (CHI) and Principal Illness Navigation (PIN) services delivered by auxiliary personnel under the direction of a billing practitioner. Clinical Social Workers (CSWs), Marriage and Family Therapists (MFTs), and Mental Health Counselors (MHCs) are recognized as auxiliary personnel and may perform CHI and PIN services under supervision. While they can bill Medicare directly for

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[29] Berman, A. H., Beckman, M., & Lindqvist, H. (2020). Motivational interviewing interventions. In M. S. Hagger, L. D. Cameron, K. Hamilton, N. Hankonen, & T. Lintunen (Eds.), *The handbook of behavior change* (pp. 661–676). Cambridge University Press. https://doi.org/10.1017/9781108677318.045

[30] Barriers to implementing motivational interviewing in addiction treatment: A nominal group technique process evaluation

services they personally provide for mental health or substance use disorders, they cannot supervise or bill for services provided by others.

CMS also proposes expanding the types of visits that can initiate CHI services to include CPT 90791 (psychiatric diagnostic evaluation) and Health Behavior Assessment and Intervention (HBAI) codes.

AAFP Comments:

AAFP supports CMS's proposal to expand the types of visits that can initiate Community Health Integration (CHI) services. This clarification is a meaningful step toward enabling a broader range of behavioral health professionals to participate in delivering social needs navigation and care coordination services, particularly when supervised by a physician.

By expanding practitioner types and initiating visits for CHI and PIN, CMS is helping practices more effectively connect patients to community resources. This is especially important for patients whose primary needs are behavioral or psychosocial, not strictly medical. To ensure sustained uptake, AAFP recommends that CMS promote education of CHI and PIN codes among physicians and consider expanding the list of initiating visits to include CCM, PCM, and BHI codes. This would further support the integration of CHI and PIN into primary care workflows and ensure that patients with complex needs receive coordinated, community-connected care.

4. Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health

CMS is proposing to delete HCPCS code G0136, which covers Social Determinants of Health (SDOH) risk assessments, starting in CY 2026, citing that its resource costs are already captured in existing services like E/M visits. This would also remove G0136 from the Medicare Telehealth Services list and edit its inclusion in the Annual Wellness Visit definitions. Additionally, CMS proposes replacing the term "social determinants of health" with "upstream driver(s)" in CHI code descriptors (e.g., G0019), arguing that the new term is more comprehensive and better reflects the root causes impacting patient health. CMS will also make conforming revisions to codes describing similar services to reflect the updated terminology, including services furnished by RHCs, FQHCs, and OTPs.

AAFP Comments:

Family physicians are uniquely positioned to identify and respond to social needs in the context of longitudinal, relationship-based care. The ability to screen for social determinants of health (SDOH) as a distinct, reimbursable service ensures that practices can dedicate the necessary time, training, and infrastructure to conduct these assessments effectively.

Embedding this work into E/M visits without separate payment risks undervaluing the clinical and operational effort required, particularly in practices serving high-risk populations. Eliminating G0136 may inadvertently disincentivize routine screening for upstream drivers of health, especially in resource-constrained settings where time and staffing are limited. This also runs counter to CMS's mission as it has previously emphasized the importance of routine care and reimbursed SDOH screening to reduce differences in health outcomes and improve care coordination.[31]

AAFP respectfully urges CMS to reconsider the proposed deletion of HCPCS code G0136, which represents a critical standalone service that enables family physicians and their care teams to identify and document social risk factors that directly influence patient health outcomes. Instead, to align with CMS's goal to capture all determinants of health, we encourage CMS preserve G0136 and instead rename "Social Determinants of Health" risk assessments to "Upstream Drivers of Health" risk assessment. Preserving this code under the new name is essential to advancing whole-person care and supporting beneficiaries' equal access to comprehensive care delivery.

Further, while we appreciate CMS's intent to use more inclusive language, replacing "Social Determinants of Health" with "Upstream Drivers" in CHI code descriptors may introduce confusion and inconsistency unless the term is clearly defined and aligned with existing public health framework. The term "upstream drivers" is not yet standardized in clinical or coding contexts and may create ambiguity in documentation, billing, and care planning. As such, we appreciate CMS's motion to encapsulate drivers of health with the new terminology but urge CMS to provide a transitionary crosswalk between codes using "Social Determinants of Health", and detailed guidance on how the change in terminology will impact for ICD-10-CM Z codes, quality measures, and many value-based care models which currently rely on the previous terminology.

Concurrently, the AAFP notes that CMS is proposing SDOH-related changes across multiple programs, such as eliminating assessment measures in the Outpatient Prospective Payment System while promoting related improvement activities and removing the SDOH screening HCPCS code in the MPFS, which reflect inconsistent terminology and a fragmented approach. **We strongly encourage CMS to holistically review all proposed SDOH-related changes across programs to ensure consistency and reduce confusion.**

As CMS finalizes policies addressing upstream or social drivers of health, the AAFP reiterates that it is critical to recognize these are fundamentally community-level challenges that require collaborative, community-based solutions. CMS policy must reflect that many communities lack adequate social services, and even where such resources

[31] IMPROVING THE COLLECTION OF Social Determinants of Health (SDOH) Data with ICD-10-CM Z Codes

exist, community-based organizations often do not have the funding, staffing, or infrastructure to support referrals from the health care system. The AAFP has repeatedly encouraged CMS to create incentives to develop community care hubs or other payer- and provider-agnostic centralized referral systems to ease the burden on all parties, including support for community-based organizations best equipped to address patients' social needs. CMS must also recognize that addressing upstream and social drivers of health at the patient level requires meaningful investments of time, resources, and infrastructure, which current fee-for-service models do not adequately support. Family physicians are well-positioned to identify and respond to patients' social needs but are limited by payment structures that undervalue this essential work. The AAFP provides tools through the EveryONE Project and supports Health in All Policies to help physicians address health-related social needs and improve population health, but additional support and systemic change are needed to make these efforts sustainable and effective.

Payment for Skin Substitutes (section II.K.)

CMS finds the current approach to paying for skin graft technology unsustainable and proposes to pay for skin substitute products as "incident-to supplies" in non-facility and hospital outpatient department (HOPD) settings. Products would be grouped into three categories based on their FDA approval pathway. A single, site-neutral payment rate would be set for all three categories. Payment rates would be updated each year based on Average Sales Price (ASP) data, when available, or hospital outpatient mean unit cost (MUC) data.

AAFP Comments:

The AAFP urges CMS to finalize this proposal to set a single, standardized rate for skin substitute products and treat them as "incident to" supplies effective January 1, 2026. This approach would correct the current approach which has led to excessive costs and inconsistent care. Skin substitutes, used to treat chronic wounds, are approved through various FDA pathways with differing levels of clinical evidence, yet are reimbursed similarly to Part B drugs under the ASP + 6% methodology. This has resulted in dramatic price inflation and a shift in care settings toward ambulatory clinics where payments are uncapped, contributing to exponential growth in Medicare spending that is unsustainable and is not contributing to corresponding improvements in patient care.

Family physicians have expressed concerns that although some patients may benefit from skin substitutes, third-party wound care providers use skin substitutes excessively and fail to treat the underlying causes of a wound, leading to exorbitant expenses and poor outcomes for patients. The scale and growth costs related to skin substitutes also has downstream effects for benchmarks used in Medicare Advantage and the Medicare Shared Savings Program.

The AAFP strongly supports this proposal which will reduce incentives for excessive product use and toward more clinically appropriate wound care. The revised policy will likely reduce waste, fraud, and abuse in the system while improving care quality for hundreds of thousands of Medicare beneficiaries.

Strategies for Improving Global Surgery Payment Accuracy (section II.L.)

CMS is again soliciting public comments on strategies to improve the accuracy of payment for global surgical packages, specifically related to the procedure shares. CMS seeks public comments on what the procedure shares should be based for the 90-day global packages. CMS also seeks comments and stakeholder input as to current practice standards and division of work between surgeons and providers of post-operative care.

Regarding the calculation of procedure shares, CMS has identified three alternative approaches to the status quo assumed procedure shares (i.e., the share of a global surgical package valuation assigned to the surgeon when modifier -54 is reported) for global surgical packages. CMS seeks comments on the best approach to utilize going forward and specifically on replacing the current procedure shares using the approach with procedure work RVUs calculated using counts of post-operative visits reported using no-pay CPT code 99024.

Additionally, in its internal review of the percentages assigned for the pre-operative, surgical care, and post-operative portions of the global packages, CMS found there are a small number of codes that do not have any assigned percentages in its files even though these codes are identified as global packages. CMS again seeks comments on whether it should consider, first, whether these codes are appropriately categorized as 90-day global package codes, and if so, on what the assigned percentages should be for each portion of the service.

AAFP Comments:

Section 1848(c)(8)(A)(i) of the Social Security Act, as added by section 523 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), states, "IN GENERAL.—The Secretary shall not implement the policy established in the final rule published on November 13, 2014 (79 Fed. Reg. 67548 et seq.), that requires the transition of all 10-day and 90-day global surgery packages to 0-day global periods." Immediately following that, section 1848(c)(8)(A)(ii), as also added by MACRA states, "CONSTRUCTION.—Nothing in clause (i) shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services or assigning values to new or revised codes for surgical services."

Over the intervening decade, as required elsewhere in section 523 of MACRA, CMS has collected data on the number and level of medical visits furnished during the global period

and other items and services related to the surgery and furnished during the global period, as appropriate. As noted in this proposed rule and prior CMS publications, that data collection effort has consistently shown that the number and level of visits furnished during the global period are a mere fraction of those assumed to be provided in the valuation of 10- and 90-day global surgical codes. As CMS states in the current proposed rule:

For procedures with 90-day global periods and 2023 dates of service, our internal analysis shows that only 28 percent of post-operative visits considered by CMS during global surgical service valuation were actually provided to enrollees as part of global surgical packages. Our internal findings and RAND's published analyses have consistently shown that only a fraction of "expected" post-operative visits are provided. Absent evidence to the contrary, which CMS has not identified despite several solicitations for comments from the public (89 FR 97961 through 97962), our interpretation is that many post-operative visits considered during the valuation of global surgical packages are not provided as part of these packages.

Despite this evidence and analysis, CMS still refuses to act on the authority provided in section 1848(c)(8)(A)(ii) and revalue the many 10- and 90-day global codes shown to be misvalued from this analysis. Instead, CMS seeks only to refine the procedure shares applicable when modifier 54 (Surgical care only) is reported with a 10- or 90-day global procedure code.

The AAFP agrees with CMS that many, if not most, post-operative visits considered in the valuation of global surgical packages are not provided as part of these packages. Consequently, most, if not all, codes with 10- and 90-day global periods are misvalued. Accordingly, the AAFP calls upon CMS to revalue all codes with a 10- or 90-day global period consistent with the authority granted the agency in section 1848(c)(8)(A)(ii) of the Social Security. We believe CMS can and should do so whether or not it changes the global period for any of those codes on a code-by-code basis, which remains permissible even under section 1848(c)(8)(A)(ii), as evidenced by the occasional changes in global period assignments that CMS already makes.

Tweaking procedure shares applicable when modifier 54 is reported will have negligible impact on proper valuation of all these codes. As CMS notes in the current proposed rule, modifier -54 is used only rarely in aggregate and is concentrated in a small number of ophthalmologic and cardiology procedures. CMS's requirement, beginning January 1, 2025, and onward, that modifier -54 must be reported in all cases where the surgeon does not **intend** to provide post-operative care, including but not limited to cases where both the surgeon and another practitioner both formally document the transfer of care as under the previous policy, will not address misvaluation of the code in question, since surgeons are not required to report modifier 54 when they intend to provide post-operative care but the actual

post-operative care provided is only a fraction of what's "expected" based on the current value of the code.

To the extent that CMS might use procedure shares to revalue all 10- and 90-day global procedure codes (whether modifier 54 is applied or not), we note that each of the alternative approaches considered by CMS begins with the flawed assumption that the total work assigned to the code is correct. As CMS's data collection and contractor analyses have shown, a portion of that work is typically not provided, which means the total work assigned, whether based on magnitude estimation or building blocks or some other method, is overstated in almost every case. Applying a procedure share to that misvalued total work means the resulting procedure work RVUs will also likely be overstated, regardless of approach.

Each alternative approach has additional flaws. For instance, under the first approach, CMS would calculate procedure work RVUs by subtracting work RVUs assigned to each post-operative visit listed in the Physician Time File for a global procedure HCPCS code from the total valuation of the global surgical package. This approach ignores the fact most codes are valued based on magnitude estimation rather than a building block approach. Subtracting work RVUs assigned to expected post-operative visits may leave no or a non-sensical amount of work RVUs left for the procedure itself. For example, under this approach, the procedure share for code 25600 (Closed treatment of distal radial fracture (eg, Colles or Smith type) or epiphyseal separation, includes closed treatment of fracture of ulnar styloid, when performed; without manipulation) is only 13.7%.

The third approach, which is based solely on a ratio of times involved, not only assumes the current total work is correct; it also seems to assume that all time is of equal value. That is, it ignores the concept underlying the resource-based relative value scale that work is a function of time and intensity by ignoring intensity in its calculations.

Under the second approach, in which CMS seems specifically interested, CMS would calculate procedures' work RVUs by subtracting the work RVUs for post-operative visits provided as part of global surgical packages. However, in comparison to the first approach, would multiply the number of post-operative visits typically provided for the global procedure HCPCS code (defined as the median count of post-operative visits reported to CMS using no-pay code 99024 among procedures without overlapping global periods with other global surgical services) by the average valuation per post-operative visit calculated for the mix (that is, number and level) of post-operative visits for the global procedure HCPCS code as listed in the Physician Time File. The flaw in this approach is that it values each observed post-operative visit equally and rewards those who provide the procedure for not reporting 99024. That said, this approach seems the least objectionable from a theoretical

basis, even though it still suffers from the flawed rationale of assuming the current total work RVUs assigned to each code is correct.

As to the small number of codes that do not have any assigned percentages in CMS's files even though these codes are identified as global packages, we believe CMS is correct to first question whether these codes are appropriately categorized as 90-day global package codes. The AAFP would argue the codes should be recategorized as 000-day global package codes and revalued accordingly.

Determination of Malpractice Relative Value Units (RVUs) (section II.M.)

For the CY 2026 update to the malpractice RVUS, CMS is not proposing any major methodological refinements to the development of MP premium data. Instead, CMS has continued to refine the universe of specialties subject to imputation and sources of imputation for each specialty. Further, CMS calculated the proposed malpractice RVUs using specialty-specific malpractice premium data that represent the expense incurred by physicians and other practitioners to obtain malpractice insurance as reported by insurers. For CY 2026, CMS obtained the most current malpractice insurance premium data available, reflecting rates with a presumed effective date of no later than December 31, 2023, from insurers with the largest market share in each state.

Among minor methodological refinements for this CY 2026 update of the malpractice RVUs, CMS proposes to map technical component (TC)-only services to the specialty of allergy/immunology, which now has a risk index value of 0.427. According to CMS, mapping the TC-only services to the specialty of allergy/immunology would be consistent with the CY 2020 and 2023 updates of the malpractice RVUs and maintain stability in its rate setting process. CMS requests comments regarding the risk index value for TC-only services.

As it has in the past, CMS proposes to apply a list of expected specialties instead of the claims-based specialty mix for low volume services (i.e., codes that have 100 or fewer allowed services) to address stakeholder concerns about the year-to-year variability in practice expense and malpractice RVUs for such codes. CMS solicits public comment on the list of expected specialties.

AAFP Comments:

The AAFP commends CMS' continued refinement and updating of its malpractice premium data collection to ensure as much specialty-specific data as possible is used to reflect the most accurate trends in professional liability premiums. We are supportive of CMS's proposals in this regard. We have reviewed the list of expected specialties to be used with low-volume services and have no suggested changes to offer.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (section III.B.)

2.b. Integrating Behavioral Health into Advanced Primary Care Management (APCM)

CMS proposes adopting Advanced Primary Care Management (APCM) add-on codes that would allow RHCs and FQHCs an easier billing process when providing Behavioral Health Integration (BHI) and Psychiatric Collaborative Care Model (CoCM) services. The agency believes doing so is aligned with the broader PFS and would support the goal of RHCs and FQHCs providing increased BHI and other advanced primary care services. CMS thus proposes requiring RHCs and FQHCs to bill the individual CPT and HCPCS codes that comprise CoCM HCPCS code G0512 and to use the same codes as are billed under the PFS. Subsequently, the agency proposes removing the requirement for RHCs and FQHCs to report HCPCS code G0512. Payment rates would be updated annually based on total PFS amounts and would be paid at the national non-facility PFS payment rate.

AAFP Comments:

A significant proportion of family physicians practice in FQHCs and RHCs, and millions of patients living in rural communities rely on RHCs and FQHCs for primary care and other comprehensive services. The AAFP is strongly supportive of federal policies that bolster financial and workforce support for these essential care providers, including securing proper payment and adequate regulatory billing flexibility to help ensure equitable access. We applaud FQHCs and RHCs for their role in delivering high-quality, comprehensive primary care to communities and patients who most need it.

The AAFP supports CMS adopting the add-on codes that would allow RHCs and FQHCs an easier billing process when providing BHI and CoCM services, as well as CMS' proposal to remove the requirement for RHCs and FQHCs to report code G0512 and for clinics to instead bill by individual HCPCS codes. We believe allowing clinics to bill individual HCPCS codes will offer CMS, as well as clinics, the opportunity to better measure and understand the utilization of individual codes in different clinic types, geographic regions, and patient populations. Additionally, we urge the agency to provide robust guidance and resources on these changes, as we have heard from multiple Medicare Administrative Contractors (MACs) that operationalizing the unbundling of G0511 was challenging without detailed educational materials.

2.c. Payment for Communication Technology-Based Services (CTBS) and Remote Evaluation

CMS proposes to unbundle HCPCS code G0071 and to instead require RHCs and FQHCs that provide advanced primary care services through Remote Evaluation and Communication Technology-Based Services (CTBS) instead report the individual codes that comprise G0071.

As with the proposed unbundling of G0512, CMS believes that unbundling G0071 would allow for easier use and implementation of APCM services and payment policy.

AAFP Comments:

The AAFP supports CMS' proposed unbundling of G0071, and we thank CMS for their efforts to ensure RHCs and FQHCs are appropriately compensated. While the AAFP strongly supports simplifying administrative processes and reducing burden, it is critically important that physicians and their care teams be paid in accordance with the level of expertise and care they provide. Additionally, the AAFP would like to reiterate our support for RHCs being eligible for reimbursement under the G2211 code, as primary care clinicians in other settings are, which we believe would help both CMS and RHCs fully account for the additional time, intensity, and practice expense inherent to longitudinal care that G2211 was designed to capture.

2.d. Aligning with the PFS for Care Coordination Services

CMS proposes care management services that are designated and paid for under the PFS also be adopted as care coordination services for RHCs and FQHCs, which the agency believes will facilitate a more efficient and transparent payment process. Going forward, CMS proposes that any new care management/coordination services added to the PFS should also be added to the list of services that can be rendered by RHCs and FQHCs for payment under this framework.

AAFP Comments:

The AAFP deeply appreciates CMS' ongoing efforts to enhance care coordination services for patients. We are supportive of this proposal, as we believe it would allow for greater streamlining of work between FQHCs, RHCs, and CMS. Many physicians that work at RHCs and FQHCs may also work in other contexts, and these changes would allow them to develop familiarity with the same set of codes across settings of care. The AAFP believes finalizing this change could also save CMS staff time, as CMS would no longer have to include separate proposals for updates to coding and payment related to care management.

3.b. Direct Supervision via Use of Two-way Audio/Video Communications Technology

CMS proposes to permanently adopt a definition of "direct supervision" for RHCs and FQHCs that permits the virtual presence of a supervising physician to include using audio/video real-time communications technology — though not audio-only — for an expanded set of services. The agency believes doing so will support continued patient access to care and preserve workforce capacity. CMS proposes to continue using the same payment

methodology as in recent years for the same list of RHC and FQHC services that are provided via telecommunication technologies in these settings.

AAFP Comments:

The AAFP strongly supports CMS' proposal to permanently adopt a definition of direct supervision for FQHCs and RHCs that permits the virtual presence of a supervising physician to include using audio/video real-time communications technology — though not audio-only — for an expanded set of services. We strongly believe in the value of physician-led, team-based care and that health professionals should work collaboratively as clinically integrated teams in the best interest of patients, which can be accomplished via real-time audio/video technology. This virtual capability continues to promote patient access, continuity, convenience, and choice, decreasing the spread of communicable diseases and providing critical support to patients and physicians in rural and other areas dealing with health professional shortages.

3.c. Payment for Medical Visits Furnished Via Telecommunications Technology

In the event that Congress does not take action to extend pandemic-era telehealth flexibilities beyond September 30, 2025, CMS proposes that RHCs and FQHCs would report HCPCS code G2025 when billing for non-behavioral health visits provided via telecommunications technology (also referred to as "medical visit services"). This would be a continuation of the payment methodology used during the COVID-19 public health emergency. CMS believes this would be the least confusing course of action for FQHCs and RHCs. The agency also seeks comment on an alternative proposal for payment that was considered but not proposed, in which RHCs would be paid under the RHC AIR methodology and FQHCs would be paid under the FQHC PFS.

AAFP Comments:

The AAFP recommends CMS finalize the alternative proposal and revise the regulations for medical visit services as was done many years ago for mental health visits. There has not been an uptick in waste, fraud, and abuse incidents related to that change for mental health visits, and we do not believe there would be an increase if the change was made for medical visit services. AAFP members who provide care in FQHCs and RHCs believe that this change in payment policy would be an improvement, allowing the clinics to be better resourced and thereby provide additional services to the community.

Ambulatory Specialty Model (ASM) (section III.C.)

CMMI is proposing a new mandatory alternative payment model to test whether adjusting payment for specialists based on their performance on targeted measures of quality, cost,

care coordination, and meaningful use of CEHRT results in enhanced quality of care, reduced costs through more effective upstream chronic condition management. The Ambulatory Specialty Model will run for five years, beginning January 1, 2027, and concluding on December 31, 2031. Final data submission would be in CY 2032, with final model payment adjustments in CY 2033.

The model will focus on care provided by select specialists to Medicare beneficiaries with the chronic conditions of heart failure and low back pain. To promote preventive care, the model will incentivize participants to ensure that their patients have a regular source of primary care and are screened to help identify risks and early signs of chronic conditions.

The model would require participation at the individual clinician level rather than organizations. CMS believes this will encourage competition and create a level playing field for solo and small practices. Participants will be assessed based on performance relative to their peers, who are also participants of the model and of a similar specialty type treating the same chronic condition.

The model leverages existing MVP policies, while deviating in specific ways, as applicable. The ASM would require participants to report on a set of measures and activities clinically relevant to their specialty type and the chronic condition of interest. ASM would also assess performance against only those clinicians treating the same chronic condition. CMS will employ a different approach for aggregating the ASM performance categories to calculate a final score and determining the ASM payment adjustment. They will focus on value and variation in performance by primarily measuring quality and cost. They will also potentially apply negative scoring adjustments for non-reporting or poor performance of improvement activities and promoting interoperability. They are considering additional positive adjustments for clinicians in small practices and those treating a large proportion of medically complex patients.

AAFP Comments:

The AAFP is strongly supportive of efforts to transition away from fee-for-service to value-based payment (VBP) approaches, as described in the AAFP's Guiding Principles for VBP, and applauds the Innovation Center's commitment to expand accountable care participation to more specialists. While the AAFP supports the Innovation Center's strategic aim to improve coordination and collaboration between primary care and specialty care, we encourage CMMI and CMS to continue partnering with other agencies and stakeholders to ensure there is a sustained focus on addressing persistent and unresolved barriers to coordination between specialists and primary care, namely: interoperability of health IT systems and limited data sharing. We are encouraged by CMMI's support for specialist and primary care partnership through the improvement activity to establish collaborative care agreements. We

ask CMMI to also incorporate additional payment opportunities for primary care practices that enter into these CCAs.

IA-1: Connecting to Primary Care and Ensuring Completion of Health-Related Social Needs and Screening (pg. 571)

As the first part of this IA, CMS proposes that ASM participants develop processes and workflows within their practices to identify patients without a PCP and assist them in finding one. CMS also proposes that the ASM specialist must always communicate relevant information back to the beneficiary's PCP following the beneficiary's visit with the ASM participant. Last, CMS proposes that ASM participants collaborate with PCPs to ensure that their patients have received HRSN screenings.

As it relates to the HRSN screenings, CMS states that feedback from interested parties has indicated that PCPs are best equipped to conduct HRSN screenings and may have established relationships with community resources to address identified needs. However, CMS still believes the specialists should have some responsibility in ensuring screenings have been completed. If a specialist identifies that a patient has not received an annual HRSN screening, they should communicate this information to the patient's PCP and encourage them to conduct the screening. Alternatively, the specialist may choose to conduct the screening, as long as they communicate the results and any follow-up actions to the patient's PCP.

AAFP Comments:

The AAFP supports the intent of this activity but has many concerns with its structure as well as CMS' incongruent approach toward quality measures and activities related to HRSNs. For example, CMS proposes to remove the MIPS improvement activity IA_AHE_12 "Practice Improvements that Engage Community Resources to Address Drivers of Health" as well as delete HCPCS code G0136 (Administration of a standardized, evidence-based social determinants of health risk assessment tool). **The AAFP is concerned that these proposals use inconsistent terminology and encourage a fragmented approach that is difficult for stakeholders to implement. We encourage CMS to holistically review all the proposed SDOH-related changes across programs to ensure consistency and reduce confusion.**

Additionally, we are concerned this activity may be difficult to operationalize for specialists and primary care physicians. Beneficiaries may not know or wish to disclose if they have been screened for HRSNs. Further, framing it as an annual screening may cause confusion for beneficiaries if they are asked about it by an ASM participant at a point in the year when they haven't seen their PCP yet. It is unclear whether CMS expects PCPs to send HRSN screening results for every beneficiary that is seen by an ASM participant. If so, this would create a significant burden for the PCP.

Finally, in the absence of a more holistic approach to support screening and connecting beneficiaries to resources, this activity will have a minimal impact. **When finalizing proposed upstream or social drivers of health policies, we encourage CMS to recognize that social or upstream drivers of health are community issues that require community solutions.** CMS policy should reflect the fact that many communities simply do not have adequate social resources or community-based organizations that are equipped to fully meet patients' diverse social needs. Even when such resources exist, community-based organizations frequently lack the funding, skills, or staff to accept referrals from the health care system. The AAFP has repeatedly encouraged CMS to create incentives to develop community care hubs or other payer- and provider-agnostic centralized referral systems to ease the burden on all parties, including support for community-based organizations best equipped to address patients' social needs.

CMS should also recognize that resources are required to systematically assess and document patient-level upstream drivers of health. Family physicians witness the impact of upstream/social drivers of health every day. The AAFP supports Health in All Policies as a strategy to improve population health and offers many resources through the EveryONE Project, including tools supporting screening for health-related social needs and a tool to search for local resources available to patients. **While family physicians are well-positioned to identify patient-level needs, fee-for-service payment models do not account for the time and effort needed to implement comprehensive screening and referral systems to connect patients to resources.**

IA-2: Establishing Communication and Collaboration Expectations with Primary Care using Collaborative Care Arrangements (CCA)

CMS proposes to require annual attestations by ASM participants on activities related to establishing collaboration expectations with primary care through formal collaborative care arrangements. An ASM participant must enter into at least one CCA with a primary care practice that includes at least three of the following elements: data sharing, co-management, transitions in care planning, closed loop connections, and care coordination integration.

ASM participants should have processes in place to provide timely updates, test results, treatment plans, and follow-up recommendations to the patient's PCP, even outside the time of a referral between the two parties. CMS believes the exchange should be bi-directional. The CCA should clearly set forth the available co-management approaches (e.g., consultative co-management, shared co-management, or principal co-management). Closed-loop communication and feedback between specialists and PCPs involve establishing a structured and coordinated process for when the patient is referred from primary care to specialty care and back. This could include elements such as structured referral templates, communication

and information sharing, collaborative treatment planning, and shared monitoring of patient outcomes.

ASM participants must ensure the CCA is with a primary care practice with whom they share at least one ASM beneficiary.

AAFP Comments:

The AAFP appreciates CMMI's efforts to increase and improve collaboration between specialists and primary care physicians. CMMI outlines that the CCAs between ASM participants and primary care practices may outline payment or renumeration between the parties. However, **we encourage CMMI to take a similar approach to the Making Care Primary program, where CMMI provided specific coding and payment for consultations between MCP participants and specialists.** The codes developed for MCP alleviated some of the challenges physicians face with the existing interprofessional consultation codes. The AAFP believes that a model-wide approach to incentivizing collaboration is more likely to have an impact. It would create a clear, compliant, and consistent incentive structure across all CCAs and provide better insight into the effectiveness of this aspect of the model during evaluation.

Medicare Diabetes Prevention Program (MDPP) (section III.D.)

CMS proposes several modifications to the Medicare Diabetes Prevention Program (MDPP) to improve uptake of the program. CMS proposes to extend virtual flexibilities adopted during the COVID-19 Public Health Emergency and for asynchronous virtual interaction with beneficiaries, address barriers related to weight collection for virtual participants, and test an online, asynchronous delivery format to allow for distance learning and online-only MDPP organizations to offer MDPP services.

AAFP Comments:

The AAFP supports the proposed changes to the Medicare Diabetes Prevention Program (MDPP). Given that obesity is a significant risk factor for type 2 diabetes—and with over 40% of the U.S. population estimated to be living with obesity—the AAFP advocates for public health policies aimed at reducing obesity rates. This includes supporting Medicare coverage for obesity screening and counseling.

Recent evaluations have shown that the MDPP can lead to weight loss among beneficiaries.[32] Uptake of the MDPP has been inconsistent due to program barriers, but CMS implemented

[32] Jacobs, Sara R., et al. Evaluation of the Medicare Diabetes Prevention Program – Final Evaluation Report. March 2025. Prepared for CMS by RTI International and Amico Consulting. Available: https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt

changes effective in 2025 to reduce barriers to supplier participation and to extend flexibilities to deliver the program virtually. These proposed changes aim to further expand access and increase supplier participation.

The AAFP remains committed to building healthier communities, lowering health care costs, and improving patient outcomes through high-quality care delivery and access. Therefore, we urge CMS to finalize these proposals which address barriers to enrollment and program uptake.

Medicare Shared Savings Program (section III.F.)

SSP Participation Options Under the BASIC Track

CMS proposes that, for agreement periods beginning on or after January 1, 2027, an ACO that is inexperienced with performance-based risk Medicare ACO initiatives and entering the BASIC track's glide path at Level A may continue to remain under a one-sided model for the duration of the agreement period (i.e., five years). ACOs must enter their second or subsequent agreement periods under Level E of the Basic Track or the ENHANCED track.

For agreement periods beginning on or after January 1, 2027, ACOs deemed inexperienced with risk but ineligible to enter the glide path in accordance with §425.600(h)(1) may enter Level E for all years of the performance period or the ENHANCED track. ACOs considered experienced with Medicare performance-based risk ACO initiatives may enter either the BASIC track Level E for all performance periods or the ENHANCED track. An ACO that has 5,000 or fewer assigned beneficiaries in either the first benchmark year, the second benchmark year, or both, in accordance with §425.110(a)(3), may only enter the BASIC track and is prohibited from participating in the ENHANCED track. ACOs inexperienced with risk may enter any level of the BASIC track. Those experienced with risk may enter Level E for all performance years.

If finalized, ACOs currently participating in their first agreement period and those entering their first agreement period with a January 1, 2026, start date will be ineligible to enter a subsequent agreement under the glide path. They would be limited to participation in Level E or the ENHANCED track for their second or subsequent agreement periods. Based on current participation data, this proposal would limit participation in a one-sided model to five performance years for 57 ACOs participating in Level A of the BASIC track.

AAFP Comments:

The AAFP supports this proposal. The AAFP encourages CMS to maintain the existing policy for ACOs entering their first agreement period with a January 1, 2026, start date (i.e., those

ACOs should remain eligible for an additional two years under a one-sided model upon entering their second agreement period).

ACO Eligibility and Related Financial Reconciliation Requirements

After reviewing data, CMS believes the 5,000-beneficiary benchmark minimum can be applied to benchmark year (BY) three only. CMS proposes to amend their requirements to specify that, for agreement periods beginning on or after January 1, 2027, ACOs applying to enter a new agreement period would be required to have at least 5,000 assigned beneficiaries in the ACO's BY3 but could be under 5,000 assigned beneficiaries in BY1, BY2, or both. CMS would use the most recent data available to estimate the number of assigned beneficiaries for BY3.

CMS proposes that if an ACO entering a new agreement period is under the 5,000-beneficiary minimum in BY1, BY2, or both, but meets the minimum in BY3, the ACO may only enter an agreement period in the BASIC track.

For agreement periods beginning on or after January 1, 2027, CMS is proposing revisions to performance payment and loss recoupment limits for ACOs that have fewer than 5,000 assigned beneficiaries in any benchmark year. The alternative limits would apply during financial reconciliation for any performance year in an agreement period for which the ACO was assigned fewer than 5,000 beneficiaries in any benchmark year.

CMS proposes comparing the alternative benchmark-based payment limit or recoupment limit with the benchmark-based limits calculated with assigned beneficiary person years for the performance year. They would apply the lesser of the two amounts in determining the final limits. This would ensure that no ACO would receive a larger cap than they would under the current methodology.

CMS proposes to exclude ACOs that fall below 5,000 assigned beneficiaries in a BY from being eligible to receive savings under the aforementioned policy. Accordingly, CMS proposes to revise §425.605(h)(1) to specify that an ACO must have at least 5,000 assigned beneficiaries in all three benchmark years at the time of financial reconciliation to qualify for shared savings at §425.605(h).

AAFP Comments:

The AAFP supports these proposals as these flexibilities may allow additional new ACOs to join the program.

Revisions to the Definition of Primary Care Services Used in SSP Beneficiary Assignment

CMS proposes revising the list of primary care services used for assignment for the performance year starting on January 1, 2026, and subsequent performance years. CMS proposes adding Enhanced Care Model Management Services (HCPCS code GPCM1, GPCM2, GPCM3) and deleting Social Determinants of Health Risk Assessment Services (HCPCS G0136), if finalized. HCPCS codes GPCM1, GPCM2, and GPCM3 represent services that, when reported as standalone services, are already included in the definition of primary care services used for assignment when furnished in conjunction with APCM services.

CMS also proposes to specify that the primary care service codes used for assigning beneficiaries include a CPT code identified by CMS that directly replaces a CPT code specified at §425.400(c)(1)(x)(A) or a HCPCS code specified at §425.400(c)(1)(x)(B), when the assignment window or expanded window for assignment for a benchmark or performance year includes any day on or after the effective date of the replacement code for payment purposes under the MPFS.

AAFP Comments:

The AAFP supports this proposal but reiterates our opposition to CMS' proposal to delete HCPCS G0136.

Proposal to Revise the Definition of a "Beneficiary Eligible for Medicare Clinical Quality Measures (CQMs)"

CMS continues to hear that the complexity of the definition of "beneficiary eligible for Medicare CQMs" is creating confusion for some SSP ACOs. To address these issues, CMS proposes to revise the definition of a "beneficiary eligible for Medicare CQMs" effective January 1, 2025. Specifically, they propose to require in (1)(ii)(B) of the definition, "at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included at §425.402(c), or who is a physician assistant or nurse practitioner, or clinical nurse specialist."

The revised definition uses "primary care services" and "performance year" instead of "claims" and "measurement period," respectively, which are used in the current definition.

AAFP Comments:

The AAFP supports this proposal and thanks CMS for being responsive to stakeholder concerns.

Proposals to Remove the Health Equity Adjustment Applied to an ACO's Quality Score and Revise Certain Terminology in SSP Regulations

After review, CMS now believes the eCQM/MIPS CQM reporting incentive and the Complex Organizational Adjustment provide duplicative incentives to that provided by the health equity adjustment. CMS notes that both the eCQM/MIPS CQM reporting incentive and the Complex Organizational Adjustment are available to more ACOs than the health equity adjustment.

Therefore, CMS proposes to remove the health equity adjustment starting with the 2025 performance year. They believe the only removing the health equity adjustment for subsequent performance years is contrary to public interest and a justifiable reason to apply the policy retroactively.

CMS states that the term "health equity" was used in such a way that could lead to confusion as to whether impermissible features, such as race and ethnicity, were included in SSP policies. CMS proposes changes to regulatory text to provide clarity and consistency.

AAFP Comments:

The AAFP strongly urges CMS to retain the health equity adjustment and consider renaming it to avoid confusion. While there may be elements of the adjustment that seem to overlap with the eCQM/MIPS CQM reporting incentive and Complex Organization Adjustment, the health equity adjustment is unique in that it is also available to ACOs that report Medicare CQMs. The eCQMs/MIPS CQMs are not always applicable to ACOs that serve specific populations (e.g., ACOs with high numbers of beneficiaries in long-term care facilities). We believe this adjustment aligns with the Administration's goals to improve health and prevent chronic illnesses as it can encourage new ACOs and support existing ACOs that serve beneficiaries at higher risk for developing chronic conditions.

We acknowledge that there may be overlap between organizations who receive the Complex Organization Adjustment and those that receive the health equity adjustment. As a solution, we suggest that CMS modify its policy so that an ACO may only receive one or the other. Alternatively, CMS could update the health equity adjustment to only apply to ACOs that report via Medicare CQMs. This would eliminate overlap between the three types of adjustments.

If CMS believes the term "health equity" could lead to confusion, we recommend that CMS revise the name to "population quality adjustment" or "upstream driver quality adjustment." Either of these terms would align with revised terminology proposed elsewhere in this rule. This would alleviate CMS' concerns that individuals are misinterpreting the applicability or intent of the adjustment.

Proposal to Update the APP Plus Quality Measure Set

CMS proposes to revise the APP Plus Quality Measure set to align with the removal of Quality ID: 487: Screening for Social Drivers of Health. The APP Plus Quality Measure set for SSP ACOs would include 10 measures (seven eCQMs/Medicare CQMs, two administrative claims-based measures, and CAHPS for MIPS) beginning with the 2028 performance year or the performance year that is one year after the eCQM specification becomes available for Quality ID 493: Adult Immunization Status, whichever is later.

AAFP Comments:

Given our previously expressed concerns regarding lack of health IT capabilities and interoperability, as well as administrative burden, and lack of community resources, we do not oppose the removal of Quality ID: 487. **That said, we want to acknowledge the importance of identifying and addressing health-related social needs (HRSNs) or upstream drivers of health. If left unresolved, HRSNs lead to poorer outcomes, and more costly care.**

In addition, we provide detailed comments on the Breast Cancer Screening (Quality ID 112), Colorectal Cancer Screening (Quality ID 113) **and** Adult Immunization Status (Quality ID 493) measures in our comments on the Quality Payment Program below. In short, we are opposed to updates to these measures as they will significantly increase the burden associated with reporting them. For both cancer screening measures, CMS is proposing to add a definition for "reviewed" to the MIPS CQM, Medicare Part B Claims, and eCQM collection types to clarify the requirement for meeting the quality action. We believe this change represents an expansion beyond the original intent of the measures and would impose additional documentation burden on clinicians without delivering meaningful improvements in patient care or outcomes, and provide additional details below. Regarding the Adult Immunization Status measure, we are opposed to the proposed revision to include the Hepatitis B vaccine for adults aged 19 and older. Many adult patients received Hepatitis B vaccinations during childhood, and documentation of these immunizations is often unavailable or inaccessible to primary care physicians. Immunization registries (IIS) remain fragmented and inconsistent across states, and interoperability challenges persist. Additionally, as noted in recent AAFP comments, vaccination data from pharmacies, health departments, and other non-clinical settings is not reliably transmitted to primary care practices.

Proposal to Add a Web-based Survey Mode to the CAHPS for MIPS Survey

Beginning with the 2027 performance year, CMS proposes that CMS-approved survey vendors must administer the CAHPS for MIPS survey via a web-mail-phone protocol.

Pursuant to the policy finalized in the 2025 PFS final rule that requires CMS-approved survey vendors to submit the range of the costs of their services, the cost of adding the web survey mode would be included as part of the overall costs of CAHPS for MIPS Survey administration publicly reported by vendors.

AAFP Comments:

The AAFP supports CMS's efforts to modernize the CAHPS for MIPS survey administration by incorporating a web-based option, but we also want to reiterate previously expressed concerns about the CAHPS survey in general. These include concerns about data lag, as well as lack of reliability and validity. The timing of the survey results in patients conflating experiences with various providers and having difficulty recalling experiences that took place months ago. The survey itself has not been updated, and the questions included are confusing, leading, and can be misinterpreted. **Overall, many physician clinics report that CAHPS performance does not correlate with whether the patient would recommend the physician or provider group to friends and family.** Instead, many physician clinics choose to use their own internal surveys for improvement purposes. These instruments have a much larger sample size and are more timely and meaningful to patients and physicians using the survey data. **We urge CMS to work with stakeholders to devise a better approach to obtaining patient satisfaction data.**

That said, we appreciate CMS's efforts to modernize CAHPS. Incorporating a web-based option a long overdue and welcome change. For years, stakeholders have urged CMS to allow survey administration via more contemporary technologies such as email and web platforms. The field test results showing a 43% response rate with the web-mail-phone protocol—compared to 28% with the mail-phone protocol—suggest that this approach could significantly improve survey participation.

Recommendation to Include SMS Text Messaging

To further enhance accessibility and response rates, the AAFP encourages CMS to consider adding SMS text messaging as an additional modality for survey administration. Text messaging is a widely used and effective communication tool, particularly among populations who may face barriers to completing surveys via mail, phone, or web. Research from the Pew Research Center supports the efficacy of text message notifications for web surveys, and we believe this could be a valuable addition to the protocol.

Reliability and Validity of Survey Data

We reiterate concerns previously expressed by AAFP and other healthcare stakeholders regarding the difficulty in obtaining a sufficient number of survey responses to ensure

reliability and validity. CMS should continue to monitor and address this issue, particularly as survey modalities evolve.

The AAFP supports CMS's proposal to adopt a web-mail-phone protocol for CAHPS for MIPS survey administration, recognizing its potential to improve response rates and modernize patient engagement. However, we urge CMS to:

- Evaluate and mitigate cost burdens on practices,
- Remove all other administrative burdens (i.e. staff time) on medical practices to administer the survey; CMS should assume all responsibility for administering the survey in all payment programs where it requires CAHPS.
- Preserve flexibility in survey administration methods,
- Explore the inclusion of SMS text messaging,
- Avoid requiring practices to provide patient email addresses, and
- Ensure survey reliability and equity across patient populations.

Proposal to Revise the Extreme and Uncontrollable Circumstances to Determine Quality and Financial Performance

The current Extreme and Uncontrollable Circumstances policies for ACOs do not unambiguously address ACOs affected by an EUC due to a cyberattack. For performance year 2025 and subsequent performance years, CMS proposes to expand the application of the quality and finance EUC policies to an ACO that is affected by an EUC due to a cyberattack, including ransomware/malware, as determined by the QPP.

An ACO affected at the legal entity level by an EUC due to a cyberattack that would like relief from SSP quality reporting requirements must submit a MIPS EUC Exception Application to the QPP as an APM Entity. If approved, CMS would apply the SSP quality and finance EUC policies to the ACO for the affected performance year. Under this proposal, CMS would not apply the quality and finance EUC policies to an ACO that submits a MIPS EUC Exception Application as an individual, group, or virtual group.

CMS proposes to apply the SSP finance EUC policies to 100% of the ACO's assigned beneficiaries when an ACO has a MIPS EUC Exception Application for a cyberattack.

If the ACO does not provide an end date in the application or by contacting the QPP Service Center to provide a date prior to the end of the application submission period, CMS would apply a 90-day default duration for the purposes of mitigating shared losses.

If the application has a start date that is less than 90 days before the end of the performance year and does not include an end date, CMS proposes to use December 31 of the performance year as the end date for which the ACO was impacted by the EUC.

CMS clarifies that an EUC that persists from one performance year to a subsequent performance year would require an EUC Exception Application for each affected performance year.

AAFP Comments:

The AAFP supports this proposal and appreciates CMS' responsiveness to the evolving nature of extreme and uncontrollable circumstances that may impact an ACO's performance.

Population Adjustment – Financial Benchmarking

CMS proposes to rename the "health equity benchmark adjustment (HEBA)" to "population adjustment." They feel it is necessary to add clarity to harmonize the adjustment's name with the naming convention used for other adjustments, such as the regional and prior savings adjustments. CMS also proposes to revise "HEBA scaler" to "scaler." The changes would apply for the performance year 2025 and subsequent performance years.

CMS notes that these proposed changes are only to revise the terminology. The calculation and application of the adjustment remain unchanged.

CMS seeks comments on this proposal.

AAFP Comments:

The AAFP strongly supports the importance of this adjustment, including the current calculation and application, regardless of the name.

Updates to the Quality Payment Program and Medicare Promoting Interoperability Program (section IV.)

3. Transforming the Quality Payment Program

a. Subgroup Reporting

(2) Maintain the MVP group reporting option for small practices

Under current policy, multispecialty groups that wish to report an MVP must divide into subgroups or report as individuals. Multispecialty groups may still participate in traditional MIPS as a single group.

CMS is concerned that requiring small group practices to divide into smaller subgroups may not meet the established case minimums for the quality measures. They are also concerned that the requirement to split into subgroups may deter some small practices from reporting MVPs. Given CMS' desire to sunset traditional MIPS in the future, they seek to adopt policies that reduce barriers for small practices to transition to MVPs.

CMS proposes to modify the definition of an MVP participant to provide that multispecialty groups that meet the requirements of a small practice may be MVP participants. As such, beginning with the 2026 performance period, the definition of an MVP participant would include individual MIPS ECs, single-specialty groups, multispecialty groups that meet the requirements of a small practice, subgroups, and APM Entities. Small practices may still elect to divide into subgroups.

AAFP Comments:

The AAFP supports this proposal. We encourage CMS to allow MVP small group reporting for multispecialty practices in instances where a subgroup would consist of fewer than 15 ECs of the same specialty or focus. Some large multispecialty groups may only have a few ECs of a specific specialty or focus. Subgroups comprised of small numbers of ECs will face the same burden and case minimum challenges, regardless of whether the group has 15 ECs or 100 ECs. Extending this policy would provide more flexibility for large multispecialty groups that wish to report MVPs.

However, the AAFP reiterates its firm opposition to mandatory subgroup reporting and sunsetting traditional MIPS in general. We strongly urge CMS to issue an interim final rule to retract the previously finalized policy that mandates subgroup reporting beginning with the 2026 performance year.

CMS consistently stated that they intended to monitor participation trends for subgroup reporting in the years leading up to mandatory subgroup reporting. CMS encouraged ECs to form and report via subgroups to become familiar with the requirements before it becomes mandatory in 2026. However, 2023 was the first year that ECs could report MVPs. CMS released the 2023 QPP Experience Report in July of this year, and it contains very little information regarding MVP reporting. Of the 12 MVPs, seven had fewer than 100 ECs who registered and submitted data. Moreover, only about half of those who registered to report an MVP ended up submitting data for the MVP. Nearly all ECs who reported an MVP also reported via another reporting option. Finally, less than 7,000 of the nearly 42,000 ECs who registered to report an MVP ultimately received their final score from an MVP. It is unclear how many, if any, ECs participated as part of a subgroup. Considering that CMS has continued to update its MVP policies each year and is still making proposals regarding MVPs

and subgroup reporting, combined with the general lack of data on MVP reporting, it is unrealistic to move forward with mandatory subgroup reporting in 2026.

In addition, we continue to be concerned that mandatory subgroup reporting still presents many operational challenges that weaken the program and create burden and complexities that detract from patient care. There are not enough MVPs to provide enough options for all multispecialty practices to make subgroup reporting appealing. For example, if some physicians in a large multispecialty practice wish to report MVPs, they may form subgroups. However, the remaining physicians in the practice could report to MIPS as a group or as individuals. Under current policy, group reporting would still include all physicians who are reporting MVPs as subgroups, which negates any potential burden reduction offered by an MVP. Even if CMS allowed exclusion of the physicians reporting an MVP from the overall group's submission, it would not be operationally feasible. There would be similar operational burden if the physicians who are not reporting an MVP report traditional MIPS as individuals.

One of the stated goals of MVP and subgroup reporting was to improve the value - as data would be directly attributable to the ECs and lead to actionable changes in the care provided to patients. At this point in their implementation, MVPs continue to lack all the necessary elements that could contribute to a MIPS program that is more relevant to ECs and yields more accurate and meaningful performance comparisons. The AAFP urges CMS to assess the number of ECs who have an MVP available to them, including assessing how availability differs across practice sizes and compositions.

(3) Proposal to Modify the MVP Group Registration Process

To implement the subgroup reporting requirement, CMS needs to determine the specialty composition of a group as a single specialty or multispecialty group. Specialty type is currently assigned to MIPS ECs at the individual level and not at the group level. While CMS initially aimed to use claims data to identify whether a group was a single specialty or multispecialty group, they recognize that claims data may not accurately reflect the actual care provided by the clinicians.

In lieu of using claims data, CMS proposes that a group would need to attest to its designation as a group that meets the requirements of a single specialty group or a multispecialty group that meets the requirements of a small practice. This proposal would not apply to subgroups because subgroup registration is an additional step in the MVP registration process.

CMS anticipates that group practices with 16 or more clinicians that are involved in a single focus of care would attest as a single specialty group for MVP reporting. Group practices with 16 or more ECs that are involved in multiple foci of care cannot register for MVP reporting as

a single group. They would need to divide into subgroups or report as individuals for reporting an MVP.

CMS proposes to update the definition of a single specialty group to mean a group that consists of clinicians in one specialty type or clinicians involved in a single focus of care. They propose to revise the definition of a multispecialty group to mean a group that consists of clinicians in two or more specialty types or clinicians involved in multiple foci of care.

AAFP Comments:

The AAFP agrees that claims data is not the most complete or accurate source for understanding the scope of care provided by physicians and clinicians. We support providing flexibility to groups in determining how they establish subgroups. We recommend that CMS further clarify these definitions and emphasize the difference in the focus of care rather than the specialty. We suggest the following definitions:

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

b. Core Elements Request for Information

CMS is concerned that many MVPs still have a large selection of measures, which may not produce sufficient comparative performance data to support patient choice of care. Accordingly, CMS is considering whether to require MVP participants to select one quality measure from a subset of quality measures in each MVP, referred to as "Core Elements." Participants would still need to select three other measures to satisfy the existing MVP reporting requirements. Core elements could be, but would not necessarily be, outcome measures. They would be measures that "represent the foundation and essence of an MVP."

CMS would propose Core Elements for existing MVPs through notice and comment rulemaking. They would identify the Core Elements for new MVPs at the time they are proposed. CMS notes that there are quality measure gaps for certain specialists and subspecialists and they may not have an applicable and available Core Element.

CMS is considering proposing Core Elements in the CY 2027 PFS proposed rule and proposing the policy for implementation prior to the sunset of traditional MIPS. They may be ready to fully transition to MVPs by the 2029 performance period.

AAFP Comments:

The AAFP strongly urges CMS not to pursue the creation of a Core Elements requirement – either in 2027 or a future year. A Core Elements requirement would be counterproductive as it would be a transition back to a one-size-fits-all approach to measurement. CMS has tried similar approaches in previous programs (e.g., cross-cutting measures in PQRS), and it did not generate the type of comparable performance data that CMS is seeking. Furthermore, it is unclear how the introduction of Core Elements would address the issue of not having sufficient comparative performance data that supports patient choice of care. If there were measures that were broadly applicable across the specialty or condition represented by the MVP, they would have been included in it from the outset. The likelihood of CMS identifying new or relevant measures that were not already included in an MVP is minimal.

Additionally, clinicians will be deterred from reporting an MVP if it includes a Core Element requirement and the required measure is not clinically relevant to the clinician. The AAFP has been and remains a strong advocate of supporting physician choice in selecting clinically appropriate performance measures to report as well as whether to report via MVPs or traditional MIPS.

MVPs are still too new and have had insufficient uptake to make fully informed recommendations regarding significant structural changes, such as establishing Core Elements. Making frequent changes to MVPs adds unnecessary complexity, confusion and further deters practices from reporting them.

c. Medicare Procedural Codes RFI

CMS is assessing utilizing Medicare procedural codes to further facilitate more MVP specialty reporting and to encourage and potentially require specialists to report an MVP applicable to their specialty or scope of care. They are considering a potential future policy to require clinicians to report a specific MVP based on the procedural codes they bill. Additionally, there may be measures within an MVP that are more relevant to an individual specialist based on the types of services they perform, so they are further considering requiring specialists to report specific measures within an MVP.

CMS would prioritize linking MVPs with high-utilization and high-cost procedures. CMS requests feedback on whether it would be appropriate to use the procedural billing codes from Medicare Part B claims data from two years prior to the performance year, an appropriate volume threshold for the procedural billing codes, and how long clinicians would need to prepare for a suggested or required MVP based on Medicare Part B claims data.

AAFP Comments:

The AAFP strongly opposes the assignment of MVPs to physicians. Well-designed, clinically relevant MVPs that provide a meaningful reduction in burden would make them a naturally appealing reporting option and CMS would not need to assign them to physicians.

CMS expressed concerns about using claims data to determine the specialty composition of groups. We agree with those concerns that also apply to this issue. The AAFP does not view claims data as an appropriate mechanism to identify and assign MVPs. They are an incomplete and insufficient view of the comprehensive and longitudinal care provided by primary care physicians. We also do not believe it would be appropriate to use a case minimum to assign MVPs. Primary care physicians diagnose and treat a wide range of conditions and provide care across the continuum of health care settings. Given the breadth of primary care, family physicians could meet the case minimum for many measures across several MVPs. CMS should not conflate a physician meeting a case minimum established by a third party for the purposes of performance measurement with a physician finding a measure clinically relevant and meaningful. The AAFP believes physicians are in the best position to determine which MVP is most meaningful and relevant to them and their patients. **We oppose the assignment of MVPs, regardless of the data source used or case minimum applied.**

d. Well-being and Nutrition Measures RFI

CMS is seeking input on well-being and nutrition measures for future years in the QPP. They are seeking comments on tools and measures that assess overall health, happiness, and satisfaction in life that could include aspects of emotional well-being, social connections, purpose, and fulfillment. CMS would like to receive input and comments on the applicability of tools and constructs that assess for the integration of complementary and integrative health, skill building, and self-care.

AAFP Comments*:*

Family physicians serve as lifelong partners in health for patients, communities, and populations. The AAFP believes that optimal health is not solely defined by the absence of disease but also by physical, emotional, social, and spiritual wellness. Family physicians have long been leaders in a whole-health approach to care, but the U.S. health system must evolve to support this type of care, as outlined in our recent supplement published in the journal *FPM*: Family Physicians: Leaders in Whole Health | AAFP.

Thus, we appreciate CMS' efforts to broaden the scope of quality measurement to reflect holistic health and well-being. However, **we encourage caution and careful consideration**

when selecting tools and measures to assess overall health, happiness, and satisfaction in life.

Incorporating measures of well-being, happiness, social connections, and purpose aligns with patient-centered care. However, we recommend that CMS consider only validated tools that are practical for use in clinical workflows, such as:

- **Well-being indices** like the WHO-5 Well-Being Index, which is brief and clinically applicable.
- **PROMIS (Patient-Reported Outcomes Measurement Information System)** measures for emotional distress and social functioning.
- **Nutrition screeners** such as the REAP-S (Rapid Eating Assessment for Participants - Short version) and the Nutrition Screening Initiative (NSI) DETERMINE checklist.

Applicability of Complementary and Integrative Health Constructs

Family physicians increasingly support whole-person care through integration of complementary health practices. CMS could explore measures that capture:

- **Access and engagement in skill-building and self-care**, such as mindfulness, stress management, and physical activity. The Patient Activation Measure (PAM) is one example of a survey-based measure that has been tested and validated to assess an individual's knowledge, skills and confidence integral to managing their own health and healthcare.
- **Documentation and use of evidence-based integrative therapies, including acupuncture, yoga, or nutritional counseling.**
- **Referral systems to community-based wellness programs**, where applicable and available, with an emphasis on accessibility.

Implementation Considerations

To ensure meaningful adoption and minimize administrative burden, we urge CMS to consider the following:

- Before implementation in any CMS program, pilot measure implementation in diverse practice settings (including small practices and rural areas) and among diverse patient populations:
    - Clinics that serve a large percentage of patients with significant socioeconomic barriers may, due to no fault of their own, perform poorly on wellbeing measures unless those measures are appropriately risk adjusted.

  - CMS should also consider cultural variations regarding the definition of wellness and the value placed on it as different cultures view wellness differently.

- Before implementation in any CMS program, CMS should require that EHR systems embed the selected well-being and nutrition measures in EHR systems so that documentation and reporting do not disrupt clinical workflows.
  - CMS should also be cognizant of the fact that over-reliance on survey-based measures creates significant administrative burden for physicians and their care teams as well as the growing risk of survey fatigue among patients.
- Provide flexible, non-punitive pathways for reporting non-traditional outcomes, especially those captured through patient-reported measures.
- Make the measures optional, not required in CMS programs.
- When first introduced in CMS programs, provide at least a two-year on-ramp for clinics to report on the measure before it becomes a measure that impacts payment.
- If CMS adds new measures for lifestyle and wellness, then it is important for the Agency to simultaneously REMOVE less meaningful measures from their programs.
- Should not just be applied in the primary care setting: these measures should also apply across the care continuum.

As noted in the 2024 article, Whole Health Revolution: Value-Based Care + Lifestyle Medicine "well-designed value-based payment (that we do not yet have enough of in the US) is highly compatible with the delivery of high quality, comprehensive, whole health care, aka value-based care, that can benefit by incorporating elements of lifestyle medicine. We must collectively be on guard and aware that the value movement is likely to plateau at some point in time if it's all about the payment. **We must bring an explicit focus on whole-person health and health care that can be delivered in a variety of ways, including by integrating lifestyle medicine principles into a variety of primary care practice settings."**

The AAFP is committed to advancing care that fosters vitality, resilience, and quality of life. We appreciate CMS' vision and look forward to collaborating on frameworks that honor a whole-health approach to care.

4. QPP Reporting and Data Submission

b. APM Performance Pathway

To conform with the changes to MIPS quality measure inventory, CMS proposes to incorporate the updated versions of MIPS quality measures used in the APP and APP Plus quality measure sets.

AAFP Comments:

The AAFP emphasizes the importance of maintaining alignment across reporting options. Divergence in specifications between MIPS CQM, Medicare CQM and eCQM formats undermines consistency and increases complexity for clinicians and practices – particularly those participating in ACOs.

Additionally, we refer CMS to our comments on specific MIPS quality measures on page XX of this letter.

Toward Digital Quality Measurement in CMS Quality Programs – Request for Information

eCQM FHIR Conversion Activities & Data Standardization for Quality Measurement and Reporting

CMS must ensure current eCQMs are specified using the FHIR standard and allow the measures to be calculated consistently using standardized data represented in FHIR. eCQMs currently use structured data defined by the Quality Data Model (QDM) and measure logic in Clinical Quality Language to evaluate performance on a quality measure concept at multiple levels - a, physician's, facility's, or organization's.

CMS continues to convert current eCQMs (authored using the QDM) to eCQM standards authored using the HL7 FHIR® Quality Improvement Core (QI-Core) IG, updating to new versions as appropriate. CMS is working with measure developers to ensure existing eCQMs are converted to FHIR and that new eCQMs are also natively developed in FHIR. CMS is considering a future requirement that all quality measures proposed for addition to CMS programs be specified in FHIR. They are also considering requirements to include FHIR-based specifications for measures developed by QCRDs.

CMS is seeking stakeholder input on challenges in specifying existing eCQMs using FHIR, gaps in the QI-Core Implementation Guide, and ideas to boost participation in FHIR testing activities like Connectathons.

Additionally, CMS continues to work with ONC as it develops a certification approach to enable reporting FHIR-based eCQMs using technology certified under the ONC Health IT Certification Program.

CMS seeks feedback regarding experiences or challenges reviewing, implementing, or testing the QI-Core, DEQM, or Bulk FHIR standards, gaps or deficiencies in the DEQM IG, additional baseline requirements or capabilities that need to be considered before FHIR-based eCQMs could be reported to CMS using BULK FHIR, and additional supports or enhancements that CMS should consider for the QI Core, DEQM, or Bulk FHIR IGs that would support quality measurement and reporting beyond the CMS eCQMs or potential dQMs.

AAFP Comments:

The AAFP recognizes the importance of transitioning to FHIR-based eCQMs to improve interoperability and data consistency. Moving electronic measures to FHIR standards will significantly improve interoperability and provide better access to external patient information, ultimately supporting administrative continuity of care, enhanced care management, and other benefits. However, **we anticipate several challenges in re-specifying existing measures, and we offer an alternative approach.**

1. Challenges in Specifying Existing eCQMs in FHIR:

- Scope and Standards: Since eCQMs are a subset of dQMs (digital quality measures), requiring FHIR standards exclusively for eCQMs without addressing the broader electronic measures ecosystem seems incomplete. **A comprehensive approach would be more effective.**
- Resource Burden on Measure Stewards: Converting QDM-based measures to FHIR is not a simple translation. It requires substantial time, technical expertise, and financial investment from measure stewards.
    - **Therefore, CMS should consider providing financial support for measure developers and stewards to re-specify, test, and obtain consensus-based entity (PQM) approval for new FHIR measures.**
- Complexity of Legacy Logic: Many existing eCQMs contain intricate logic built in Clinical Quality Language (CQL) that may not map cleanly to FHIR-based representations, particularly when dealing with nested population criteria or nuanced temporal relationships.
- Vendor Readiness and Certification Gaps: Health IT vendors may not yet support the full suite of FHIR APIs needed for accurate measure calculation, especially for smaller practices or those using legacy systems.
    - **Even when all health IT vendors can support FHIR APIs, there are still barriers for medical practices. Thus, CMS should consider providing financial support for physicians and practices to offset vendor-related costs.**

2. Gaps in the QI-Core Implementation Guide

The AAFP and other stakeholders have identified several areas where the QI-Core IG may fall short:

- Limited Support for Certain Data Elements: Some clinical concepts used in current eCQMs—especially those related to behavioral health, upstream drivers of health, and/or patient-reported outcomes—lack robust representation in QI-Core.
- Bulk FHIR Import/Export Limitations: There are unresolved issues around Bulk FHIR workflows, including provenance tracking and multi-tenant data exchange.
- Inconsistent Mapping Guidance: The mapping of QDM elements to FHIR resources is not always straightforward, and clearer guidance is needed to ensure consistency across measure developers.

We encourage CMS to consider an alternative approach. To best utilize government, provider, and physician practice resources, we recommend that CMS focus its efforts on FHIR-based dQMs rather than the interim step of FHIR specifying electronic clinical quality measures (eCQMs).

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

To ensure this transition is successful, objective criteria and deliverables must be established to determine whether the field (i.e., physicians and technology developers) is ready to progress to the next stage of implementing FHIR dQMs:

- Demonstrated technical capability, such as successful end-to-end testing of FHIR dQM reporting.
- Sufficient adoption rates of FHIR-enabled systems across provider types.

- Training and technical support readiness for provider organizations.
- Evidence of data quality and completeness in reported dQMs
- Stakeholder consensus on burden, feasibility, and patient safety considerations.

By confirming readiness in this way, we can help the health care community adopt new standards with confidence, accelerate the availability of more timely and accurate information, reduce the reporting burdens currently placed on the system, and ultimately improve patient experiences of care and outcomes. **Therefore, we urge CMS to release a transparent timeline and actively engage with the entire health care community for feedback: physicians, hospitals, ACOs, health plans, patients, and EHR developers.** Specifically, the process and timeline must outline when the technical requirements for FHIR-based reporting will be available with adequate time for developers to integrate them into their products, and when these requirements will be incorporated into federal certification requirements.

At the same time, **CMS should build the internal capabilities needed to receive dQM data through FHIR-based application programing interfaces and release guidance and education to assist the health care ecosystem in this transition.** Subsequently, once CMS determines that developers are ready and certified to support this reporting and CMS can receive the data, a reasonable timeframe during which practices, hospitals, ACOs, and others must begin reporting these measures should be proposed.

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

The AAFP, along with many other stakeholder organizations, are eager to assist CMS in this move and we welcome the opportunity to participate in its planning and execution.

Timeline Under Consideration for FHIR-based eCQM Reporting

As noted in the 2023 IPPS/LTCH PPS proposed rule, CMS is considering proposing a transition period during which healthcare providers that satisfy quality reporting requirements by using the eCQM collection type may report using either QDM or FHIR-based eCQMs.

CMS is considering a similar transition for MIPS and other programs that use the eCQM collection type. During the transition, those that choose to satisfy quality reporting requirements by reporting eCQMs could choose to submit either QDM-based or FHIR-based eCQMs to meet respective reporting requirements. CMS refers to this concept as the "reporting options" period.

CMS notes that MIPS ECs may satisfy the quality reporting requirements through several options and reporting by eCQM is not a requirement. They are not proposing to limit any collection types for MIPS ECs to report quality measures.

CMS acknowledges that participants may update certified health IT and implement dQMs at different speeds. They are considering at least a two-year reporting options period before any future proposal to require only FHIR-based reporting eCQMs.

AAFP Comments:

The AAFP supports CMS' commitment to advancing interoperability and data exchange through the adoption of Fast Healthcare Interoperability Resources (FHIR). However, **a 24-month timeline for mandatory implementation of FHIR-based eCQM reporting is wholly inadequate, and likely impossible.**

For the reasons expressed in the previous section, we encourage CMS to consider an alternative approach. To best utilize government, provider, and physician practice resources, we recommend that CMS focus its efforts on FHIR-based dQMs rather than the interim step of FHIR specifying electronic clinical quality measures (eCQMs).

The AAFP supports CMS' goal of modernizing quality reporting systems through the use of FHIR-based standards. However, success will depend on thoughtful pacing, appropriate support mechanisms, and responsiveness to the diverse needs of the physician community. We urge CMS to engage stakeholders continually during the transition period and adjust timelines and requirements based on readiness assessments and real-world feedback.

Measure Development and Reporting Tools

CMS has decided not to advance the FHIR-based Measure Calculation Tool. They seek feedback on the capabilities that would be most useful for CMS to support in a FHIR-based eCQM reporting model and additional concerns CMS should take into consideration when developing FHIR-based reporting requirements for systems receiving quality data.

AAFP Comments:

The AAFP appreciates the opportunity to provide feedback on the decision not to advance the FHIR-based Measure Calculation Tool and to offer recommendations regarding future FHIR-based electronic Clinical Quality Measure (eCQM) and/or dQM reporting models.

To ensure usability and scalability of a future FHIR-based eCQM and/or dQM reporting approach, we encourage CMS to prioritize the following capabilities:

- User-Friendly Interfaces: Tools that allow clinicians and EHR vendors to easily navigate, implement, and validate FHIR-based measures without needing deep technical expertise.
- Real-Time Data Exchange: Support for real-time or near real-time bidirectional data exchange between provider systems and CMS to reduce lag and improve data timeliness.
- Robust Testing and Validation Environment: A sandbox environment for testing data submissions and validating measure performance across diverse platforms.
- Automated Feedback Loop: Timely and detailed feedback on measure calculation results, including benchmarking and gaps in care analytics.
- Standardized Implementation Guides: Clear documentation to reduce ambiguity and ease adoption across varying system architectures.
- Support for De-Centralized Data Reporting: Facilitate reporting directly from EHRs or data intermediaries, reducing the need for proprietary middleware.

Additionally, when developing FHIR-based reporting requirements for systems receiving quality data, CMS should also address the following:

- Data Integrity and Provenance: Ensure consistent data definitions and traceability across systems to support auditability and accountability.
- Small Practice Burden: Consider the technical and financial barriers facing solo and small group family medicine practices. Provide streamlined reporting pathways and financial support where needed.
- Vendor and System Variability: Account for variability in readiness and capability among EHR vendors, including legacy systems with limited FHIR support.
- Alignment Across Programs: Harmonize reporting standards with other federal and private payer quality programs to reduce duplication and administrative burden.
- Privacy and Security Requirements: Reinforce strong protections for patient data, including encryption standards and access controls.

The AAFP remains committed to advancing meaningful, data-driven quality improvement while supporting family physicians and other clinicians across practice settings. We

encourage CMS to co-design future tools and models with clinical end-users to ensure they are practical, equitable, and enhance care delivery—not hinder it.

General Solicitation of Comments

CMS proposes a number of additional questions for stakeholder feedback. These focus on reducing reporting burden in FHIR-based quality reporting and beyond, including whether reuse of existing technologies and standards could streamline provider workflows. CMS also seeks input on how TEFCA's nationwide health information exchange infrastructure, particularly its support for FHIR APIs and patient discovery might facilitate quality measure exchange aligned with the FHIR Roadmap. Additionally, stakeholders are asked to consider how TEFCA could enable secondary uses of data, such as for treatment and research.

AAFP Comments*:*

The AAFP appreciates CMS' continued engagement with stakeholders as it works to reduce reporting burden and improve the usability of FHIR-based electronic clinical quality measures (eCQMs) and digital quality measures (dQMs). We welcome the opportunity to respond to the questions posed:

1. Reducing Reporting Burden Across Entities: To reduce burden associated with FHIR-based quality reporting, CMS should consider:
    a. Reducing costs and resource needs for physician clinics .
    b. Ensure that claims-based measures, including prescription medication-focused measures that look at Rx fill rates.
    c. Simplification of Data Requirements: Limit data elements to those routinely captured in clinical workflows. Avoid overly complex or duplicative data structures.
    d. Minimized Customization: Standardize reporting requirements across payers and programs to avoid fragmentation and reduce redundant work.
    e. Incremental Implementation Timelines: Provide adequate time for practices to plan, adopt, and validate new technology without disruption to care delivery.
    f. Support for EHR Interoperability: Collaborate with vendors to ensure FHIR capabilities are uniformly implemented and available within certified EHRs.
2. Reducing Burden Beyond CMS eCQMs/dQMs: CMS should consider the broader quality reporting environment and:

a. **Alignment with Non-CMS Programs**: Streamline reporting with private payers, state Medicaid programs, and other value-based initiatives to eliminate redundancy, as well as incongruence.

b. **Feedback Integration**: Solicit insight from physicians and other clinicians on the usability and feasibility of quality measures, and refine measures based on their insight.

c. **Access to Shared Resources**: Ensure access to centralized repositories for guidance, implementation tools, and validated data specifications.

The AAFP strongly encourages CMS to continue fostering collaboration among physicians, measure developers and stewards, EHR companies, other health IT vendors, and other stakeholders to ensure that quality reporting advances the goals of better care, reduced burden, and improved outcomes. Future initiatives should prioritize usability, transparency, and equity—particularly for smaller and resource-constrained practices.

MIPS Performance Category Measures and Activities

Quality Performance Category

High Priority Measure Definition

In the 2023 PFS final rule, CMS amended the definition of high priority measure to include quality measurement pertaining to health equity. They defined health equity as "the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, and other factors that affect access to care and health outcomes."

CMS believed adding the term "health equity" to their definition of a high priority measure was the best way to address disparities exacerbated by the pandemic. They now believe these disparities are best addressed through other mechanisms. They propose to remove quality measurement pertaining to health equity from the definition of the term "high priority measure." If finalized, the term "high priority measure" would mean an outcome (including intermediate outcome and patient reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure beginning with the 2026 performance period.

AAFP Comments:

The AAFP respectfully expresses concern regarding the proposed removal of quality measurement pertaining to health equity from the definition.

CMS' previous inclusion of health equity as a high priority domain recognized a critical reality: disparities in care and outcomes persist across racial, ethnic, socioeconomic, and other lines. Family physicians witness this daily, and many are actively working to dismantle barriers to equitable care. Removing health equity from the definition of high priority sends a discouraging signal to the field at a time when this work must be accelerated—not deprioritized.

Quality measurement specific to health equity drives data transparency, incentivizes improvement, and fosters accountability across care settings. It is a foundational tool—not merely a symbolic gesture—for identifying and addressing structural inequities. While alternative mechanisms to address disparities are important and complementary, they should not replace targeted measurement.

As value-based payment models expand, measures that reflect health equity enable family physicians to provide culturally competent, person-centered care while holding systems accountable for outcomes in underserved populations. Removing these measures risks obscuring the needs and experiences of patients who are most at risk of poor outcomes.

AAFP urges CMS to reconsider its proposal and retain health equity as a high priority measure domain. We also recommend:

- Continuing investment in developing and refining validated health equity-related measures .
- Providing technical assistance and resources to support implementation, especially in small and rural practices .
- Aligning health equity measurement across programs to reduce burden and confusion.

As noted in our Health Equity policy, the AAFP adopted the Healthy People 2020 definition of health equity as "the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities."

Further, our policy states, Family physicians promote health equity by considering the balance of health-related social needs that impact the health of an individual, family, community, population, and environment. "Family physicians can mitigate health inequity by collaborating with entities including but not limited to: government, business, educational systems and health and social service providers, to affect positive change for the populations they serve."

AAFP members are deeply committed to advancing health equity and ensuring that all individuals have the opportunity to achieve optimal health. CMS has a vital role to play in this work. If CMS chooses to remove "health equity" from the definition of a high priority measure, we look forward to working with the agency on its future plans to "address health disparities through other mechanisms."

Selection of Quality Measures

For CY 2026, CMS is proposing a total of 190 quality measures. The proposal includes:

- Addition of 5 quality measures, including 2 eCQMs.
- Removal of 10 quality measures from the MIPS quality measure inventory.
- Substantive changes to 32 existing quality measures.
- Revisions to the definition of a high-priority measure.

The AAFP offers the following feedback on the proposed updates to quality measures included in MIPS.

High-Priority and Patient-Reported Outcome Measures (PROMs)

We appreciate efforts to add optional quality measures that meet rigorous criteria, such as those outlined in the AAFP Performance Measures Criteria policy. Allowing physicians to choose which quality measures they want to report on is critical. They must be able to choose the measures that are most relevant to the patient population they serve, as well as are feasible to report using their existing health information and/or EHR systems.

We also appreciate efforts to include optional patient-reported outcome measures (PROMs). We place great value on the patient's voice and experience. However, we encourage CMS to acknowledge the many challenges that come with PROMs (including but not limited to patient survey fatigue, added administrative burden, added cost, difficulty in obtaining enough responses to achieve statistical significance, etc.). We encourage CMS to review comments we submitted previously specific to PROMs and to:

- Ensure that PROMs are validated, actionable, and not overly burdensome for clinicians or patients.
- Provide technical assistance and EHR integration support to facilitate adoption.

Thoughtful Measure Removal

We support the removal of measures that are no longer clinically relevant, extremely topped out, or unsupported by current guidelines. We also look forward to working with CMS on its stated goal of addressing health care disparities "through other mechanisms."

The AAFP supports CMS' efforts to modernize and streamline quality measurement in Medicare. We believe that quality measures used in value-based payment programs should meet the criteria outlined in our Performance Measures Criteria policy, which include but are not limited to the following:

- Clinically meaningful
- Patient-centered
- Feasible for implementation in diverse practice settings
- Aligned with evidence-based guidelines

As noted in our 2024 position paper, Performance Measurement in Value-based Payment Models for Primary Care:"

"...The success of VBP [value-based payment] is highly dependent on alignment across payers and unlikely to work if only a small subset of a practice's patient population is included. Increased investment in primary care across public and private payers using VBP models designed for primary care will contribute significantly to improving health, eliminating inequities, reducing unnecessary health care spending and improving the well-being of the care team.

To help facilitate the transition away from fee-for-service (FFS) payment and toward VBP arrangements that sustainably support the kind of robust primary care essential to a high-performing health care system, the American Academy of Family Physicians (AAFP) has established a set of guiding principles to describe the ideal design for key components of VBP models for primary care." Among those principles:

"Performance measures should focus on processes and outcomes that matter most to patients and have the greatest impact on overall health and unnecessary spending. VBP measures, as well as the mechanisms of measurement, should be parsimonious and aligned across payers to reduce unnecessary administrative burden."

We look forward to continued collaboration with CMS to ensure that quality measurement supports high-value health care and improved outcomes.

Cost Performance Category

CMS is not proposing to add or remove any cost measures for the CY 2026 performance period. CMS is proposing substantive changes to the Total per Capita Cost (TPCC) measure.

CMS is proposing revisions to the operational list of care episode and patient condition groups and codes to reflect the coding changes from the annual measure maintenance process.

Beginning in 2026, CMS proposes that all new cost measures will be informational-only for their first two years. During this period, clinicians will receive confidential scores and feedback, but these scores will not affect their MIPS cost category or final score. Starting in the third year, the measures would be incorporated into MIPS scoring and considered for public reporting. CMS does not plan to apply this policy to previously implemented or modified measures. Informational-only measures may be included in MVPs, but they will remain non-impactful to scoring until their third year.

AAFP Comments:

The AAFP supports the proposed revisions to the operational list of care episode and patient condition groups and codes.

The AAFP supports the proposal to keep new cost measures as informational-only for their first two years in the program. We encourage CMS to evaluate the impact substantive measure changes would have on the measure reliability and year-over-year comparability. We ask CMS to consider expanding it to measures that have undergone substantive changes, including the Total per Capita Cost Measure. Alternatively, CMS could provide a one-year information-only feedback period for measures that have undergone substantive changes.

The AAFP appreciates CMS' proposed revisions to the TPCC methodology to address concerns where groups were inappropriately attributed to them based on billing by NPPs. However, we are still concerned that there is no mechanism to account for when a patient's relationship with the primary care physician has ended. Additionally, TPCC does not reflect current clinical practice or guidelines because TPCC does not account for differences in cost related to the types of treatments the patient needed during the year. Moreover, the risk adjustment methodology is based only on chronic conditions in a prior year and does not consider current acute conditions or newly diagnosed chronic conditions that are treated for the first time during the current year.

The TPCC and other cost-based measures such as the Medicare Spending Performance Benchmark (MSPB), and the Episode Based Cost Measures (EBCMs) hold primary care physicians accountable for costs they cannot control, penalize physicians for increasing utilization of recommended preventive health services, and fail to capture long-term cost savings generated by high-quality, longitudinal primary care. Notably, physicians are held accountable for the total cost of care without being comprehensively paid for providing person-centered primary care services that are proven to reduce health care spending over time. Further, this evaluation occurs within a fee-for-service based system that does not

provide the stability and flexibility offered by prospective payments. We therefore continue to believe that TPCC should not be used in the MIPS program.

Successful continuous improvement efforts are facilitated by timely and actionable information provided as a feedback loop to those charged with driving change. The cost performance category is unique in that all the data is calculated retrospectively by CMS using claims; nothing is reported by eligible clinicians. This means that physicians are reliant on CMS to share timely, actionable information about their performance. Under the TPCC, physicians are held accountable for costs that are incurred well beyond the scope of their direct care without an actionable data feedback loop that allows them to intervene on a timely basis.

There are numerous variables that can affect cost, many which primary care physicians cannot control even when providing the best possible care. While CMS is using a TPCC methodology that takes many factors into consideration, including patient risk, clinician specialty, and outlier spending, there are many factors, particularly related to utilization driven by patient choice and other clinicians, which drive TPCC performance that the primary care physician cannot influence when it happens in isolation. Without better information on the drivers of TPCC performance, primary care physicians are left in the dark and cannot be held accountable for spending that they do not direct. This is especially problematic for small, independent practices – especially solo practices.

Improvement Activities

CMS proposes to remove the "Achieving Health Equity" (AHE) subcategory. CMS notes that this proposal does not represent a shift away from improving access, enhancing care coordination, and strengthening patient engagement. Rather, it is aligned with other programs that have shifted focus to identifying improvement objectives on topics of prevention, nutrition, and well-being. CMS proposes to recategorize the five existing improvement activities from the AHE subcategory to the other subcategories.

CMS proposes to add a new subcategory called "Achieving Health and Wellness" (AHW). It would emphasize CMS' priority of "overall health promotion and address broader aspects of healthcare that go beyond direct treatment of diseases." They propose to reassign "Chronic Care and Preventive Care Management for Empaneled Patients (IA_PM_13)" to this new subcategory. If this subcategory is finalized, CMS will consider adding more activities in future rulemaking.

CMS proposes three new activities for the 2026 performance period:

- Improving Detection of Cognitive Impairment in Primary Care (IA_PM_XX)

- Integrating Oral Health Care in Primary Care (IA_PM_XX)
- Patient Safety in Use of Artificial Intelligence (IA_PSPA_XX)

CMS proposes modifications to seven existing activities. They propose to reassign IA_AHE_1 and IA_AHE_6 to the Expanded Practice Access subcategory, IA_AHE_3 and IA_BHE_7 to the Beneficiary Engagement subcategory, and IA_AHE_10 to the Patient Safety and Practice Assessment subcategory. They propose to reassign IA_PM_13 to the new Achieving Health and Wellness subcategory.

CMS proposes to broaden IA_BMH_1 to include a comprehensive physical health screening on all patients taking anti-psychotic medications rather than focusing on patients with diabetes. They propose to rename the activity from "Diabetes Screening" to "Antipsychotic-Medication-Associated Physical Health Condition Assessment and Monitoring."

CMS believes that they are evolving the IA category to emphasize activities that demonstrably improve patient health outcomes while also encouraging the most efficient use of healthcare resources. CMS proposes to remove eight previously finalized improvement activities that they feel meet Removal Factor 7, which states they may remove an activity if they determine it is obsolete. The activities include IA_AHE_5, IA_AHE_8, IA_AHE_9, IA_AHE_11, IA_AHE_12, IA_PM_6, IA_PM_26, and IA_ERP_3. These activities do not reflect how CMS is currently prioritizing the best clinical practice. They note that they have already suspended these activities for the 2025 performance period.

AAFP Comments*:*

The AAFP supports the proposed activity "Improving Detection of Cognitive Impairment in Primary Care." Primary care physicians develop trusted and longitudinal relationships with their patients that allow them to engage in regular conversations about maintaining cognitive health and play a key role in early detection and prevention of cognitive impairment.

The AAFP supports the proposed activity "Integrating Oral Health Care in Primary Care." Family physicians play a key role in promoting good oral health during patient visits. The AAFP supports efforts to improve collaboration and integration of oral and dental health into primary care as a crucial part of patients' overall health, including conducting oral health risk assessment and screening in primary care, providing counseling and education on the importance and impact of oral health, and providing referrals to dental health providers.

Finally, we also support the proposed activity "Patient Safety in Use of AI."

The AAFP supports the potential expansion of the "Diabetes Screening" activity to encompass all patients taking anti-psychotic medications. However, we ask CMS to provide clarity regarding the activity's requirements. The rationale states the proposed change is to "modify

this activity to broaden the patient population by requiring a comprehensive physical health screening on all patients taking anti-psychotic medications." This description is not fully aligned with the proposed revised activity description, which focuses on implementing "at least one process improvement during treatment of patients taking anti-psychotic medication related to one or more component(s) of appropriate antipsychotic medication assessment and monitoring." None of the components listed include a comprehensive physical health screening.

Furthermore, process improvement is a wholly different activity to what is proposed as well as the original activity, both of which are specific to conducting a screening. Given the departure from the original activity and the discrepancy between the rationale and proposed description, we request that CMS provide a clearer description of both the extent of the changes and the activity's actual requirements.

The AAFP disagrees with CMS' proposal to remove several activities. It does not appear that CMS considered that the removal of many of these activities is inconsistent policies proposed elsewhere in the rule or expressed priorities of the administration. For example, CMS proposes to remove IA_AHE_9 "Implement Food Insecurity and Nutrition Risk Identification and Treatment Protocols." It is unclear why CMS would propose to remove an activity because it "does not reflect CMS' high prioritization of measurable clinical outcomes as well as the topics of prevention, nutrition, and well-being" when elsewhere in the same proposed rule they are seeking feedback on potential payment of lifestyle interventions and medically-tailored meals. It is also unclear how an activity that includes identifying nutrition risk does not align with CMS' prioritization of nutrition. **If CMS prioritizes healthy nutrition habits because they contribute to healthier lifestyles and prevent chronic disease, they should clearly understand how an activity that identifies and provides support to patients with or at risk for poor nutritional status is directly related to that priority.**

Similarly, CMS proposes to remove IA_AHE_12 "Practice Improvements that Engage Community Resources to Address Drivers of Health." Yet CMS proposes an improvement activity in the Ambulatory Services Model that requires participants to verify the patient has been screened for HRSN because CMS recognizes "the importance of addressing patients' upstream drivers of health." CMS also acknowledges that unmet needs can "impact a patient's well-being and contribute to the development of or exacerbation of diseases, lead to unnecessary health care costs, and worsen overall outcomes." **If CMS understands the importance and impact of screening within ASM, it should also be clear that a MIPS improvement activity that explicitly requires physicians to "select and screen for drivers of health that are relevant for the eligible clinician's population using evidence-based tools" is equally important.**

Promoting Interoperability Performance Category

Proposal to Modify the Security Risk Analysis Measure

The current Security Risk Analysis measure requires an EC to attest to conduct an analysis as required under the HIPAA Security Rule. However, it does not require ECs to manage their security risk or to attest to having implemented security measures to manage their security risk. The HIPAA Security Rule implementation specification for risk management requires the implementation of security measures sufficient to reduce risks and vulnerabilities to a reasonable and appropriate level to comply with 45 CFR 164.306(a).

CMS proposes adding a risk management component to the measure that would require ECs to "conduct security risk management activities, in accordance with the requirements under 45 CFR 164.308(a)(1)(ii)(A) and (B). The proposed change aligns with the Medicare Interoperability Program's proposal in the FY 2026 Hospital IPPS/LTCH proposed rule.

ECs would attest to each of the measure's components separately. CMS is not changing the timing of when the EC completes each component as long as they are completed during the calendar year in which the performance period occurs. They are also not proposing any changes to the scoring approach to the Security Risk Analysis measure. To meet the requirements of the category, the EC must attest "Yes" to the two components of the measure. If an EC fails to attest or attests "No" to either component, they will receive a score of zero for the entire promoting interoperability category.

AAFP Comments:

The AAFP supports this proposal, as we did in response to the FY 2026 Hospital IPPS/LTCH proposed rule. We believe it appropriately balances the need for risk analysis and management while still minimizing mandatory reporting requirements for physicians. The AAFP supports requiring hospitals to attest not only to having conducted a security risk analysis, but also to having implemented policies and procedures to support ongoing management of security risks to electronic protected health information associated with the use of EHRs. We are strongly supportive of making data reliably interoperable while maintaining patient confidentiality, and we believe this proposal correctly strikes the balance of better safeguarding patients' data without unnecessarily burdening hospitals or the medical professionals who work there.

Proposal to Modify the High Priority Practices Safety Assurance Factors for EHR Resilience (SAFER) Guide Measure

The Higher Priority Practices SAFER Guide measure requires ECs to conduct and attest "yes" to having completed an annual self-assessment using the High Priority Practices SAFER

Guide. Beginning with the 2026 performance period, CMS proposes modifying the High Priority Practices SAFER Guide measure to specify that MIPS ECs must utilize the 2025 version of the High Priority Practices SAFER Guide. CMS is not proposing changes to the scoring policies for this measure.

AAFP Comments:

The AAFP supports this proposal. We appreciate ASTP publishing the 2025 SAFER Guides and replacing the 2016 SAFER Guides, which were outdated. We support requiring the use of the 2025 SAFER Guides as well as the measure remaining an attestation, which we believe minimizes the reporting burden for physicians.

Proposal to Adopt Measure Suppression Policy for the MIPS PI Category Beginning with the CY 2026 Performance Period

CMS has identified a need to account for the impact of changing conditions that are beyond a MIPS EC's control, and which arise outside of rulemaking for a given performance period when deciding to use a measure to calculate scores or determine whether an EC meets the definition of a meaningful EHR user.

CMS is proposing a measure suppression policy that would allow them to exclude a measure from scoring due to circumstances that impede the effective measurement of a measure within its applicable objective or to exclude a measure from the determination of a meaningful EHR user for measures that are not scored. They would determine whether a circumstance warrants suppressing a measure based on their consideration of one or more of the following:

- Nature, breadth, and duration of the circumstance's effect on MIPS EC's, hospital's, and CAH's ability to fulfill the measure requirement;
- Availability of certified health IT modules to fulfill the measure;
- Circumstance affects the measure such that calculating the measure score would lead to misleading or inaccurate results, which may impede performance or compliance;
- Out-of-date or conflicting technical standards;
- Technical or operational capacity of required partners; or
- Other factors as determined by CMS.

Under this policy, CMS' decision to suppress a measure would still require the measure to be reported. However, it would not affect the score for the applicable objective or determination

of a meaningful EHR user for measures that are not scored. CMS proposes implementing this policy beginning with the CY 2026 performance period.

CMS will notify MIPS ECs, eligible hospitals, and CAHs of the suppression via existing communication channels.

AAFP Comments:

The AAFP does not object to this proposal. However, we seek clarification from CMS on the purpose of continuing to require the measure be reported if it will be suppressed. We acknowledge and appreciate that physician burden for this reporting is low due to it being an attestation, and we understand the data collected from the measure continuing to be reported could be useful. It would be helpful to the AAFP for CMS to detail the reasoning behind proposing to continue to collect the data from measures even if the measures are going to be suppressed.

Proposal to Suppress the Electronic Case Reporting Measure by Excluding the Measure from Scoring for the MIPS PI Performance Category for the CY 2025 Performance Period

The CDC recently informed CMS that it has temporarily paused electronic case reporting registration and onboarding of new health care organizations to establish a more efficient and automated process. Some ECs, eligible hospitals, and CAHs may not meet the electronic case reporting registration and onboarding requirements by the end of the CY 2025 performance period.

CMS proposes to suppress the Electronic Case Reporting measure by excluding it from calculations for scoring purposes. ECs would still be required to report the measure (attest either "Yes" or "No") or claim an applicable exclusion. However, if they report responses, their score for the Public Health and Clinical Data Exchange Objective would not be adversely affected, regardless of the response reported for the measure.

If finalized, ECs should report the measure in accordance with applicable specifications. If the measure is not finalized, CMS encourages ECs to claim an exclusion, if applicable.

CMS is using the proposed rule to communicate to EC's how they intend to address the issues related to the CDC's pause on onboarding.

CMS notes that the objective requirements and the 25 points attributed to the objective will remain the same if they finalize the proposal. It would still be a required measure, even if suppressed and excluded from scoring calculations. If finalized, the 25 points attributed to the objective would apply to the measure(s) that are not suppressed.

AAFP Comments:

As with our earlier response to the proposal regarding CMS adopting a measure suppression policy for the MIPS PI category beginning with the CY 2026 performance period, the AAFP does not object to this proposal. While we appreciate that physician burden for reporting this measure is low due to it being an attestation and that the data collected from the measure continuing to be reported could be useful, it would be helpful to the AAFP for CMS to detail the reasoning behind proposing to continue to collect the data from this measure even if it's going to be suppressed.

RFI on Changing the Query of Prescription Drug Monitoring Program (PDMP) Measure from an Attestation-based Measure to a Performance-based Measure

A recent report from the PDMP Training and Technical Assistance Center (TTAC) found that 49 of the 54 PDMPs have taken steps to integrate PDMP data into EHRs, HIEs, and Pharmacy Dispensing Software (PDS) systems. CMS continues to work with federal partners and industry stakeholders to advance common standards for information exchange between PDMPs, EHRs, PDS systems, HIEs, and exchange networks.

The HTI-2 proposed rule includes a proposal for a PDMP certification criterion entitled "Prescription Drug Monitoring Program Databases – Query, receive, validate, parse, and filter" that would enable bi-directional interaction and electronic health information exchange between certified Health IT Modules and PDMP databases using a consistent approach to querying PDMP data. The criterion would be a functional criterion agnostic to a specific PDMP standard, but would include transport, content, and vocabulary proposals, where appropriate. ONC has not finalized this proposal.

Beginning with the CY 2023 performance period, CMS finalized the current Query of PDMP measure as an attestation measure. Attesting "yes" would indicate that the EC used data from CEHRT to conduct a query of a PDMP for prescription drug history for at least one electronically prescribed Schedule II opioid or Schedule III or IV drug.

AAFP Comments:

The AAFP strongly recommends retaining the Query of PDMP as an attestation measure. We believe there must be substantial progress toward developing and integrating PDMPs before it would be appropriate to consider transitioning to a performance measure. The AAFP recommends that CMS monitor the National EHR Survey (NEHRS) data to track whether the majority of certified EHRs and standalone e-Prescribing software have internal PDMP integration. Additionally, CMS must allow the Drug Enforcement Agency's (DEA) recently proposed rule to go through the full notice and comment rulemaking process. Once finalized, healthcare stakeholders will need sufficient time to implement any new or updated

PDMP query requirements as well as time to identify and fully address issues that arise related to those changes. The AAFP recently submitted robust comments https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/LT-DEA-TelemedicineRule-031725.pdfin response to the DEA's notice of proposed rulemaking to establish a Special Registration framework for telehealth providers. **We urge CMS, DEA, and other federal agencies to work together to provide the resources states need to achieve a successful, nationwide network of PDMPs.**

While the AAFP does not currently support transitioning the Query of PDMP to a performance measure, we strongly recommend that CMS include exceptions for small and rural practices, as well as school-based care, in any future measure. The AAFP supports e-prescribing of controlled substances (EPCS) and national-level guidelines to avert a patchwork of policies that ultimately result in greater administrative burden for physicians and delay access to necessary prescriptions. Family physicians that work in a small or independent practice environment have unique needs and may require specific, targeted support to be successful. Additionally, CMS should offer exclusions for physicians without access to a PDMP, and patients for whom a PDMP is not accessible through (from within) CEHRT should be excluded from the denominator a performance measure.

The AAFP recommends that CMS keep the first two years of a Query of PDMP performance measure as informational only. This would align with CMS' policies for new measures in the quality and cost performance categories. An information-only period could provide limited, partial support for varying levels of readiness and capacity for performance-based reporting, particularly for small and rural practices. We believe policy and programs should incentivize state entities with PDMP oversight and EHR vendors and standalone e-Prescribing technologies to actively work toward enabling interfacing present within EHR and other e-Prescribing systems' IT infrastructures and prescribing workflows. Furthermore, we strongly urge CMS to wait until data indicate greater technical readiness across a majority of certified EHRs and states before considering a Query of PDMP performance measure.

Regarding the previous proposal by ONC in the HTI-2 proposed rule to use Health IT Modules certified to the "Prescription Drug Monitoring Program (PDMP) Databases – Query, receive, validate, parse, and filter" certification criterion including bilateral exchange with a Prescription Drug Monitoring Program, AAFP's recent comments indicate general support with additional recommendations. The AAFP remains very supportive of public health data exchange and believes public health agencies should be required to use the same standards as those required of CEHRT. The AAFP agrees with CMS and ASTP/ONC that public health data exchange holds considerable promise for the health care system. However, we acknowledge that meaningful advancement will only take place when all parties actively participate in meeting the data exchange requirements and are incentivized to use the same

standards nationwide. We encourage CMS and ASTP/ONC to collaborate closely on how to expand the alignment of public health IT infrastructure across HHS, as well as with other federal agencies.

In response to CMS' request for feedback on a broader set of performance-based measure concepts that could advance the agency's priorities on PDMPs we note that transitioning the PDMP query measure to a performance-based measure is not advisable now for several reasons. Developing a new performance-based measure requires significant effort and resources, which is not justified if the measure would not meet key performance measure criteria. The AAFP policy on Performance Measures Criteria states that performance measures should be evidence-based, address significant gaps or disparities, and target conditions with substantial severity and prevalence. The measure should be clinically relevant, important to physicians and patients, and focused on improving health outcomes. When intermediate clinical outcomes or processes of care are assessed, the casual pathway to improve patient-oriented outcomes should be strong. While PDMP queries for opioids and benzodiazepines are prudent with every prescription, there may not be an evidence base supporting the same for every Schedule II drug. Performance measures should be reliable, reproducible, and consistent across different practice settings. Independent small or solo practices may face significant administrative burdens if they lack integrated PDMP query capabilities within CEHRT used. Ease of data collection and reporting is crucial, and lacking standardized PDMP reporting capabilities (conveying numerator, denominator, inclusion and exclusion insights) could add significant administrative burdens. Performance measure construct validity should be established through research and testing, but variable access across practice settings to integrated PDMP query capabilities within CEHRT used could negatively impact this. Therefore, investing significant effort into making this measure performance-based is not considered a prudent use of resources.

RFI on the Modification of the Query of PDMP Measure to Include All Schedule II Drugs

PDMP requirements for reporting and use differ from state to state. Currently, almost every state collects data on Schedules II, III, and IV drugs that are prescribed. Beginning with the CY 2023 performance period, CMS expanded the Query of PDMP measure to include Schedule II opioid or Schedule III or IV drugs electronically prescribed. They are now considering proposing in future rulemaking to expand the measure to include all Schedule II drugs, rather than only including Schedule II opioids. This would include controlled substances such as central nervous system stimulants that can be prescribed for ADHD.

AAFP Comments:

The AAFP supports the use of PDMPs as a tool to improve patient safety and reduce medication misuse, while emphasizing the need for consistent national standards,

streamlined access, and targeted support for small and independent practices. It should be noted that PDMP requirements vary widely by state, including which agency oversees the program, covered drug schedules, reporting frequency, mandatory enrollment, and inter-state data sharing. Some states also require opioid or substance use training to access PDMP data.

Expanding PDMP measures to include all Schedule II drugs may be manageable for large health systems with integrated EHRs, but it presents challenges for smaller or rural practices lacking built-in PDMP query functionality. As noted by ONC/ASTP in 2023, whether PDMP access is embedded within the EHR or requires external navigation can significantly impact efficiency—taking seconds versus minutes per query. Although access to state PDMPs is improving, many physicians still rely on external systems, underscoring the need for better EHR integration to enhance usability and reduce both clinical and administrative burden.

Additionally, it's important to assess potential impacts across diverse care settings and populations when considering expansion of this measure. In school-based programs, limited PDMP access at the point of prescribing could delay treatment for children needing medications like those for ADHD. Similarly, nursing home settings may face challenges, as EPCS requirements have already proven difficult, and PDMP access may be equally constrained. To avoid unintended burdens, exclusions should be considered for independent practices, school-based care, nursing homes, and rural providers. Additionally, CMS should evaluate whether PDMP systems can accommodate increased query volumes and consider a multi-year phased implementation.

RFI Regarding Performance-based Measures

In follow-up to the RFI regarding the Public Health and Clinical Data Exchange objective included in the CY 2025 PFS proposed rule, CMS is seeking to further refine their discussion of possible future measures to address commenter concerns and seek to ensure any future proposals align with their goals of ultimately improving public health outcomes.

As part of their exploration of alternative measure concepts, CMS is considering revising their approach to scoring the measures under the objective. ECs can earn 25 points for reporting the two required measures and an additional five bonus points for reporting any of the three optional bonus measures.

ASTP/ONC, CMS, and CDC plan to continue exploring opportunities to leverage FHIR-based capabilities within certified health IT to support public health reporting. CMS is seeking comments on how future updates could impact the potential measure strategies discussed in this section.

AAFP Comments:

The AAFP is very supportive of public health data exchange and applauds the goals laid out in this RFI. We support CMS defining a minimum threshold for "completeness" of certain data elements, and we would recommend that threshold align with the version of USCDI currently in ASTP/ONC standards – USCDI v3. CMS and ASTP/ONC should work together to ensure that the timeline of adopting newer, expanded versions of USCDI are aligned going forward. More broadly, we recommend HHS focus its collaboration with CDC, ASTP/ONC, and additional agency partners on ensuring public health agencies' data exchange is properly incentivized and required to be certified to the same standards as physician CEHRT. We believe that is the current best approach to move the health care system closer to the goals laid out by the Public Health Data Strategy.

The AAFP supports revising the scoring approach to specify that MIPS eligible clinicians can earn a maximum of 10 bonus points for the objective instead of the current five. Additionally, we do not think it is necessary for CMS to score all public health measures based on performance for which a numerator and denominator are finalized. Given that there are already quality outcome measures, we do not believe performance-based measures are needed. However, if CMS were to move forward with this concept, the AAFP believes scoring a subset of measures based on performance would be more than adequate.

The AAFP believes some of the most promising uses of FHIR for public health reporting include automated, real-time data exchange to reduce manual data entry and delays; integration with USCDI standards to ensure consistency and completeness of data elements; Bulk FHIR exports to simplify clinical quality data submissions by allowing CMS to perform quality metric calculations; and bidirectional exchange with public health agencies (PHAs), which would improve data completeness and timeliness. To best reduce reporting burden and improve data quality, the AAFP recommends the implementation of real-world testing before mandating new FHIR-based reporting functionalities; increased/unified standardization across stakeholders to ensure interoperability; financial and technical implementation support for small and independent practices; and streamlined reporting requirements to minimize duplication and administrative burden.

The AAFP would strongly support CMS streamlining measures in the Promoting Interoperability performance category if FHIR APIs are broadly implemented in certified health IT. Widespread adoption of FHIR APIs could support CMS in reducing administrative burden by eliminating overlapping or duplicative measures and shifting focus from process-based measures to outcome-based measures that better reflect care quality. We reiterate that any changes would need to be preceded by real-world testing and significant stakeholder engagement to ensure that streamlined measures are clinically meaningful and feasible.

RFI Regarding Data Quality

CMS defines data quality as the degree to which health information is accurate, complete, timely, consistent, and reliable. As the prevalence of electronic health information grows, the need for high-quality data will become increasingly important. CMS wants to encourage and support ECs' use of modern technologies and standards to ensure data are usable, complete, accurate, timely, and consistent.

AAFP Comments:

The AAFP believes strongly that data quality hinges on timely and reliable access to information. AHIMA's Public Policy Statement on Data Quality and Integrity reinforces this, stating that health data is most valuable when available promptly for patient care and public health use. Primary care physicians often face significant burdens due to missing data at the point of care, including time-consuming retrieval, review, and reconciliation processes.

To address these challenges, the AAFP's position paper on Information Sharing in Value-Based Payment Models advocates for clinically relevant, actionable data to be accessible in a timely, accurate, secure, and efficient manner—without imposing undue administrative or financial strain. Building on this, the new AAFP Primary Care Information Blueprint identifies the essential data and bidirectional information needed to support success in value-based care. AAFP recommends CMS account for variability in vendor readiness and capability, particularly among legacy systems, and incentivize alignment with FHIR standards to reduce data fragmentation. The AAFP's recent response to CMS' Health Technology Ecosystem RFI outlines related and additional data and health IT recommendations.

Building on these recommendations, it's essential to recognize the role of infrastructure and policy in enabling timely access to and the quality of critical data. Primary care practices have found regional Health Information Exchanges (HIEs) and Health Data Utilities (HDUs) have helped improve access to essential data, though gaps remain—especially in payer-generated data such as patient attribution, performance metrics, and referral quality. The AAFP recommends CMS continue supporting implementation of CMS-0057-f and its APIs to improve access to such data. These information exchange networks also offer data quality support, which is especially vital for small and independent practices with limited resources. Continued and sustained investment in stakeholder-agnostic, patient-centric networks like HIEs and HDUs is essential to improve state and federal interoperability objectives. As CMS collaborates with other federal agencies to enhance health information quality, the AAFP urges alignment of the CMS Interoperability Framework and Aligned Networks with Cures Act requirements, TEFCA, and QHINs.

MIPS Final Score Methodology

Performance Category Scores

Scoring the Quality Performance Category for the Following Collection Types: Medicare Part B Claims Measures, eCQMs, MIPS CQMs, QCDR Measures, the CAHPS for MIPS Survey Measure, and Administrative Claims Measures

In general, a measure in its second consecutive year as being considered topped out can receive a maximum of seven measure achievement points. Measures that have been topped out for three consecutive years are eligible to be proposed for removal through notice-and-comment rulemaking, with CMS providing exceptions for topped out measures that are frequently used by certain specialties impacted by limited measure choice.

Since MVPs contain a limited set of quality measures, CMS proposes to also apply this analysis and criteria to MVPs. Any MVPs that are not able to meet or exceed the threshold will be flagged as "at-risk." CMS would also consider additional factors, including whether the topped-out measure is considered a cross-cutting measure or is a broadly applicable measure (included in three or more MVPs), and whether the MVP contains more than 10 measures by collection type.

AAFP Comments:

AAFP appreciates the opportunity to comment on CMS' proposal regarding the scoring of topped out measures and the implications for clinicians participating in the Merit-based Incentive Payment System (MIPS) and MIPS Value Pathways (MVPs). **We believe this new policy should apply to ALL measures, not just a limited subset of potentially topped out specialty-focused measures.**

When working to identify topped out measures, we encourage CMS to very carefully analyze the measure data by demographic criteria to ensure that the measure truly is topped out for ALL patient subpopulations. This will prevent situations where the measure may be topped out for some subpopulations but there's significant room for improvement in other patient subpopulations (while the total average hides the latter).

While the 75% achievement point threshold is a reasonable starting point for identifying "at-risk" MVPs, the AAFP urges CMS to consider a more nuanced approach. The rigid application of this threshold may not fully capture the challenges faced by clinicians in specialties with limited measure sets, particularly when topped out measures are among the few relevant options. We recommend that CMS incorporate additional qualitative factors, such as clinical relevance, patient impact, and alignment with value-based care principles, when evaluating MVPs for risk.

To mitigate the risk of MVPs being flagged as "at-risk," the AAFP encourages CMS to:

- Expand the pool of available quality measures specifically for subspecialty-focused MVPs.
- Prioritize the inclusion of measures that reflect care coordination, preventive services, and chronic disease management even within subspecialty MVPs.
- Avoid penalizing clinicians for using topped out measures when those measures remain clinically meaningful and widely applicable.

Benchmark Methodology for Scoring Administrative Claims-based Quality Measures in the Quality Performance Category

CMS currently scores administrative claims measures using performance period benchmarks. Benchmarks are created using a decile-based approach. CMS assigns measure achievement points based on which benchmark decile range the measure performance rate falls between.

CMS has observed lower scores for the administrative claims-based quality measures than for the non-administrative claims-based measures. Mean scores for administrative claims-based measures are between five to six points out of 10. Mean scores for non-administrative claims-based measures are around seven to nine points out of 10.

CMS believes a key factor in the lower scores is the use of performance year benchmarks for administrative claims-based measures. The benchmark methodology uses a decile range based on linear percentile distributions. This results in clinicians who perform around the median receiving less than 7.5 points, the equivalent of the performance threshold.

Another factor impacting administrative claims-based measure scores is that not all clinicians are scored on an administrative claims-based measure. Administrative claims-based measure may have the effect of lowering scores of MIPS ECs who are scored on such measures compared to those who are not scored on administrative claims-based measures.

Recently, CMS revised their scoring methodology for the cost performance category to address similar concerns. The methodology is now based on standard deviation, median, and an achievement point value that is derived from the performance threshold. Specifically, for a MIPS EC whose average costs attributed under a cost measure are equal to the median costs for all MIPS ECs that had the measure attributed them, CMS assigns an achievement point value equal to 10% of the performance threshold. For the CY 2025 performance period, this was 7.5 points.

CMS is proposing to modify the scoring methodology for the quality administrative claims-based measures beginning with the CY 2025 performance period. Like the cost category methodology, the quality methodology would be based on standard deviation, median, and an achievement point value that is derived from the performance threshold. A MIPS EC's whose performance rate under an administrative claims-based measure is equal to the median performance rate for all MIPS ECs scored on that measure would receive an achievement point value equal to 10% of the performance threshold.

For each administrative claims-based measure, the cutoffs for benchmark ranges would be calculated based on standard deviations from the median. To determine the benchmark ranges, CMS would adhere to the following principles: (1) center the majority of performance rates around the performance threshold-derived point value; (2) determine benchmark ranges according to the statistical distribution curve of the performance rate; and (3) distribution of achievement points for administrative claims-based quality measures should be reflective of overall program performance.

AAFP Comments:

The AAFP supports the overall proposal and encourages CMS to apply it not just to administrative claims-based measures but to ALL quality measures.

The AAFP agrees with CMS' observation that the current decile-based benchmark methodology for administrative claims-based measures has resulted in disproportionately lower scores compared to non-claims-based measures. This discrepancy undermines the fairness and consistency of MIPS scoring and may inadvertently penalize clinicians—particularly primary care physicians—who rely on administrative claims-based measures due to limited reporting options or practice infrastructure.

We commend CMS for acknowledging this issue and proposing a revised methodology that aligns more closely with the approach used in the Cost Performance Category. Using standard deviation and median-based benchmarks represents a more statistically sound and equitable framework for scoring.

The AAFP also supports CMS' proposal to assign an achievement point value equal to 10% of the performance threshold for clinicians whose performance rate equals the median. This adjustment better reflects average performance and helps ensure that clinicians are not penalized for falling near the statistical center of the distribution. It also promotes consistency across performance categories and reduces unintended scoring disparities.

Considerations for Primary Care and Small Practices

Family physicians and other primary care clinicians often face unique challenges in measure reporting, particularly when relying on administrative claims. We urge CMS to:

- Ensure that the revised methodology does not inadvertently disadvantage small or rural practices with limited patient volume.
- Monitor the impact of the new scoring approach on measure reliability and clinician engagement.
- Provide clear guidance and education to help clinicians understand how their scores are derived under the new methodology.
- Provide frequent and ***timely*** feedback to clinicians on their performance throughout the measurement year to allow them time to improve.

The AAFP supports CMS' proposal to revise the benchmark methodology for administrative claims-based quality measures and appreciates the thoughtful alignment with the cost category scoring approach. We believe this change will enhance fairness, improve clinician confidence in the MIPS program, and better reflect the realities of primary care practice. We encourage CMS to apply this improved methodology to ALL quality measures.

We look forward to continued collaboration with CMS to ensure that MIPS scoring methodologies promote equity, accuracy, and meaningful quality improvement.

MIPS Payment Adjustments

Establishing the Performance Threshold

Section 1848(q)(6)(D)(i) of the Act requires the Secretary to compute a performance threshold for each payment year based on the mean or median (selected once every three years) of the MIPS final scores for all ECs from a prior performance period. In the CY 2025 PFS final rule, CMS finalized a policy to use the mean to determine the performance threshold for the CY 2025 performance period through the CY 2027 performance period. CMS notes that statute does not specify when the Secretary should calculate the performance threshold that would apply for each payment year. CMS interprets this to mean that they can establish a performance threshold that would apply to multiple MIPS payment years.

Since there have been several large programmatic changes to the QPP in recent years, CMS believes establishing the same performance threshold for the 2028, 2029, and 2030 payment years would provide stability and predictability to MIPS ECs. As such, CMS proposes to use

the mean of 75 points from the 2017 performance period for the 2028, 2029, and 2030 payment years. CMS acknowledges that this proposal extends beyond the period they finalized to use the mean as the methodology (CY 2025-2027 performance periods). They state that current statutory authority does not have a requirement that prevents them from setting the methodology for a longer time frame. They plan to reassess the methodology in future rulemaking.

AAFP Comments:

The AAFP supports this proposal and appreciates CMS' efforts to provide stability and predictability within MIPS.

Third Party Intermediaries General Requirements

Proposal to Require Web-Mail-Phone Protocol for the Administration of the CAHPS for MIPS Survey

In 2023, CMS field tested a web-based survey mode to the current mail-phone protocol of CAHPS for MIPS survey administration. They found the addition resulted in a 43% response rate compared to 28% for the mail-phone protocol from the CY 2022 performance period CAHPS for MIPS Survey.

CMS proposes to require that, beginning with the CY 2027 performance period, CMS-approved survey vendors would have to administer the CAHPS for MIPS Survey via a web-mail-phone protocol. CMS also proposes to modify their requirements to ensure an entity is prepared to administer the web-mail-phone protocol prior to CMS approval.

AAFP Comments:

The AAFP supports CMS' efforts to modernize the CAHPS for MIPS survey administration by incorporating a web-based option, but we also want to reiterate our previously expressed concerns about the CAHPS survey in general. Incorporating a web-based option a long overdue and welcome change. For years, stakeholders have urged CMS to allow survey administration via more contemporary technologies such as email and web platforms. The field test results showing a 43% response rate with the web-mail-phone protocol—compared to 28% with the mail-phone protocol—suggest that this approach could significantly improve survey participation.

Cost Implications and Practice Flexibility

While we agree that a multimodal approach is likely to increase response rates, we urge CMS to assess and disclose the cost implications for medical practices. Implementing a three-mode protocol may introduce new financial and operational burdens, particularly for small

and rural practices. Practices should retain the flexibility to choose the survey administration method most appropriate and cost-effective for their patient population.

We also emphasize that for any CMS programs where CAHPS becomes a required component—now or in the future—CMS should fully cover the cost of survey administration to avoid shifting financial responsibility onto physician practices.

Recommendation to Include SMS Text Messaging

To further enhance accessibility and response rates, the AAFP encourages CMS to consider adding SMS text messaging as an additional modality for survey administration. Text messaging is a widely used and effective communication tool, particularly among populations who may face barriers to completing surveys via mail, phone, or web. Research from the Pew Research Center supports the efficacy of text message notifications for web surveys, and we believe this could be a valuable addition to the protocol.

Reliability and Validity of Survey Data

We reiterate concerns previously expressed by AAFP and other healthcare stakeholders regarding the difficulty in obtaining a sufficient number of survey responses to ensure reliability and validity. CMS should continue to monitor and address this issue, particularly as survey modalities evolve.

The AAFP supports CMS' proposal to adopt a web-mail-phone protocol for CAHPS for MIPS survey administration, recognizing its potential to improve response rates and modernize patient engagement. However, we urge CMS to:

- Evaluate and mitigate cost burdens on practices,
- Remove all other administrative burdens (i.e. staff time) on medical practices to administer the survey; CMS should assume all responsibility for administering the survey in all payment programs where it requires CAHPS.
- Preserve flexibility in survey administration methods,
- Explore the inclusion of SMS text messaging,
- Avoid requiring practices to provide patient email addresses, and
- Ensure survey reliability and equity across patient populations.

Advanced APMs

QP Determinations

Under current policy, an EC who has fully engaged with an AAPM may still not earn QP status because it is calculated at the APM Entity level. Individual level determinations are only made under specific circumstances, such as when an ECs appears on a Participation List for more than one APM Entity but does not achieve QP status based on any APM Entity-level determinations. They also make individual determinations for ECs on an Affiliated Practitioner list.

CMS is proposing a new provision to add a QP determination at the individual level for all AAPM participants, beginning with the 2026 QP performance period. This proposal would not impact their policies for APM Entity level determinations or their policy for Affiliated Practitioners. Instead, CMS would add a calculation of Threshold Scores for QP determinations at the individual level for each NPI associated with an EC participating in an AAPM based on services furnished across all TINs to which the EC has reassigned their billing rights. An EC would be a QP for a year under the Medicare option if they meet or exceed the corresponding QP payment amount threshold or QP patient count threshold for that QP Performance Period at the APM Entity level or as an individual EC. CMS also proposes to make this change for the All-Payer Combination Option.

CMS also proposes similar changes for Partial QP determinations, allowing ECs to qualify at either level.

To improve attribution, CMS proposes modifying the sixth criterion in the definition of "attribution-eligible beneficiary." Beginning in 2026, a beneficiary would qualify if they had at least one claim for a covered professional service from an EC on the APM Entity's Participation List during the QP Performance Period.

Lastly, CMS proposes removing the **Medical Home Model 50 EC limit** starting in 2026, with corresponding changes to the Aligned Other Payer and Medicaid Medical Home Models.

AAFP Comments:

The AAFP supports these proposals. The AAFP has been opposed to the Medical Home Model limit since its inception and thanks CMS for removing it.

Appendix 1 – Table Group A: New MIPS Quality Measures Proposed for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years

A.1 Patient Reported Falls and Plan of Care

Measures the percentage of patients (or caregivers as appropriate) with an active diagnosis of a movement disorder, multiple sclerosis, a neuromuscular disorder, dementia, or stroke who reported a fall occurred and those that fell had a plan of care for falls documented at every visit. It is a process measure and a high priority measure. It would be available as a MIPS CQM. The PRMR Clinician Recommendation Committee recommended this measure. This measure was previously available in MIPS as a QCDR measure. It is not currently endorsed by a CBE.

AAFP Comments:

The AAFP appreciates the intent behind the "Patient Reported Falls and Plan of Care" quality measure, which seeks to improve outcomes for patients with movement disorders, neurological conditions, and cognitive impairment by ensuring that falls are identified and addressed through documented care plans. **We support it as an optional measure in the MIPS program, and we offer the following feedback:**

Falls are a leading cause of injury, hospitalization, and loss of independence among older adults and individuals with neurological or cognitive conditions. The AAFP strongly supports efforts to reduce fall risk and improve care coordination for vulnerable populations. This measure aligns with our clinical priorities by:

- Encouraging proactive identification of fall events through patient or caregiver reporting.
- Promoting individualized care planning to mitigate future risk.
- Supporting continuity of care across visits and care settings.

We recommend that CMS and measure developers ensure that the definition of "plan of care" remains flexible and clinically appropriate, allowing physicians to tailor interventions based on individual patient needs, preferences, and risk factors.

Considerations for Implementation

While the measure's intent is commendable, the AAFP urges CMS to consider the following:

- **Administrative burden**: Documentation requirements should be streamlined to avoid excessive reporting that detracts from clinical care.

- **Clear attribution to Neurologists:** This measure is most applicable to neurologists and thus should be a measure option within that specialty.
- **Visit frequency**: Requiring documentation at every visit may be overly rigid, particularly for patients with stable conditions or infrequent visits. A more reasonable interval may improve feasibility.
- **Caregiver involvement**: Clear guidance should be provided on how caregiver-reported falls are documented and validated, especially in cases of cognitive impairment.

The AAFP supports the inclusion of fall-related quality measures that promote patient safety, care planning, and interdisciplinary coordination. **That said, we encourage CMS to refine the "Patient Reported Falls and Plan of Care" measure to ensure it is practical, equitable, and aligned with the realities of clinical practice. This measure is most appropriate for attribution to neurologists.** With thoughtful implementation, this measure can contribute meaningfully to improving outcomes for high-risk populations.

A.3 Diagnostic Delay of Venous Thromboembolism (DOVE) in Primary Care (eCQM 3749e)

Measures the percentage of episodes for patients 18 years of age and older with documented VTE symptoms in the primary care setting and who had a diagnosis of VTE that occurs >24 hours and within 30 days following the index primary care visit where symptoms for the VTE were first present. It is an intermediate outcome and a high priority measure. CMS states it is intended to be reported by integrated health systems with access to both ambulatory and inpatient documentation. This measure could be added to the Value in Primary Care MVP in the future and could be a potential addition to the MIPS Family Medicine, Geriatrics, and Internal Medicine specialty sets. The PRMR Clinician Recommendation Committee recommends this measure with the condition that implementation burdens are addressed for facilities with less sophisticated EHRs.

AAFP Comments:

The AAFP appreciates the intent of this measure. We acknowledge the developer's time and effort to thoughtfully create a measure that is directly implemented as an eCQM, thereby reducing physician and health system burden to implement. We also appreciate the inclusion of natural language processing (NLP) and discrete data elements. **However, we do not support the addition of this measure for use in MIPS as it is currently specified. We would like to reiterate many of the concerns we expressed in late 2024 when this measure was carefully evaluated as part of the "Measures Under Consideration" (MUC) process:**

- This measure should be specified for use with clinicians beyond just primary care. Given the primary care physician shortage, the plethora of patient entry points into the health care system, as well as the goals of the measure to decrease delayed DVT diagnosis and treatment, this measure should be applied more broadly. It should also include urgent care.
- As currently specified, this measure could unfairly penalize primary care physicians who do not have immediate access (<24 hours) to ultrasound diagnostics.
- As acknowledged by the measure developer, a "measure to quantify delayed diagnosis of VTE within a CMS payment program may motivate primary care clinicians to overuse VTE diagnostic resources to avoid a high DOVE rate." We agree. This measure could lead to an increase in unnecessary ED visits.
- We question the lack of risk stratification.
- Reliability for this measure is below the acceptable threshold for roughly 60% of measured entities in testing.
- The inclusion of "cough" and other vague symptoms seems too broad. Often primary care physicians are squeezing patients in for brief acute visits, overbooking at times, because it's the right thing to do for the patient. A cough, especially during respiratory season, does not always prompt a long line of questioning related to DVT.
- Many health systems have limited or zero implementation of natural language processing (NLP) tools that would be required to support this metric as an eCQM today. Implementation of this could increase costs and resources required to build out these tools.
- When this measure was evaluated as part of the 2024 "Measures Under Consideration" (MUC) process, the measure developer mentioned several times that they do not intend for this measure to be used to penalize primary care physicians. However, the MIPS program ties performance to payment and thus penalties are possible.
- A better way to realize the overall goals of this measure would be to develop and widely disseminate easy-to-use tools to assist primary care and other physicians in clinical decision support so they do not miss the diagnosis rather than implement a performance measure with possible penalties.
- There currently is not enough data on the near- and long-term effects of this metric. It has the potential to increase costs if physicians practice defensive medicine to not miss one case of VTE within 24 hours in patients who present with a wide

variety of symptoms including cough and any lower extremity pain vs. practicing evidence-based medicine and ordering appropriate tests as indicated.

- This measure could be a good quality improvement measure for internal quality improvement purposes ONLY within a medical clinic. As proposed, we do not support the implementation of this measure in MIPS or any other value-based payment program where payment is tied to performance.

A.4 Screening for Abnormal Glucose Metabolism in Patients at Risk of Developing Diabetes (eCQM)

Measures the percentage of adult patients with risk factors for type 2 diabetes who are due for glycemic screening for whom the screening process was completed during the measurement period. It is a process measure. This measure aligns with the USPSTF clinical guidelines for pre-diabetes screening, which recommends screening for prediabetes and DM type 2 in adults aged 35 to 70 years who are overweight or have obesity. The PRMR Clinician Recommendation Committee recommended this measure. It is not currently endorsed by a CBE.

AAFP Comments:

The AAFP supports this as an optional measure in the MIPS program, and we offer ways that the measure could be revised and improved.

Alignment with Clinical Guidelines and Primary Care Practice

The AAFP supports the intent of this measure, which reflects evidence-based screening practices and is consistent with the USPSTF's Grade B recommendation. Family physicians routinely assess patients for diabetes risk and initiate appropriate screening using validated methods such as HbA1c, fasting plasma glucose, or oral glucose tolerance tests.

It is estimated that 80% of individuals with prediabetes are undiagnosed. This measure addresses a critical gap in preventive care and supports early intervention strategies that can reduce long-term complications and costs.

Measure Type and Utility

As a process measure, this eCQM is straightforward and actionable. It encourages timely screening. However, we urge CMS and measure developer/steward to ensure that:

- The measure allows flexibility in test selection based on clinical appropriateness.
- It avoids incentivizing unnecessary or overly frequent screening, particularly in low-risk patients.

- It includes clear guidance on coding and documentation to minimize administrative burden.

Concerns About Endorsement and Reliability

We note that this measure is not currently endorsed by a consensus-based entity (CBE). The AAFP recommends that the measure developer/steward seek endorsement to ensure the measure meets rigorous standards for reliability, validity, and feasibility. Additionally, we encourage CMS to monitor the measure's performance across diverse practice settings and patient populations to ensure equitable implementation.

Recommendations for Improvement

To enhance the measure's impact and usability, the AAFP recommends:

- Revise the measure so that it includes/accepts data from Continuous Glucose Monitors (CGMs) (i.e. it should be revised to include a glucose management indicator, GMI)
- Include stratification options to assess disparities in screening rates by race, ethnicity, and socioeconomic status.
- Clarify the screening interval for patients with previously normal results, as evidence on optimal rescreening frequency remains limited.
- Ensure that the measure does not penalize practices that prioritize shared decision-making and individualized care plans.

Table Group B: Modifications to Previously Finalized Specialty Measure Sets Proposed for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years

CMS proposes to add the following measures to the Family Medicine Specialty Set:

- Diagnostic Delay of VTE in Primary Care (eCQM CBE# 3749e)
- Screening for Abnormal Glucose Metabolism in Patients at Risk for Developing Diabetes
- Hepatitis C Sustained Virological Response

CMS proposes to remove the following measures from the Family Medicine Specialty Set:

- Non-recommended Cervical Cancer Screening in Adolescent Females (Quality ID 443)
- Screening for Social Drivers of Health (Quality ID 487)

- Connection to Community Service Provider (Quality ID 498)
- Adult COVID-19 Vaccination Status (Quality ID 508)

AAFP Comments:

Regarding the Diagnostic Delay of VTE in Primary Care and Screening for Abnormal Glucose Metabolism in Patients at Risk for Developing Diabetes measures, please see our comments in the previous section (Table A) for detailed feedback on these measures.

Regarding the measures proposed for removal, we do not oppose the removal of the two social drivers of health (upstream drivers) measures given our previously expressed concerns regarding lack of health IT capabilities and interoperability, as well as administrative burden, and lack of capacity or availability of needed resources in many communities. We also do not oppose the removal of the COVID-19 vaccine measure for administrative and data reasons we previously expressed. Nor do we oppose the removal of the non-recommended cervical cancer screening measure given that the measure is no longer being maintained by the measure steward.

The AAFP's position on these measures in no way diminishes our view on the importance of identifying and addressing health-related social needs (HRSNs) or upstream drivers of health. If left unresolved, HRSNs lead to poorer outcomes, and more costly care. Thus, we look forward to working with CMS on its future plans to "address health disparities through other mechanisms."

Table Group C: Previously Finalized Quality Measures Proposed for Removal for the CY 2026 Performance Period and Future Years

- Non-recommended Cervical Cancer Screening in Adolescent Females (Quality ID 443) – CMS proposes removing this measure because the measure steward (NCQA) would no longer maintain the measure.
- Screening for Social Drivers of Health (Quality ID 487) – CMS proposes removing this measure because they no longer believe it addresses a priority area, and they do not consider it a high-priority measure. They also want to align with other CMS quality programs, where they also proposed removing it.
- Connection to Community Service Provider (Quality ID 498) – CMS proposes removing this measure because they no longer believe it addresses a priority area, and they do not consider it a high-priority measure. They also want to align with other CMS quality programs, where they also proposed removing it.

- Adult COVID-19 Vaccination Status (Quality ID 508) - CMS proposes removing this measure because they no longer believe it addresses a priority area, and they do not consider it a high-priority measure. They also want to align with other CMS quality programs, where they also proposed removing it.

AAFP Comments:

As noted previously, the AAFP is very committed to the importance of identifying and addressing health-related social needs (HRSNs) or upstream drivers of health. Due to our concerns regarding lack of health IT capabilities and interoperability, administrative burden, and lack of community resources we do not oppose the removal of these measures.

Table Group D: Proposed Substantive Changes to Previously Finalized MIPS Quality Measures for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (pg. 1666)

Within this Table, CMS outlines proposed changes to 32 existing quality measures. Below, the AAFP offers comments on CMS' policy for scoring quality measures that undergo substantive changes, as well as detailed comments on the proposed substantive changes to select measures applicable to family medicine.

AAFP Comments:

The AAFP urges CMS to reconsider its current policy for scoring quality measures that undergo substantive changes. Truncating the performance period to nine months introduces significant challenges, particularly in generating reliable measure scores and benchmarks. This approach undermines the stability and predictability that physicians need to meaningfully engage in quality reporting.

In this proposed rule, CMS outlines substantive changes to 32 of the 190 quality measures in the program—impacting nearly 18% of all measures. These changes trigger new benchmarks, leaving physicians uncertain about how their performance will be assessed. If CMS is unable to calculate a benchmark from truncated data, it defaults to a performance period benchmark, which may not reflect actual clinical performance and could result in inequitable scoring outcomes.

To promote continued participation and ensure robust data collection, AAFP recommends that CMS award maximum credit to physicians who report on substantively revised measures. This would incentivize submission and support the development of reliable benchmarks for future program years.

AAFP also encourages CMS to assess the impact of substantive changes—including coding updates—on measure score reliability. If year-over-year performance shifts are

attributable to changes in measure specifications or coding rather than actual clinical performance, CMS should classify these as substantive changes and reassess the reliability of the scores accordingly.

Finally, AAFP recommends that CMS consider treating substantively revised measures as informational only during the initial implementation year. This approach would allow time for adequate data collection and analysis without penalizing physicians for factors beyond their control.

AAFP remains committed to advancing meaningful quality measurement that improves patient care and supports important practice-level quality improvement initiatives with timely and actionable results. We welcome continued dialogue with CMS to ensure that quality programs are equitable, transparent, and clinically relevant.

D.2 Advance Care Plan (Quality ID 047)

CMS proposes to remove the Medicare Part B Claims collection type for this measure as it has reached the end of the topped-out lifecycle. They are proposing to maintain it for the MIPS CQM collection type.

AAFP Comments:

The AAFP questions CMS proposal to remove the Medicare Part B Claims collection type for this measure. Within the voluntary nature of measure reporting within the MIPS program, clinicians are likely to select the measures on which they best perform. Therefore, there is no way to calculate a nationally representative sample of performance given the way the program is designed.

That said, we support CMS decision to retain the measure for the MIPS Clinical Quality Measure (CQM) collection type. Advance care planning remains a critical component of patient-centered care, particularly for older adults. Maintaining this measure within MIPS CQMs ensures that practices with robust electronic reporting capabilities can continue to document and improve performance in this area.

However, **we urge CMS to consider the following implementation recommendations**:

- **Provide Clear Guidance on Reporting Expectations** - CMS should issue updated documentation and educational resources to clarify how the measure should be reported under MIPS CQMs, especially for practices transitioning away from claims-based reporting.
- **Support Small and Rural Practices** - Many small and rural practices may lack the infrastructure to report via MIPS CQMs. We recommend that CMS explore technical

assistance programs and financial support to help these practices maintain participation in quality reporting.

- Ensure Alignment Across Programs - CMS should ensure that the Advance Care Plan measure remains harmonized across other federal programs and private payer initiatives to reduce duplication and administrative burden.
- Monitor Impact and Utility - We encourage CMS to monitor the continued utility of the measure under MIPS CQMs and consider future updates to ensure it remains clinically relevant and feasible for reporting.

The AAFP appreciates CMS' thoughtful approach to measure lifecycle management and supports efforts to streamline quality reporting while preserving meaningful metrics. We look forward to continued collaboration to ensure that quality measures reflect the realities of clinical practice and support improved patient outcomes.

D. 4 Documentation of Current Medications in the Medical Record (Quality ID 130)

CMS proposes to update the denominator exception for the eCQM collection type. It proposes to replace the medical reason value set with the Acute Health Crisis Direct Reference Code (DRC) as this code better represents the intent of the denominator exception.

AAFP Comments:

The AAFP appreciates CMS' efforts to update this measure. Specifically, we appreciate the intent behind replacing the broad medical reason value set with the more targeted Acute Health Crisis DRC. **In most cases, we generally support the move toward more precise coding. However, we want to emphasize the importance of ensuring that the new DRC does not inadvertently exclude valid cases where documentation is clinically inappropriate but not emergent.**

To that end, we recommend the following actions to CMS if it chooses to replace the medical reason value set with the Acute Health Crisis DRC:

- Preserve Flexibility for Clinicians - We recommend CMS consider retaining a limited subset of the medical reason value set to account for valid but non-emergent scenarios where documentation may still be clinically inappropriate (e.g., patient refusal, severe cognitive decline, severe pain, end-of-life care).
- Clarify Definitions and Coding Guidance – We encourage CMS to provide clear guidance on what constitutes an "acute health crisis" and ensure that EHR vendors

and clinicians have access to updated coding resources to support accurate reporting.

- Monitor Impact on Performance Rates - We urge CMS to monitor the impact of this change on performance rates and clinician burden, especially in primary care settings where acute crises may be less frequent but other valid exceptions may arise.

We would also like to reiterate general measure feedback that we provided to the American Institutes for Research (AIR) about this measure in May 2025:

- Feasibility – **This measure remains burdensome** given the requirement to document all OTC meds and all supplements in addition to all the patient's prescription drugs. Many patients often do not report OTC and other nutritional supplements they take.
- The revised language for the denominator exception clarifies the intent "Documentation of an acute health crisis where time is of the essence and delay of treatment would jeopardize the patient's health status." We note that there is a SNOMEDCT code (705016005) used in the specifications. However, we do not believe this code is commonly known or used. Thus, the feasibility of collecting this data element may be low.
- Potential unintended consequences – provider burden, including time spent trying to document the plethora of vitamins and nutritional supplements on the market. Many physician clinics would have to build out lists in their electronic health record (EHR) systems and ensure all nutritional supplement data is documented in discrete data fields.
- **If this measure is retained and required, it should be required of all providers (including specialists), not just primary care physicians.**
- The denominator CPTs seem to include optometry visits, but not dental visits. Thus, we suggest adding dental visits.
- Physicians under MIPs have no control over other specialties and/or disciplines. Optometrists who accept Medicare and report this CPT code may or may not reconcile medications, but there is no method for them to attest on behalf of the physician.

<u>D.5 Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Quality ID 134)</u>

CMS proposes to revise the guidance and numerator for the eCQM collection type to clarify that pharmacological interventions include prescribed or active depression medications.

They propose to update the guidance for determining the appropriate plan of care in instances where the screening tool doesn't adequately establish a diagnosis of depression. They propose to add guidance to clarify instances of multiple screening.

AAFP Comments:

The AAFP appreciates CMS' efforts to update this measure. Specific to the proposed changes, we support the addition of guidance stating that pharmacological interventions include prescribed or active depression medications.

It is also important to acknowledge that many patients receive care outside of their PCP's office. Efforts to require mental and behavioral health providers to document in an EHR, and link visits related to mental and behavioral health via a Health Information Exchange (HIE) would benefit all stakeholders.

D.11 Dementia: Cognitive Assessment

CMS proposes to revise the measure description, guidance, and numerator to clarify the timing of the routine assessment of cognition and review of the results to ensure that the patient had a diagnosis of dementia at the time of assessment.

AAFP Comments:

The AAFP appreciates CMS' efforts to revise the measure's description, guidance, and numerator to clarify that the cognitive assessment must occur after a confirmed diagnosis of dementia. We support this clarification, as it aligns the measure more closely with clinical workflows and ensures that assessments are appropriately targeted to patients with a documented diagnosis.

However, we offer the following considerations and recommendations:

Clinical Relevance and Feasibility

- Support for Clarification: We agree that clarifying the timing of the assessment relative to diagnosis is clinically appropriate. This change will help ensure that the measure reflects meaningful care processes and avoids penalizing clinicians for assessments conducted during the diagnostic workup.
- Feasibility Concerns: We urge CMS to consider the documentation burden this clarification may introduce, particularly for small and rural practices. CMS should provide clear guidance on acceptable documentation formats and workflows to support compliance.

Alignment with Improvement Activities

- The AAFP supports the intent of the related Improvement Activity, "Improving Detection of Cognitive Impairment in Primary Care," which complements this measure by encouraging earlier detection and structured assessments.
- We recommend CMS explore opportunities to align these efforts more explicitly, such as through shared benchmarks or bundled reporting options.

Broader Context and Future Considerations

- Specialty Set Inclusion: We appreciate that this measure is currently in the neurology specialty measure set, which is where it is most appropriate.

D.13 Closing the Referral Loop: Receipt of Specialist Report (Quality ID 374)

CMS proposes to update the guidance and numerator for the eCQM collection type to align with current measure logic, which requires a report from the referral.

AAFP Comments:

The AAFP appreciates CMS' efforts to revise the measure's guidance and numerator to align with current measure logic. However, we continue to have concerns about this measure in general:

- Holding primary care clinicians accountable for the actions of patients and/or subspecialists is not appropriate.
- Oftentimes, a PCP refers a patient to a subspecialist, and the patient decides never to pursue that referral.
- Even when patients choose to follow-through on a referral from their PCP, the specialty clinic to which the patient was referred sometimes does not send a report back to the patient's PCP. These specialty clinics should be held accountable for providing the report back to the PCP electronically.

We also want to acknowledge that this measure is closely aligned with similar measures in other MIPS categories:

- Improvement Activity IA_CC_1: "Implementation of use of specialist reports back to referring clinician or group to close referral loop."
- Promoting Interoperability Measures: Such as "Support Electronic Referral Loops by Receiving and Reconciling Health Information."

We strongly encourage CMS to consider offering cross-category credit within MIPS to reduce reporting burden and reward practices for meaningful infrastructure investments.

D.16 Immunization for Adolescents (Quality ID 394)

CMS proposes to revise the measure description and numerator to add the pentavalent serogroup meningococcal vaccine as numerator compliant for patients for which it is suggested. This aligns with CDC ACIP recommendations that children may receive pentavalent vaccines starting at age 10.

AAFP Comments:

The AAFP appreciates the opportunity to comment on CMS' proposed revisions to the Immunization for Adolescents quality measure (Quality ID 394). **We support the goal of improving adolescent vaccination rates. However, we have repeatedly opposed the use of the immunization composite measures as performance measures tied to payment for individual clinicians due to systemic and structural data limitations.**

Support for Clinical Alignment - The AAFP supports CMS' proposal to incorporate the pentavalent meningococcal vaccine into the measure.

Interoperability and Registry Challenges - As noted in prior AAFP comments on immunization measures, interoperability challenges persist across state immunization information systems (IIS). Many adolescents receive vaccines in pharmacies, schools, or public health settings, and data from these sources is not always reliably transmitted to primary care practices. IIS are not interoperable across states or health systems. This leads to gaps in data that unfairly penalize clinicians under performance-based programs like MIPS. **We strongly urge CMS to continue investing in IIS modernization and data exchange infrastructure to support accurate measure reporting.**

Administrative Burden - Physicians and their staff must manually track down and enter immunization records, which is time-consuming and costly.

Vaccine Hesitancy and Patient Autonomy - Holding clinicians accountable for vaccination rates does not account for patient refusal, which are beyond the clinician's control.

Equity and Access Considerations - We encourage CMS to monitor the impact of this measure on underserved populations. Adolescents in rural or low-income communities may face barriers to accessing recommended vaccines. CMS should consider stratifying performance data by demographic factors to identify and address disparities.

Specific Recommendations

- Do not use this measure as a clinician-level performance measure tied to payment in MIPS or Medicare Advantage Star Ratings.
- Limit its use to health plan-level accountability, such as in HEDIS, where data aggregation is more feasible.
- Improve immunization data infrastructure before implementing composite vaccine measures in value-based programs.
- Partner with CDC, ONC, and other federal agencies to modernize IIS and ensure bidirectional data exchange

The AAFP encourages CMS to continue addressing documentation, interoperability, and equity challenges to ensure that immunization measures are both meaningful and feasible for primary care clinicians.

D. 17 Osteoporosis Management in Women Who Had a Fracture (Quality ID 418)

CMS proposes to revise the list of tests for measuring bone mineral density by removing CT bone density axial and ultrasonography for densitometry as meeting performance. The changes would ensure testing required for numerator compliance is better aligned with guidelines and best practices.

AAFP Comments:

The AAFP supports CMS' proposed revisions to the numerator note. These changes improve alignment with current clinical guidelines and best practices for osteoporosis screening and management. By specifying the most clinically relevant and widely used BMD modalities, CMS enhances the measure's clarity and utility for reporting clinicians.

ID.19 IVD All or None Outcome Measure (Optimal Control) (Quality ID 441)

CMS proposes to update multiple components of the measure to align with AHA/ACC/ACCP/ASPC/NLA/PCNA Guidelines. This includes revising normal blood pressure measurement to 130/80 and switching from Statin Use Unless Contraindicated to High Intensity Statin Use Unless Contraindicated. They are also proposing to remove coding for arterial embolism and thrombosis from the CAD Risk-Equivalent Conditions denominator criteria as they do not share the same pathophysiology or treatment goals and misalign with the intent of the measure.

AAFP Comments:

The AAFP appreciates the opportunity to comment on CMS' proposed revisions to the Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control) (Quality ID441).

Support for Clinical Alignment - The AAFP supports CMS' effort to align this measure with updated clinical guidelines.

Concerns About Feasibility and Burden - We caution that the "all-or-none" structure of this measure may disproportionately penalize clinicians for missing a single component, even when most care goals are met. This structure can be particularly challenging for practices serving complex or underserved populations. Physicians should "get credit" for tobacco cessation counseling, regardless of whether the patient chooses to quit smoking. We also recommend CMS provide continued credit for moderate-dose statins, particularly in instances where patients cannot tolerate a high dose but can tolerate a moderate dose.

Implementation Support - Given the complexity of this measure, we recommend CMS provide technical assistance and EHR integration resources to support accurate reporting. This is especially important for small and rural practices with limited health IT infrastructure.

We welcome future opportunities to provide more detailed feedback to help shape future revisions to this measure.

D.25 Clinician and Clinician Group Risk-Standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Quality ID 484)

CMS proposes to revise the denominator eligible population by removing the exclusion regarding QP status. This would broaden the scope of the measure and account for all MIPS participants, particularly those in APM entities who may have QP status.

AAFP Comments:

The AAFP has concerns about this measure and do not support the proposed change to the measure specifications to remove the exclusion for anyone with a QP status from the measure.

The AAFP notes that the attribution methodology varies significantly across important MIPS and MVP quality and cost measures, such as Hospital-wide Readmissions (HWR), Multiple Chronic Conditions and TPCC. This variation in methodologies (e.g., plurality of charges vs. plurality of visits) can result in different physicians being accountable for different, but related measures. The lack of a cohesive approach to attribution within the MIPS program is not sustainable and must be addressed to create a system that promotes and facilitates

meaningful and actionable feedback to physicians. Consistent, predictable, and actionable feedback provided in a timely manner will ultimately help CMS achieve its primary goal of achieving better care for its beneficiaries.

D.27 Adult Immunization Status (Quality ID 493)

CMS proposes to revise the measure to include Hepatitis B vaccine in the list of routine vaccinations of adults aged 19 and older. If this proposed change is finalized, it would not allow for a direct comparison of performance data from prior years data to performance data. CMS would use a performance period benchmark for scoring.

AAFP Comments:

The AAFP appreciates CMS' ongoing efforts to improve adult immunization rates and supports the inclusion of evidence-based vaccines in quality measures. However, we have significant concerns regarding the proposed revision to the Adult Immunization Status (Quality ID 493) measure to include the Hepatitis B vaccine for adults aged 19 and older.

Many adult patients received Hepatitis B vaccinations during childhood, and documentation of these immunizations is often unavailable or inaccessible to primary care physicians. Immunization registries (IIS) remain fragmented and inconsistent across states, and interoperability challenges persist. As noted in recent AAFP comments, vaccination data from pharmacies, health departments, and other non-clinical settings is not reliably transmitted to primary care practices.

This raises critical questions:

- Will clinicians be required to order serologic titers to verify immunity?
- Will they be expected to track down historical records from decades ago?

If titers are required, all associated costs must be fully covered to prevent financial barriers for patients—particularly those in underserved or low-income communities. Otherwise, physicians serving these populations may be unfairly penalized with lower performance scores due to systemic data limitations and cost-related patient noncompliance.

CMS has acknowledged that adding Hepatitis B to the measure will prevent direct comparison with prior years' performance data. While we understand the rationale for using a performance period benchmark, we urge CMS to:

- Clearly communicate this change to stakeholders.

- Provide technical assistance to help practices understand the new scoring methodology.
- Consider a phased implementation to allow practices time to adjust workflows and educate patients.

The AAFP recommends the following:

- **Delay Implementation until interoperability and registry functionality are improved.**
- **Ensure full insurance coverage for titers if required for compliance.**
- **Provide clear guidance on acceptable documentation sources and workflows.**
- **Monitor for unintended consequences, including over-testing or unnecessary repeat vaccinations.**

The AAFP remains committed to promoting adult immunization and reducing administrative burden. We urge CMS to reconsider this proposal or implement safeguards to ensure that the measure reflects clinical reality and does not penalize physicians for systemic data gaps.

Table Group DD: Proposed Substantive Changes to Previously Finalized MIPS Quality Measures Available Only for Use in Relevant MVPs for the CY 2026 Performance Period/2028 MIPS Payment Year and Future Years (pg. 1698)

DD.1 Breast Cancer Screening (Quality ID 112)

CMS proposes to update the description and stratification for the eCQM collection type to align with the latest clinical guidelines. They are also proposing to add a definition for "reviewed" to the MIPS CQM, Medicare Part B Claims, and eCQM collection types to clarify the requirement for meeting the quality action. The definition would read, "Reviewed – to meet the quality action, there must be documentation in the medical record that the clinician reviewed the mammography report and discussed the findings with the patient. The mammography report may also be provided by the patient for the clinician's review/discussion during the visit and should be documented in the medical record."

DD.2 Colorectal Cancer Screening (Quality ID 113)

CMS proposes to add a definition of reviewed to the MIPS CQM, Medicare Part B Claims Measure, and Medicare CQM collection types. The definition would read, "Reviewed – to meet the quality action, there must be documentation in the medical record that the clinician reviewed the mammography report and discussed the findings with the patient. The

mammography report may also be provided by the patient for the clinician's review/discussion during the visit and should be documented in the medical record."

AAFP Comments:

The AAFP opposes the proposed changes to the MIPS CQM and Medicare CQM specifications for the Breast Cancer Screening (BCS) and Colorectal Cancer Screening (CRC) measures, specifically the addition of a definition for "reviewed" to qualify as meeting the quality action.

We believe this change represents an expansion beyond the original intent of the measures and would impose additional documentation burden on clinicians without delivering meaningful improvements in patient care or outcomes. The proposed definition introduces a level of specificity that is not currently required in the electronic Clinical Quality Measure (eCQM) specifications, and we do not support its inclusion in the eCQM version now or in the future.

Conclusion

The AAFP appreciates the opportunity to provide input on the proposed rule. Should you have any questions, please contact Kate W. Gilliard, Sr. Manager, Federal Policy and Regulatory Affairs, at kgilliard@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

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American Academy of Physicians, Board Chair