September 12, 2025

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via regulations.gov

RE: CMS-1834-P, "Medicare and Medicaid Programs: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Quality Reporting Programs; Overall Hospital Quality Star Ratings; and Hospital Price Transparency"

Dear Dr. Oz:

On behalf of the American Academy of Family Physicians (AAFP), which represents 128,300 family physicians and medical students across the country, I write in response to the Hospital Outpatient Prospective Payment System (OPPS) CY 2026 Proposed Rule as published in the July 17, 2025 issue of the *Federal Register*. We appreciate the opportunity to comment and offer the following recommendations in response:

- Eliminate the Inpatient Only (IPO) list, a list of services that are not eligible for payment when furnished outside an inpatient hospital;
- Extend site-neutral payment policy to include drug administration services to align payment for independent physician practices with hospital-owned sites;
- Remove burdensome measures from the Outpatient Quality Reporting (OQR) program depend on factors beyond a physician or health system's control;
- Update and expand hospital price transparency requirements to improve the usability of data reported;
- Maintain the existing definition and criteria used by CMS to qualify as an "approved medical residency programs" that is eligible for Direct Graduate Medical Education (DGME) and Indirect Graduate (IME) payments.

We also provide comments in response to CMS' request for information about developing a more consistent payment policy for Software as a Service (SaaS).

IX. Services That Will Be Paid Only as Inpatient Services

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C. CY 2026 Changes to the IPO List

Summary
CMS plans to phase out the Inpatient Only list (IPO), a list of 1,731 services that are not eligible for payment when offered outside an inpatient hospital, over a three-year period. CMS believes that physicians and patients should work together to choose the most appropriate location for medical procedures. CMS expects that OPPS beneficiary cost-sharing will be lower and notes cost-sharing for non-hospital sites is limited to the annual hospital inpatient deductible.

AAFP Comment
The AAFP has long advocated to advance site-neutral payment policy to discourage vertical consolidation and reduce beneficiary cost-sharing. **We encourage CMS to finalize this proposal to eliminate the IPO list as it would encourage competition by allowing freestanding ambulatory surgical centers and other lower-cost settings to compete with inpatient hospitals.** The AAFP continues to recommend the elimination of site-based payment differentials to discourage anticompetitive behavior by hospitals and health systems.

X. Nonrecurring Policy Changes

A. Method To Control Unnecessary Increases in the Volume of Outpatient Services Furnished in Excepted Off-Campus Provider-Based Departments (PBDs)

Summary
In 2019, to address incentives that encourage hospital-physician vertical consolidation, CMS set the payment rate for clinic visits in off-campus provider-based departments (PBDs) to the physician-fee schedule rate. CMS is concerned that there is still evidence of continued growth in the volume of outpatient department services caused by site-differential payment policy. As such, CMS proposes extending the site-neutral payment policy for clinic visit services to all drug administration services. Sites designated as rural sole community hospitals (SCH) would remain exempt from site-neutral payment.

AAFP Comments
The AAFP strongly supports this proposal and the expansion of site-neutral payment policy. We urge CMS to apply site-neutral payment policies to drug administration and continue to remove site-differential payments for other services. We have provided extensive comments and testimony on policies that encourage anticompetitive and harmful forms of consolidation in health care, noting that site-differential payments are a major driver of physician consolidation. There is strong evidence that vertical integration (such as hospital acquisitions of physician practices) leads to higher prices and costs, including insurance premiums, without improving quality of care or patient outcomes.[i]

The AAFP strongly believes site-neutral payment policy discourages harmful forms of consolidation but are concerned that eliminating the site-differential for drug administration may jeopardize the financial viability of some rural sites that will lead to downstream unintended consequences. While mergers or acquisitions may help to preserve financially challenged rural sites of care, these transactions frequently lead to the closure of service lines deemed unprofitable, reducing access to care in these communities.[ii] We urge CMS to consider exceptions to address these unique challenges faced by rural providers that could hamper access to care for beneficiaries in those communities.

The AAFP supports the exclusion of sites designated as rural sole community hospitals (SCH) from this proposal. To qualify for the SCH designation, a hospital must be the sole source of care in an isolated community, based on meeting criteria that assess the distance (in miles or travel time) from the SCH to the next closest inpatient hospital.[iii] Closing an SCH means patients would have to take long trips (generally, more than 35 miles) to receive treatment. Because it is not unusual for certain drugs administered by infusion or injection to require repeat visits over the course of weeks or months, the closure of an SCH or elimination of drug administration services would create a significant burden on patients. The AAFP supports delivery system support for physicians serving rural communities to eliminate disparities in access to quality care. We therefore agree with CMS that there is a need to exempt rural SCH to protect continued access to necessary care in geographically isolated settings. While the AAFP has long advocated for an expansion of site neutrality to all on-campus and off-campus hospital-based departments and other facilities, we have also encouraged careful implementation to protect access to care in rural and other underserved communities and continue to do so.

XV. Hospital Outpatient Quality Reporting (OQR) Program

Summary
CMS plans to remove multiple measures from the OQR program, such as Screening for Social Drivers of Health and Screen Positive Rate for Social Drivers of Health. CMS considers these measures to be an unnecessary administrative burden.

AAFP Comments
The AAFP supports the elimination of social drivers of health (SDOH) screening measures from the quality review programs as we agree they are an administrative burden. However, we have concerns about broader proposed changes to SDOH-related policy across multiple CMS payment programs, including these changes to the OQR combined with other proposals in the Physician Fee Schedule (PFS) to eliminate payment for SDOH assessment. **The AAFP is concerned that CMS is proposing to use inconsistent terminology and strategy across payment systems, producing a fragmented and sometimes conflicting set of requirements that will be difficult for stakeholders to implement.** For example, the OPPS proposed rule suggests the possibility of future measures to address "Wellness and

Nutrition" while the proposed PFS rule proposes to replace social drivers of health with "upstream drivers of health." The PFS rule proposes to eliminate resources to administer a health-related needs assessment, but then later encourages a quality improvement activity that involves ensuring health-related needs assessments are consistently administered. We encourage CMS to holistically review all proposed changes to SDOH-related policy across all payment programs and ensure they are consistent.

When finalizing policy related to upstream or social drivers of health, we also encourage CMS to consider that these drivers are community issues that require community solutions. Many communities lack adequate social resources and community-based organizations 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 must also acknowledge the need for resources to assess and record patient-level upstream or social 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.**

Additionally, issues surrounding data interoperability and sharing have led to a lack of infrastructure and limited capacity to exchange patient-level information on health-related social needs between providers and community organizations. This shortfall makes it impossible for providers to reliably report on whether patients were successfully connected to suitable resources. Without the necessary structures—both adequate physician and community resources as well as the ability to reliably share and communicate data with community organizations—**we oppose performance measures that hold physicians accountable for whether patients receive resources to address their health-related social needs.**

We agree that screening patients for unmet health-related social needs provides valuable insight on the patient and community level resources needed to address upstream drivers of health. However, without the resources and capabilities necessary to identify, document, and refer patients based on their needs, these measures are unreasonable. We are concerned that comments in the proposed OPPS rule suggest CMS may consider future measures to hold

providers accountable for addressing SDOH needs: *"Further, we note that these [SDOH screening] measures document an administrative process and report aggregate level results, and do not shed light on the extent to which providers are ultimately connecting patients with resources or services and whether patients are benefiting from these screenings."* **The AAFP believes that physicians must not be held accountable for providing resources to address upstream or social determinants of health that are unavailable in the community, and we strongly discourage the use of any measure that would hold physicians accountable for connecting patients to resources.**

In summary, we recommend CMS establish a consistent approach to SDOH-related policy across all programs to ensure physicians and other providers have resources needed to screen and document patient-level drivers of health. CMS should also prevent the use of measures that may unfairly hold physicians accountable for community and other factors beyond their control.

XIX. Updates to Requirements for Hospitals To Make Public a List of Their Standard Charges

Summary
CMS proposes adding requirements to existing hospital price transparency regulations that would improve the clarity and usefulness of the data. This includes requirements to publish payer-allowed charges at the tenth, median, and ninetieth percentiles when negotiated rates are based on percentages or algorithms, include the name of a hospital executive who attests that the data in the file in complete and accurate, include the organization's Type 2 National Provider Identification Number (NPI), and reduce the civil monetary penalty for noncompliance if the hospital agrees to waive their right to a hearing.

AAFP Comments
The AAFP believes in the value of transparency in health care and has long supported federal policies promoting price transparency. We support sharing data that would enable patients and their health care teams to compare prices across facilities and insurers. To make informed referrals in value-based care, our members need clear data on clinicians' and facilities' costs and quality performance. We appreciate CMS redoubling their efforts to hold hospitals accountable to provide clear and accurate healthcare prices. As primary care services typically offer high value at a relatively low cost, they do not significantly contribute to elevated or disproportionate health care pricing. We recommend that CMS continue to delay enforcement of Good Faith Estimate requirements for primary care practices, and to consider permanent exemptions for certain practice and facility types.

We support the additional hospital price transparency requirements proposed by CMS in this rule, and recommend CMS take additional steps in future rulemaking to further improve hospital price transparency, including:

- Requiring hospitals to post a negotiated rate in dollars and cents without exception, even if the negotiated rate is based on a percentage or algorithm;
- Requiring a standard code format to report on services, including Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS), not facility-specific codes;
- Mandating that hospitals disclose prices across a nationally uniform set of high cost, high-volume services, instead of allowing hospitals to selectively report 230 of the 300 shoppable services as under current regulation;
- Removing the price estimator loophole that allows hospitals to bypass the requirement to post the 300 shoppable services;
- Removing the current $2 million maximum fine and increasing the civil monetary penalty for hospitals with 31 beds or more to $300 per bed per day to create a stronger financial incentive for noncompliant hospitals to comply.

XXI. Graduate Medical Education Accreditation

CMS currently defines "approved medical residency programs" as those accredited by recognized national organizations (e.g., ACGME, AOA, CODA, CPME) or those that lead to board certification. These programs are eligible for Medicare funding through Direct Graduate Medical Education (DGME) and Indirect Medical Education (IME) payments. The methodology for calculating these payments is based on hospital-specific per-resident amounts and the number of full-time equivalent (FTE) residents, adjusted for Medicare's share of inpatient days and teaching intensity.

To comply with Executive Order 14279, which directs federal agencies to investigate and eliminate diversity, equity, and inclusion (DEI)-related standards in medical education accreditation, CMS is proposing to revise the criteria for medical residency programs to qualify as "approved" residency programs to now include a prohibition accrediting bodies from requiring or encouraging DEI initiatives that may unlawfully discriminate based on race. CMS is seeking public comment on this proposal, which would take effect January 1, 2026, and is also considering recognizing additional accrediting organizations to foster competition and improve the quality of accreditation.

AAFP Comments

The AAFP strongly encourages CMS to reconsider the proposed rule to revise the definition of "approved" residency programs. This provision poses significant risks to the family medicine workforce, medical education standards, and public health outcomes. The AAFP has long supported federal, state, and local initiatives that encourage medical students and residents to pursue careers in family medicine, especially in rural, minoritized, and under-resourced communities. We believe that a family medicine workforce reflective of the American population results in better educational outcomes at all levels of training and improves health outcomes for all Americans. Diverse physician teams are better equipped to

understand upstream drivers of health, build trust with patients, particularly for vulnerable populations. This is especially true for patients of color, who experience higher rates of illness, reduced access to care, and lower quality of care.[iv]

If finalized, this proposed rule could pose significant challenges for family medicine residency programs, many of which are community-based and rely on Medicare GME funding. Programs may be forced to revise recruitment strategies and curricula to comply with new federal standards, even when such changes conflict with clinical priorities and community needs.

CMS's proposal to revise the definition of "approved" residency programs has the potential for significant disruption to the family medicine residency pipeline. According to the Primary Care Scorecard, only 24.4% of new physicians entered primary care in 2022, and just 19.8% did so outside of hospital-based settings.[v] This marks the lowest rate in a decade, despite growing demand for primary care services. The lack of funding for community-based training programs further compounds this issue, limiting the number of new family physicians entering the workforce.

A shrinking primary care workforce has direct public health and financial consequences. In 2022, more than 30% of U.S. adults already lacked a usual source of care - the highest level in a decade.[vi] This gap is likely to widen if the primary care pipeline continues to shrink, further expedited by this proposed rule.

As access to primary care declines, patients will increasingly rely on emergency departments for non-emergency issues. This will lead to rising demand for emergency care, longer wait times, increased patient acuity, and increased downstream care costs for the entire health care system. This not only drives up costs but also strains emergency care infrastructure, contributing to provider burnout and reduced care quality. Moreover, the shift away from training informed by diverse American experiences risks further eroding trust in healthcare institutions, which is already low among rural, low-income, and Black communities. A 2024 Pew Research Center survey found that individuals from these groups report significantly lower trust in the healthcare system.[vii] Reduced trust can lead to lower participation in preventive and necessary care, increasing the burden of avoidable illness and downstream healthcare costs on the overall system.

III. Proposed OPPS Ambulatory Payment Classification (APC) Group Policies

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

CMS is considering developing payment policy for Software as a Service (SaaS) in response to stakeholder comments that the lack of a consistent payment policy for Saas creates barriers to patient access of FDA-approved technologies. CMS seeks to ensure that any SaaS

payment policy is consistent across sites of care, payment systems, and type of SaaS. To inform any proposed policy, CMS asks the following questions:

1. What factors could Medicare consider when setting payment rates for SaaS?
2. What APCs, existing or new, should we use to pay for SaaS?
3. How should we assess the costs of SaaS, and how can we account for hospital acquisition costs?
4. What cost or claims data should be used to establish the payment rates for the services?
5. Why are the geometric mean costs, as provided in our claims data, for SaaS currently assigned to APCs (both clinical and New Technology APCs) consistently lower than the manufacturers' purported costs of the technologies?
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?
7. What kinds of efficiencies, if any, would SaaS provide for services performed in hospital outpatient departments and ambulatory surgical centers?
8. In the context of setting Medicare payment rates, how can CMS best reflect the quality and efficacy of SaaS technologies?

AAFP Comments

1. What factors could Medicare consider when setting payment rates 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.** While we appreciate CMS' desire to have a single payment policy that applies to all settings, not all settings have the same resources available to implement

SaaS. Nearly one-third of family physicians practice in independently owned settings.[viii] 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 to the practices most in need of these tools. We encourage CMS to consider providing direct reimbursement mechanisms for SaaS-related costs, add-on codes or modifiers to reflect the operational burden of deploying SaaS in community-based settings and consider additional 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. We recommend CMS review our response to the CY 2026 Medicare Physician Fee Schedule regarding 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. Further, CMS must ensure that private patient data is consistently safeguarded, and data protections are robust and enforceable.

d. **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.

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.[ix]

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 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.[x] Similarly, the General Services Administration, which oversees federal SaaS procurement, may also provide aggregated pricing data through its supply schedules or cloud acquisition programs.[xi] 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 or facility size, setting, 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 providers to collect real-world cost data through targeted, low-burden surveys to better understand their unique cost pressures and implementation challenges.

8. *In the context of setting Medicare payment rates, 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**. Providers 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.

We appreciate the opportunity to provide input on the proposed rule. Should you have any questions, please contact Julie Riley, Sr. Strategist, Regulatory and Federal Policy, at jriley@aafp.org.

Sincerely,

Steve Furr, M.D., FAAFP

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American Academy of Physicians, Board Chair

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