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

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Dr. Oz:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 124,500 family physicians and medical students nationwide, we appreciate the opportunity to comment on the CY 2027 Medicare Physician Fee Schedule (PFS) proposed rule. We thank the Centers for Medicare and Medicaid Services (CMS) for its efforts to modernize Medicare payment, improve care delivery, and strengthen access to high-quality primary care.

The AAFP supports these goals. Many of the proposals and requests for information included in this rule recognize a reality that family physicians have long known: the most valuable aspects of care, especially in primary care, are the trusted relationships, continuity, and long-term commitment to patients that allow physicians and care teams to deliver quality care over time. As CMS evaluates opportunities for reform, the AAFP urges the agency to ensure that any payment policy it implements strengthens, rather than fragments, those foundational elements of care. Doing so will improve outcomes, promote more appropriate use of health care resources, and help sustain a strong primary care workforce.

Patients do not want their care to be a series of discrete services, codes or billable encounters but unfortunately that is often how they experience it. Rather, they value care that is provided by trusted physicians and clinicians who deliver care that is more meaningful and effective than the sum of its parts. This is why the most impactful primary care happens over time – not in a single service or encounter. It is delivered over multiple encounters by members of a trusted care team and covers a wide range of needs, with each visit building on those that came before it. When patients are cared for by the same physician or care team year after year, clinicians develop a deep understanding of a patient's medical history, priorities, and circumstances. This knowledge improves care coordination, clinical decision making, and ensures treatment is tailored to a patient's unique needs. While individual components of primary care, like preventive services, chronic disease management, and care

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coordination each have individual value, their impact on a patient's health is amplified when delivered within the context of a trusted relationship. The relationship is not another service layered on top of care; it is what transforms individual services into comprehensive care.

The AAFP acknowledges that CMS and the PFS are largely limited to a fee-for-service (FFS) structure that is intentionally designed to pay for discrete services. However, CMS has demonstrated its sincere interest in addressing undervalued or unrecognized aspects of primary care throughout this year's rule. CMS clearly grapples with how services are valued, how technology can transform practice, and how payment can impact patients. In some areas, CMS appropriately recognizes the unique value created through ongoing physician-patient relationships. However, in other areas, CMS risks focusing too heavily on individual services, technologies, or discrete payment mechanisms without fully considering their impact on the physician-patient relationship. Technology can accelerate and simplify the delivery of needed information, identify gaps in care, and support clinical decision-making, but it cannot replace the value created when a trusted physician truly knows their patient, understands their circumstances, and applies that knowledge across years of care. Likewise, policies that discourage continuity or fragment care may undermine the outcomes they are intended to incentivize.

As CMS works to finalize the rule for 2027, the AAFP encourages the agency to view the physician-patient relationship as a clinical asset worth protecting. CMS must consider how each proposed reform, be it a specific code, new payment methodology, or emerging technology, will either enhance or fragment this trusted relationship. **Accordingly, the AAFP urges CMS to evaluate its policies through a simple lens: whether they strengthen or weaken the relationships, continuity, and accountability that allow family physicians to deliver comprehensive, coordinated, and person-centered care.** Policies that strengthen those relationships will improve care. Policies that fragment or continue to undervalue them risk undermining the very outcomes Medicare seeks to achieve.

In response to the specific proposals CMS presents in the 2027 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:

- Continue to develop improved approaches to paying for primary care that recognize the relationships, accountability and continuity that make primary care so effective yet undervalued in a system designed to pay for individual encounters.
- Do not finalize the proposed policy to reduce payment for separately identifiable evaluation and management services furnished on the same day as a procedure, as

doing so would penalize family physicians who routinely address multiple, and often unrelated, patient needs during a single encounter.

- Finalize the proposed expansion of the primary care exception and continue to consider adding additional codes in future rule making so that primary care residents can enter independent practice with sufficient experience addressing the increasingly complex needs of the Medicare population.

Determination of PE RVUs (section II.B.) – *Included in Volume 1*

2. Practice Expense Methodology

For calendar year 2027, CMS proposes the following changes to its practice expense (PE) relative value unit (RVU) methodology:

- Modify step 8 to calculate indirect PE based on both work RVUs and clinical labor RVUs for all services except 010- and 090-day global period codes;
- Remove steps 12 through 17 that rely on the indirect practice cost index (IPCI) from the calculation of the PE RVUs over a two-year transition period, and;
- Add a new step to apply a stabilization adjustment to the PE RVUs (proposed step 19).

AAFP Response

The AAFP supports the proposed modification to step 8 of the PE RVU methodology. As CMS notes in the proposed rule, step 8 in its current form inadvertently advantages services that can be reported using technical, professional, and global components (typically diagnostic and imaging services) by using both work RVUs and clinical labor RVUs in the allocation of indirect PE RVUs for such services while only using work RVUs or clinical labor RVUs in the allocation of indirect PE RVUs for all other services. We agree with CMS that it would be more accurate to use the same allocation methodology for all physician fee schedule services except 010- and 090-day global period codes. As noted elsewhere in the proposed rule, ongoing questions and concerns about the current valuation of work and clinical labor RVUs for 010- and 090-day global period codes remain. The proposed change to step 8 in the PE RVU methodology should not be extended to those codes until those other questions and concerns are addressed.

As detailed in the proposed and final rules on the 2026 Medicare physician fee schedule, CMS has chosen not to accept the updated PE per hour data from Physician Practice Information (PPI) and Clinician Practice Information (CPI) surveys, as provided by the American Medical Association and others. That survey data would have allowed CMS to update the 2007 PE per hour data that forms the basis of the IPCI.

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The AAFP remains disappointed that CMS did not find the PPI and CPI survey data satisfactory for purposes of updating the PE per hour data used in its PE RVU methodology, particularly the IPCI. However, given CMS' decision in this regard, the AAFP reluctantly supports CMS' proposal to otherwise remove the steps in the methodology that rely on IPCI over a two-year transition period. As CMS notes, the PE per hour data used in the IPCI has become increasingly dated (now, almost 20 years old). Consequently, it has resulted in a PE methodology that privileges historic survey data over incorporation of more recent data about specific services. We agree with CMS that its various steps to improve the data used in the pricing inputs and the indirect allocation methodologies support removal of the steps of the current methodology that rely on the IPCI for the calculation of the PE RVUs. The current steps proposed for removal effectively favor antiquated, aggregate specialty-level survey data over code level inputs and allocators and consequently limit the influence of improvements to inputs and allocation methodologies.

The AAFP supports, in concept, the idea of adding a PE stabilization factor to the PE RVU methodology to mitigate volatility in PE RVUs and avoid unintended consequences. The proposed cap of five percent on increases or decreases from one year to the next would certainly accomplish that goal. We assume this cap on year-to-year changes would not limit the ultimate changes in PE RVUs for a given service resulting from input changes. For instance, if changes in the PE inputs to a service resulted in a 10 percent increase in PE RVUs, we assume the proposed cap would limit the changes to five percent in the first year and another five percent in the second, so PE RVUs would ultimately be where the inputs dictate they should be to maintain relativity within the fee schedule. Thus, we understand the proposed cap to work as another phase-in of RVU changes, like that in the current Step 19 (proposed to be renumbered as Step 20) in the PE RVU methodology, although this proposed cap would operate only on PE RVUs. If this understanding is incorrect, we would appreciate further explanation of how the proposed cap would operate and its relationship to the existing phase-in of significant RVU reductions.

(e) Setup File Information

In its PE setup file, CMS adjusts volume and time to account for payment modifiers and other special payment rules, such as multiple procedure payment reductions, in the utilization data. Beginning in CY 2027, CMS proposes to use a new approach to account for payment modifiers and other special payment rules. For each paid claim line, CMS would calculate the ratio of allowed charges to the national physician fee schedule payment amount to account for differences resulting from payment modifiers and other special payment rules, as well as differences in geography. CMS proposes to use the same ratio to adjust time, rather than a separate calculation under our current methodology, except for anesthesia, for which CMS calculates time using only procedures with modifiers indicating they are personally

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performed. CMS believes these proposed changes will allow it to more accurately capture any combination of modifiers and special payment rules and automatically account for updates in modifiers and/or special payment rules in future years while having a minimal impact on the resulting PE RVUs.

AAFP Response

The AAFP agrees that calculating the ratio of allowed charges to the physician fee schedule amount for each paid claim line would largely allow CMS to account for applicable payment modifiers and special payment rules. However, as CMS notes, it would also account for differences in geography. As a matter of policy, the AAFP supports the elimination of all geographic adjustment factors from the Medicare Physician Fee Schedule except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). To the extent the proposed new approach to accounting for payment modifiers and other special payment rules also accounts for and potentially adjusts RVUs based on geography, the AAFP opposes it and would, instead, recommend that CMS continue to use its current approach or otherwise find an approach that does not further geographically adjust Medicare payments.

4. Changes to Direct PE Inputs for Specific Services

d. Updates to Practice Expense (PE) Methodology—Site of Service Payment

For 2026, CMS finalized a policy to allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated to services furnished in the non-facility setting. Implementation of this policy resulted in an unintended, but significant, site of service differential for physician visits in nursing facility settings based solely on whether the beneficiary's stay is covered under Part A. To rectify this unintended consequence for 2027, CMS proposes to equalize the rate for nursing facility visits without regard to the beneficiary's Part A status by setting the facility PE RVU equal to the non-facility PE RVU for CPT codes 99304-99310 and 99315-99316.

AAFP Response

The AAFP agrees that a physician practice's indirect practice expenses when furnishing nursing facility care are not a function of whether the patient's nursing facility stay is covered under Part A or Part B. Thus, the AAFP supports CMS' proposal to equalize the rate for nursing facility visits without regard to the beneficiary's Part A status by setting the facility PE RVU equal to the non-facility PE RVU for CPT codes 99304-99310 and 99315-99316.

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Request for Comments on How PE Costs Vary

To better inform its consideration of how to account for practice expenses under the physician fee schedule methodologies, including the differentials reflected in the facility/non-facility settings of care, CMS seeks comment on how PE costs vary for physicians and other professionals, not only based on whether they practice in part or exclusively in a facility setting but also based on how their costs vary when they are employed by health systems, hospitals, or other entities. CMS seeks information that will help illuminate to what extent these costs are truly incurred when professionals are employed by a hospital and/or practice primarily in the hospital and are not already accounted for in the existing outpatient prospective payment system payments. CMS seeks comment on the amount of indirect PE hospital-employed physicians incur when they furnish care within a facility.

In consideration of the accuracy of the current 50 percent indirect PE allocation for services furnished in the facility setting, CMS also seeks comment on whether and how it might, alternatively or additionally, define and identify physicians and professionals who are employed by hospitals, health systems, or other entities to ensure the services they furnish are not inappropriately consuming PE RVUs that would be more appropriately assigned to services furnished by professionals incurring comparatively greater practice expenses. Specifically, CMS seeks comment on whether a new HCPCS modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting, or whether there are other methods CMS could consider.

Lastly, CMS seeks comment regarding the primary variables it should consider continuing to improve its data sources, allocation methodologies, and payment rates across settings of care, to best reflect the resources involved in furnishing physician fee schedule services in a complex marketplace, across settings of care. CMS remains interested in objective data regarding payment arrangements between hospitals, health systems, other employers and physicians, including which costs are incurred and whether the full range of costs are truly incurred by physicians and other professionals in these kinds of employment relationships.

AAFP Response

The AAFP continues to support CMS' intent to question the assumptions underlying its PE RVU methodology, to seek out objective data that will inform the methodology, and to update the methodology accordingly. Unfortunately, the AAFP still does not have any information or objective 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.

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The AAFP continues to believe that 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.

The AAFP also continues to believe that the 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). That said, the AAFP is not persuaded that a new HCPCS modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting, in part because physicians may be employed by a variety of entities with equally various impacts on indirect PE.

In sum, like CMS and MedPAC, the AAFP agrees that the assumptions underlying the current allocation of indirect PE RVUs are flawed and that change is needed. The AAFP supported CMS' proposal (subsequently finalized) for 2026 of a 50 percent indirect PE allocation for services furnished in the facility setting as directionally appropriate of the needed change and would appreciate the further discussion from CMS in the current proposed rule. The AAFP remains unclear how CMS arrived at the 50 percent 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 move toward a better supported version as part of future rate setting. 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' 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.

5. Strategies To Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

a. Professional and Technical Components

To facilitate more consistent comparisons across services and settings, CMS has developed a public use file that displays, for services that are not currently billable with technical component (TC) and professional (26) modifiers, RVUs amounts that reflect the relative resources involved in furnishing professional and technical aspects of the services. CMS excluded services with 010- and 090-day global surgery periods from display in this public use file. CMS notes that the current structure of global surgery services has effectively obscured how the components of care are individually valued and limited CMS' ability to disaggregate them for purposes of this public use file. Consequently, CMS seeks comment on how to address this problem, either in possible improvements to the global surgery packages or, at least, in the best way to make their component pieces transparent. Further, CMS seeks comment on:

- the utility of displaying RVUs associated with professional and technical aspects of services that are not currently billable with TC/26 modifiers (which CMS refers to as "globals"), including how CMS may use this information to assess payment differences across settings;
- potential approaches CMS could consider in future rulemaking to improve transparency for services currently paid as globals, including feedback on how CMS could develop methodologies to more clearly identify and, where appropriate, disaggregate the underlying components of these services; and
- how CMS could "right-size" payments for the globals over time to ensure they remain aligned with current clinical practice and resource costs, are more readily updated based on empirical data, and do not obscure differences in cost and value across settings of care.

AAFP Response

With respect to global surgery packages and the way in which they effectively obscure how the components of care are valued, the AAFP has long maintained that CMS should change all 010- and 090-day global surgery periods to 000-day global surgery periods and revalue the affected codes accordingly. The utility of displaying RVUs associated with professional and technical aspects of services that are not currently billable with TC/26 modifiers (which CMS refers to as "globals") is not readily apparent to the AAFP. The display in the public use file does not really make more transparent how the RVUs break out between professional and technical components and between direct and indirect PE RVUs compared to how they

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are currently displayed in the fee schedule. Rather than developing methodologies to more clearly identify and, where appropriate, disaggregate the underlying components of these services, CMS' time and resources would be better spent "right-sizing" payments for all physician fee schedule services over time by identifying and using more empirical data on physician time, clinical practice patterns, and practice expense resource costs and by changing all 010- and 090-day global surgery periods to 000-day global surgery periods and revaluing the affected codes accordingly.

b. Global Surgical Package

CMS proposes pausing the data collection required by MACRA based on RAND's findings over the past several years. CMS notes that it has several years of data that have continued to illustrate how post-operative visits in the global periods are not occurring, yet Medicare is still paying for these visits under the current global payment policy. CMS believes the current data collection may be causing undue burden to physicians and that pausing the data collection will aid in burden reduction for them. Nonetheless, CMS questions whether a more robust data collection would be appropriate and seeks comment on whether it should have all physicians and other qualified healthcare providers (QHPs) report CPT code 99024. CMS also seeks comments on other data sources it might consider to more accurately value global surgical services and on potential revaluation strategies that it may consider through future rulemaking.

AAFP Response

As noted above, the AAFP has long maintained that CMS should change all 010- and 090-day global surgery periods to 000-day global surgery periods and revalue the affected codes accordingly, as it originally planned to do in 2015. While section 523(a) of MACRA effectively prohibited CMS from the policy finalized for 2015, section 1848(c)(8)(A)(ii) of the Social Security Act, as added by section 523(a) of MACRA states that "Nothing in clause (i) [prohibiting the transition of all 010- and 090-day global services to 000-day global service] shall be construed to prevent the Secretary from revaluing misvalued codes for specific surgical services."

CMS has fulfilled the data collection requirement established by section 523(a) of MACRA. As CMS notes in the current proposed rule, that data, over several years, has continued to illustrate how post-operative visits in the global periods are not occurring, yet Medicare is still paying for these visits under the current global payment policy. In essence, that data has illustrated that most, if not all 010- and 090-day global services are misvalued and should be revalued, which is consistent with section 1848(c)(8)(A)(ii) of the Social Security Act.

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We agree with CMS' proposal to pause the data collection required by MACRA. Further, if the current data collection represents an undue burden, requiring all physicians and QHPs to report code 99024 would be an even greater undue and unnecessary burden.

The time for data collection has passed while the time for action has arrived. We urge CMS to move forward with revaluation of misvalued 010- and 090-day global surgical services. The public use file provided with this proposed rule to display the imputed RVUs associated with both the 10- and 90-day post-operative visits based on a purely arithmetic approach provides a good starting place. For each 010- or 090-day global surgical service where the median 99024-observed post-operative visits deviates from the number of post-operative visits in the CMS time file by greater than 1, CMS should revalue the code by removing the number of visits not observed based on that median.

Payment for Medicare Telehealth Services (section II.C.)

1. Changes to the Medicare Telehealth Services List

CMS proposes adding five new HCPCS codes to the Medicare Telehealth Services List:

- GACP1: Advance care planning services furnished under the direction of a treating physician or other qualified health care professional (first 20 minutes);
- GACP2: Advance care planning services (each additional 20 minutes; add-on code to GACP1);
- GSMAS: Shared medical appointment for 2 to 10 patients with a common medical condition that integrates group education, counseling, peer support, and individualized clinical care; led by a physician or qualified nonphysician practitioner and billed once per patient, per session;
- GSLPP: Individual treatment of speech, language, voice, communication, and/or auditory processing disorders for pediatric patients;
- GADV1: Evaluation and treatment of vaccine adverse effects (each additional 15 minutes; add-on code billed with specified office/outpatient and home-based E/M services).

AAFP Response

As noted in our previous [comments](#), the AAFP appreciates CMS' continued commitment to the established three-step process for evaluating requests to add or remove services from the Medicare Telehealth Services List.

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We also reiterate our comments on the addition of the five proposed HCPCS codes, as discussed in our response in this letter to Section II.D., Valuation of Specific Codes. Should CMS finalize these codes, we urge the agency to add all newly established PFS services to the Medicare Telehealth Services List when they are separately payable under the PFS and can be furnished via telehealth while meeting the applicable standard of care.

The AAFP continues to [support](#) the expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. Telehealth remains an essential modality for delivering primary care, and Medicare policy should continue to support beneficiary access to these services. Accordingly, CMS should presume telehealth eligibility for services that satisfy applicable statutory and clinical requirements, thereby promoting access, continuity, and patient-centered care.

2. Telehealth Flexibilities and Modifiers

CMS proposes to update its regulations to implement the telehealth flexibilities extended by the Consolidated Appropriations Act, 2026. These flexibilities include the waiver of geographic restrictions on Medicare telehealth services, the expansion of permissible originating sites to include a beneficiary's home and other eligible locations, and the expansion of the types of practitioners eligible to furnish Medicare telehealth services. CMS also proposes to continue the delayed in-person visit requirement for telehealth mental health services and the coverage of certain audio-only telehealth services through the statutorily specified timeframes. In addition, beginning January 1, 2027, CMS would require the use of modifiers BB and BC on certain telehealth claims to identify services furnished by practitioners that contract with, or have payment arrangements with, the entity that owns the virtual care platform. CMS states that these modifiers are intended to improve transparency in telehealth claims data and would not affect payment.

AAFP Response

The AAFP supports CMS' implementation of section 6209(g) of the 2026 CAA. We previously shared our [support](#) for the enactment of these provisions and appreciate the continued telehealth flexibilities afforded under the law, particularly for mental and behavioral health services. Family physicians play a critical role in addressing the nation's behavioral health needs and are often the first, and sometimes only, source of mental health care for patients and communities. Continued access to telehealth helps ensure timely, patient-centered behavioral health services, especially in rural, under-resourced, and health professional shortage areas.

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Thus, the AAFP continues to support delaying the in-person visit requirement for mental health services furnished via telehealth. Maintaining this flexibility reduces unnecessary barriers to care and promotes access to clinically appropriate mental health services while preserving the physician-patient relationship and continuity of care.

Further, as telehealth platforms and platform-affiliated care arrangements become increasingly prevalent, we understand CMS' intent to gather accurate and transparent claims data with modifiers BB and BC to better understand patterns of telehealth platform utilization. CMS states that these modifiers are intended to improve transparency and collect information on telehealth platform-affiliated arrangements without affecting payment. We agree that appropriately designed reporting requirements may provide valuable information regarding the evolving role of telehealth platforms in care delivery. As we noted in our [CY26 PFS comments](#), this data may be particularly important in the behavioral health setting and may help inform future policy discussions on appropriate telehealth platform oversight. Specifically, this data may support CMS in distinguishing between platforms that enhance the continuity of physician-led care by improving access, reducing administrative burden, and supporting care coordination, and those that may inappropriately influence or constrain clinical decision making. This information can be useful to ensure future Medicare telehealth policies support high-quality, patient-centered care and preserve independent clinical judgment.

That said, given that the purpose of the proposed modifiers BB and BC is to improve transparency and generate meaningful data rather than affect payment, we encourage CMS to prioritize data integrity and reporting accuracy over rapid implementation.

Accordingly, the AAFP urges CMS to delay implementation of the BB and BC modifier requirements until at least January 1, 2028, and to issue comprehensive operational sub-regulatory guidance prior to the effective date. A one-year implementation period following the release of final guidance would provide stakeholders adequate time to update billing systems, modify workflows, train staff, and ensure consistent modifier application across a wide range of practice and telehealth platform models.

At a minimum, we recommend CMS clearly define key terms such as "virtual telehealth platform," "contracts with," and "payment arrangements with"; clarify how the modifiers should be applied across common practice, employment, and platform-affiliated models; specify data reporting responsibilities when multiple entities are involved in furnishing or billing a service; and provide detailed examples illustrating when modifiers BB and BC should and should not be reported.

Without clear and detailed guidance, similarly situated entities may report comparable arrangements differently, reducing the reliability and usefulness of the resulting claims data.

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More robust implementation guidance will minimize physician confusion, improve reporting consistency, and ensure CMS collects the accurate and actionable information necessary to evaluate the role of telehealth platforms in Medicare.

4. Changes To Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians With Virtual Presence

CMS seeks to modify its current teaching physician policy for telehealth services involving residents. Under the current policy, billing requires the teaching physician, resident, and patient to each be in separate locations during a three-way telehealth visit. In CY 2027, CMS proposes allowing billing for telehealth services on the Medicare Telehealth Services List when the resident is physically present with the beneficiary and the teaching physician participates virtually, or the teaching physician is physically present with the beneficiary and the resident participates virtually. CMS indicates it generally interprets physical presence as being in the same room as the beneficiary and seeks comment on other scenarios.

Additionally, CMS is proposing to update payment for HCPCS Q3014 (Telehealth Originating Site Facility Fee) based on the projected 2.5 percent MEI increase, from \$31.85 in 2026 to \$32.65 in 2027.

AAFP Response

We strongly support CMS' proposal to revise the teaching physician virtual presence policy for services involving residents. By allowing either the teaching physician or the resident to be physically present with the patient, rather than requiring all participants to be in separate locations, CMS would remove an unnecessary operational constraint that does not meaningfully improve educational quality or patient safety, while maintaining existing teaching physician supervision and documentation requirements. This proposed policy more accurately reflects how care and graduate medical education are delivered in community-based, rural, and distributed training environments. It preserves teaching physician oversight while providing residency programs with greater flexibility to deploy faculty resources and train residents in settings where physician shortages are most acute.

Further, as stated in our comments in response to CY25 PFS, 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 appropriateness of virtual supervision should be determined by the nature of the service and the competency of the resident, rather than by the modality through which the patient receives care. Allowing virtual presence in appropriate circumstances would promote access, continuity, convenience, and patient choice while supporting physician workforce development in rural, under-resourced, and health professional shortage areas. The AAFP continues to believe that surgical, high-risk,

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interventional, endoscopic, or other complex procedures under anesthesia should remain excluded from this policy. Finally, we appreciate this proposal complementing CMS' broader efforts to modernize physician supervision and graduate medical education, including the proposed expansion of the Primary Care Exception. Together, these proposed policies provide greater flexibility to align supervision with patient needs and resident competency.

Valuation of Specific Codes, Including Potentially Misvalued Codes (PMVC) (section II.D.)

c. Valuation of Specific Codes for CY 2027

(27) Maternity Care Services ((CPT codes 59320, 59325, 59412, 59871, 59XX1, 59XX2, 59XX3, 59XX4, 59030, 59051, 59XX5, 59XX6, 59414, 59300, 59XX7, 59XX8, 59XX9, 59X10, 59X11, 59X12, and 59160))

CMS proposes to refine the RUC's recommended utilization crosswalk to remove four E/M visits (two level 2 established patient office visits and two level 4 established patient office visits) from the utilization estimate calculation and reallocate those RVUs within the code family to the new labor and delivery codes. This would mean reallocating 11,810 additional work RVUs to the new labor and delivery codes (CPT codes 59XX1-59XX8). Since the RUC provided a utilization estimate of 12,791 for CPT codes 59XX1-59XX8, this would result in a 15 percent increase in work RVUs for each labor and delivery code. CMS is otherwise proposing to accept the RUC-recommended work RVUs for each of the new and revised maternity care services codes.

CMS expresses concerns that its adoption of the new codes for maternity care would be disruptive based on how the longstanding, existing code structure is currently accounted for in clinical practice patterns. CMS seeks comment on whether it should create 15 new HCPCS G-codes for calendar year 2027 that reflect the previous MMM global code structure, with the code descriptors and work RVUs detailed in Table A-D3 of the proposed rule. These new codes would maintain the current coding structure and payment for maternity services while CMS continues to consider the potential impact that changes in the maternity care code family have on clinical outcomes for maternal care. These codes would be used in lieu of adoption of the new CPT codes for purposes of Medicare payment. CMS is specifically interested in additional information to support or oppose this concern and to support or oppose the creation of HCPCS G-codes in lieu of adoption of the new CPT codes. CMS also seeks comment on any other HCPCS G-codes that may be needed to reflect the necessary service elements for this code family. The proposed HCPCS G-codes would adopt all current

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conditions of payment for the MMM global codes, as well as maintain the MMM global period, if finalized.

AAFP Response

The AAFP supports the proposal to adopt the new maternity code set and proposed relative values with the reallocation of additional work RVUs to the new labor and delivery codes. Moving toward a uniform system that recognizes the distinct care of antepartum, labor management, delivery and postpartum services is imperative to improving patient care and maternal outcomes in the US.

The maternity global codes were established over 30 years ago without consideration of value-based payment; it was during a time when one physician typically provided all the care throughout the pregnancy, and it eased the burden of billing. The delivery of maternity care has changed significantly in the past 30 years. Dozens of updated clinical guidelines have been released in that time period, changing the recommendations for obstetric care. This includes extending labor to avoid cesarean delivery, having at least two touchpoints postpartum, and closer monitoring of the patient postpartum based on the individual, and finally, the recent Tailored Prenatal Care, which recommends an individualized visit schedule based on the patient's medical and social wants and needs, utilizing telehealth and measuring health-related social needs.

The current maternity care coding bundles established more than 30 years ago were not created with those guidelines in mind. The new maternity care codes that will be effective January 1, 2027, facilitate and incentivize current standards of care. Tests, ultrasounds and labs were already carved out of the maternity care global codes and are not a part of the conversation.

The new maternity care codes facilitate transparency of billing, which is a huge advantage for patients. The previous global codes were developed long before the law exempted prenatal visits, screenings, and postpartum visits from copayments. Services such as induction of labor, screenings, and pregnancy-related visits should not incur copayments for all plans that are not grandfathered into the Affordable Care Act requirements, which is estimated to be 93 percent of plans in the US and Medicaid plans. Labor and delivery are subject to and have always been subject to copayment. Now, when patients receive their explanation of benefits, there will be separate codes for labor management and delivery that will clearly define the cost and their portion of cost-sharing.

The new maternity care codes also facilitate clearer billing for physicians. There have been billing issues using the bundled codes for years; even when they were expanded, they have still caused issues. For instance, transfers of care during pregnancy and during labor have

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caused financial issues across the country, especially in rural areas. Additionally, many family physicians provide prenatal care but do not ultimately perform the delivery, making it difficult for the bundled maternity codes to accurately account for the services they furnish. Likewise, people are more transient. Employment changes, health insurance changes, and care teams change. Consequently, there are often transfers of care during pregnancy and during labor. The maternity care global codes did not accommodate for the typical scenarios of modern medicine. As such, the maternity global codes are confusing.

The AAFP strongly opposes CMS' alternative proposal to maintain current coding through the creation of HCPCS G-codes in the Medicare physician fee schedule as it will create unnecessary chaos and confusion. A competing billing system consisting of 15 G-codes that reflect the previous MMM global codes would be an unnecessary administrative strain for physicians and their patients. Allowing competing coding systems will create disparities based on what codes the plan decides to ascribe to without patient input. Practices frequently contract with 10-14 payers – or more. The requirements those payers represent can seem like substantially more than 10-14 when there is significant variation in payment policies between Medicare and employer sponsored, Medicaid and Marketplace plans. Allowing health plans the flexibility to choose the maternity services code structure they adopt would require practice administrators, electronic health records, and practice financial specialists to implement multiple systems to ensure the correct co-payments are being charged, the billing and revenue cycles are on target, the corresponding coding system is assigned to the individual plan, and that all other practice workflows and payment policies align – for each individual patient.

This is too much to ask offices, practices and clinics to manage. They may be forced to limit their maternity services, and patient access could be jeopardized. Ironically, one intent of the new maternity care services codes was to expand access by allowing the tailored prenatal care visit schedule, opening more access to complex patients that require more visits and using telehealth and remote patient monitoring when appropriate and desired by the patient.

The maternity code development process was an inclusive one. Throughout this process, all interested parties, including CMS, were involved. More than a dozen professional medical societies, including those representing nurses, nurse midwives, obstetricians, and family physicians, met before submission of the first proposal to the AMA. The relevant CPT workgroup held public meetings where comments were accepted and welcomed, and representatives from the payer community were present throughout the process.

The AMA has done a good job recognizing the challenges associated with this change in maternity care coding by releasing the technical specifications in February and assigning the code numbers in April. This has given everyone involved additional time to prepare for

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implementation, and we are confident our members who provide maternity care will be prepared to report their services under the new codes effective January 1, 2027, especially if CMS does not take the undesirable step of creating and using G-codes that mirror the antiquated maternity care bundled codes.

In summary, the AAFP is excited that CPT has updated the maternity care codes. Those new codes will provide transparency to patients, allow physicians to feel less burdened when they provide individualized, patient-centered care, and facilitate production of large-scale datasets that can be used to improve maternity mortality and morbidity outcomes in the US. Accordingly, the AAFP urges CMS to finalize the maternity care services codes as accepted by the CPT Editorial Panel and to **NOT** create or use any G-codes that mirror the antiquated bundled maternity care codes.

(48) Remote Monitoring (CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470)

For calendar year 2027, CMS proposes to require that remote therapeutic monitoring (RTM) services be furnished only to established patients, which is currently the case with remote physiologic monitoring (RPM) services. CMS also proposes that entities reporting RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of RPM or RTM services. The initiating visit would need to be a face-to-face (in-person or telehealth) visit during which RPM or RTM was discussed with the patient.

Further, CMS proposes to only allow payment for RPM or RTM services when furnished by clinical staff employed by the practice. If finalized, this will mean that for the purposes of billing Medicare, beginning January 1, 2027, the RPM and RTM codes could not be billed in cases where the service is not performed by clinical staff of the billing practitioner, and CMS will not allow contracting out to third-party companies. Per CMS, this does not mean the clinical staff must necessarily always be physically located within the practice, nor does it require that the beneficiary be on-site for the provision of remote monitoring services. Under CMS' proposed revised policy, the time spent by clinical staff providing RPM or RTM services can be counted, provided that the clinical staff are under the general supervision of the billing practitioner, all other requirements of the "incident to" regulations are met, and the clinical staff is a direct employee of the practice. CMS seeks comment on this proposal, specifically on how often third-party billing currently occurs and how this policy, if finalized, could impact access to remote monitoring services.

Regarding valuation of these services, CMS cites that they believe a lack of data regarding the typical device used in the provision of RPM and RTM services has led to possible overpayment. Therefore, CMS proposes to decrease the PE RVUs for several of these services

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using crosswalks to other services and eliminating all direct practice costs for the treatment management codes. These changes will result in significant payment reductions in RPM and RTM services in 2027. As noted below, CMS also proposes bundling the RPM and RTM CPT codes and creating four new HCPCS G-Codes in 2027 to describe remote monitoring services, which would lead to immediate implementation of significant cuts to the monthly supply codes. CMS solicits comment on its proposed valuation of the RTM and RPM codes, specifically information regarding the typical devices used in furnishing RPM or RTM, not just their associated costs and invoices, but robust evidence detailing what physicians and others are paying for these devices, including discounts or other typical pricing details. CMS seeks other types of pricing data and information for RPM or RTM devices, including if the costs include software, hardware, or both, as well as more information about the typical devices.

Finally, CMS seeks comment on the idea of bundling CPT codes 99453, 99445, 99454, 99091, 99470, 99457, 99458, 98975, 98984, 98976, 98985, 98977, 98986, 98978, 98979, 98980, and 98981 through the creation of new codes that describe initial set up and monthly monitoring/management for RPM and RTM, respectively. For payment for remote monitoring services under the physician fee schedule, CMS is considering and seeking comment on the creation of four new HCPCS G-Codes:

- GRPM1: RPM initial set-up and patient education.
- GRPM2: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), per calendar month, including:
 - Device(s) supply with daily recording(s) or programmed alert(s) transmission.
 - 2 or more days of data transmission.
 - Treatment management services, requiring at least one real-time interactive communication with the patient/caregiver; time totaling at least 20 minutes.
- GRTM1: RTM initial set-up and patient education.
- GRTM2: Remote monitoring of therapeutic parameter(s) (eg, therapy adherence, therapy response, digital therapeutic intervention), per calendar month, including:
 - Device(s) supply for data access or data transmissions.
 - 2 or more days of data transmission.
 - Treatment management services, requiring at least one real-time interactive communication with the patient or caregiver; time totaling at least 20 minutes.

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CMS seeks comment on these HCPCS G-codes and on any other revisions needed to the code descriptors to reflect the necessary service elements for this code family. Per CMS, these HCPCS G-codes would adopt all current conditions of payment for the remote therapeutic and remote physiologic codes finalized in prior rulemaking, as well as the proposed established patient, initiating visit, or supervision or both requirements outlined above, if finalized. As drafted, all service elements outlined in the G-code descriptors would be required each calendar month. Further, CMS seeks comment on implementing these HCPCS G-codes in rural health clinics and federally qualified health centers.

Regarding potential valuation of these G-codes, for GRPM1 and GRTM1, which could be PE-only codes describing RPM and RTM initial set-up and patient education on use of equipment, respectively, CMS suggests crosswalking the direct PE inputs from CPT code 99473 (Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration). CMS seeks comment on this valuation, specifically information regarding the typical clinical workflow for the initial set-up and patient education on the use of equipment services used in furnishing RPM or RTM and their associated costs.

For GRPM2, CMS suggests crosswalking the work RVU input of 0.61 RVUs from CPT code 99457 and the direct PE inputs from CPT code 99474 (Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient). And, for GRTM2, CMS suggests crosswalking the work RVU input of 0.62 RVUs from CPT code 98980 and the direct PE inputs from CPT code 93270 (External patient and, when performed, auto activated electrocardiographic rhythm derived event recording with symptom-related memory loop with remote download capability up to 30 days, 24-hour attended monitoring; recording (includes connection, recording, and disconnection)).

AAFP Response

The AAFP appreciates CMS' interest in supporting receipt of RTM and RPM services by Medicare beneficiaries. Reduced readmissions, improved chronic disease management, better care coordination and high patient satisfaction are some of the biggest benefits from RPM programs.

The AAFP supports CMS' proposal to require that RTM services be furnished only to established patients, which is consistent with the current requirement for RPM services. The AAFP also supports CMS' proposal that entities reporting RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of RPM or RTM services and

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that such an initiating visit would need to be a face-to-face (in-person or telehealth) visit during which RPM or RTM was discussed with the patient. Our support is predicated on our understanding that the initiating visit does not need to be dedicated solely to RTM or RPM initiation. The AAFP generally supports having some form of clinician-patient conversation before RTM or RPM enrollment, and we believe that can occur in the context of any face-to-face visit with the patient rather than one dedicated solely to RTM or RPM enrollment.

The AAFP believes there is value in physicians having an established relationship with their RTM patients and initiating RPM or RTM services in the context of a face-to-face encounter; in-person or via telehealth would be typical in family medicine.

The AAFP is strongly opposed to CMS' proposal to only allow payment for RPM or RTM services when furnished by clinical staff employed by the practice and to effectively prohibit contracting RPM or RTM services out to third-party companies. Many small independent and rural practices, and some health systems, rely on vendors for device logistics, onboarding, monitoring, and program administration. The AAFP does not have any data on how often third-party billing currently occurs. However, we believe this proposal would make RPM much harder to scale and could limit Medicare patients' access to RPM services, since those practices who outsource this service probably don't have the in-house capacity to do it themselves (hence their decision to outsource it). We have also heard that many large health systems furnish RPM services through subsidiaries whose employees may not meet CMS' requirement that RPM staff be employed by the billing practice. While the AAFP supports proposals to ensure that practices providing RTM or RPM services have established relationships with patients and prevent inappropriate billing by companies not involved in the patient's direct care, the AAFP does not believe CMS should dictate how practices who are involved in a patient's direct care provide such services to their established patients. The practice of medicine is outside of CMS' purview.

Regarding the valuation of these services, CMS states it is making its proposed RVU changes due to a lack of current data on the typical devices and other resources used in the provision of RPM and RTM services. The AAFP recommends CMS refrain from finalizing these valuation changes and believes it would be far better to collect the needed data than to arbitrarily reduce payments for the services without any data to serve as a foundation for revised RVUs. The RTM and RPM code families went through the RUC process in January 2025. The RUC was scheduled to begin re-examining the RPM and RTM services in January 2028. However, given CMS' concern regarding the direct practice expense inputs on the typical devices used and typical clinical staff workflow/time for these services, our understanding is that the RUC will place all 19 RPM and RTM codes on the next Level of Interest to review practice expense only in January 2027. Thus, the AAFP recommends CMS refrain from implementing any changes to the RPM and RTM direct practice expenses or creating G codes until specialty

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societies and the RUC can review these services in January 2027. Finalizing the proposed RVU changes in the interim would introduce unnecessary volatility in the valuation of these services.

Finally, the AAFP opposes the idea of bundling CPT codes 99453, 99445, 99454, 99091, 99470, 99457, 99458, 98975, 98984, 98976, 98985, 98977, 98986, 98978, 98979, 98980, and 98981 into four new HCPCS G-codes that describe initial set up and monthly monitoring/management for RPM and RTM, respectively. CMS argues the creation of these G-codes could alleviate administrative burden by reducing the number of remote monitoring codes from 17 to four. Unfortunately, if finalized, CMS' proposal would only add to administrative burden by increasing the number of remote monitoring codes from 17 to 21: four for Medicare and 17 for all other payers. The AAFP agrees that the current RTM and RPM coding and billing structure is administratively complex and that there is room for improvement in the coding of these services. However, the proposed consolidation and creation of G-codes is not an improvement for practices that contract with multiple private payers whose payment policies will require use of the current CPT codes. The preferred method for improving the code set is for CMS to work with the AMA and the specialty societies to revise the existing CPT code families for these services rather than create dueling code sets that add to administrative burden of physician practices.

(50) Smoking and Tobacco Use Cessation (CPT codes 99406, 99407) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) (HCPCS codes G2011, G0396, G0397)

CMS proposes applying the same upward adjustment of 19.1 percent to the work RVUs for these time-based services that it made to the time-based psychotherapy codes, which CMS finalized in the calendar year 2024 final rule. Although the upward adjustment of 19.1 percent for the time-based psychotherapy codes has been implemented over a four-year period, with calendar year 2027 being the fourth year, CMS proposes to apply the full 19.1 percent to smoking and tobacco use cessation services and SBIRT services in 2027, which would ensure these services are brought into alignment with the psychotherapy codes at the completion of the 4-year phase-in timeline, rather than initiating a new multiyear phase-in period.

AAFP Response

The AAFP supports the proposed increase in the work RVUs for these services. As CMS notes in the proposed rule, smoking and tobacco cessation and SBIRT services are evidence-supported behavioral health interventions. Quitting smoking provides immediate health improvements, including lowering the likelihood of developing lung cancer and other smoking-related cancers, and it reduces the risks of coronary heart disease, stroke, and chronic obstructive pulmonary disease. Evidence-based smoking and tobacco cessation

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treatments are effective, including the combination of behavioral counseling and medication therapy. SBIRT effectively addresses substance use. In primary care and other clinical settings, SBIRT has been shown to help decrease unhealthy substance use and misuse. Given the evidence supported role these services play in preventing and managing chronic disease and behavioral health conditions including alcohol and/or substance misuse, the AAFP agrees with CMS that valuation should more accurately reflect the clinical intensity and work associated with these time-based services.

(51) Psychiatric Collaborative Care Model (CoCM) (CPT codes 99492, 99493, 99494, G2214) and APCM BHI add-on codes (HCPCS Codes G0568, G0569)

CMS believes a blended level 3 and 4 E/M rate would be more appropriate to value CoCM than the current valuation. Therefore, CMS proposes to refine the work RVUs of CoCM as follows: CPT codes 99492 would be adjusted from a work RVU of 1.88 to 2.75, 99493 from a work RVU of 2.05 to 2.26, and 99494 from a work RVU of 0.82 to 1.13, which is 50 percent of code 99493.

CMS also proposes conforming changes to the valuation of HCPCS codes G2214, G0568, and G0569, which also describe psychiatric collaborative care services. For code G2214, CMS proposes to refine the work RVU from 0.77 to 1.13, representing one half of the time described by the existing code that describes subsequent months of CoCM services (CPT code 99493), consistent with how the code was valued in the calendar year 2021 PFS final rule. For code G0568, CMS proposes to refine the work RVU from 1.88 to 2.75, aligning with the direct crosswalk to the work RVU of CPT code 99492. For HCPCS code G0569, CMS proposes refining the work RVU from 2.05 to 2.26, as this code was valued based on a direct crosswalk to the work RVU of CPT code 99493.

Additionally, consistent with the changes proposed for CPT codes 99492-99494, CMS proposes refinements to the direct PE inputs for HCPCS codes G2214, G0568, and G0569 by revaluing the rate of Behavioral Health Care Manager (L057B) with a per minute rate of \$0.57 to \$0.70. This proposed change is based on a crosswalk of valuing Behavioral Health Care Manager (L057B) to the clinical labor CORF social worker/psychologist (L045C), as opposed to basing the rates to genetic counselors as discussed in the calendar year 2017 final rule. CMS notes that three other HCPCS codes (G2086, G2087, and G2088) also include clinical labor minutes for a Behavioral Health Care Manager (L057B), and therefore as part of this proposal, CMS also proposes the same increase in valuation for L057B from \$0.57 to \$0.70 would also apply to those three codes.

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AAFP Response

The AAFP strongly supports the continued expansion and refinement of Medicare policies that sustain and strengthen this evidence-based model of integrated behavioral health care. CoCM is a well-established, team-based approach that embeds behavioral health services within primary care through collaboration among a primary care physician, a behavioral health care manager (BHCM), and a psychiatric consultant. A substantial and growing body of research demonstrates that CoCM improves clinical outcomes, enhances care coordination, and reduces total health care costs over time.ⁱ These outcomes are especially critical given the increasing demand for mental health services and the central role primary care plays in meeting that need.

The AAFP strongly supports CMS' proposal to reassign the BHCM labor rate within the CoCM model to that of the CORF social worker/psychologist (L045C) at \$0.70. This adjustment more accurately reflects the qualifications, training, and responsibilities required of BHCMs. These professionals serve as the primary point of contact for patients, ensuring ongoing engagement, monitoring progress, and facilitating communication across the care team. Their clinical expertise is essential to the success of the model and must be appropriately recognized in payment policy.

While we appreciate CMS' acknowledgment that effective CoCM payment policies can generate long-term savings for the Medicare program, we are concerned that the proposed valuation methodology does not fully capture the complexity and intensity of these services. Specifically, the proposed blended rate based on level 3 and level 4 evaluation and management (E/M) services undervalues the work involved.

Patients enrolled in CoCM are not low-acuity cases. Rather, they are selectively identified based on higher levels of need and complexity. These patients often present with multiple mental health conditions, co-occurring medical illnesses, and/or exacerbated chronic diseases. Many also face significant social determinants of health challenges, such as housing instability or food insecurity.ⁱⁱ In one study, 11 percent of patients screened positive for suicide risk, underscoring the clinical severity of this population. Importantly, evidence shows that CoCM reduces suicide risk, attempts, and deaths through proactive identification and sustained patient engagement.ⁱⁱⁱ

CoCM is a dynamic, treat-to-target model requiring continuous monitoring and iterative treatment adjustments. Most patients require multiple treatment modifications during an episode of care, each involving registry review, symptom tracking, patient engagement, consultation with psychiatric specialists, and coordinated decision-making among team members. This level of sustained, multidisciplinary clinical effort extends well beyond what is reflected in current valuation.

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Additionally, the model is grounded in measurement-informed care, requiring the routine use of validated patient-reported outcome tools to guide treatment decisions. These processes not only improve patient outcomes but also enhance the capacity of primary care providers to deliver evidence-based behavioral health care.

While the time of the BHCM is partially captured in practice expense calculations, the cognitive work and coordination required of physicians and psychiatric consultants are not adequately reflected in current work relative value units (wRVUs). This imbalance must be addressed to ensure accurate valuation.

Given this level of complexity, cognitive effort and coordination required, the AAFP strongly urges CMS to adopt a valuation that reflects at least a level 4 E/M service, and preferably a blended rate of level 4 and level 5 services. The current proposal does not adequately account for the medical decision-making, care coordination, and clinical oversight required.

Specific Recommendations on wRVUs

To restore appropriate relativity and align payment with clinical complexity, the AAFP recommends the following:

- For CPT code 99492 (initial month of CoCM), adopt a blended rate of CPT codes 99204 and 99205, resulting in 3.67 wRVUs.
- For CPT code 99493 (subsequent month), adopt a blended rate of CPT codes 99214 and 99215, resulting in 2.99 wRVUs.
- For CPT code 99494 (add-on service), set the value at one-half of 99493, or 1.50 wRVUs.
- For CPT code G2214, set the value at one-half of 99493, or 1.50 wRVUs.

If CMS determines it cannot adopt the full wRVU recommendations outlined above, we strongly urge the agency to establish a valuation floor at no less than a level 4 evaluation and management (E/M) service. As reflected in the table below, a level 4 benchmark more appropriately captures the clinical complexity, intensity, and care coordination inherent in CoCM services.

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The finalized values should be applied to the corresponding code with the Advanced Primary Care Management series of codes (HCPCS Codes G0568, G0569)

Code	2026 wRVUs	Total \$ 2026 (non fac)	Proposed (Blend 99203/13 and 99204/14) wRVUs	Change (wRVUs)	Total \$ (non fac)	99204/14 wRVUs	Change (wRVUs)	Total \$ (non fac)	Blend 99204/14 and 99205/15 wRVUs	Change (wRVUs)	Total \$ (non fac)
99492	1.88	\$160.32	2.75	0.87	\$225.28	3.25	1.37	\$241.70	3.67	1.79	\$255.50
99493	2.05	\$144.96	2.26	0.21	\$169.13	2.56	0.51	\$178.98	2.99	0.94	\$193.10
99494	0.82	\$61.46	1.13	0.31	\$80.46	1.28	0.46	\$85.38	1.5	0.68	\$92.61
G2214	0.77	\$60.79	1.13	0.31	\$84.07	1.28	0.51	\$89.00	1.5	0.73	\$96.22

This approach more accurately reflects the intensity of services provided and restores the relativity originally established when these codes were introduced. Adequate reimbursement is essential to sustaining and expanding CoCM adoption across primary care settings. Without appropriate valuation, practices may be unable to invest in the infrastructure, staffing, and workflows necessary to implement this model effectively. Strengthening payment policy will not only support provider participation but also improve access to high-quality behavioral health care for Medicare beneficiaries.

Given that a significant proportion of individuals seek mental health treatment in primary care, ensuring the viability of evidence-based integration models like CoCM is critical. Doing so will yield substantial long-term benefits, including improved population health outcomes and reduced overall health care expenditures.

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

CMS proposes to replace HCPCS code G2211 with a modifier (referred to as MOD1 in this proposed rule and to be replaced with a two-digit HCPCS modifier, if finalized). The modifier would be described as “Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, 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.” Further, CMS proposes to value this modifier as equal to 16 percent of the base code to which it’s appended.

CMS also proposes to create a second modifier (referred to as MOD2) that would represent visit complexity in Medicare accountable care organizations (ACOs). The modifier would be described as “Visit complexity inherent to new or established office/outpatient or home or

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residence evaluation and management service, associated with medical care services furnished by a participant or practitioner participating in a Medicare accountable care organization. Services must serve as the continuing focal point for all needed health care services and/or be part of ongoing care related to a patient's single, serious condition or complex condition." CMS proposes this modifier would be valued at 32 percent of the associated E/M visit when performed by Shared Savings Program ACO participants, ACO professionals and ACO providers/suppliers. Given that ACO Primary Care Flex (ACO PC Flex) Model participation is predicated on participation in the Shared Savings Program, CMS proposes that ACO PC Flex Model ACOs may also utilize the MOD2 modifier. Finally, CMS proposes that LEAD Participant Providers billing under a Participant TIN that is in a LEAD ACO may bill modifier MOD2.

CMS proposes that use of either code is voluntary. CMS also proposes that allowed charges associated with modifier MOD1 and MOD2 will be used in beneficiary assignment to Medicare ACOs such as those under LEAD. The limits that apply to G2211 vis-à-vis modifier 25 would also apply to MOD1 and MOD2. That said, CMS seeks comments on whether it should consider changes to this policy, such as allowing MOD1 or MOD2 to be billed with modifier -25 when an O/O E/M is performed on the same day as a 0-, 10-, or 90- day global procedure.

AAFP Response

The AAFP appreciates CMS thinking critically about how to better recognize visit complexity in the context of E/M services. The proposal to replace HCPCS code G2211 with a pair of modifiers is intriguing and has some merit. For instance, the proposal recognizes that visit complexity is not an additional service, per se, but rather a facet of the E/M service above and beyond that captured in the base code. The proposed change to modifiers would also do a better job of paying physicians more appropriately for visit complexity to the extent it's reflected in medical decision making and thus the level of service. Lastly, the differential in payment between the two proposed modifiers is consistent with the current differential in conversion factor updates that otherwise favors physicians who are qualifying alternative payment model participants (QPs).

That said, on balance, the AAFP is opposed to CMS' proposal to replace HCPCS code G2211 with two modifiers, MOD1 and MOD2, with MOD2 (visit complexity in the context of an ACO) paying twice as much as MOD1. Our opposition is based on the following factors.

First, we believe it is premature to reconfigure how Medicare expects physicians to report and get paid for visit complexity. CMS effectively implemented G2211 in 2024, and its initial utilization was much less than CMS expected. Physicians are still learning when and how to

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report G2211. CMS should refrain from converting G2211 to a modifier until G2211 is better understood and its adoption becomes more widespread.

Second, we fear this proposed change in payment policy will have a negative impact on cost-sharing for many Medicare beneficiaries, especially those in ACOs. This will be especially true for the most complicated patients whose visits tend to be coded with upper-level E/M codes.

Third, many employed physicians will be hurt financially if their employers don't adjust the dollars paid per RVU in their contracts. Many employed physicians have a productivity element in their employment contracts that is tied to RVU production. Replacing G2211 with modifiers will reduce the RVUs these physicians generate without necessarily any commensurate adjustment to what they're paid per RVU by their employers. The employers may benefit from any enhanced payment resulting from the shift to use of modifiers, but there's no guarantee that enhanced payment will flow to the employed physicians who generate it. More than two thirds of AAFP members are employed physicians. We do not want to see them harmed by this potential policy change.

Fourth, from an operational perspective, our understanding is that an add-on code is easier to report than a modifier in some health records and billing systems. We understand this may be especially true for smaller practices. We do not wish to add to the burdens already faced by these practices.

Finally, the AAFP is opposed to CMS' proposal because the greater payment for MOD2 (visit complexity in the context of an ACO) ignores the fact that non-ACO physicians remain accountable for the care they deliver, which is often very high quality and not discernibly different from the care delivered by physicians participating in formal ACOs. In this context, we note that Advanced Primary Care Management codes may be reported by physicians outside of ACOs. Further, the proposed payment differential between MOD1 and MOD2 ignores the fact that ACOs may not be available to some physicians, such as those practicing in rural areas. We believe the proposed policy would unfairly discriminate against such physicians.

(54) Shared Medical Appointments (SMAs)

CMS proposes to create coding and valuation specifically for SMAs. The proposed HCPCS G-code (temporarily designated as GSMAS) would be described as a "Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other

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practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session.”

The proposed SMAs would be limited to beneficiaries who have received a professional service from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months. Beneficiaries would be required to consent to SMA participation and confidentiality terms. CMS proposes that SMAs would be 60-minute sessions. SMA sessions could be held either in-person or via telehealth. In instances where another qualified healthcare professional, such as a registered dietitian, provides a service during the SMA session, such as group medical nutrition therapy, that service would be considered part of the SMA and not separately billable.

CMS proposes requiring each SMA session to include the following components:

- Evaluation and Management (E/M) elements, consistent with the complexity of the beneficiary’s condition.
- Individualized clinical care with medical documentation in the medical record that reflects the specific services that the individual beneficiary received during the SMA session.
- Education, based upon evidence-based content, and discussions related to self-care, wellness, and disease management.
- Discussion of positive lifestyle changes, focusing on behavior modification.
- Medication management as clinically appropriate and applicable.

In addition to medical record documentation requirements, CMS seeks comments on additional guardrails to consider in preventing fraud, waste and abuse when billing SMAs, such as following an evidence-based protocol for delivery of the intervention, conducting fidelity checks to ensure it is being delivered as intended, identifying key outcomes and goals that are established in shared decision making, and ensuring that the interventionist is trained in the intervention as appropriate. CMS also seeks comment on how to determine when SMAs would be clinically appropriate, including identifying which medical conditions would be considered modifiable with lifestyle change.

To value the code, CMS proposes to use a building block methodology that sums the values associated with two reference codes. The first reference code is 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires

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a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded). Code 99213 has a work RVU of 1.30, and a total work time of 30 minutes, which is based on a pre-service evaluation time of 5 minutes, an intraservice time of 20 minutes, and a post service time of 5 minutes. The other reference code is 96202 (Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes). This code has a work RVU of 0.43 and a total work time of 15 minutes, which is based on a pre-service evaluation time of 2 minutes, an intraservice time of 10 minutes, and a post service time of 3 minutes. The proposed building block methodology yields a work RVU of 1.73 and a total work time of 45 minutes, which is based on a pre-service evaluation time of 7 minutes, an intraservice time of 30 minutes, and a post service time of 8 minutes.

AAFP Response

The AAFP has long been a proponent of SMAs (or group visits), and we appreciate CMS' proposal to further recognize the value of this service by creating a dedicated code for it. The proposed descriptor represents a reasonable starting place for such a code.

In general, the AAFP supports the proposed required components for each SMA session and accompanying limitations (e.g., number of patients, length of session, patient consent.) We believe these required components and limitations are sufficient guardrails to prevent fraud, waste, and abuse with one exception.

The one limitation that the AAFP would recommend CMS modify is the requirement that limits SMAs to beneficiaries who have received a professional service from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice "within the previous 12 months." The AAFP believes SMAs should be available to all established patients within a practice, not just those who have received a professional service within the previous 12 months. The proposed limitation echoes the CPT definition of an established patient apart from the phrase "within the previous 12 months." CPT refers to the "past three years" (i.e., 36 months). Extending the limitation to all established patients would also be administratively simpler for practices. We encourage CMS to modify the limitation accordingly.

The AAFP also supports using a building block methodology to value the proposed code. However, for the first building block based on E/M code 99213, the AAFP would advocate for CMS using 99214 (Office or other outpatient visit for the evaluation and management of an

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established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded). As the most [frequently billed code](#), 99214 is a more typical evaluation and management service in the Medicare population, reflective of the multiple chronic conditions that most Medicare beneficiaries have (e.g., diabetes mellitus, obesity, hypertension, hyperlipidemia) which will typically be the focus of SMAs.^{iv} The AAFP believes code 99214 better reflects the “pre-existing clinical relationship and the anticipated clinical profile of beneficiaries that would participate in an SMA,” which was otherwise CMS’ rationale for choosing 99213 as the first building block.

(55) Vaccine adverse effects management (HCPCS Code GADV1)

CMS proposes an add-on code and payment for diagnosis and management of a suspected vaccine adverse reaction for services going above and beyond those captured in an evaluation and management (E/M) visit. The code (temporarily labeled as GADV1) would be described as “Office or other outpatient evaluation and management service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or qualified healthcare professional (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350).” It would be payable when a physician or nonphysician practitioner (NPP): (1) establishes and documents a temporal relationship to vaccination, and (2) performs a medically appropriate assessment to rule out alternative causes. For the purposes of valuation, CMS proposes a direct crosswalk for HCPCS code GADV1 to HCPCS code G2212 (Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215, 99483 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99358, 99359, 99415, 99416) (do not report G2212 for any time unit less than 15 minutes)) for 0.61 work RVUs and for direct PE inputs. The proposed new code would be on the Medicare Telehealth List.

Additionally, CMS welcomes comments on whether a second HCPCS code for 15 minutes of physician or NPP work time should be finalized and structured as a stand-alone code to more accurately capture the work entailed in cases where a patient is being evaluated for only a vaccine related complaint, outside the context of an E/M visit being furnished for a separate complaint. CMS also welcomes comments on whether such a stand-alone HCPCS code should also be crosswalked for its work RVU and PE inputs to HCPCS code G2212.

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AAFP Response

The AAFP agrees with CMS that vaccines prevent serious illnesses and even death in persons who receive them and serve a public health benefit. The AAFP also agrees with CMS that modern vaccines are safe and effective. As CMS notes, before a vaccine is licensed, the Food and Drug Administration (FDA) takes steps to make sure the vaccine is safe, including requiring that a vaccine goes through extensive safety testing.

As CMS also notes, when adverse reactions occur, they are most commonly mild, local reactions such as redness at the injection site. Systemic reactions such as fever are less common, and severe allergic reactions (e.g., anaphylaxis) are the rarest, least frequent reactions. Family physicians are familiar with identifying any type of reaction and competent in responding to them, if they occur, at the time of vaccine administration.

The AAFP appreciates CMS' desire to ensure that when family physicians and others address any adverse effects of vaccine administration, they are appropriately compensated for the work and practice expenses involved. The proposed code is one way to do that, although the distinction between the proposed code and existing evaluation and management services is unclear. If CMS chooses to finalize the proposed code, it needs to better address the logic and justification for creating a new code that otherwise overlaps with existing codes. In addition, existing ICD-10-CM diagnosis codes already allow physicians to document both the adverse clinical condition and its relationship to vaccine administration. Therefore, CMS should articulate a clearer distinction between the proposed GADV1 service and work that is already reportable through established E/M coding and diagnosis reporting mechanisms.

The AAFP does not expect the code will be frequently used. Adverse reactions to vaccines are not typical, and as noted, the most common reactions are mild, local ones that won't require the requisite 15 minutes to report GADV1.

The AAFP does not believe a second HCPCS code for 15 minutes of physician or NPP work time should be finalized and structured as a stand-alone code to more accurately capture the work entailed in cases where a patient is being evaluated for only a vaccine related complaint, outside the context of an E/M visit being furnished for a separate complaint. The AAFP believes existing E/M codes are sufficient for this purpose.

(56) Health Coaching (CPT codes 0591T, 0592T, and 0593T)

CMS proposes conditions of payment and valuation for the following Category III CPT codes:

- 0591T (Health and well-being coaching face-to-face; individual, initial assessment, 60-90 minutes)
- 0592T (Individual, follow-up session, at least 30 minutes)

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- 0593T (Health and well-being coaching, group [2 or more individuals], at least 30 minutes).

CPT code 0593T would be billed once per beneficiary in the group.

CMS also proposes to adopt the CPT prefatory language for 0591T, 0592T, and 0593T as follows:

Health and well-being coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning processes together with content education to work toward their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach. The health and well-being coach is qualified to perform health and well-being coaching by education, training, national examination and, when applicable, licensure/regulation, and has completed a training program in health and well-being coaching whose content meets standards established by an applicable national credentialing organization. The training includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories, which are used to assist patients to develop intrinsic motivation and obtain skills to create sustainable change for improved health and well-being.

Further, CMS proposes that CPT codes 0591T, 0592T, and 0593T may be performed under direct supervision of the billing practitioner and that, when the service is performed under direct supervision by auxiliary personnel, the auxiliary personnel must have received appropriate certification to perform the services, which includes, but is not limited to, fulfilling the following:

- National Board for Health and Wellness Coaching National Standards,
- the National Commission for Health Education Credentialing eligibility for Certified Health Education Specialists, or
- the American Holistic Nurses Credentialing national standards for Certified Nurse Coaches.

CMS also proposes that appropriate certification for auxiliary personnel to perform the services can also be fulfilled by receiving training from the evidence-based health promotion and disease prevention programs funded under the Older Americans Act and overseen by the Administration for Community Living (ACL). CMS solicits comment on these various certification standards for auxiliary personnel performing these services. CMS notes that occasionally, community-based organizations (CBOs) are the entities that employ health

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coaches and that individuals employed by CBOs may operate under general supervision of the billing practitioner, if the training and certification guidelines outlined above are met.

CMS proposes national payment allowances for CPT codes 0591T, 0592T, and 0593T. Specifically, CMS proposes to crosswalk work and direct PE inputs for 0591T and 0592T to CPT codes 99490 (Chronic care management) and 99439 (Chronic care management, each additional 20 minutes), respectively, since, like Chronic Care Management (CCM), these visit-based services are performed under general supervision. For 0593T, since it is a group visit billed in 30-minute increments, CMS proposes to crosswalk the work and PE inputs to CPT code G0109 (Group diabetes self-management training). Therefore, CMS proposes a work RVU of 1.00 for CPT code 0591T, 0.70 for CPT code 0592T, and 0.23 for CPT code 0593T.

Finally, since multiple sessions in the same calendar month may be needed, CMS is not proposing frequency limitations for these codes, as long as they are reasonable and necessary. CMS solicits comments on the valuation of these services and the conditions of payment as well as whether it should consider creating HCPCS G-codes to describe these services for CY 2027, rather than actively pricing these Category III CPT codes that describe health coaching services, including what the potential benefits of G-codes would be compared to using the existing codes.

AAFP Response

In general, the AAFP supports CMS' proposal to establish conditions of payment and national payment allowances for CPT codes 0591T-0593T, all of which are currently contractor priced under the Medicare physician fee schedule. More standardized Medicare coverage and payment for health and well-being coaching is consistent with the AAFP's support for lifestyle medicine and whole-person health. The AAFP believes health coaching can enhance patient engagement, improve self-management behaviors and drive better health outcomes, especially when offered in settings offering longitudinal primary care. Our hope is that national payment allowances and standardized conditions of payment under Medicare will better support physicians and care teams who have invested in health coaching.

The AAFP also supports CMS' proposal to adopt the CPT prefatory language for 0591T, 0592T, and 0593T. Adopting language already tied to these codes in CPT will facilitate their use under Medicare and ease administrative burden for those reporting the services.

The AAFP does have a question related to CMS' proposal. Given CMS' proposal elsewhere in the proposed rule to prohibit separate billing for services such as medical nutrition therapy when performed as part of a shared medical appointment, does CMS also intend to prohibit the reporting of health coaching (CPT codes 0591T-0593T) and shared medical appointments on the same date of service?

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Regarding the proposed valuation of the codes, we believe CMS may be undervaluing the direct PE inputs for 0591T and 0592T by crosswalking them directly to 99490 and 99439, respectively. For instance, the descriptor for 0591T states 60-90 minutes of health coaching, whereas 99490 is for the first 20 minutes of clinical staff time spent in chronic care management (CCM) in a calendar month and only includes 25 minutes of clinical staff time assigned by CMS, less than a half to a third of what's expected for 0591T. Similarly, 0592T describes at least 30 minutes of health coaching, while 99439 describes 20 minutes of clinical staff time spent in CCM and only includes 25 minutes of clinical staff time assigned by CMS. For both 0591T and 0592T, the AAFP recommends that CMS assign clinical staff time consistent with what's required by the code descriptors.

The proposed crosswalk of 0593T to G0109 seems reasonable.

CMS should refrain from creating HCPCS G-codes to describe these services for calendar year 2027 or any other year for that matter. These codes have been around since 2020, and the most frequently used one under Medicare, 0592T, was reported only 129 times in 2024, the most recent year for which Medicare claims data is available. The Category III codes are adequate for now. When or if they are no longer adequate, the next logical step would be to have the CPT Editorial Panel consider converting the existing Category III codes to Category I codes. Creating G-codes that duplicate the existing Category III codes would only serve to create confusion and unnecessary administrative complexity.

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

CMS proposes to reduce payment when a separately identifiable office/outpatient E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, and 90-day global procedure. Under this proposal, the most expensive service (either surgical or E/M visit) would be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. CMS welcomes comments on the value of this adjustment, including whether it would be more appropriate to match a different multiple procedure payment reduction value, such as 25 percent. CMS also seeks comments on whether it should also apply this proposed policy to other E/M visits, such as inpatient E/M visits.

AAFP Response

As CMS notes in the proposed rule, it proposed a similar policy (not finalized) in the proposed rule on the 2019 Medicare physician fee schedule. It was a bad idea then, and it has gotten no better in the intervening years. The AAFP opposes this proposal.

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First, this proposed policy is not patient centered. It encourages medical practices to turn patients away for same-day procedures and have patients return another day to have the procedure performed. Even if many physician practices choose not to do so, the perverse incentive remains. CMS suggests it can monitor problematic utilization patterns and potentially address this practice in conditions of participation. We find this to be an inadequate solution to a potential problem of CMS' own making that still leaves patients harmed when it occurs. The potential consequence is especially problematic for patients of limited means and/or limited mobility (i.e. the complex and high-needs patients about which CMS is most concerned). Access becomes an issue.

Second, this proposed policy could hamper progression toward value-based payment models to which CMS is otherwise encouraging family physicians to migrate. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families, and communities. However, family physicians are financially dependent on the thin margins associated with the current fee-for-service payments to pay for day-to-day business expenses and the costs associated with transitioning to and remaining successfully in value-based contracts. The proposed policy significantly hampers family physicians' ability to operate a medical practice and transition to value-based care.

Third, this proposed policy is "penny wise and pound foolish" and contrary to the increased investment in primary care that CMS is otherwise trying to make. CMS expects to reduce expenditures under the PFS under this proposal. We expect primary care practices who cannot absorb the cut to their already thin margins will be forced to either ask patients to return another day for the procedure or refer patients out to higher-cost sub-specialists to do the procedure. We believe delayed care or sub-specialty care could cost the agency more money than if it simply continues to pay primary care physicians for providing procedures on the same day as the primary care office visit, where appropriate.

Further, as noted above, family physicians and primary care physicians provide comprehensive, cost-effective care to their patients, which includes medically necessary procedures that often result from the undifferentiated diagnoses with which patients present. CMS has claimed that it finds value in such comprehensive, cost-effective care and has made a concerted effort in recent years to invest in such care through the physician fee schedule and other means. Given such claims and action, the AAFP fails to understand why CMS would undertake to implement such a policy that works against comprehensive, cost-effective care.

Relatedly, the AAFP is concerned about the impact of this proposal on osteopathic physicians who provide osteopathic manipulative treatment (OMT). OMT is a hands-on treatment performed by doctors of osteopathic medicine (DOs) to diagnose and treat musculoskeletal

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dysfunction and support the body's overall function and healing.¹ While OMT is classified as a procedure for billing purposes, it is often furnished as part of a comprehensive primary care visit and is a core component of care delivery for many osteopathic family physicians. In these encounters, physicians frequently evaluate new concerns, manage chronic conditions, address preventive care needs, and perform OMT during the same visit. Reducing payment for the separately identifiable E/M service would fail to recognize the distinct cognitive work performed by the physician and would disproportionately affect osteopathic primary care practices that integrate OMT into routine patient care.

Fourth, the proposed policy ignores the way CMS has already set the relative values of the procedures in question. As CMS acknowledges in the proposed rule, the RUC already accounts for overlap in procedures typically done on the same day as an E/M in its recommendations to CMS. To the extent CMS accepts the RUC's recommendations (which it does most of the time), this overlap has already been accounted for. The proposed reduction double-counts that reduction. It also ignores the fact that the physician has identified the E/M service as "significant, separately identifiable" from the procedure through use of modifier 25.

Fifth, the proposed policy ignores the experience of private payers who have tried the same thing. In 2019, Anthem, who had announced plans to implement the same policy, announced their decision to halt the policy. In a statement released by Anthem at the time, they stated, "the company believes making a meaningful impact on rising health care costs requires a different dialogue and engagement between payers and providers." The AAFP agrees with this statement and believes physician engagement is key prior to implementing policies that reduce access to affordable quality care.

Finally, CMS has justified this proposal as a means of addressing perceived overlap between E/M services and procedures, particularly in the context of procedural specialties and global surgical packages. However, family physicians typically furnish minor office-based procedures that arise naturally from the evaluation and management of an undifferentiated patient, rather than planned procedural episodes of care. **Accordingly, if CMS elects to move forward with any version of this policy, it should exempt primary care physicians and other clinicians predominantly furnishing primary care services. Doing so would help ensure the policy does not undermine the comprehensive, same-day care that CMS has otherwise sought to encourage throughout this proposed rule.**

(59) Revisions to Teaching Physician Policy Related to the Primary Care Exception

CMS proposes that all levels of an office/outpatient E/M service provided in primary care centers, and meeting the requirements in 42 CFR 415.174 (Exception: Evaluation and management services furnished in certain centers), may be provided under direct supervision

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of the teaching physician in such cases where the teaching physician believes such care is clinically appropriate and without the presence of a teaching physician. Specifically, CMS proposes to modify the requirements at 42 CFR 415.174 for certain E/M codes to expand coverage of services for teaching physicians as part of a graduate medical education (GME) program by allowing physician fee schedule payment for a service furnished by a resident provided under direct supervision. CMS proposes to modify paragraph (a) of 42 CFR 415.174 to state that certain E/M codes (as specified by CMS in program instructions), may be paid by the physician fee schedule and to remove the language "of lower and mid-level complexity" to potentially allow for certain moderate and higher-level E/M codes to be billed if the visit meets all the criteria in 42 CFR 415.174. Specifically, CMS proposes 42 CFR 415.174 (a) to read as follows: "In the case of certain evaluation and management codes (as specified by CMS in program instructions), Medicare Administrative Contractors (MACs) may make physician fee schedule payment for a service furnished by a resident without the presence of a teaching physician. For the exception to apply, all of the following conditions must be met."

AAFP Response

The AAFP fully supports this proposal. Like CMS, the AAFP believes this proposal would provide appropriate autonomy to residents as well as the teaching physician if the specific GME program would support it. We also believe the proposal appropriately defers to the clinical judgment of that GME program as to whether higher level visits may be performed without the presence of the teaching physician. This approach better aligns residency training with the realities of practice and allows teaching physicians to focus their supervision on residents who need the most guidance, rather than on services subject to arbitrary billing distinctions. The AAFP has long pushed for this type of expansion to the primary care exception to Medicare's teaching physician rules. We urge CMS to finalize this proposal in the final rule on the 2027 Medicare physician fee schedule.

We also encourage CMS to continue modernizing the Primary Care Exception through future rulemaking. Specifically, CMS should consider expanding the list of services eligible under the PCE to include additional preventive and whole-person care services, such as smoking and tobacco cessation counseling, behavioral counseling interventions, and other services that are fundamental to comprehensive primary care. Allowing residents to furnish these services under appropriate supervision would better align residency training with the realities of modern family medicine, strengthen preparation for independent practice, and ensure that future physicians develop the skills necessary to deliver longitudinal, preventive, and relationship-based care. Consistent with our previous recommendations, we believe residency programs are best positioned to determine the appropriate level of supervision for these services based on resident competency and patient needs.

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4. Potentially Misvalued Services Under the PFS

(7) Hyperbaric oxygen under pressure (HCPCS code G0277)

The RUC has requested the deletion of HCPCS code G0277 (Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval) and recommended that CPT code 99183 be revised to be time-based as well to appropriately describe the treatment delivery, attendance and supervision. The RUC concluded that maintaining a separate G-code creates unnecessary coding complexity without adding clinical or administrative value and that one clear and consistent coding structure should exist for this service.

In 2015, CMS created HCPCS code G0277 to describe direct practice expense inputs associated with CPT code 99183 (Physician or other qualified health care professional attendance and supervision of hyperbaric oxygen therapy, per session). At the time, CMS noted that under the Outpatient Prospective Payment System (OPPS), the treatment used to be reported using separate treatment code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30-minute interval.) Therefore, CMS created HCPCS code G0277 to report the treatment delivery and to maintain consistency with the OPPS coding and PFS payment systems.

HCPCS code G0277 was identified as a high-volume growth code that has Medicare utilization of 10,000 or more. High utilization of this magnitude reflects that the code has been broadly adopted across multiple care settings and underscores its operational importance within the Medicare program. Deleting or replacing a high-volume code without an equivalent can disrupt billing practices, create reporting gaps, and impose unnecessary administrative burden on providers who have integrated it into their standard practice. As such, CMS believes there is a reason to continue to maintain the use of the G-code for hyperbaric oxygen therapy since HCPCS code G0277 is utilized in multiple Medicare payment systems to report the time the patient uses the hyperbaric oxygen therapy. Accordingly, CMS proposes to maintain HCPCS code G0277.

AAFP Response

The AAFP supports CMS' proposal to maintain HCPCS code G0277. As CMS notes, the code is used with significant frequency across multiple care settings. Physicians who report the code understand how to do so appropriately. They also understand the current distinction between G0277 and 99183. Deleting code G0277 and revising code 99183 would only create confusion where none currently exists.

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Redesigning Primary Care to Make America Healthy Again (section II.E.)

CMS is seeking comment on how Medicare can better support and value primary care as part of broader efforts to improve health outcomes and promote prevention. CMS notes that primary care remains the foundation of a high-functioning health care system and is seeking input on how Medicare payment policies should evolve in response to longstanding concerns about primary care valuation, emerging technologies, and lessons learned from previous payment and delivery system reforms. The agency requests feedback on three primary topics: the valuation of primary care services under the Physician Fee Schedule, the impact of technology and artificial intelligence on primary care delivery and payment, and the role of prospective primary care payment models within Medicare.

AAFP Response

The AAFP appreciates CMS' recognition that primary care remains undervalued within the PFS and agrees that further reforms are needed to better support longitudinal, relationship-based care. Family physicians have long raised concerns that the PFS does not adequately recognize the work required to provide comprehensive, continuous care, particularly the non-face-to-face services that support prevention, chronic disease management, care coordination and longitudinal relationships between patients and their trusted care team. While CMS has taken important steps in recent years to better recognize this work, significant challenges remain. We therefore welcome this opportunity to provide feedback on how Medicare can better support and sustain high-quality primary care. We also encourage the agency to continue to collect feedback from stakeholders outside of the PFS rulemaking process. Many of the questions raised in this RFI have substantial implications for the future of primary care payment and warrant careful consideration by physicians, researchers, health systems, and other stakeholders. **The timing of this RFI within the annual PFS rulemaking cycle necessarily limits the amount of attention that can be devoted to these issues while stakeholders are simultaneously reviewing and responding to numerous other proposals throughout the rule.** Additional opportunities for engagement through standalone RFIs, listening sessions, technical expert panels or other forums would allow for more thoughtful and detailed feedback as CMS considers these important issues.

2. Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule

CMS expresses concern that current Medicare payment policies may not adequately recognize the ongoing work associated with longitudinal primary care relationships. While the agency has previously taken steps to better support primary care through policies such as HCPCS code G2211, CMS believes the current office and outpatient E/M structure may not

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fully capture the resources required to furnish comprehensive, continuous care over time. As a result, CMS is seeking feedback on whether future payment and coding policies should better distinguish between longitudinal care, acute care, and consultative services, and how such services should be valued under the Physician Fee Schedule. CMS also seeks comment on whether certain care management activities should be incorporated into future primary care visit constructs.

AAFP Response

The AAFP agrees that Medicare payment policies still do not adequately recognize the value of longitudinal primary care. Family physicians remain responsible for much of the work that keeps patients healthy and out of the hospital, including managing chronic conditions, coordinating care across multiple settings, addressing preventive health needs, reviewing test results, adjusting medications and responding to patient concerns between visits. Although CMS has taken meaningful steps in recent years to better recognize this work through policies such as G2211 and APCM, important gaps remain.

We appreciate CMS' interest in better recognizing longitudinal care, but we caution against assuming that primary care visits can be easily categorized as longitudinal, acute, or consultative. In family medicine, a single visit often includes elements of all three. A patient may present with an acute concern while also receiving ongoing chronic disease management, preventive care, medication management, and care coordination. As a result, creating new visit categories would be more complicated in practice than it appears on paper and would introduce additional coding and administrative complexity without meaningfully improving payment accuracy.

Before establishing new visit categories or coding structures, CMS should evaluate whether additional improvements can be made within existing policies. The agency has already created several mechanisms intended to better recognize longitudinal care, including G2211, care management services, and APCM. Building on and refining these policies may be a more practical approach than creating new visit types, modifiers, or G-codes.

Ultimately, we encourage CMS to focus less on categorizing visits and more on recognizing the functions that distinguish high-quality primary care. Continuity, accountability, care coordination, prevention, chronic disease management and longitudinal relationships are what drive the value of primary care. Medicare payment policies should support and encourage these activities while minimizing unnecessary complexity and administrative burden.

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3. Care Management Code 'Family'

CMS notes that it has established a growing family of care management services over the past decade, including chronic care management (CCM), principal care management (PCM), transitional care management (TCM), advanced primary care management (APCM), and remote monitoring services, to recognize the work involved in coordinating and managing patient care between office visits. However, the agency expresses concern that uptake of these services has remained lower than expected and is seeking feedback on whether the current code family could be simplified, standardized, or otherwise redesigned to improve utilization and better support longitudinal care. CMS is also seeking comment on supervision requirements, documentation and program integrity safeguards, the role of technology-enabled care management and whether separate technology-enabled care management services should be established.

AAFP Response

The AAFP appreciates CMS' continued efforts to better recognize the non-face-to-face work required to manage chronic disease, coordinate care, and support longitudinal relationships with patients. However, we do not believe the limited utilization of the care management code family is primarily the result of confusion about the distinctions among the codes. The code descriptors describe different clinical circumstances: CCM supports ongoing management of multiple chronic conditions, PCM addresses a single serious condition, TCM supports patients following a transition from an institutional setting and APCM provides a broader monthly payment for advanced primary care. CMS itself identifies cost-sharing and non-trivial documentation requirements as the primary barriers stakeholders have cited to broader adoption.

The AAFP believes beneficiary cost-sharing remains one of the most significant barriers to broader adoption of care management services across the entire code family. Family physicians regularly report that patients decline participation in CCM, PCM, APCM and other care management services once they learn the service may result in additional out-of-pocket costs. As the AAFP noted in previous comments,^v utilization data should not be interpreted as evidence that care management activities are not occurring. In many cases physicians furnish the underlying care coordination, medication management, chronic disease management and patient outreach activities but elect not to bill for the service because patients are unwilling or unable to assume additional cost-sharing obligations. If CMS seeks to increase utilization of care management services, eliminating beneficiary cost-sharing would likely have a greater impact than restructuring the existing code family.

In addition to cost-sharing, the challenges associated with CCM and PCM are largely similar and stem from administrative and operational requirements rather than confusion about the

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purpose of the services themselves. Both services require significant documentation, beneficiary consent, care planning, time tracking and other operational workflows that can be difficult to implement, particularly for smaller and independent practices that operate with limited staff and budgets. As we have previously commented,^{vi} family physicians have reported that the administrative burden associated with documenting and billing these services often outweighs the financial benefit of furnishing them. In addition, many physicians report that payment for CCM and PCM does not adequately reflect the staffing, technology, and clinical resources required to provide meaningful care coordination and longitudinal patient support.

The challenges associated with TCM are distinct from those affecting CCM and PCM. Successful TCM billing often depends on factors outside the physician's control, including the timely receipt of discharge notifications and clinical information from hospitals and other facilities. Family physicians frequently encounter difficulties obtaining the necessary information to contact patients within the required timeframes, perform medication reconciliation and coordinate appropriate follow-up care. The AAFP encourages CMS to focus on improving information exchange and reducing operational barriers associated with care transitions rather than modifying the underlying TCM code structure.

Regarding APCM, these codes have successfully addressed many longstanding concerns associated with CCM by eliminating monthly time-tracking requirements and creating a broader framework for longitudinal primary care services. However, important implementation barriers remain.

First, practices continue to express concerns regarding documentation requirements, reporting obligations and beneficiary cost-sharing. Second, CMS has never clearly stated whether APCM may be billed during a month in which no direct patient encounter or discrete interaction occurs. As a result, many practices take a conservative approach and only report APCM during months when the patient is seen or otherwise engaged. This significantly undermines one of the core goals of the code. Longitudinal primary care infrastructure requires practices to invest in staffing, technology, care coordination capabilities and population health activities regardless of whether a patient presents in a given month. When practices are uncertain whether APCM can be billed absent a documented encounter, APCM becomes a less predictable revenue stream, and practices are understandably reluctant to make substantial upfront investments. **CMS should provide explicit guidance clarifying that APCM is intended to support ongoing accountability for a patient panel and not merely compensate for discrete monthly interactions.** CMS should also ensure their information (e.g., website and Medicare Learning Network) is updated in a timely manner, and the guidance is communicated broadly.

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Finally, CMS should recognize that the success of any care management strategy depends not only on Medicare payment policy but also on broader payer alignment. One critical reason care management codes have not been impactful for primary care practices is that many commercial insurers were slow to recognize or pay for CCM and TCM services. Additionally, very few private payers have adopted APCM outside of their Medicare Advantage plans. This creates a fragmented environment in which practices must maintain separate workflows for different payers while receiving only limited financial support from Medicare. There are patients in all age groups that could benefit from care management services. It is important that practices have appropriate financial support that allows them to sustain care management programs for their entire patient population. Managing chronic conditions earlier will translate into improved outcomes and lower costs for patients when they enter Medicare.

If CMS seeks to fundamentally transform how primary care is financed and delivered, it should use its considerable convening authority to encourage broader adoption of care management and longitudinal primary care payments across all public and private payers. Family physicians can make transformational investments in care coordination infrastructure when payments for those services are supported consistently across payers and patient populations. While incremental payments from a single payer may not be sufficient to drive practice transformation, similar payment approaches across Medicare, Medicaid, Medicare Advantage plans and commercial insurers can collectively create the financial foundation necessary to redesign care delivery. CMS should bring public and private payers together to align around common approaches to longitudinal care management, reduce administrative variation and promote broader adoption of these services across the healthcare system.

4. Payment Implications of Technology Enablement of Primary Care

CMS seeks comment on how advances in health information technology, digital health tools, and artificial intelligence may transform primary care delivery and whether Medicare payment policy should evolve accordingly. Specifically, CMS asks how technology-enabled care should be valued under the Physician Fee Schedule; whether payment should reflect changes in physician time, intensity, productivity, or outcomes; and how CMS should evaluate the quality, safety, and impact of technology-enabled primary care. CMS also seeks input on whether certain technology-supported activities are inadequately recognized under current coding and payment structures and whether alternative payment approaches may be warranted.

AAFP Response

The AAFP strongly supports the development and deployment of technologies that help family physicians and their care teams provide more accessible, comprehensive, coordinated

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patient-centered care. Health information technology (IT), digital health tools, and artificial intelligence (AI) have significant potential to reduce administrative burden, improve care coordination, enhance clinical decision-making, and strengthen longitudinal relationships between patients and their physicians when thoughtfully designed and implemented. The AAFP strongly believes technology should support the four core functions of primary care: first contact, comprehensiveness, continuity and coordination of care. For example, AI-enabled tools may help family physicians identify care gaps, summarize relevant patient information, support population health management, facilitate referrals and care transitions, improve clinical documentation and surface evidence-based recommendations at the point of care. These types of uses can expand physician capacity and allow family physicians to devote more time to direct patient care.

The AAFP has consistently maintained that technology should strengthen, not supplant, the patient-physician relationship . Family medicine is built upon longitudinal relationships, contextual knowledge, trust and accountability developed through ongoing interactions between patients and their physician-led care teams. The AAFP's [Ethical Application of Artificial Intelligence in Family Medicine policy](#) states that AI should at minimum preserve, and ideally enhance, the patient-physician relationship and the four C's of primary care. **Consistent with that principle, the AAFP believes AI and other emerging technologies should augment physician judgment, improve situational awareness, and support care delivery rather than replace physician expertise or operate independently of established care relationships. Technologies that displace clinical accountability, fragment care, or create parallel channels of care delivery risk undermining the goals of primary care and should not be incentivized .**

The success of technology-enabled primary care will also depend on ensuring physicians have timely access to complete and actionable information. The AAFP has long supported a national interoperable health data ecosystem that facilitates efficient information sharing without imposing unnecessary financial or administrative burdens on practices. In particular, the AAFP [supports](#) a "push" approach to interoperability in which clinically relevant information, including claims data from payers, is proactively shared with a patient's primary care physician rather than requiring physicians to search multiple systems for needed information. Examples [include](#) admission, discharge, and transfer notifications; referral closure information; laboratory and imaging results; medication fill notifications; immunization registry data; quality and cost data; accurate attribution lists; and other data necessary to coordinate care and succeed in value-based care arrangements.

Technology should ensure that this information flows seamlessly to the physician responsible for longitudinal care management. Achieving this goal requires more than the adoption of individual technologies; it depends on a broader health IT ecosystem that supports

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standardized, secure, timely, and bidirectional information exchange across physicians, payers, hospitals, pharmacies, public health entities, HIEs/HDUs, and other participants in the health care system. CMS should continue supporting the interoperable infrastructure, data standards, governance frameworks, APIs, and exchange networks necessary to ensure that clinically relevant information is available in a usable format and integrated into physician workflows at the point of care. **Without this broader ecosystem of interoperable infrastructure, aligned standards, sustainable investment, and shared accountability across stakeholders, even the most promising technologies will be unable to consistently deliver on their potential to improve care coordination, support longitudinal care relationships, reduce administrative burden, and advance value-based care .**

The AAFP [further believes](#) that physicians, especially those in small, independent, rural, and underserved practices, should receive financial and technical support necessary to adopt technologies that improve patient care. Technology adoption policies should recognize that these practices often face limited infrastructure and staffing resources despite serving communities with significant access challenges. **CMS should evaluate and prioritize technologies based on their ability to measurably improve patient outcomes, strengthen continuity of care, reduce documentation burden, support value-based care, bolster primary care infrastructure and enhance the patient experience. Measures should focus on meaningful clinical improvements rather than technology use or coding intensity .** Additionally, current payment systems generally recognize physician work rather than technology investment. CMS should focus payment policies on rewarding improved patient outcomes, reducing burden, supporting longitudinal primary care relationships, and recognizing care coordination activities. **We caution against creating technology-specific reimbursement mechanisms that could rapidly become outdated or unintentionally incentivize technology utilization over patient benefit .**

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

CMS seeks comment on how technology and artificial intelligence could improve the effectiveness, efficiency, personalization, and outcomes of the Medicare Annual Wellness Visit (AWV). The agency is interested in how technology may support activities before, during and after the visit; whether AI-enabled AWVs can improve preventive care and patient outcomes; and what barriers may exist to technology-enabled AWV delivery models. CMS also requests feedback on whether and under what circumstances technology companies could participate in AWV-related services and how such models should be evaluated to ensure they improve patient outcomes rather than simply increasing visit volume or documentation.

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AAFP Response

The AAFP appreciates CMS' interest in exploring how technology and AI can improve preventive care delivery and support Annual Wellness Visits (AWVs). AI-enabled technologies may help physician practices identify eligible patients, conduct outreach, summarize relevant clinical history, identify preventive care gaps, prepare visit materials, facilitate documentation and support follow-up activities. These technologies may also help reduce administrative burden and increase care capacity which is particularly important for many practices facing workforce shortages and growing patient demand. The AAFP supports continued exploration of technologies that help physician-led care teams deliver more timely, efficient, and coordinated preventive care services.

However, the value of an AWV extends beyond completing a series of required assessments or preventive screenings. Family physicians use AWVs as opportunities to integrate preventive care recommendations with a patient's medical history, chronic disease management needs, behavioral health concerns, social circumstances, family context, care preferences and long-term health goals. This type of contextualized decision-making is only possible within an ongoing, trusted relationship between a patient and a physician-led care team. Our [Ethical Application of Artificial Intelligence policy](#) specifically recognizes that AI should preserve and enhance primary care's continuity, coordination, comprehensiveness, and first-contact functions. Similarly, we believe that technologies which improve access but undermine continuity, fragment care, or displace clinical accountability are inconsistent with the goals of primary care.

For this reason, the AAFP has concerns regarding any care model that would allow technology vendors, AI companies, or other third parties to independently furnish significant portions of preventive care services outside a patient's established primary care relationship. While technology can support patient engagement and certain administrative or educational functions, preventive care should remain integrated within physician-led care delivery. Separating preventive care activities from the patient's primary care physician risks creating fragmented records, duplicative services, inconsistent recommendations, and uncertainty regarding responsibility for follow-up care. Most importantly, such models may weaken the continuity and accountability that contribute to better patient outcomes over time. CMS should therefore ensure that any technology-enabled AWV approach strengthens rather than bypasses the patient's existing primary care team.

The AAFP encourages CMS to prioritize technology models that reinforce longitudinal care relationships. For example, technologies that automatically transmit AWV findings, patient-reported data, care-gap information, or preventive screening results directly into the patient's

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longitudinal health record and make that information readily available to their primary care physician are consistent with AAFP policy and advocacy on improving interoperability. Similarly, AI tools that summarize patient histories, identify needed preventive services, facilitate referral follow-up, or support shared decision-making can improve care when deployed under physician oversight and integrated into existing workflows. In contrast, technologies that create stand-alone preventive care encounters disconnected from a patient's primary care physician are less likely to improve care coordination and continuity.

Ultimately, CMS should evaluate technology-enabled AWP models based on whether they strengthen the core functions of primary care. The most promising technologies are those that reduce administrative burden, improve information sharing, support care coordination, enhance continuity, and return time to patients and their physician-led care teams. **The goal should not be technology-substituted primary care, but rather technology-enabled primary care that deepens patient relationships, improves preventive care delivery, and supports the long-term health of Medicare patients .**

The AAFP strongly believes that technologies used in connection with the AWP should augment, not replace, physician-led clinical care. While AI-enabled tools may assist with information gathering, patient outreach, risk stratification, preventive care reminders, documentation support, or other administrative and operational functions, **the AAFP strongly opposes the use of agentic AI systems to independently perform clinical functions without appropriate human clinical oversight .** Preventive care recommendations, clinical assessments, patient-specific counseling, initiation of treatment plans, ordering decisions, and other activities requiring clinical judgment must remain under the authority of a physician or other appropriately qualified clinician.

While AI may assist, inform, prepare, or facilitate these activities, **it should never independently exercise clinical judgment or serve as a substitute for the professional accountability that accompanies the delivery of patient care .** Consistent with the principles of primary care, technologies deployed in support of the AWP should strengthen continuity, preserve clinical accountability, and reinforce the trusted relationship between patients and their physician-led care teams. **CMS should therefore avoid policies that incentivize autonomous AI-delivered preventive care services or create pathways through which technology vendors, AI companies, or other third parties can function as de facto substitutes for a patient's established primary care physician .** Instead, technology-enabled AWP models should require meaningful human oversight and be evaluated based on their ability to enhance physician capacity, improve preventive care delivery, and support longitudinal, relationship-based care.

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6. Developing Prospective Payment in the Shared Savings Program

CMS seeks comment on whether and how it should establish prospective primary care payment (PPCP) within the Medicare Shared Savings Program (MSSP) and potentially across Original Medicare. Building on lessons from prior Innovation Center models, CMS is exploring alternatives to traditional fee-for-service payment, including hybrid, capitated and population-based payment approaches that could better support care coordination, population health management, and other non-visit-based primary care activities. The agency requests feedback on ACO readiness for prospective payment, eligibility criteria, payment design, care delivery requirements, accountability mechanisms, and the role of primary care capitation in advancing value-based care and improving patient outcomes.

AAFP Response

The AAFP supports creating a voluntary prospective primary care payment option within the MSSP. Properly designed prospective payments could provide practices with more predictable revenue and greater flexibility to improve access, strengthen care teams, manage chronic conditions, deliver preventive services, and respond to patients' clinical and social needs. These payments must represent a meaningful increase in Medicare's investment in primary care rather than simply repackaging historically inadequate fee-for-service revenue. Prospective payments must also be appropriately risk-adjusted, accompanied by timely data, structured to protect patient choice, and delivered transparently to the primary care practices responsible for furnishing care.

The AAFP offers the following responses to CMS' specific questions regarding the design and implementation of prospective primary care payment models.

b. Primary Care Capitated Payment Arrangements Considerations for the Shared Savings Program

- *To what extent are Shared Savings Program ACOs and ACO participants, and their associated health care providers (referred to herein as "ACO providers/suppliers"), ready to take on capitated payment arrangements? Please describe ACO and ACO participant level of readiness for each of the following:*
 - *Hybrid capitation (a combination of capitated and OM payments).*
 - *Full capitation for primary care services (that could enable ACOs to provide downstream payments to ACO participants).*
 - *PBPs as a fixed percentage of expected OM claims.*

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AAFP Response

Prospective payments provide a reliable revenue stream that better supports the comprehensive care provided by ACOs – particularly the non-visit-based care that is largely uncompensated under the current FFS model. The AAFP supports the permanent addition of hybrid capitation, full primary care capitation and population-based payment as voluntary participation options within the MSSP.

ACOs will vary in their readiness to take on capitated payment arrangements. Many larger and long-term MSSP participants may already have the operational infrastructure in place to administer a capitated arrangement, whereas small, rural, and physician-led ACOs may need technical assistance, implementation funding, and protections against payment volatility. CMS should offer flexible participation options that account for the varying levels of operational and financial readiness to implement hybrid, full, or population-based capitated arrangements.

We recommend against any structure that requires progression toward full primary care capitation or full capitation. While some larger ACOs may have the more sophisticated infrastructure that is required to administer full primary care capitation, it does not necessarily follow that they will want to absorb the associated operational burden, nor does it mean that their participating practices wish to transition to full primary care capitation. Participation in full primary care capitation should be voluntary and is a business and operational decision that should not be placed on an artificial timeline.

Eligibility for Participation

- *Should CMS limit access to capitated payment arrangements exclusively to ACOs participating in two-sided risk tracks (BASIC tracks C, D, E or the ENHANCED track), or should all ACOs be eligible to receive some form of capitated payments, regardless of the ACO's participation track? ACOs participating in two-sided risk tracks must establish a repayment mechanism prior to the start of an agreement period, and we are interested in whether similar proof that an ACO could repay losses should be required as a condition for receiving capitated payments, even for ACOs in one-sided risk tracks.*

AAFP Response

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 percent of a primary care practice's revenue needs to be prospective to sustainably support

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comprehensive, team-based primary care.^{vii} Offering capitated arrangements to all risk tracks in the 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. Limiting hybrid payment participation to risk-bearing ACOs would be a deterrent and disadvantage for new, physician-led, and rural ACOs. Providing upside only ACOs with the opportunity to benefit from hybrid payment aligns with CMS' goal of having 100 percent of Medicare beneficiaries in an accountable care relationship by 2030.

- *Should CMS limit capitated payment arrangements to ACOs with prior risk-bearing experience – either through participation in a previous Shared Savings Program agreement period in a two-sided risk track (BASIC tracks C, D, E or the ENHANCED track) or through prior participation in a risk-bearing track in an Innovation Center model, such as ACO REACH – or should risk-bearing ACOs in their first Shared Savings Program agreement period also be eligible to participate in capitated payment arrangements? Why would commenters support one approach over the other? We are interested in whether prior experience with risk-bearing should be an explicit prerequisite for capitated payment eligibility or whether risk-bearing ACOs in their first agreement period should also be eligible to participate in capitated payment arrangements.*

AAFP Response

Consistent with the AAFP's position that capitated arrangements should not be limited by MSSP track, we similarly do not believe a capitated option should be limited to ACOs with prior risk-bearing experience. The AAFP notes that previous Innovation Center models that included hybrid or capitated arrangements did not require prior risk bearing experience nor does the LEAD model. Relevant experience may demonstrate readiness, but it is not the only way an ACO can develop the necessary capabilities.

Limiting participation in a capitated arrangement to ACOs in a two-sided risk track as well as those with prior risk-bearing experience will create unnecessary barriers to participation and will slow adoption. A hybrid or capitated payment arrangement inherently carries a certain level of financial risk for participants as they are managing to a more fixed budget rather than one that is solely driven by FFS. These ACOs would benefit from the reliable, prospective revenue that would support further development of the infrastructure needed to assume the downside risk required in BASIC Levels C, D, and E and the ENHANCED track. Allowing ACOs in one-sided models and those without previous risk-bearing experience to participate in a capitated arrangement would provide new and physician-led ACOs with a more gradual transition through the program.

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CMS should instead evaluate objective indicators such as governance, financial controls, claims-processing capacity, data systems, practice-payment infrastructure, implementation plans, and experience with other value-based arrangements. First-agreement-period ACOs that satisfy these standards should be eligible. This approach would protect program integrity without creating an unnecessary barrier to new entrants.

- *Should CMS permit some, but not all, ACO participants within an ACO to participate in capitated payment arrangements, or should CMS require all ACO participants within an ACO to participate in capitated payment arrangements?*

AAFP Response

CMS should not require all ACO participants within an ACO to participate in capitated payment arrangements. Practices differ substantially in readiness, patient populations, financial reserves, scope of services, and experience with alternative payment models. ACOs may either drop certain participants or forego participation altogether if some but not all their participants are capable or interested in transitioning to a capitated arrangement. The AAFP believes it is important to provide flexibility to ACOs and their participants to decide together what is the best option for them rather than placing ACOs in an all-or-nothing position.

- *To what extent should the payment design and structure differ based on the level of risk or participation track of an ACO?*

AAFP Response

CMS should not tie the payment design or structure to the level of risk or participation track of an ACO. Instead, CMS could establish an operational readiness assessment as a component of the existing SSP application.

- *What percentage of base year OM payments should be replaced by PCC, and what factors should guide this determination? For example, under the ACO REACH model, the PCC payment – including both the base PCC and the enhanced PCC – is set at 7 percent of the REACH ACO's prospective monthly performance year benchmark, a level designed to provide ACOs with a predictable, non-visit-based revenue stream for primary care services.*

AAFP Response

While CMS has made great strides in addressing issues related to the current benchmarking methodologies, stakeholders still have concerns with the benchmarking methodology that must be addressed, as discussed in our response to the proposals in the MSSP section of this

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rule. If these issues are not addressed, using the benchmarks to establish capitated payment levels would only further entrench their negative effects on the MSSP.

The AAFP cautions against simply “replacing” FFS payments with a capitated structure, as this simply perpetuates the long-standing underinvestment in primary care within the PFS. The AAFP recommends that CMS work with CMMI, primary care researchers, and other experts across the industry to analyze the staffing and operational costs and resources required to deliver high-quality, team-based primary care that improves patient outcomes and lowers costs. Because of its comprehensive, longitudinal whole-person orientation, high-quality primary care relies heavily on clinical and non-clinical team members to perform many patient-facing services that are not directly compensable under the physician fee schedule. The AAFP believes strongly that CMS should apply an explicit primary care adjustment above historical Medicare FFS spending to account for the long-term undervaluation of primary care. Increasing the overall investment in primary care, as described throughout this letter, is paramount to improving health outcomes and reducing overall health care costs for Medicare beneficiaries.

Consistent with the AAFP’s [“Capitation, Primary Care” policy](#), the AAFP believes capitated payments should be adequately risk-adjusted for a patient’s clinical diagnoses, demographic factors, and upstream drivers of health. Capitation rates should be adjusted so that they sufficiently address the cost of providing care in different geographic locations. Adjustments should ensure rates remain equitable among geographic locations and reflect public policy goals (e.g., encouraging physicians to practice in underserved areas). When supported by a predictable, prospective revenue stream that is risk-adjusted for the clinical and upstream drivers of health of their patients, primary care practices thrive and can make meaningful shifts toward preventive rather than reactive medicine.

- *What services should be included in primary care capitation (and reciprocally, in a fee reduction) to accurately capture an appropriate scope of primary care services furnished to beneficiaries, balancing the importance of providing up-front flexible payments, with the potential for risk to practices if service utilization grows? For example, under both the ACO REACH and ACO PC Flex models, the set of services eligible for primary care capitated payments is based on a specific list of CPT and HCPCS codes billed by primary care specialists (health care providers with specific specialty codes). In both models, the PCC bundle includes certain E/M office visits along with CCM, behavioral health integration, transitional care management, AWWs, advance care planning, and virtual communication services.*

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AAFP Response

The AAFP believes the following services are appropriate to be paid through primary care capitation payment: (1) care management services, (2) communications such as emails, phone calls, and patient portals with patients and their caregivers, (3) behavioral health integration services, and (4) office-based evaluation and management visits, regardless of modality, for new and established patients. The AAFP supports taking a tiered approach to primary care capitation that recognizes each practice's capabilities and the unique needs of their patient populations. Similar to how the PCC is structured in the LEAD model, CMS should allow ACOs to select the level of fee reduction for the services included in the primary care capitation.

CMS should clearly identify the services along with the relevant CPT and HCPCS codes, if available, included in the capitated payments and/or subject to a fee reduction, while also recognizing that a prospective payment is intended to support important work that does not correspond to a discrete code. As noted elsewhere in our comments, simply translating CPT codes into a capitated amount does not address the historic undervaluation of primary care services.

Services not included in the capitated amount should remain separately payable at or above current rates as appropriate. These include procedures and preventive or other services CMS wishes to incentivize.

Given the AAFP's concerns regarding foundational issues embedded in the current PFS approach to primary care payment, relying solely on historical PFS payment rates to set capitated payment rates will result in codifying the current inequities. **Success of capitated payment is contingent on not only changing the structure but on correcting for the long-term undervaluation of primary care.** Considering historic primary care FFS payments as an actuarially equivalent reference point is a non-starter for a successful capitated payment option.

- *Should capitated payments be paid to ACOs and distributed downstream to ACO participants, or should CMS make payments directly to ACO participants that provide primary care services, similar to how CMS makes payments for APCM services, and what are the implications of each approach? Should CMS consider alternative mechanisms for delivering capitated payments directly to ACO Participants that are also primary care practices participating in Shared Savings Program ACOs? If so, what payment design, infrastructure, and policy considerations should guide the development of such alternative payment mechanisms?*

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- *If capitated payments are issued directly to ACOs, should CMS require ACOs to provide a specific percentage of those payments to ACO participants that provide primary care services? How might this be audited? Additionally, should CMS require ACOs to have written capitated payment agreements with ACO participants to specify that a minimum percentage of the capitated payment will flow to ACO participants?*

AAFP Response

ACOs have varying organizational structures which will require CMS to take a very thoughtful approach to ensure payments intended to support primary care, including capitated payments, reach the primary care practices where physicians and care teams are delivering the care. The AAFP recognizes that many ACOs also make significant investments in care management, technology, data infrastructure, and other capabilities that support high-quality primary care. Accordingly, CMS should design payment policies that both support these investments and ensure that an appropriate share of capitated payments reaches the primary care practices responsible for caring for aligned Medicare beneficiaries. To that end, the AAFP suggests two options for consideration:

1. Pay capitation to primary care practices directly. This is the preferred approach and guarantees that capitation is applied in the primary care setting where care is delivered to aligned Medicare beneficiaries.
2. Pay capitation to ACOs with stipulations that establish a maximum level of retention by ACO (for delivery of specific qualified services) and/or minimum percentage that must flow to primary care practices. This option will require that CMS put a strong audit mechanism in place to ensure adherence accompanied by clear and meaningful financial penalties for ACOs that do not abide by these stipulations.

Care Delivery Requirements

- *Should CMS require ACOs seeking to participate in capitated payment arrangements to make commitments to specific care delivery goals as a condition for participation? If so, what goals should be required and how should compliance be assessed and enforced?*

AAFP Response

The AAFP believes a structure that allows ACOs to elect the level of fee reduction for the primary care capitation, similar to that offered in the LEAD model, could serve as a proxy for explicit care requirements. By selecting the level of fee reduction, ACOs will have the flexibility to elect the level of fee reduction that aligns with their current care delivery capabilities. As such, CMS should not impose additional care delivery requirements on

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physician-led ACOs that elect to receive capitated payments. While such requirements may be warranted for new programs or ACOs that are not physician-led, the AAFP believes that, by virtue of their participation in the MSSP, ACOs and their participant practices have already shown commitment to meaningful care delivery transformation aimed at improving patient outcomes and lowering costs.

A primary benefit of a capitated payment arrangement is that it provides additional flexibility to the physician to provide care in new and innovative ways that meet each individual patient's needs rather than being limited by specific coding or care delivery requirements. Given that ACOs already have a proven track record of success without such requirements, we do not believe it is necessary to introduce additional requirements simply as a condition for participation in a capitated arrangement in the MSSP. Additionally, we believe the quality reporting standard required to earn shared savings serves as sufficient incentive and guardrail for ACOs to transform their care delivery in meaningful ways that are tailored to their patient population such that prescriptive care delivery requirements would only create an additional and unnecessary reporting burden.

c. Primary Care Capitated Payment Arrangements Considerations outside of the Shared Savings Program

CMS is considering extending these efforts to develop a bundled or capitated approach, called a "global period" in the broader Medicare program. Surgical and maternity care services are examples of global periods. CMS notes they have not previously proposed a primary care "global" period because of the difficulty in ascertaining where a primary care relationship starts and stops through claims data or other information available to them.

AAFP Response

The AAFP does not think it is appropriate to apply the global period concept to a primary care bundled payment. By definition, primary care is longitudinal – patients and primary care physicians develop relationships over different periods of time – frequently lasting many years. Unlike procedural services, primary care relationships vary widely in duration and scope, making a fixed global period an inappropriate way to define a period of care. Given the ongoing nature of primary care, a global period would also need to be ongoing which runs counter to the more defined and time-limited nature of the global period, CMS would need to develop an entirely new structure to retrofit primary care into a mechanism that was never meant to be used that way. This would introduce an unnecessary level of complexity for both CMS and physician practices.

CMS uses maternity care services as an example of care that is managed by a global period. However, the maternity care service coding structure is changing and explicitly eliminating

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the global period and antepartum bundles. Furthermore, the AAFP and others have long voiced concerns with global surgery services,^{viii} and CMS itself acknowledges the ongoing challenges with accurate valuation, accountability and transparency of these codes. Considering the issues with existing global periods, the AAFP struggles to understand why CMS believes it would be appropriate to apply the concept to primary care, which FFS is ill-suited to support in the first place.

The AAFP reiterates our support for hybrid payment for primary care that moves away from sole reliance on FFS. We support hybrid payments for all primary care physicians, regardless of whether they are part of an ACO. To be successful, however, hybrid payment must represent a meaningful increase in Medicare's payment approach to primary care, not simply a different method of distributing historically inadequate payment. Primary care practices need predictable, prospective revenue sufficient to support comprehensive, continuous, relationship-based care, including care coordination, preventive services, chronic disease management and the multidisciplinary teams required to meet patients' increasingly complex and diverse needs. Payment reform that changes the structure of payment without addressing the longstanding undervaluation of primary care will not achieve the goals of improved access, better outcomes, or a stronger primary care workforce.

The AAFP believes CMS may be trying to apply global primary care packages as a proxy for attribution. However, there are fundamental differences between attribution used for prospective hybrid payment and global periods and we caution CMS against inadvertently conflating the two ideas.

To administer a prospective payment in FFS, CMS would need to use prospective attribution. The most common attribution method relies on historical claims to match patients with physicians. Additionally, payers are increasingly encouraging patients to identify their physician (i.e., voluntary attribution). Regardless of the methodology, CMS would need to prospectively attribute patients at enrollment with regular updates throughout the year to know the physicians to whom they would provide prospective payments. Attribution can be updated annually or on a rolling basis. In contrast, a global period relies on a triggering event, thus it is not prospective. Payment only occurs *after* the triggering event has occurred. The AAFP believes attribution is the more appropriate concept for CMS to use. As noted in the AAFP's position paper "[Value-based Payment Models for Primary Care, Establishing Accountability](#)," the AAFP recommends prioritizing patient selection and using historical claims data as a secondary step.

In addition to attribution, there are functional differences between the two approaches. Prospective payments, such as capitation or other population-based payments, are intended to provide a stable revenue stream to support longitudinal and proactive care provided by a

physician-led primary care team. When combined with FFS payments for services CMS wishes to incentivize or services not routinely required by all patients, the resulting hybrid payment must be sufficient for the practice to assume accountability for a patient's comprehensive care needs. The predictability of a prospective payment gives practices a reliable foundation on which they can build their care teams to meet their patients' needs along with flexibility to bill for services that fall outside the parameters established for the prospective payment. This is different from a global period in which a single payment is intended to cover a defined set of services provided during a defined period of time. The restrictive nature of a global period could stymie the innovation that is sparked by the flexibility provided by hybrid payment arrangements that the AAFP believes is more appropriate for primary care.

Supporting Beneficiaries Planning for Future Medical Decisions (section II.G.)

1. Advance Care Planning (ACP) Services (HCPCS Codes GACP1 and GACP2)

CMS currently pays for Advance Care Planning (ACP) services under CPT code 99497, which describes the first 30 minutes of ACP furnished face-to-face by a physician or other qualified health care professional with the patient, family member, or surrogate, and CPT code 99498, an add-on code for each additional 30 minutes. CMS adopted these codes for separate Medicare payment beginning in CY 2016 and also established ACP as an optional element of the Annual Wellness Visit at the beneficiary's discretion. CMS has stated that ACP may be furnished as a separate medically necessary Part B service or as part of an AWV, and that the services may be furnished using a team-based approach when applicable Medicare "incident to" requirements are met.

For CY 2027, CMS proposes to create two new HCPCS G-codes, GACP1 and GACP2, to describe ACP services furnished by clinical staff under the direct supervision and direction of a treating physician or other treating qualified health care professional. GACP1 would describe the first 20 minutes of clinical staff time, and GACP2 would describe each additional 20 minutes. Under the proposal, CPT codes 99497 and 99498 would be used to report only time personally spent by the billing practitioner, while GACP1 and GACP2 would be used to report qualifying clinical staff time. CMS states that this coding structure would more accurately distinguish and value the work of the billing practitioner from the time spent by clinical staff in furnishing ACP services.

CMS states that the proposal is intended to more accurately distinguish and value the respective contributions of practitioners and clinical staff in team-based ACP delivery. The

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agency cites stakeholder feedback indicating that ACP services may be underutilized because some practitioners believe only their own time is billable, despite longstanding Medicare policy permitting clinical staff involvement under appropriate supervision. CMS also notes that ACP utilization, while increasing since 2016, may not be commensurate with beneficiary need. CMS is seeking comment on alternative coding approaches, including whether practitioner and staff time should be combined within a single code, and how proposed coding should align with Medicare's "incident to" requirements and typical clinical workflows. CMS further proposes adding GACP1 and GACP2 to the Medicare Telehealth Services List to improve beneficiary access to ACP services.

AAFP Response

The AAFP [supports](#) the use of advance directives and other ACP tools to ensure that patients' goals, values and preferences guide healthcare decision-making when they are no longer able to communicate those preferences themselves. We [believe](#) that respect for patient preferences, continuity of care, and shared decision-making are essential components of high-quality ACP. And family physicians play a central role in ACP, as they are often the clinicians responsible for coordinating care across settings and maintaining long-term relationships with patients and their families.ⁱ In fact, in a 2025 study of family medicine and primary care clinicians, 70 percent reported that initiating advance care planning discussions is the responsibility of primary care clinicians.ⁱⁱ

Further, the AAFP has long advocated for federal policies that support meaningful advance care planning, including supporting the creation of CPT codes for ACP services in the 2016 Medicare Physician Fee Schedule. We therefore appreciate CMS' goal of appropriately recognizing the contributions of interdisciplinary care teams in furnishing ACP services. However, **we recommend that CMS first pursue clarification of existing ACP policies and coding guidance for 99497 and 99498 before establishing new HCPCS codes GACP1 and GACP2.**

Medicare policy already recognizes the team-based nature of ACP service delivery. In the CY 2016 PFS final rule, CMS [explicitly permitted](#) clinical staff participation in ACP when the billing practitioner manages, participates in, and meaningfully contributes to the service. As stated in the CY 2016 PFS final rule, CMS adopted this policy because ACP is frequently provided by physicians, nonphysician practitioners, and clinical staff working collaboratively as part of a care team. Although CPT codes 99497 and 99498 describe physician or qualified health professional time, the existing valuation of CPT code 99497 already incorporates clinical staff activities through its practice expense inputs, reflecting the reality that ACP is often a team-based service.

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That said, we agree with CMS that uncertainty regarding the treatment of clinical staff time may contribute to underutilization of ACP services. However, available evidence suggests that physician confusion is likely only one of several barriers to ACP uptake and may not be the primary factor limiting utilization. For example, a recent qualitative study examining primary care settings found that physicians face persistent time scarcity resulting from a mismatch between available clinical time and increasing practice demands, leading to challenges in delivering communication-intensive services, including ACP, and other relationship-based aspects of care.ⁱⁱⁱ Further, a recent study found that ACP interventions delivered in connection with a scheduled primary care visit resulted in substantially higher rates of documented ACP discussions and advance directive completion than interventions delivered outside the context of a clinical encounter, suggesting that ACP integration into existing clinical workflows may also be a key determinant of uptake.^{iv}

CMS itself acknowledges several additional factors that may affect ACP uptake, including clinician training and comfort initiating ACP discussions, interoperability challenges, accessibility of ACP documentation at the point of care, beneficiary cost-sharing, and limitations in existing quality measures. Given the range of potential barriers, we encourage CMS to further evaluate the relative contribution of these factors before establishing a new coding framework.

Further, we are concerned that establishing separate codes for clinical staff time may inadvertently risk increasing administrative burdens and disrupting clinical workflows for physicians. CMS itself has long recognized that ACP is often delivered collaboratively rather than through discrete, independently furnished services. To report GACP1 and GACP2, practices would need to separately track, document, and attribute practitioner and clinical staff time during what is often a single, collaborative ACP encounter. This approach may create additional documentation requirements, increase coding complexity, and introduce new compliance considerations associated with distinguishing and allocating time across members of the care team. These administrative requirements may be particularly challenging for small and independent physician practices with limited administrative resources.

Moreover, it is unclear whether these additional administrative requirements would meaningfully improve beneficiary access to ACP services. To the extent that ACP uptake is constrained by workflow limitations, competing clinical demands, clinician training, or other operational barriers, requiring more granular time accounting may add complexity without increasing the number of ACP conversations furnished to beneficiaries.

Thus, we strongly encourage CMS to further evaluate the relative contribution of coding-related, workflow, training, interoperability, and other barriers to ACP utilization before

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establishing new ACP codes. If CMS determines that physician uncertainty regarding clinical staff participation is a significant barrier to ACP uptake, we urge CMS to:

- Issue additional sub-regulatory guidance clarifying the role of clinical staff in furnishing ACP services under existing Medicare policy, including by updating relevant Medicare Learning Network materials and other physician education resources and providing examples of compliant team-based ACP workflows; and
- Engage with the CPT Editorial Panel to consider revisions to the descriptors or instructional guidance for CPT codes 99497 and 99498 to explicitly reflect the role of clinical staff in furnishing team-based ACP services.

These approaches would directly address the concern identified by CMS while preserving a familiar coding framework and avoiding unnecessary administrative complexity.

2. Request for Information (RFI) on Community-Based Palliative Care

D. The Future of the Care Management Services

CMS is reconsidering the future of the care management services that form the basis for payment adequacy for important between-visit care, and is requesting feedback on the following questions:

- How should we differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries?
- What are the essential service elements that must be included? For example(s), continuity with a designated team member, access to timely clinical support, comprehensive symptom and caregiver assessment, electronic care plans, coordination with treating physicians, patient/caregiver education, timely follow up after ED/discharge. What other service elements should be included? Should any not be included?

AAFP Response

The AAFP agrees that seriously ill beneficiaries often require more intensive care management than is addressed through traditional evaluation and management services alone. Family physicians frequently coordinate care for patients with advanced chronic illness, functional decline, and complex care needs across multiple settings and providers. Per longstanding [AAFP policy](#), we believe that future serious illness care management services should support continuity of care, symptom management, advance care planning, caregiver support, and coordination across the healthcare continuum.

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However, before establishing distinct serious illness care management service requirements, we encourage CMS to clearly identify the specific gaps in existing Medicare payment and coding policies that such a service is intended to address. Many of the functions CMS identifies as central to serious illness care may already be furnished through existing Medicare services, including E/M visits, ACP, CCM, PCM, TCM, and APCM. Accordingly, it is not yet clear which patient needs or care management activities cannot be supported within the current framework of care management services. If CMS determines that existing services do not adequately support serious illness care, any new service should be strategically designed to address the identified gap rather than creating an overlapping care management category with duplicative eligibility, documentation, care planning, quality reporting, or administrative requirements. Further, duplicative or overly prescriptive requirements may risk discouraging participation from small, independent, rural, and resource-constrained practices, limiting access to community-based serious illness care. Thus, we encourage CMS to ensure that any new or revised care management service requirements support, rather than complicate or duplicate, the longitudinal care family physicians provide to seriously ill beneficiaries.

Current Procedural Terminology (CPT) Request for Information (RFI) (section II.H.)

Following passage of HIPAA, HHS regulation defined the combination of HCPCS and CPT-4 as the nationally required medical data code sets for physician services, physical and occupational therapy services, radiologic procedures, clinical laboratory test, other medical diagnostic procedures, hearing and vision services, and transportation services. CMS notes that HHS has only specified in regulation that HCPCS and CPT-4 be used in combination. There is no specification in HIPAA statute regarding use of these code sets.

CMS provides an overview of concerns with reliance on the CPT and RUC process, including potential conflicts of interest.

CMS seeks feedback on several areas regarding the influence of the CPT® coding system and AMA process on physician payment policy as part of the Secretarial priority to Make America Healthy Again.

AAFP Response

The AAFP strongly [supports](#) the use of CPT as the standard medical code set for physician services. The AAFP is an active participant in the CPT Advisory Committee and [supports](#) the use of CPT as the standardized code set adopted by payers and CMS. Despite its

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shortcomings, the CPT process has [well-established criteria](#) for new or revised codes, including that codes must be consistent with current medical practice and the clinical efficacy of the procedure or service must be documented in literature. The CPT Editorial Panel and CPT Advisory Committee include practicing physicians representing multiple specialties to ensure that a variety of viewpoints are represented. **The AAFP strongly supports physician involvement in the CPT and RUC processes. The AAFP believes that physicians are best positioned to define, assess, and value the services and procedures that they provide.**

Although all systems can benefit from process improvement, the AAFP does not believe that CPT needs to be replaced. CPT is hardcoded throughout the health care system, from regulation to practice workflows. Accordingly, replacing CPT would unnecessarily create massive disruption to nearly every stakeholder in such a way that it could bring the entire health system to a halt. Ultimately, even patients themselves would feel the harm of such a seismic change.

Replacing CPT would require far more than adopting a new code set. CPT is the common language that connects physicians, health systems, health plans, vendors, clearing houses, electronic health records, quality reporting programs, analytics platforms, medical education, research, and countless federal and state laws and regulations. Nearly every claim submission process, coverage policy, contract payment system, utilization management program, practice workflow and health IT product in American healthcare is built around CPT. Transitioning to an entirely different coding framework would require extensive work to these connected systems, resulting in significant financial costs, operational disruption, and workforce training demands across the health care sector. During such a transition, physicians would face significantly increased administrative burden, payment delays and likely claims denials that would ultimately impede access to care and threaten the stability of the entire system. These concerns are compounded when considering that CMS can only force a coding transition on Medicare claims, with other payers free to adopt the new coding system or maintain CPT. Accordingly, most stakeholders would need to retain their knowledge of and capability to process CPT while learning the new coding system. This would mean the harms of such reform would not be limited to a transition period but would exist in perpetuity.

In primary care, the problems associated with CPT are largely symptomatic of the underlying problems associated with fee-for-service. The AAFP's long-held [position](#) is that fee-for-service is incompatible with the comprehensive, continuous, and relationship-based nature of primary care. This structural mismatch is administratively burdensome and compounded by the PFS' budget neutrality requirements that have resulted in a systematic undervaluation

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of primary care for decades and contributed to the level of primary care workforce dissatisfaction and dissipation we are currently witnessing.^{ix}

The fee-for-service system is, by definition, not intended to pay for longitudinal or comprehensive services. The PFS is designed to pay for the delivery of discrete services, and CPT is designed to describe discrete services - neither system is built to appropriately capture the cognitive work of primary care and other non-procedural-based specialties. Furthermore, each unique code has its own payment policy and documentation requirements that are often cited as significant drivers of administrative burden.

As the standardized coding system adopted for use in the PFS, CPT has merely adapted to the payment environment in which it is used. The AAFP recognizes the CPT code set is not perfect, but we do not believe replacing CPT would address the fundamental incompatibility between FFS and longitudinal primary care. The underlying payment system is flawed. Any coding system and valuation process that support it only perpetuate and exacerbate those flaws.

The number of CPT codes continues to increase each year. Interested parties propose new codes to capture each distinct service at the most granular level. The AAFP is concerned about the increasing number of new CPT codes, but we again note that it is one of many byproducts created by FFS and not the root cause of our concerns. When financial success is tied to billing a higher volume of discrete services, it only follows there will be a corresponding increase in the volume of codes created to maximize payment opportunities. Unfortunately, each new code only adds to the tension created by the budget-neutral requirements of the PFS. While this approach is beneficial for some, it is ill-suited for primary care.

Primary care is team-based and spans everything from basic preventive services to more complex services involving chronic care management, integrated behavioral health, and care coordination. Comprehensive care is not easily parsed out into individual services – meaning primary care physicians are left with a few codes that, not only inadequately represent the complexity of their work, but are becoming an increasingly smaller piece of a fee schedule that is already stretched beyond its limits.

The subsequent valuation process for each new code further compounds the issue. Despite studies showing primary care visits are more complex compared to other specialties, most of primary care encounters are captured using only nine office/outpatient evaluation and management codes. In those nine codes, primary care physicians are, “managing multiple chronic problems, working with limited evidence, balancing multiple guidelines, registries and interdependent disorders, and polypharmacy. They coordinate care with multiple physicians, increasing the risk of error.”^x

Yet, in the most recent revaluation of office/outpatient E/M services, the RUC process relied on the same vignette in all surveys, despite more than 50 specialties participating in the survey, including many that do relatively few and much more straight-forward E/M visits than primary care. This approach undervalues the input of the primary care specialties that provide the most complex E/M services and do so most commonly.

As shown below, when comparing the vignettes used for the surveys of an office visit (99214) and a procedure (45379), the differences in specificity are striking. It becomes evident that this process makes it more difficult to quantify the physician work involved in more cognitive interactions than for more specific procedural service vignettes. It also struggles to account for evolving clinical practice as new treatments and technologies become available, leading to the delivery of more complex E/M visits.

99214	45379
Office visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.	A 50-year-old patient with abdominal pain and constipation swallowed a diagnostic capsule, which became lodged at the ileo-cecal valve. Colonoscopy with removal of the foreign body is performed.

It is worth noting that the preamble to the proposed rule incorrectly asserts that when a new code is defined, it is "assigned a payment value" by the AMA/Specialty Society RVS Update Committee (RUC). The RUC does not assign, and cannot assign payment amounts or values. It recommends the relative resources involved in furnishing a service: physician work and the direct practice expense inputs of clinical staff time, supplies, and equipment. Whether and how any such recommendation is translated into a payment amount is a separate determination reserved entirely to CMS.

Even where CMS accepts a RUC recommendation on relative resources, the payment a physician ultimately receives is governed by the statutory framework that Congress enacted - the budget-neutrality adjustment required under §1848(c)(2)(B)(ii)(II), the conversion factor under §1848(d), the geographic practice cost indices under §1848(e) - and by the practice expense methodology CMS developed under the resource-based mandate of §1848(c)(2)(C)(ii) to allocate inputs into practice expense relative value units. These steps are prescribed by Congress or administered by CMS, not the RUC.

The AAFP appreciates that CMS seeks solutions to longstanding issues within the PFS throughout this year's rule. However, we caution the agency against attempting to replace CPT. While it is not without flaws, the greatest challenges arise from the underlying FFS payment system and budget neutrality requirements that govern it, not the coding framework itself. Replacing CPT would create enormous disruption while leaving these

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fundamental problems unsolved. Accordingly, rather than pursuing wholesale changes to the code set, CMS should focus on policies that better support longitudinal, comprehensive, and relationship-based care.

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

CMS proposes to pay RHCs for Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services. If finalized, these services would be paid through the RHC's all-inclusive rate (AIR) as stand-alone encounters. Under this proposal, DSMT and MNT services could be furnished by providers other than RHC practitioners, such as registered dietitians, but must be furnished under the direct supervision of an RHC practitioner. This means the supervising practitioner would be required to be present at the RHC and "immediately available" to provide direction but would not have to be present in the exam room when the service is being rendered. DSMT or MNT services provided on the same day as another qualified visit would only yield one AIR payment.

AAFP response

The AAFP supports CMS' proposal to allow RHCs to bill for DSMT and MNT services as stand-alone visits paid through the RHC AIR. These evidence-based services play a critical role in helping patients prevent and manage diabetes and other chronic conditions, improve health outcomes, and reduce the risk of costly complications. We agree with CMS that the current policy creates an unnecessary inconsistency between RHCs and FQHCs, which may limit access to DSMT and MNT services for Medicare beneficiaries receiving care in rural communities. Aligning payment policy across these settings will help ensure that patients have equitable access to clinically appropriate nutrition and diabetes management services regardless of where they receive care.

We also support CMS' proposal to permit DSMT and MNT services to be furnished by qualified practitioners, such as registered dietitians, under the direct supervision of an RHC practitioner. This approach appropriately recognizes the value of team-based care and allows RHCs to leverage the expertise of qualified health professionals while maintaining practitioner oversight. Providing separate reimbursement for DSMT and MNT encounters furnished in RHCs will strengthen the ability of rural practices to offer comprehensive, patient-centered care and improve access to services that are essential for the prevention and management of chronic disease. We urge CMS to finalize this proposal as proposed.

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Limiting Medicare Coverage of Certain Individuals (section III.E.)

CMS proposes to implement section 71201 of H.R. 1, which added section 1899C to the Social Security Act and restricts Medicare eligibility to: U.S. citizens and nationals; lawful permanent residents (LPRs); Cuban-Haitian Entrants (CHEs); and individuals lawfully residing in the United States under a Compact of Free Association (COFA). To implement these statutory changes, CMS proposes to create a Medicare-specific definition of "eligible noncitizen" limited to LPRs, CHEs, and COFA migrants. Effective July 4, 2025, Medicare Parts A and B, including the Part B Immunosuppressive Drug benefit, would be limited to U.S. citizens, U.S. nationals, and eligible noncitizens. Existing statutory requirements applicable to LPRs, including the five-year continuous residency requirement for certain enrollment pathways, would remain unchanged.

If finalized, the Social Security Administration (SSA) would conduct a one-time review of individuals enrolled in Medicare as of July 4, 2025, to identify beneficiaries who do not meet the new eligibility requirements. Affected individuals would receive notice and an opportunity to establish eligibility. For those determined ineligible, Medicare coverage would terminate effective February 1, 2027, following the statute's 18-month transition period, with existing Medicare appeal rights available. CMS also proposes an ongoing process for terminating coverage for individuals subsequently determined not to meet, or no longer meeting, section 1899C eligibility requirements. SSA would provide notice and appeal rights, and coverage generally would terminate prospectively at the end of the month following the month in which notice is issued. CMS proposes an effective date of January 1, 2027, and states that no such terminations would occur before that date.

CMS also proposes a new six-month Special Enrollment Period (SEP) for individuals who subsequently gain or regain qualifying citizenship, nationality, or immigration status. The SEP would begin when an individual provides SSA with documentation establishing eligibility.

Finally, CMS proposes conforming changes to Medicare Advantage (Part C), Part D, and Cost Plan regulations to align with section 1899C. Because eligibility for these programs depends on Part A and/or Part B eligibility, individuals who do not meet the new requirements would be ineligible to enroll or remain enrolled and would be subject to prospective disenrollment. CMS also proposes replacing existing Part C and Part D SEPs tied to "lawful presence" with new enrollment opportunities tied to attaining eligible noncitizen status.

AAFP Response

The AAFP [believes](#) that all people should have access to essential health care services, regardless of their immigration status. For decades, Medicare and Title II benefits were administered through a largely aligned lawful-presence framework. Section 1899C

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introduces a new circumstance in which certain beneficiaries may continue receiving Social Security retirement or disability benefits while simultaneously losing Medicare coverage.

While CMS acknowledges that Title II and Medicare eligibility will no longer be coextensive for certain noncitizens, we believe the proposed provision provides limited discussion of the operational and beneficiary impacts of this divergence, including beneficiary confusion, notice requirements, appeals administration, and the potential for individuals to reasonably assume that continued receipt of Social Security benefits means continued Medicare eligibility. This creates a materially more complex eligibility landscape for beneficiaries and providers. After H.R. 1, certain noncitizens may remain eligible for Social Security Title II benefits under the longstanding lawful-presence framework while becoming ineligible for Medicare under section 1899C.

The proposed rule also should be considered in the broader context of concurrent federal policy changes affecting noncitizen access to HHS-administered or HHS-funded programs. HHS has recently adopted a revised interpretation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which we offered [comments](#) in response to, that may affect eligibility determinations or verification practices for other HHS-administered programs. As a result, beneficiaries may increasingly encounter different immigration-status standards across federal health and income-support programs, creating operational and beneficiary communication challenges that CMS does not fully address in the proposed rule.

Further, CMS proposes a January 1, 2027, effective date with Medicare coverage for individuals identified through the one-time SSA review terminating effective February 1, 2027. This timeline is highly compressed given the scope and complexity of the operational transition. SSA must review Medicare enrollment records for individuals enrolled as of July 4, 2025; identify individuals who may not meet section 1899C requirements; issue notices; provide affected beneficiaries an opportunity to establish eligibility; process documentation updates; and support appeals before coverage is terminated.

Without additional safeguards, eligible individuals may fall through the cracks of incomplete or outdated SSA records, conflicting immigration-status data, limited English proficiency, disability-related barriers, lack of access to documentation, processing delays, or confusion about why continued receipt of Social Security benefits does not necessarily mean continued Medicare eligibility. These risks are heightened for individuals with complex or changing immigration statuses and for beneficiaries who rely on caregivers, authorized representatives, or community-based organizations to navigate Medicare enrollment and appeals processes.

Given the scale of the operational transition and the new divergence between Medicare and Title II eligibility standards, we strongly recommend CMS delay implementation and

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strengthen procedural safeguards before proceeding with verification-based terminations. At a minimum, we recommend CMS:

- Delay verification-based terminations until CMS and SSA have issued comprehensive operational guidance and demonstrated implementation readiness, including clear eligibility determination standards, documentation requirements, beneficiary notification processes, meaningful opportunities for beneficiaries to correct records before termination, and guidance on how the new Medicare-specific eligibility framework will interact with existing Title II eligibility and lawful-presence determinations;
- Ensure all notices satisfy the statute's comprehension requirement through multilingual, accessible, plain-language communications and referral pathways to enrollment assistance, legal services, and other community-based support organizations.
- Prohibit terminations based solely on data matching or incomplete administrative records; and
- Maintain Medicare coverage for affected beneficiaries while eligibility is under review.

Further, we support CMS' proposal to establish an SEP for individuals who gain or regain qualifying citizenship, nationality, or immigration status and encourage the agency to extend the SEP beyond the proposed six months. The SEP is a critical beneficiary protection because section 1899C creates a new category of individuals who may otherwise satisfy Medicare eligibility requirements but be unable to enroll, or may lose coverage, solely because they do not meet Medicare's immigration-status criteria at a particular point in time. Unlike traditional Medicare enrollment events, changes in immigration status do not occur on predictable timelines and often do not align with existing enrollment periods. A longer SEP, particularly during the initial implementation period, would better account for the time required to obtain immigration documentation, correct SSA records, resolve data discrepancies, and navigate a new and more complex eligibility framework. Whether extended or finalized as proposed, the SEP will be essential to ensuring that individuals who subsequently become eligible have a meaningful and administrable pathway to Medicare coverage without avoidable gaps in care.

Medicare Shared Savings Program (section III.G.)

3. Quality Performance Standard and Other Quality Reporting Requirements

b. Proposal to Extend MIPS CQMs Collection Type

To address concerns expressed by the Accountable Care Organization (ACO) community regarding the transition to digital quality measure (dQM) reporting, CMS proposes to extend the availability of the Merit-based Incentive Payment System (MIPS) clinical quality measure (CQM) collection type for ACOs reporting the APM Performance Pathway (APP) Plus quality measure set for PY 2027 and subsequent PYs. CMS also proposes to extend associated MIPS CQM reporting incentive. Subject to future notice and comment rulemaking, CMS anticipates sunsetting the MIPS CQM collection type beginning in PY 2030, when Fast Healthcare Interoperability Resources (FHIR) based reporting becomes mandatory for all the electronic clinical quality measures (eCQMs) and proposed Medicare eCQMs included in the APP Plus quality measure set.

AAFP Response

The AAFP supports CMS' proposal to allow Medicare CQMs to satisfy quality reporting requirements within the APP Plus measure set. Providing ACOs with multiple quality reporting options recognizes the diverse technical capabilities of participating organizations and supports a measured transition toward digital quality measurement. Family physicians continue to experience challenges related to interoperability, data exchange, and health IT readiness, and preserving Medicare CQMs as a reporting option will help mitigate unnecessary administrative burden during this transition. The AAFP encourages CMS to maintain reporting flexibility, clearly communicate future transition expectations, and ensure that any eventual movement toward Medicare eCQMs or FHIR-based reporting occurs only after adequate testing, demonstrated feasibility, and broad readiness across practice settings. The AAFP appreciates CMS' recognition that Shared Savings Program ACOs face unique operational and technical challenges during the transition to FHIR-based quality measurement. Many ACOs must aggregate data across multiple tax identification numbers, health systems, and EHR platforms, creating complexities that often exceed those faced by individual reporting entities. CMS appropriately acknowledges that these organizations may require additional implementation support and lead time as FHIR-based reporting capabilities mature.

The AAFP supports CMS' phased transition approach for the Shared Savings Program and encourages the agency to maintain reporting flexibility while FHIR-based capabilities continue to evolve. CMS should provide robust technical assistance, testing opportunities, and implementation resources for ACOs, participating practices, and measure stewards

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responsible for developing FHIR-based measure specifications. In addition, particular attention should be given to physician-led, rural, and smaller ACOs that may have fewer resources available to support technology modernization initiatives. As CMS moves forward, the transition should remain focused on reducing reporting burden, improving interoperability, and ensuring that differences in performance reflect quality of care rather than variability in technology capabilities or data aggregation infrastructure.

c. Proposal to Extend the Scoring of ACOs Reporting Medicare CQMs Using Flat Benchmarks

CMS proposes to extend the use of flat benchmarks to score all Medicare CQMs for PY 2027 and subsequent PYs. They also propose to use flat benchmarks for Quality IDs 001, 134, and 236 for PY 2026.

AAFP Response

The AAFP supports CMS' proposal to continue utilizing flat benchmarks for Medicare CQMs and appreciates the agency's efforts to provide greater stability and predictability during the ongoing transition to digital quality measurement. Family physicians and MSSP ACOs continue to navigate significant operational changes related to evolving quality reporting requirements, and a consistent benchmarking methodology may help reduce uncertainty. The AAFP particularly appreciates CMS' efforts to minimize unintended scoring volatility for measures highly relevant to primary care, including depression screening, blood pressure control, and diabetes management. However, CMS should provide additional justification regarding its decision to move away from the previously finalized transition to historical benchmarking and should clearly communicate its long-term benchmarking strategy for Medicare CQMs, Medicare eCQMs, and future FHIR-based reporting approaches. The AAFP also encourages CMS to ensure that flat benchmarks continue to support meaningful performance differentiation and ongoing quality improvement.

d. Proposal to Address SSP ACOs' Challenges with Meeting the MIPS Data Completeness Requirement

Quality data reporting from PYs 2023 and 2024 indicate that there is slow uptake of eCQM reporting. CMS also continues to hear about ACOs' challenges with reporting on all payer/all patient measures and meeting data management requirements.

In light of these challenges, CMS proposes to revise the quality reporting requirements at §425.508(c), to include that for PYs beginning on or after January 1, 2026, SSP ACOs may exclude one or more participant TINs from an ACO's submission of eCQM/MIPS CQM/Medicare CQM/Medicare eCQM (if finalized) data for each measure.

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Applicable exclusions include: unforeseen circumstance(s) that are outside of the control of the SSP ACO and the ACO is unable to access quality data for the participant TIN, the participant taxpayer identification number (TIN) has certified electronic health record technology (CEHRT) that is intended for specialty use and does not support the measure(s) included in the APP Plus quality measure set, and other circumstances as determined by CMS. ACOs may not exclude a participant TIN based on their beneficiaries' demographics or health status.

CMS proposes that, after the exclusion of participant TINs, the ACO's submission of data for each measure must include participant TINs that represent at least 95 percent of the beneficiaries assigned to the ACO prior to the application of the measure specifications.

CMS would provide ACOs with a new aggregate report that contains the data necessary to determine how many beneficiaries would be represented by the TINs for which the ACO plans to report.

CMS proposes to use its authority to apply the proposed policy to PY 2026, as it would be in the public interest and afford ACOs that earn shared savings the opportunity to devote greater resources to providing better quality care to beneficiaries.

If finalized, ACOs will have the option to report the five Medicare eCQMs or a combination of eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs to meet the quality requirements of the SSP. Medicare eCQMs would not be eligible for the Complex Organization Adjustment.

AAFP Response

The AAFP appreciates CMS' efforts to respond to stakeholder feedback regarding the ongoing challenges that ACOs face in aggregating and reporting all payer data across their ACO participant TINs. The AAFP generally supports CMS' proposal to allow ACOs to exclude participant TINs from its quality data submission for unforeseen circumstances and those outside of the ACO's control. We encourage CMS to expand their applicable exclusions to include ACO participant TINs using CEHRT that does not support the use of the measures included in the APP Plus quality measure set, regardless of if the CEHRT is intended for specialty use. It is our understanding that there are still instances of CEHRT used by primary care physicians that are unable to support all the measures in the APP Plus quality measure set. We believe expanding this exclusion to all types of CEHRT is important as it will provide flexibility for ACOs and ACO participants who have been asked to change and adapt to new or shifting quality reporting requirements on an annual basis.

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f. Proposal to Update the APP Plus Quality Measure Set

Beginning with PY 2027, CMS proposes that the APP Plus quality measure set would include eight measures (five eCQMs/MIPS CQMs/Medicare CQMs/Medicare eCQMs, two administrative claims-based measures, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey measure). CMS proposes to remove the Initiation and Engagement of SUD Treatment (Quality ID: 305) and Adult Immunization Status (Quality ID: 493) from the APP Plus quality measure set.

AAFP Response

The AAFP appreciates CMS' continued efforts to improve the APM Performance Pathway (APP) and support participation in alternative payment models through a predictable and streamlined reporting framework. As noted in our [Guiding Principles for Value-Based Payment](#), the AAFP supports value-based payment arrangements that adequately resource and advance comprehensive, longitudinal primary care while minimizing unnecessary administrative burden.

Support Efforts Toward APP Plus Measure Set Stability, but Oppose MCC Measure

The AAFP supports CMS' proposal to remove the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Quality ID 305) and Adult Immunization Status (Quality ID 493) measures from the planned expansion of the APP Plus quality measure set.

Family physicians continue to experience substantial operational challenges associated with quality reporting, including interoperability limitations, incomplete data exchange, and the growing complexity of managing multiple quality reporting collection types. We appreciate CMS' recognition that ACOs and participating practices require a stable measure environment as they prepare for long-term adoption of digital quality measurement.

The AAFP agrees that adding measures before the necessary eCQM, Medicare CQM, and Medicare eCQM collection infrastructures are fully operational could create avoidable reporting burden without improving quality measurement accuracy or utility.

While we appreciate CMS' efforts to maintain stability in the measure set, we oppose the use of the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measure (measure 484). We have concerns about several aspects of the measure, including:

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- Primary care remains chronically underfunded, limiting practices' ability to provide proactive care coordination and care management services that can help prevent avoidable hospitalizations. Although CMS has created billing codes for care management and community health integration services, beneficiary cost-sharing requirements discourage utilization. As a result, practices frequently provide these services without payment or do not have sufficient resources to offer them at all.
- Admission-based measures are not appropriate for MSSP, as they may create incentives to avoid necessary hospital admissions rather than support clinically appropriate care.
- The measure does not adequately account for broader access and system-level challenges that affect hospitalization rates. In addition, persistent primary care workforce shortages often result in lengthy wait times for appointments, limiting timely access to preventive and chronic disease management services.
- Attribution methodologies remain inconsistent across administrative claims-based quality and cost measures, including MCC, Hospital-Wide Readmissions (HWR), and Total Per Capita Cost (TPCC). Differences in attribution approaches, such as physician accountability and patient assignment methodologies, result in different patient populations being attributed to physicians across measures.
- The attribution methodology can also assign beneficiaries to specialists rather than primary care physicians. Specialists are unlikely to provide many of the preventive and comprehensive care services that influence long-term population health outcomes, further weakening the relationship between measure performance and the actual care delivered by the measured entity.
- The measure may hold primary care physicians accountable for outcomes driven by factors beyond their control. Hospitalization rates are influenced by factors such as medication affordability, formulary restrictions, transportation barriers, food insecurity, access to community support services, and other social determinants of health. As a result, performance on this measure may reflect barriers to care rather than the quality of care delivered by physicians.
- The measure's risk adjustment methodology raises significant concerns. Unlike other ambulatory quality and cost measures that rely on HCC-based approaches, this measure uses a different risk adjustment framework. Lack of alignment across measures undermines quality improvement efforts and may fail to appropriately

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account for patient complexity. We are particularly concerned that important factors affecting hospitalization risk, such as active cancer, transplant status, and substance use disorders, may not be adequately captured.

Collectively, these issues create substantial concerns regarding the measure's validity, fairness, and usefulness as an accountability metric. The AAFP urges CMS to remove this measure and pursue more meaningful approaches that accurately reflect the quality of care delivered by physicians and ACOs while accounting for factors outside their control.

Support a Deliberate Transition to Digital Quality Measurement

The AAFP continues to support CMS' long-term vision for digital quality measurement and greater measure alignment across programs. However, successful implementation depends on the readiness of health IT infrastructure, consistent data standards, and reliable interoperability across care settings.

Family physicians continue to report significant challenges obtaining complete and actionable data from hospitals, specialists, laboratories, health plans, and public health agencies. As CMS advances Medicare CQMs and Medicare eCQMs within the APP, we urge the agency to ensure that reporting requirements are aligned with the current capabilities of physician practices and ACOs. In many cases, performance on these measures reflects the completeness of data exchange rather than the quality of care delivered by physicians. For example, under the Diabetes: Eye Exam measure (CMS eCQM ID: CMS131v14; Quality ID 117), patients frequently report receiving a diabetic retinal exam from an outside eye care provider, but documentation of that service is often unavailable through the EHR or health information exchange. Practices must manually request records, frequently by fax, and invest significant staff time tracking responses. When records are not received, physicians may be scored as failing to meet the measure despite delivering appropriate care and follow-up. CMS should recognize that gaps in interoperability and data sharing continue to limit the accuracy and fairness of quality measurement and should avoid holding physicians accountable for factors outside their control.

The AAFP recommends that CMS establish clear readiness and quality criteria before requiring widespread adoption of new digital reporting approaches, including demonstrated feasibility, testing across diverse practice settings, and evidence that necessary data are available without imposing significant manual abstraction or reconciliation burden on physicians and their staff.

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Measure Alignment

Before incorporating additional Universal Foundation measures into the APP Plus measure set, CMS should demonstrate:

- Availability of reliable collection pathways.
- Minimal additional reporting burden.
- Broad interoperability across health IT systems.
- Meaningful actionability for participating physicians.
- Testing across small, independent, rural, and resource-constrained practices.

As noted above, the AAFP opposes the inclusion of MCC outcomes measure (measure 484). We also oppose the continued use of the CAHPS for MIPS measure. We remain concerned that CAHPS survey results may not reliably reflect patient experience for clinicians or entities with small patient populations. In these settings, low survey response rates can introduce substantial variability and may disproportionately affect performance scores, resulting in outcomes that are more reflective of limited sample size than actual quality of care or patient experience. CMS should carefully consider the reliability and validity of these measures for small populations before using them for accountability or payment purposes.

Additional Recommendations

The AAFP appreciates CMS' efforts to maintain stability in the APP Plus quality measure set, and we support the proposed removal of the planned additions of Quality IDs 305 and 493. We encourage CMS to continue advancing digital quality measurement in a deliberate manner that prioritizes interoperability, measure alignment, and reporting feasibility for physicians and ACOs.

That said, we oppose the continued use of the MCC measure (Quality ID 484) due to concerns regarding its validity, attribution methodology, risk adjustment approach, and reliance on factors outside physicians' control. We also urge CMS to carefully evaluate the reliability of the CAHPS for MIPS measure in small populations and avoid using measures that may not accurately reflect the quality of care delivered.

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4. Shared Savings Program Certified Electronic Health Record Technology (CEHRT) Use Requirements

b. Proposal to Simplify Shared Savings Program CEHRT Use Requirements

Beginning with PY 2027, CMS proposes to sunset the requirement that SSP ACOs report the MIPS Promoting Interoperability performance category. Instead, ACOs would be required to perform one of three activities: 1) Use certified electronic health record technology (CEHRT) to completely report at least one ACO quality measure; 2) attest that the ACO uses FHIR-based technology to support reporting of at least one ACO quality measure; or 3) attest to meeting one of the following three ACO CEHRT use metrics of electronic prescribing, health information exchange (HIE) bi-directional exchange, or provider-to-patient exchange.

AAFP response

The AAFP supports CMS' proposal to revise the Shared Savings Program's CEHRT use requirements, and we appreciate the agency's continued efforts to reduce unnecessary administrative burden while preserving incentives for interoperability and health information exchange. We agree that the current approach of requiring SSP ACOs to report a quality measure under the MIPS Promoting Interoperability (PI) performance category and satisfy associated scoring requirements creates operational challenges that are not always aligned with the goals of accountable care. As CMS notes, the existing policy can require ACOs to devote substantial time and resources to compliance activities that may not directly advance care coordination, population health management, or patient outcomes.

We support CMS' proposal to replace the current PI reporting requirement with a more flexible framework that would allow ACOs to demonstrate CEHRT use through one of three pathways. The proposed approach recognizes that ACOs differ significantly in their organizational structures, health IT capabilities, and readiness to adopt emerging interoperability standards. Providing multiple options for compliance will enable organizations to select the pathway that best reflects their current capabilities while continuing to promote the broader goal of electronic information sharing. This flexibility is particularly important for physician-led ACOs and organizations that include small, independent, rural, or otherwise resource-constrained practices that may face unique challenges in meeting prescriptive reporting requirements. Reducing unnecessary CEHRT reporting burden may also help preserve participation by physician-led ACOs and small or independent practices, which often face disproportionate administrative and technical challenges despite serving critical roles in their communities.

The AAFP has long supported policies that promote interoperable health information exchange while minimizing documentation and reporting obligations that divert physician

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time away from patient care. Family physicians routinely use health IT to coordinate care across settings, manage chronic conditions, reconcile medications, and facilitate transitions of care. However, overly complex reporting structures can impose significant burdens on practices without producing commensurate improvements in interoperability or patients' health. We therefore appreciate CMS' efforts to focus on meaningful use of health IT rather than maintenance of a reporting framework that has become increasingly disconnected from the practical realities of care delivery. While we support CMS' continued movement toward FHIR-enabled interoperability and digital quality measurement, implementation timelines should continue to recognize variation in readiness across vendors, ACOs, and participating practices.

We also support CMS' efforts to better align SSP requirements with broader federal interoperability initiatives and ongoing transitions toward digital quality measurement. The health care system is in the midst of a significant shift toward more automated, standards-based exchange of health information. As CMS continues to advance the use of FHIR-based technologies and digital quality measurement infrastructure, it is appropriate to modernize legacy reporting requirements that may no longer represent the most effective method of assessing health IT adoption and interoperability performance.

Importantly, the proposal would allow ACOs to continue participating successfully in the Shared Savings Program while transitioning toward newer approaches to quality measurement and information exchange. We believe this measured approach will help avoid unnecessary disruptions for organizations that are already making substantial investments in health IT while still encouraging continued progress toward more advanced interoperability capabilities. By providing multiple compliance options, CMS can support innovation and modernization without creating unintended barriers to participation in value-based care models.

The AAFP further agrees that reducing duplicative reporting requirements may help strengthen participation in accountable care arrangements and other advanced APMs. Family physicians continue to face numerous administrative obligations across Medicare's quality, payment, and reporting programs. Policies that streamline overlapping requirements and reduce redundant data submission allow physicians and ACOs to devote greater attention to patient care, quality improvement, and population health management activities. We believe the proposed CEHRT framework represents a reasonable and practical approach that maintains CMS' commitment to interoperability while providing meaningful burden reduction for SSP participants.

For these reasons, we support CMS' proposal to align CEHRT requirements for SSP ACOs with evolving interoperability and digital quality measurement initiatives. We believe the

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proposed changes will preserve incentives for information sharing, provide appropriate flexibility for participating organizations, reduce unnecessary administrative burden, and better support family physicians participating in accountable care models.

4. Certified Electronic Health Record Technology Use Requirements

c. Request for Information on Applying Electronic Prior Authorization Measures to Shared Savings Program ACOs

CMS requests feedback on whether and how electronic prior authorization (ePA) requirements should be incorporated into SSP ACO participation requirements beginning in CY 2028. Specifically, CMS seeks comment on whether SSP ACOs should be required, or permitted as an option, to use specific FHIR-enabled CEHRT modules to electronically complete at least one prior authorization (PA) request and determination for a medical item or service. CMS also seeks input on creating a new ACO-specific ePA measure for prescription drugs that would require use of FHIR-enabled CEHRT modules to electronically complete at least one prescription drug PA request and determination during the performance period. Finally, CMS requests stakeholder feedback on broader considerations that should inform the development and implementation of ePA measures for SSP ACOs, including issues related to interoperability, technology readiness, implementation feasibility, and potential impacts on ACO participation and operations.

AAFP Response

The AAFP supports the continued advancement of ePA through standards-based, interoperable workflows and appreciates CMS' interest in exploring how ePA may be incorporated into SSP ACO participation requirements. Family physicians and physician-led ACOs continue to experience significant administrative burden associated with PA, and we believe broader adoption of FHIR-based ePA technologies has the potential to improve transparency, streamline workflows, and reduce reliance on manual processes. However, any SSP ePA requirements should be implemented only after there is clear evidence of payer readiness, demonstrated vendor implementation, and successful real-world adoption across diverse practice environments. Physicians and ACOs should not be held accountable for technologies, APIs, or workflows that remain outside of their control.

If CMS elects to incorporate ePA into SSP CEHRT use requirements, we recommend that ePA remain an optional pathway rather than a mandatory requirement and that ACOs be permitted to satisfy CEHRT requirements through multiple interoperability-focused activities, as proposed elsewhere in this rule. We do not currently support creation of a new ACO-specific ePA measure, including a prescription drug ePA measure, until the necessary FHIR-enabled infrastructure is broadly available and implemented consistently across payers,

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vendors, and care settings. CMS should also account for the substantial variation in readiness among ACOs and participating practices, particularly those that are small, independent, rural, or safety-net organizations. Any future SSP ePA policies should include robust exclusions and hardship accommodations, prioritize alignment with broader CMS and ONC interoperability initiatives, and focus on reducing administrative burden rather than creating additional reporting obligations. As with other interoperability requirements, CMS should ensure that implementation is paced to real-world readiness and supports the meaningful use of technology rather than technology adoption for its own sake.

5. Financial Methodology

c. Proposed Changes to the SSP Financial Methodology to Encourage Additional Savings in Two-sided Risk

CMS believes that the disparity in the sharing rates between BASIC track Level E and the ENHANCED track has inadvertently and prematurely driven ACOs to take on the maximum risk allowed. CMS is concerned that the combination of ACOs transitioning too quickly and the decreased net savings associated with the ENHANCED track are resulting in decreased savings for the Medicare Trust Fund.

CMS wishes to encourage less experienced ACOs to progress to the ENHANCED track when they are adequately prepared and to increase net savings opportunities for the Trust Fund. To that end, for agreement periods beginning on or after January 1, 2027, CMS proposes to increase the shared savings rate of BASIC track Level E to 60 percent. The current maximum shared savings rate of 50 percent will continue to apply to ACOs completing existing agreement periods in the BASIC track.

AAFP Response

The AAFP supports this proposal. We appreciate CMS' commitment and support of ACOs by providing opportunities to earn higher savings for ACOs that may not be ready to assume the higher level of downside risk in the ENHANCED track. We support policies that recognize the importance of allowing ACOs to develop and mature before assuming greater levels of financial risk. Increasing the sharing rate for BASIC track Level E will better support ACOs by allowing them more time to develop the infrastructure, technology, and staff required to support coordinated, team-based care. It's also been demonstrated that ACOs generate more savings over time – with savings increasing by the third year of participation. We agree with CMS that some ACOs may transition to the ENHANCED track before they are ready to assume the greater downside risk. This artificially accelerates the speed with which ACOs must develop and hone the skills and capabilities required to succeed in value-based payment arrangements. The result of this has caused more ACOs to drop out of the program

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after the first three years, undermining the goals of value-based payment. We believe this proposal will better support the long-term success of ACOs and the transition to value-based payment.

(2) Proposal to Reduce the Maximum Weight on the Regional Adjustment for ACOs Under the ENHANCED Track

CMS is concerned that higher gross savings performance by ACOs in the ENHANCED track may be related to a higher regional adjustment than reflective of genuine savings. For agreement periods beginning on January 1, 2027, CMS proposes reducing the maximum weight used in the positive regional adjustment for lower-spending ACOs in the ENHANCED track from 50 percent to 35 percent. They would replace the existing phase-in schedule and use 35 percent for all agreement periods. The percentages for ACOs with higher spending and for ACOs in the BASIC tracks would not change.

AAFP Response

The AAFP opposes this proposal. We are concerned that CMS' proposal to reduce the maximum weight on the regional adjustment factor for ACOs in the ENHANCED track will negatively impact long-term ACOs. ACOs that have been long-term MSSP participants have spent years investing and building their care coordination and population health management infrastructure to support the high-quality, low-cost care they provide to their beneficiaries. It is these investments that have allowed them to become more efficient and generate greater savings. The AAFP notes that CMS states their assessment is descriptive and only "raises the possibility" that the scale of higher regional adjustments may drive performance rather than genuine savings. The AAFP encourages CMS to do more rigorous analysis demonstrating statistical significance of this effect. Prematurely implementing this policy risks increasing the benchmark ratchet effect and returns to a policy that punishes ACOs for being more efficient.

d. Proposal to Increase the Prior Savings Adjustment by Increasing the Scaling Factor

CMS proposes changing the prior savings adjustment scaling factor from 50 percent to 75 percent. CMS believes the current methodology may not provide sufficiently strong or consistent incentives for ACOs to generate and sustain savings.

AAFP Response

The AAFP supports this proposal and agrees with CMS that it is a step toward more fully recognizing the strong historical performance of ACOs and providing incentives for ACOs to generate and sustain savings. However, this policy is unlikely to have a meaningful impact because of the current 5 percent cap on the adjustments to historical benchmarks,

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particularly when combined with CMS' proposal to reduce the regional efficiency adjustment for ACOs in the ENHANCED track. We strongly encourage CMS to increase the combined cap on the upward benchmark adjustments to at least 7 percent and explore additional ways to preserve and strengthen protections against the benchmark ratchet for long-standing ACO participants.

e. Proposal to Risk Adjust the 5 Percent Cap on Upward Adjustments to the Historical Benchmark

CMS has received feedback from ACOs serving medically complex populations that the five percent cap applied to the three upward adjustments to the historical benchmark (regional, prior savings and population) is too restrictive. For agreement periods beginning on January 1, 2027, and subsequent years, CMS proposes to risk adjust the five percent cap on each of the upward adjustments to the historical benchmark. CMS would risk-adjust the national per capita expenditures used in calculating each adjustment cap.

AAFP Response

The AAFP supports this proposal. The current flat cap approach suppresses the historical benchmark for ACOs serving disabled and dual-eligible Medicare beneficiaries. As a result, these ACOs are placed at a disadvantage for providing care to patients with complex needs.

The AAFP encourages CMS to ensure adequate protections to prevent the policy from negatively impacting ACOs. We recommend that CMS not risk adjust the cap below 1.0.

While this is a positive step, we continue to believe the 5 percent cap on upward benchmark adjustments limits an ACO's ability to realize the full value of the efficiencies generated through long-term participation in the MSSP. ACOs continue to invest in staff and infrastructure to meet the needs of their patient population. These include investments in health information technology, data management, population health initiatives, and many other non-billable services – all vital pieces of the infrastructure needed to provide efficient high-quality care. As a result, there is a growing disconnect between an ACO's true operating cost and its historical benchmark. In essence, the more mature and efficient an ACO becomes, the less the benchmark reflects the resources needed to sustain those improvements.

Given CMS' goal to have 100 percent of beneficiaries in an accountable care relationship by 2030, ACOs will need to expand their infrastructure to meet the needs of their growing population. It is vital that the program continues to support ACOs as key partners in helping CMS realize its goal. We strongly encourage CMS to increase the combined cap on the upward benchmark adjustments to at least 7 percent and explore additional ways to preserve

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and strengthen protections against the benchmark ratchet for long-standing ACO participants.

f. Proposal to Incentivize New Participation through a Growth Adjustment to the Historical Benchmark

CMS wishes to continue promoting growth in the SSP, including the number of participants and the number of beneficiaries in the program. For agreement periods beginning January 1, 2027, and subsequent years, CMS is proposing a growth adjustment to the historical benchmark. The upward adjustment would be applied in addition to the existing regional adjustment, prior savings adjustment and population adjustment, up to the proposed cap of 5 percent of ACO risk-adjusted national per capita expenditures (if finalized). New growth would be measured as the number of assigned beneficiary person years inexperienced with a shared savings initiative who are assigned to an ACO professional who is inexperienced with a shared savings initiative (either through plurality of primary care services or voluntary alignment).

CMS proposes establishing an incentive factor to determine a dollar amount for the adjustment. It would be calculated as 5 percent of the ACO's per capita historical benchmark. CMS would multiply the new growth share by the incentive factor to determine the dollar amount added to the ACO's historical benchmark. The amount would be added to the highest of the positive regional adjustment, prior savings adjustment, and population adjustment, or no adjustment. The total amount could not exceed 5 percent of national per capita Medicare expenditures.

CMS proposes applying the growth adjustment proposal for agreement periods beginning on January 1, 2027, and subsequent years.

AAFP Response

The AAFP generally supports this proposal. However, we encourage CMS to remove the requirement that beneficiaries must also be assigned to a new ACO professional. We support CMS' goal to increase the number of beneficiaries in an accountable care relationship but believe the impact of this policy will be diminished by the proposed restrictions. ACOs would have a greater incentive to grow their beneficiary population if they are rewarded for the growth regardless of whether the beneficiary is assigned through a new or existing ACO professional.

g. Proposal to Reform the Accountable Care Prospective Trend (APCT) Component of the Benchmark Update Factor

In 2023, CMS added the Accountable Care Prospective Trend to the benchmark update factor. Under current policy, the ACPT is set at the outset of an agreement period and does not change throughout an ACO's agreement period. If there is a substantial discrepancy between the ACPT and the actual growth rates, an ACO's shared savings may be negatively impacted.

For agreement periods beginning on or after January 1, 2027, CMS proposes establishing a performance year-specific modified United States Per Capita Cost (USPCC) annualized growth rates used to construct the ACPT values, which would apply to the performance year regardless of an ACO's agreement period start date. The proposal does not change the methodology CMS uses to calculate the modified USPCC annualized growth rates for any given performance year. It would only change the timing of the calculation. CMS would calculate and publicly report the modified USPCC annualized growth rates in the summer of the year preceding a given performance year.

CMS also proposes establishing a guardrail on instances in which the modified USPCC cumulative growth rates used to construct the ACPT values differ substantially from observed cumulative growth in national assignable expenditures. The proposed guardrail would not allow the modified USPCC cumulative growth rate for each of the ESRD population and the Aged/Disabled population to be more than 1.0 percentage point below or 1.5 percentage points above the corresponding observed cumulative growth in national assignable expenditures for that population. It would be applied at reconciliation for a given performance year. CMS refers to the difference between the modified and observed cumulative growth rates as the "delta modified USPCC."

For agreement periods beginning on or after January 1, 2024, and before January 1, 2027, CMS proposes to establish a guardrail on instances in which the modified USPCC cumulative growth rates used to construct the ACPT values are substantially lower than observed cumulative growth in national assignable expenditures.

Retroactively applying the guardrail would delay PY2025 financial reconciliation and delay providing financial results and shared savings payments to ACOs. CMS plans to issue PY2025 financial results and distribute shared savings payments in November 2026 and December 2026, in accordance with the finalized policy. All ACOs covered by this proposal would either benefit or be unaffected by it.

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AAFP Response

The AAFP appreciates CMS' efforts to address concerns with financial benchmarking methodology. The downward ratchet effect of benchmarks based on historical spending combined with the long-term impacts of rebasing and the goal of having all Medicare fee-for-service beneficiaries in an accountable care arrangement by 2030 make current benchmarking strategies untenable. We supported the ACPT as a mechanism to recognize the broader impact of ACOs on Medicare. By establishing the ACPT growth factors at the beginning of an ACO's entire 5-year agreement period and leaving them unchanged, CMS provided a level of certainty to ACOs. However, the substantial discrepancies between the actual cumulative growth and the ACPT in CY2024 have had a negative impact across the program. We appreciate that CMS recognized the issues and responded to stakeholder feedback by reducing the ACPT's weight in CY 2024.

The AAFP supports CMS' proposal to establish a performance-year specific modified USPCC annualized growth rates to construct the ACPT. We thank CMS for their responsiveness to stakeholder feedback. The AAFP also appreciates that CMS proposes a guardrail on instances where the modified USPCC cumulative growth rates used to construct the ACPT values differ substantially from observed cumulative growth in national assignable expenditures. We support CMS' application of an asymmetrical guardrail as it would allow ACOs to share in more savings than losses. The AAFP believes these updates are an important step toward improving the accuracy of the ACPT.

Request for Information (RFI) on Duplicate Laboratory Testing, Imaging, and Result Sharing and Interoperability (section III.I.)

CMS is seeking stakeholder input on concerns related to duplicate laboratory and imaging testing, which the agency attributes in part to the inability of physicians and other health care providers to reliably access test results generated outside their own health IT systems. CMS notes that laboratory and imaging data are often siloed within electronic health records (EHRs), which contributes to incomplete care coordination, delayed treatment decisions, unnecessary repeat testing, and increased health care costs. To address these concerns, CMS is exploring multiple payment and program integrity approaches, including potentially clarifying billing instructions, implementing Medicare Administrative Contractor (MAC) edits, applying payment recoupment mechanisms, and establishing frequency limitations for certain laboratory and imaging services where clinically appropriate. CMS also seeks feedback on how duplicate testing should be defined, whether payment consequences

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should apply when tests are repeated within a specified timeframe, and what exceptions may be necessary to ensure access to clinically appropriate care.

Additionally, CMS requests feedback on opportunities to improve interoperability and result sharing for diagnostic laboratory testing and imaging services. The agency highlights longstanding challenges with the exchange of diagnostic information, including fragmented systems; inconsistent adoption of standards; technical barriers; and difficulties related to authentication, authorization, and patient matching. CMS notes that duplicate testing may be a symptom of broader interoperability shortcomings and expresses interest in increasing participation in national interoperability networks to facilitate standardized exchange of laboratory and imaging results. The agency seeks input on potential incentives, certification approaches, implementation guidance, and data standards that could support more effective information sharing. CMS also requests comment on whether payment, quality, or participation policies should create accountability when the failure to make diagnostic results available contributes to avoidable repeat testing and whether additional requirements, such as standardized FHIR-based data exchange capabilities, should be considered as a condition of Medicare participation or payment.

AAFP response

The AAFP shares CMS' goals of reducing unnecessary duplicative laboratory and imaging testing and advancing the interoperable exchange of diagnostic results. We agree that duplicate testing can increase costs, contribute to care fragmentation, delay treatment decisions, and, in some cases, expose patients to unnecessary risk. We also agree with CMS' conclusion that the primary driver of duplicative testing is often the inability of physicians and other health care providers to reliably access laboratory and imaging results generated outside their own health IT systems. **The root cause of the problem is not physician ordering behavior; it is the continued existence of siloed data, inconsistent interoperability, information blocking, and barriers that prevent clinically relevant information from following patients across care settings .**

As a result, payment policies aimed at reducing duplicate testing would largely address a symptom of the problem rather than its root cause. If physicians do not know a prior result exists or cannot access it despite reasonable efforts, payment penalties, MAC edits, recoupments, or rigid frequency limitations will not resolve the underlying interoperability failures that caused the duplicate test to occur. **As such, we oppose automatic MAC edits resulting in non-payment, payment-integrity recoupment actions, or other payment penalties directed at ordering physicians when duplicate testing may result from unavailable, inaccessible, or non-interoperable data .** Before considering such policies, CMS should first determine whether the ordering physician had reasonable access to the prior

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result and whether the information was available in a form that could be readily incorporated into clinical decision-making. Absent such a determination, payment policies risk penalizing physicians for interoperability failures entirely outside of their control.

The AAFP is concerned that payment penalties tied to duplicate testing could create unintended consequences for patient care. Physicians who fear non-payment or future recoupment may become hesitant to order clinically appropriate repeat testing, particularly in cases where prior results are incomplete, inconsistent, unavailable, or of uncertain reliability. Such policies could ultimately place patients at risk while doing little to address the underlying information-sharing failures that caused the duplication to occur. **Additionally, we caution against the broad application of frequency limitations. Though evidence-based frequency limits may be appropriate in limited circumstances, clinical medicine frequently requires repeat testing at intervals that cannot be reduced to a universal payment rule.** Disease progression, response to treatment, changes in patient condition, specimen quality concerns, transitions between care settings, and the inability to access prior results may all justify repeat testing. Accordingly, any future frequency limitation policies should be developed through a transparent process involving physicians who routinely order and interpret such tests, and they should be limited to a narrow set of services for which strong clinical evidence supports a defined interval. The burden of demonstrating medical necessity should not be shifted onto physicians through complex administrative requirements simply because an automated system identifies a test as potentially duplicative.

The AAFP [strongly supports](#) standards-based interoperability and the seamless exchange of laboratory and imaging data. Family physicians should have timely access to clinically relevant diagnostic information regardless of where the test was performed, the technology used to generate the data, or the format in which the information was originally stored. We [continue to believe](#) that health information exchange should operate primarily through a “push” model rather than a “pull” model. Critical information, including laboratory and imaging results, should be proactively and automatically delivered to a patient’s primary care physician and care team rather than requiring physicians to search across multiple portals, health systems, and vendor-specific platforms to locate information that may or may not be available. Expecting physicians to discover and retrieve information from disparate sources is inefficient, contributes to administrative burden, and undermines coordinated care. Effective interoperability should ensure that clinically relevant diagnostic information follows the patient and arrives where it is needed, when it is needed, without requiring additional effort from physicians or their staff.

We therefore urge CMS to focus its efforts on eliminating the barriers that prevent data sharing rather than imposing payment consequences on physicians who lack access to necessary information . Accountability should rest with entities that fail to make diagnostic

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results available, usable, and reusable, including health systems, laboratories, imaging providers, health information networks, health IT developers, and others that maintain or control access to the data. We encourage CMS and ONC to continue monitoring whether existing information blocking policies and disincentives are effectively changing behavior and, if not, to evaluate additional approaches that would more directly address organizational and technical barriers to information sharing. **Too often, physicians know the needed information exists but remain unable to access it because of health system policies, technical limitations, business decisions, or interoperability gaps that prioritize organizational interests over patient care .**

The AAFP [supports](#) continued development and adoption of national interoperability standards, and we appreciate CMS' interest in potential minimum standards for laboratory and imaging result exchange. We generally support efforts to improve standardization and exchange through approaches such as FHIR-based diagnostic reports, enhanced conformance testing, implementation guidance, and participation in interoperability networks.

However, interoperability requirements should be implemented in a manner that recognizes the significant variability in readiness across the health care system. Small, rural, independent, and underserved practices often face substantial financial and technical barriers to adopting new technologies. The AAFP [encourages](#) the development and expansion of trusted, neutral data-sharing infrastructure such as health information exchanges (HIEs), health data utilities (HDUs), and other community-governed entities that facilitate secure, standards-based exchange across disconnected health care organizations. CMS should consider policies that support participation in trusted, neutral data-sharing entities, which can help ensure laboratory and imaging results are available, usable, and reusable across care settings regardless of organizational affiliation.

Accordingly, the AAFP urges CMS to prioritize incentives, technical assistance, and neutral data infrastructure investments that support patient-centered adoption of interoperable systems rather than conditioning physician payment on capabilities that many practices cannot yet reasonably implement . Any future interoperability strategy should be accompanied by sufficient financial and technical support, particularly for practices with limited resources.

Finally, we wish to [emphasize](#) that interoperability efforts must be accompanied by strong safeguards related to data quality, privacy, patient matching, authentication, authorization, and data stewardship. Exchanged data must be accurate, timely, complete, and clinically meaningful to support patient care and avoid introducing additional risks. Physicians and patients must have confidence that information is being shared securely, used appropriately,

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and made available in ways that improve care coordination rather than increase administrative complexity. We encourage CMS to continue working closely with ONC and stakeholders across the health care ecosystem to advance a patient-centered, standards-based interoperability framework that promotes timely access to laboratory and imaging results, reduces unnecessary duplication, and addresses the true causes of information fragmentation in health care.

CY2027 Modifications to the Quality Payment Program Reporting and Data Submission (section IV.)

3. Transforming MIPS: MVP Strategy

c. Proposal to Update Timeline for Full MVP Implementation

CMS proposes to require all MIPS eligible clinicians and entities to report through a MIPS Value Pathway (MVP) beginning with the CY 2029 performance period. As part of its long-term strategy to transform the Quality Payment Program, CMS would phase out traditional MIPS reporting and transition participants to specialty- and condition-focused MVPs that align quality measures, cost measures, and improvement activities around a more cohesive set of population health and clinical priorities. CMS believes this transition would reduce reporting burden, improve measure relevance, and create a more meaningful assessment of clinician performance.

AAFP Response

The AAFP appreciates CMS' efforts to advance MIPS Value Pathways (MVPs) and supports the agency's vision of a more clinically relevant, patient-centered reporting framework. The concept of connecting quality measures, improvement activities, cost measures, and interoperability requirements around a coherent clinical focus is preferable to the fragmented reporting structure of traditional MIPS.

However, we have concerns regarding CMS' proposal to require MVP participation beginning with the CY 2029 performance period.

Many MVPs remain relatively new and have not achieved widespread adoption. Additionally, substantial questions remain regarding the underlying MIPS policies that MVPs rely upon, including measure validity, specialty applicability, subgroup reporting requirements, and the operational burden associated with implementation. Requiring universal MVP participation before these issues are fully resolved may create significant disruption for physicians already struggling with reporting requirements. We understand it is difficult to assess the impact of a

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policy until it is implemented – particularly when there is little uptake to see the impact at scale. Since many MVP policies, including the reporting and scoring policies, are still in flux, it is likely that practices will continue to be reluctant to transition to MVPs when they are uncertain of how they will perform. To strike a middle ground, we encourage CMS to explore incentives or protections for practices that voluntarily report an MVP. This would both allow CMS to continue refining its MVP policies and allow practices to explore MVPs with fewer uncertainties.

The AAFP does not think it is appropriate to sunset MIPS until the MVP policies have been more fully vetted and practices can have more confidence that the policies will remain stable. We are also concerned that the proposed timeline to sunset traditional MIPS is too close to the timeline to transition to mandatory digital quality measures. Rather than easing burden, mandatory implementation of both within such a short timeframe will increase the financial pressures and burden on practices. One of the biggest challenges in the early days of MIPS was that the policies continued changing from year to year. We encourage CMS to apply lessons learned from those experiences and caution against pushing forward and simply repeating the same cycle with a different reporting mechanism.

The AAFP also encourages CMS to work with specialty societies regarding whether there are sufficient MVP options available for the various subspecialties that may be part of their specialty. While CMS' data may imply there will be MVPs to cover approximately 98 percent of specialties, we question whether this would translate into an equally high percentage of eligible clinicians who view the available MVPs as *relevant* to their specialty or subspecialty.

The AAFP recommends that CMS:

- Delay mandatory MVP participation until sufficient data demonstrates that MVP reporting is less burdensome and more meaningful than traditional MIPS.
- Continue offering traditional MIPS as an alternative reporting pathway during a longer transition period.
- Establish clear benchmarks for determining MVP readiness before eliminating traditional MIPS.
- Conduct focused testing with small and rural practices prior to mandatory implementation.

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4. QPP Reporting and Data Submission

b. APM Performance Pathway (APP)

CMS proposes several updates to the APP and APP Plus quality measure sets. To provide greater stability as ACOs transition to digital quality measurement, CMS proposes to remove the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measure (Quality ID 305) and the Adult Immunization Status measure (Quality ID 493) from the planned expansion of the APP Plus measure set. CMS would continue to include the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions measure (Quality ID 484) and the CAHPS for MIPS measure. CMS also discusses the continued transition to Medicare CQMs and Medicare eCQMs and the potential incorporation of additional Universal Foundation measures into the APP Plus measure set.

AAFP Response

The AAFP appreciates CMS' continued efforts to improve the APM Performance Pathway (APP) and support participation in alternative payment models through a predictable and streamlined reporting framework. As noted in our [Guiding Principles for Value-Based Payment](#), the AAFP supports value-based payment arrangements that adequately resource and advance comprehensive, longitudinal primary care while minimizing unnecessary administrative burden.

Support Efforts Toward APP Plus Measure Set Stability, but Oppose MCC Measure

The AAFP supports CMS' proposal to remove the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Quality ID 305) and Adult Immunization Status (Quality ID 493) measures from the planned expansion of the APP Plus quality measure set.

Family physicians continue to experience substantial operational challenges associated with quality reporting, including interoperability limitations, incomplete data exchange, and the growing complexity of managing multiple quality reporting collection types. We appreciate CMS' recognition that ACOs and participating practices require a stable measure environment as they prepare for long-term adoption of digital quality measurement.

The AAFP agrees that adding measures before the necessary eCQM, Medicare CQM, and Medicare eCQM collection infrastructures are fully operational could create avoidable reporting burden without improving quality measurement accuracy or utility.

While we appreciate CMS' efforts to maintain stability in the measure set, we oppose the use of the Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (MCC) measure (measure 484). We have concerns about several aspects of the measure, including:

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- Primary care remains chronically underfunded, limiting practices' ability to provide proactive care coordination and care management services that can help prevent avoidable hospitalizations. Although CMS has created billing codes for care management and community health integration services, beneficiary cost-sharing requirements discourage utilization. As a result, practices frequently provide these services without payment or do not have sufficient resources to offer them at all.
- Admission-based measures are not appropriate for MSSP, as they may create incentives to avoid necessary hospital admissions rather than support clinically appropriate care.
- The measure does not adequately account for broader access and system-level challenges that affect hospitalization rates. In addition, persistent primary care workforce shortages often result in lengthy wait times for appointments, limiting timely access to preventive and chronic disease management services.
- Attribution methodologies remain inconsistent across administrative claims-based quality and cost measures, including MCC, Hospital-Wide Readmissions (HWR), and Total Per Capita Cost (TPCC). Differences in attribution approaches, such as physician accountability and patient assignment methodologies, result in different patient populations being attributed to physicians across measures.
- The attribution methodology can also assign beneficiaries to specialists rather than primary care physicians. Specialists are unlikely to provide many of the preventive and comprehensive care services that influence long-term population health outcomes, further weakening the relationship between measure performance and the actual care delivered by the measured entity.
- The measure may hold primary care physicians accountable for outcomes driven by factors beyond their control. Hospitalization rates are influenced by factors such as medication affordability, formulary restrictions, transportation barriers, food insecurity, access to community support services, and other social determinants of health. As a result, performance on this measure may reflect barriers to care rather than the quality of care delivered by physicians.
- The measure's risk adjustment methodology raises significant concerns. Unlike other ambulatory quality and cost measures that rely on HCC-based approaches, this measure uses a different risk adjustment framework. Lack of alignment across measures undermines quality improvement efforts and may fail to appropriately account for patient complexity. We are particularly concerned that important factors

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affecting hospitalization risk, such as active cancer, transplant status, and substance use disorders, may not be adequately captured.

Collectively, these issues create substantial concerns regarding the measure's validity, fairness, and usefulness as an accountability metric. The AAFP urges CMS to remove this measure and pursue more meaningful approaches that accurately reflect the quality of care delivered by physicians and ACOs while accounting for factors outside their control.

Support a Deliberate Transition to Digital Quality Measurement

The AAFP continues to support CMS' long-term vision for digital quality measurement and greater measure alignment across programs. However, successful implementation depends on the readiness of health IT infrastructure, consistent data standards, and reliable interoperability across care settings.

Family physicians continue to report significant challenges obtaining complete and actionable data from hospitals, specialists, laboratories, health plans, and public health agencies. As CMS advances Medicare CQMs and Medicare eCQMs within the APP, we urge the agency to ensure that reporting requirements are aligned with the current capabilities of physician practices and ACOs. In many cases, performance on these measures reflects the completeness of data exchange rather than the quality of care delivered by physicians. For example, under the Diabetes: Eye Exam measure (CMS eCQM ID: CMS131v14; Quality ID 117), patients frequently report receiving a diabetic retinal exam from an outside eye care provider, but documentation of that service is often unavailable through the EHR or health information exchange. Practices must manually request records, frequently by fax, and invest significant staff time tracking responses. When records are not received, physicians may be scored as failing to meet the measure despite delivering appropriate care and follow-up. CMS should recognize that gaps in interoperability and data sharing continue to limit the accuracy and fairness of quality measurement and should avoid holding physicians accountable for factors outside their control.

The AAFP recommends that CMS establish clear readiness and quality criteria before requiring widespread adoption of new digital reporting approaches, including demonstrated feasibility, testing across diverse practice settings, and evidence that necessary data are available without imposing significant manual abstraction or reconciliation burden on physicians and their staff.

Measure Alignment

Before incorporating additional Universal Foundation measures into the APP Plus measure set, CMS should demonstrate:

- Availability of reliable data collection pathways.
- Minimal additional reporting burden.
- Broad interoperability across health IT systems.
- Meaningful actionability for participating physicians.
- Testing across small, independent, rural, and resource-constrained practices.

As noted above, the AAFP opposes the inclusion of MCC outcomes measure (measure 484). We also oppose the continued use of the CAHPS for MIPS measure. We remain concerned that CAHPS survey results may not reliably reflect patient experience for clinicians or entities with small patient populations. In these settings, low survey response rates can introduce substantial variability and may disproportionately affect performance scores, resulting in outcomes that are more reflective of limited sample size than actual quality of care or patient experience. CMS should carefully consider the reliability and validity of these measures for small populations before using them for accountability or payment purposes.

Additional Recommendations

The AAFP appreciates CMS' efforts to maintain stability in the APP Plus quality measure set, and we support the proposed removal of the planned additions of Quality IDs 305 and 493. We encourage CMS to continue advancing digital quality measurement in a deliberate manner that prioritizes interoperability, measure alignment, and reporting feasibility for physicians and ACOs.

That said, we oppose the continued use of the MCC measure (Quality ID 484) due to concerns regarding its validity, attribution methodology, risk adjustment approach, and reliance on factors outside physicians' control. We also urge CMS to carefully evaluate the reliability of the CAHPS for MIPS measure in small populations and avoid using measures that may not accurately reflect the quality of care delivered.

c. Fast Healthcare Interoperability Resources®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs Request for Information

CMS requests stakeholder feedback on its long-term vision for transitioning quality measurement across the Quality Payment Program (QPP) and other CMS clinician and hospital quality programs to Fast Healthcare Interoperability Resources (FHIR)-based digital quality measurement. CMS discusses opportunities to improve interoperability, reduce manual reporting burden, enhance data quality, and support greater alignment across quality programs through the use of standardized, electronic data exchange. The agency also seeks

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input on implementation considerations, measure development, technology readiness, and strategies to support successful adoption of FHIR-based quality measurement.

AAFP Response

The AAFP supports CMS' ongoing efforts to modernize quality measurement infrastructure and the long-term goal of advancing interoperable, standards-based digital quality measurement. The AAFP has long supported efforts to improve the efficiency, accuracy, and usefulness of quality reporting while reducing administrative burden associated with manual data collection, abstraction, and submission.

Successful implementation of this transition depends on the readiness of the broader health care ecosystem. Family physicians continue to encounter challenges related to interoperability, incomplete data exchange, and variation in health IT capabilities across care settings. Many physician practices, particularly in small, independent, and/or rural settings, remain unable to reliably and efficiently access the complete data necessary to support fully automated digital quality reporting.

In addition, the development, testing, validation, and maintenance of FHIR-based measures require significant technical expertise and financial investment from measure developers and stewards. CMS should continue investing not only in physician-facing implementation support, but also in resources that help measure developers convert and maintain clinically meaningful measures in FHIR-based formats.

A successful transition should ultimately reduce burden and improve measurement accuracy without creating new administrative challenges for physicians.

(2) Transition to FHIR-based quality measurement in the Quality Payment Program and other CMS clinician and hospital quality programs

CMS seeks feedback on a phased transition from existing quality reporting approaches to FHIR-based quality measurement across the QPP and other CMS quality programs. The agency discusses maintaining current reporting pathways during the transition period while FHIR-based measures, technical standards, and reporting infrastructure continue to mature. CMS requests stakeholder input on implementation timelines, interoperability requirements, measure development and maintenance, benchmarking methodologies, and other factors necessary to support broad adoption of digital quality measurement across physician practices, hospitals, and reporting entities.

AAFP Response

The AAFP supports CMS' proposed phased transition to FHIR-based quality reporting and appreciates the agency's recognition that stakeholders require sufficient time to develop the

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capabilities necessary to support digital quality measurement. The AAFP agrees that maintaining existing reporting pathways during the transition period will help promote adoption while minimizing disruption to physicians and reporting entities. CMS' proposal appropriately recognizes that readiness varies across physician practices, health systems, EHR developers, registries, and measure stewards.

As CMS advances this transition, the AAFP encourages the agency to establish clear readiness criteria for measures undergoing conversion to FHIR-based reporting. CMS should ensure that measures are supported by well-defined technical specifications, broad EHR availability, successful testing across diverse practice settings, and demonstrated interoperability before finalizing transition requirements. The AAFP also encourages CMS to continue supporting measure developers and stewards through technical assistance, testing resources, and implementation support, as the availability of high-quality FHIR-based measures will be critical to the success of CMS' broader digital quality measurement strategy. Finally, CMS should continue pursuing alignment across quality programs and provide clear guidance regarding future benchmarking, scoring, and submission requirements well in advance of implementation.

(3) Additional Considerations for Shared Savings Program Transition to FHIR-based Quality Measurement

CMS seeks feedback on issues unique to transitioning Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) to FHIR-based quality measurement. The agency recognizes that ACOs often aggregate data across multiple practices, health systems, and electronic health record platforms and seeks input on challenges related to data exchange, infrastructure readiness, measure reporting, and operational feasibility. CMS requests stakeholder feedback on implementation approaches, technical assistance needs, and other strategies that could support successful adoption of FHIR-based quality measurement within the Shared Savings Program.

AAFP Response

The AAFP appreciates CMS' recognition that Shared Savings Program ACOs face unique operational and technical challenges during the transition to FHIR-based quality measurement. Many ACOs must aggregate data across multiple tax identification numbers, health systems, and EHR platforms, creating complexities that often exceed those faced by individual reporting entities. CMS appropriately acknowledges that these organizations may require additional implementation support and lead time as FHIR-based reporting capabilities mature.

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The AAFP supports CMS' phased transition approach for the Shared Savings Program and encourages the agency to maintain reporting flexibility while FHIR-based capabilities continue to evolve. CMS should provide robust technical assistance, testing opportunities, and implementation resources for ACOs, participating practices, and measure stewards responsible for developing FHIR-based measure specifications. We believe particular attention should be given to physician-led, rural, and smaller ACOs that may have fewer resources available to support technology modernization initiatives. As CMS moves forward, the transition should remain focused on reducing reporting burden, improving interoperability, and ensuring that differences in performance reflect quality of care rather than variability in technology capabilities or data aggregation infrastructure.

d. MIPS Performance Category Measures and Activities

(1) Quality Performance Category

(b) Proposal to Update Definition of Collection Type

CMS proposes to revise the definition of a quality measure collection type to better reflect current reporting mechanisms and support future quality reporting initiatives. The agency notes that existing collection type definitions were developed before the introduction of newer reporting pathways and digital measurement approaches, and believes updates are necessary to improve clarity, consistency, and program administration. CMS states that these changes would provide greater flexibility as the Quality Payment Program continues to evolve and as clinicians transition to newer reporting models and technologies.

AAFP Response

The AAFP supports CMS' proposal to add Medicare eCQMs to the definition of collection type and appreciates the Agency's efforts to advance digital quality measurement while preserving reporting flexibility for MSSP ACOs. However, CMS should ensure that adoption of Medicare eCQMs remains voluntary until health IT infrastructure, interoperability, and data exchange capabilities are sufficiently mature. The AAFP urges CMS to establish explicit readiness criteria and demonstrate feasibility across diverse practice settings before requiring broader adoption of Medicare eCQMs or other FHIR-based digital reporting approaches. The proposal should reduce, rather than increase, reporting burden for family physicians and their care teams.

(c) Proposals to Modify Quality Data Submission Criteria

(i) Proposal to Designate MIPS Core Measures

CMS proposes to establish a set of MIPS Core Measures selected from the existing quality measure inventory and aligned with specific specialties, clinical conditions, and episodes of

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care. Under the proposal, clinicians reporting through traditional MIPS or an MVP would generally be required to report at least one applicable core measure, replacing the current outcome- or high-priority-measure reporting requirement. CMS states that the proposal is intended to improve comparability across clinicians, focus reporting on measures that reflect essential aspects of care, and support the agency's broader strategy of aligning quality measurement around a more standardized set of clinically meaningful measures. CMS also proposes policies for identifying, maintaining, and updating core measures over time, including provisions for clinicians who do not have an applicable core measure available.

AAFP Response

The AAFP appreciates CMS' goal of improving comparability and transparency within MIPS. However, we remain concerned that a MIPS Core Measure requirement may reduce physician flexibility and move quality reporting toward a one-size-fits-all model that does not adequately reflect the comprehensive and individualized nature of primary care. Family physicians care for diverse patient populations across the lifespan, and no small subset of measures can fully capture that complexity. The AAFP urges CMS to maintain meaningful measure choice, limit any mandatory core measure requirements, and demonstrate that designated core measures are broadly applicable, clinically meaningful, and within the physician's ability to influence before implementing this policy. We recommend CMS test the approach and evaluate its effects on reporting burden, measure validity, and physician participation before further expanding the requirement.

(ii) Proposal to Remove High Priority Measure Designation and High Priority Quality Measure Retention Consideration

CMS proposes to eliminate the high-priority measure designation and remove consideration of high-priority status from quality measure retention policies. CMS states that this change is appropriate because many measures currently designated as high priority would also qualify as newly proposed MIPS Core Measures, making the separate designation duplicative. As part of this proposal, CMS would replace the existing requirement to report an outcome or high-priority measure with a requirement to report at least one applicable MIPS Core Measure and would no longer consider high-priority status as a factor when determining whether a quality measure should remain in the MIPS inventory. The agency believes these changes would simplify quality reporting requirements and better align measure selection and retention policies with its proposed core measure framework.

AAFP Response

The AAFP appreciates CMS' efforts to simplify MIPS quality reporting and recognizes the overlap between many proposed MIPS Core Measures and existing high-priority measures.

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However, the high-priority designation serves a distinct purpose by drawing attention to quality domains such as patient outcomes, care coordination, patient safety, patient experience, and appropriate use that are foundational to high-quality primary care. The AAFP is concerned that eliminating both the high-priority designation and its role in measure-retention decisions could unintentionally increase the risk that important primary care measures will be removed from the program. If CMS finalizes this proposal, we urge the agency to establish alternative retention safeguards and monitoring mechanisms that preserve measurement in areas critical to comprehensive, longitudinal, and patient-centered primary care.

(iii) Proposal to Implement Data Submission Requirement for MIPS Core Measures

(B) Proposal for MIPS Core Measure Data Submission Requirements with Self-Attestation

CMS proposes to require clinicians who report through traditional MIPS or an MVP to submit at least one applicable MIPS Core Measure as part of their quality measure set. Recognizing that some clinicians may not have an available or appropriate core measure, CMS proposes a self-attestation process that would allow clinicians to attest that no applicable core measure exists for their practice, specialty, patient population, or reporting circumstances. CMS states that this approach is intended to balance the goal of improving comparability across participants through greater use of core measures while maintaining flexibility for clinicians whose care is not adequately captured by the available measure inventory. The agency also seeks to use information gathered through the attestation process to identify potential gaps in the MIPS Core Measure inventory and inform future measure development and refinement.

AAFP Response

The AAFP appreciates CMS' recognition that not all physicians will have an available and applicable MIPS Core Measure and supports the proposed self-attestation pathway as an important safeguard. However, the AAFP remains concerned that a mandatory Core Measure reporting requirement may not adequately reflect the breadth and diversity of comprehensive primary care. Family physicians care for patients across the lifespan and in a wide variety of practice settings, and no single measure can capture the full value of that care. The AAFP urges CMS to broaden the flexibility available through the attestation process, minimize associated administrative burden, and closely monitor the policy's impact before expanding reliance on MIPS Core Measures as MVP participation becomes mandatory. Additionally, CMS should evaluate whether high attestation rates signal measure applicability gaps that warrant refinement of the Core Measure inventory.

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(C) Proposal to Exempt Small Practices from MIPS Core Measure Reporting Requirement

CMS proposes to exempt clinicians and groups that qualify as small practices from the proposed MIPS Core Measure reporting requirement and associated self-attestation process. CMS acknowledges that small practices often face unique resource, staffing, and health information technology challenges that can make compliance with new reporting requirements more burdensome. Under the proposal, small practices would retain the flexibility to voluntarily report MIPS Core Measures but would not be required to report a core measure or submit an attestation if an applicable core measure is unavailable. CMS states that this exemption is intended to reduce administrative burden while allowing the agency to continue evaluating the applicability and effectiveness of the broader MIPS Core Measure framework.

AAFP Response

We do not support the proposed core measure requirement. However, if it is implemented, the AAFP supports CMS' proposal to exempt small practices from the MIPS Core Measure reporting and attestation requirements. Family physicians practicing in small, rural, and/or independent practices continue to face significant administrative, financial, and health IT challenges that can make new reporting requirements disproportionately burdensome. The proposed exemption appropriately recognizes these realities while preserving flexibility for small practices to voluntarily report Core Measures when clinically relevant and operationally feasible. The AAFP encourages CMS to maintain this flexibility in future years and to monitor whether persistent measure applicability challenges suggest the need for broader refinements to the MIPS Core Measure framework.

We encourage CMS to maintain the existing small-practice definition and not create barriers that would unintentionally exclude physician-owned practices from receiving the exemption.

(iv) Proposal to Modify Data Submission Criteria for Medicare CQMs

CMS proposes to modify quality data submission criteria for Medicare Clinical Quality Measures (Medicare CQMs) by incorporating Medicare CQMs as a reporting option within the APP Plus quality measure set. The agency states that this change is intended to support broader participation in value-based care programs while advancing the transition toward digital quality measurement. CMS believes that allowing ACOs to report Medicare CQMs alongside other quality reporting options will provide greater flexibility as organizations vary in their readiness to implement Medicare eCQMs and other emerging digital reporting approaches. The proposal is intended to promote quality measure alignment across CMS programs while maintaining multiple reporting pathways during the transition to a more interoperable and digitally enabled quality measurement framework.

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AAFP Response

The AAFP supports CMS' proposal to allow Medicare CQMs to satisfy quality reporting requirements within the APP Plus measure set. Providing ACOs with multiple quality reporting options recognizes the diverse technical capabilities of participating organizations and supports a measured transition toward digital quality measurement. Family physicians continue to experience challenges related to interoperability, data exchange, and health IT readiness, and preserving Medicare CQMs as a reporting option will help mitigate unnecessary administrative burden during this transition. The AAFP encourages CMS to maintain reporting flexibility, clearly communicate future transition expectations, and ensure that any eventual movement toward Medicare eCQMs or FHIR-based reporting occurs only after adequate testing, demonstrated feasibility, and broad readiness across practice settings.

(v) Proposal to Implement Data Submission Criteria for Medicare eCQMs

CMS proposes to establish data submission criteria for Medicare electronic Clinical Quality Measures (Medicare eCQMs) as a quality reporting collection type within the APP Plus quality measure set. Unlike traditional eCQMs, Medicare eCQMs would be calculated using data limited to an ACO's assigned beneficiary population, with the goal of improving alignment between quality measurement and the beneficiaries for whom participating organizations are accountable. CMS states that incorporating Medicare eCQMs into the APP Plus reporting framework would expand digital quality measurement options available to Shared Savings Program ACOs and support the agency's broader transition toward more interoperable, patient-centered, and digitally enabled quality reporting. The agency notes that Medicare eCQMs would be available alongside other reporting options as organizations continue to build the technical capabilities necessary to support digital quality measurement.

AAFP Response

The AAFP supports CMS' proposal to establish data submission criteria for Medicare eCQMs as an optional collection type within the APP Plus measure set. Aligning quality measurement with an ACO's assigned beneficiary population has the potential to improve measure validity and better reflect the patients for whom physicians are accountable. The AAFP appreciates CMS' efforts to provide MSSP ACOs with additional reporting flexibility and recognizes the potential role of Medicare eCQMs in the long-term transition to digital quality measurement. However, family physicians continue to encounter substantial interoperability, data exchange, and health IT challenges that may limit the feasibility of widespread Medicare eCQM adoption. Therefore, **CMS should maintain Medicare eCQMs as a voluntary reporting option, preserve alternative collection types during the transition period, and establish**

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transparent readiness criteria before requiring Medicare eCQMs or future FHIR-based reporting requirements. CMS should also demonstrate that Medicare eCQMs reduce rather than increase reporting burden across diverse practice settings, including small, rural, physician-owned, and independent practices.

(d) Proposal to Modify Data Completeness Criteria

(i) Proposal to Modify Data Completeness Criteria for Medicare CQMs

CMS proposes to modify the data completeness criteria applicable to Medicare Clinical Quality Measures (Medicare CQMs) reported through the APP Plus measure set. The proposal is intended to align Medicare CQM reporting requirements with the assigned beneficiary population used for APP reporting and to support consistency across available quality reporting options. CMS states that these revisions would help facilitate participation in value-based care programs while maintaining Medicare CQMs as a viable reporting pathway during the agency's broader transition toward digital quality measurement. The agency also notes that maintaining Medicare CQMs alongside emerging digital reporting approaches is intended to provide organizations with continued reporting flexibility as interoperability capabilities, data exchange infrastructure, and quality measurement technologies continue to evolve.

AAFP Response

The AAFP supports CMS' proposal to extend the availability of the Medicare CQM collection type and maintain its associated data completeness framework. Preserving Medicare CQMs as a reporting option provides important flexibility for MSSP ACOs as they continue preparing for the transition to digital quality measurement. The AAFP particularly supports CMS' efforts to align Medicare CQM reporting with the ACO's assigned beneficiary population, which will improve accountability, better reflect primary care relationships, and help address longstanding challenges associated with meeting data completeness requirements. However, family physicians continue to experience significant interoperability and data exchange barriers that remain outside their control. Accordingly, CMS should continue evaluating whether the 75 percent data completeness threshold remains appropriate and should establish transparent readiness criteria before sunseting Medicare CQMs or requiring broader adoption of FHIR-based reporting approaches. Any future transition should demonstrably reduce reporting burden and be supported by mature, interoperable health IT infrastructure across diverse practice settings.

(ii) Proposal to Implement Data Completeness Criteria for Medicare eCQMs

CMS proposes to establish data completeness criteria for Medicare electronic Clinical Quality Measures (Medicare eCQMs) reported through the APP Plus quality measure set. Consistent

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with the Medicare CQM collection type, CMS proposes that organizations would generally be required to meet a 75 percent data completeness threshold for each reported measure among applicable assigned beneficiaries. CMS states that adopting standardized data completeness requirements across collection types will promote consistency in quality reporting, support implementation of the new Medicare eCQM reporting option, and facilitate the agency's broader transition toward digital quality measurement. The agency also notes that the Medicare eCQM collection type is intended to align quality measurement more closely with an ACO's assigned beneficiary population while maintaining reporting flexibility as organizations develop the infrastructure necessary to support digital quality reporting.

AAFP Response

The AAFP supports CMS' proposal to establish data completeness criteria for the new Medicare eCQM collection type and appreciates the agency's efforts to align reporting requirements across APP Plus collection types. The AAFP agrees that applying a consistent data completeness standard may facilitate operational implementation and support the gradual adoption of digital quality measurement. We also support CMS' efforts to focus Medicare eCQM reporting on assigned beneficiaries, which may better align quality measurement with physician accountability and patient attribution. However, we reiterate our concerns about significant interoperability, data exchange, and health IT implementation challenges that may affect physicians' ability to meet data completeness requirements. CMS should closely monitor the operational impact of the 75 percent threshold, maintain Medicare eCQMs as a voluntary reporting option, and establish clear readiness criteria before expanding reliance on Medicare eCQMs or future FHIR-based reporting approaches. CMS should demonstrate that digital reporting approaches reduce administrative burden and are feasible across diverse practice settings before requiring broader adoption.

(e) Addition of New Quality Measures (Described in Appendix 1)

(i) Pre-Rulemaking Process

CMS describes the quality measure pre-rulemaking process used to identify, evaluate, and select measures for potential inclusion in the Quality Payment Program. The agency discusses recommendations received through the Pre-Rulemaking Measure Review (PRMR) process and explains how stakeholder input from clinicians, patients, measure developers, and other interested parties informs quality measure development and selection. CMS states that participation in the pre-rulemaking process helps promote transparency, improve measure quality and relevance, and support alignment across federal quality programs. As part of this discussion, CMS outlines considerations related to future measure adoption,

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replacement, and maintenance as the Quality Payment Program continues to evolve and transition toward digital quality measurement approaches.

AAFP Response

The AAFP supports CMS' continued participation in the Pre-Rulemaking Measure Review process and appreciates the opportunities it provides for physician, patient, and other stakeholder engagement during quality measure review and selection. The AAFP believes that transparent, multi-stakeholder review helps improve measure relevance, identify implementation challenges, and promote accountability in measure selection. However, CMS should carefully balance stakeholder input with the expertise of quality measurement specialists and the real-world experience of physicians who are subject to these measures, ensuring that policy decisions are informed by those most knowledgeable about measure development, implementation, and use. We also urge CMS to provide clear justification when proposing measures that do not receive favorable recommendations through the PRMR process and should demonstrate how stakeholder concerns were addressed. As CMS advances digital quality measurement and explores FHIR-based reporting approaches, the AAFP urges the Agency to prioritize measures that are clinically meaningful, evidence-based, feasible to implement, applicable across diverse primary care settings, and capable of improving patient outcomes without increasing administrative burden. The [AAFP Performance Measures Criteria policy](#) outlines the important requirements that should be met before measures are used as accountability measures tied to payment.

(ii) Removal of Quality Measures

CMS discusses its process for removing quality measures from the MIPS quality measure inventory and proposes the removal of measures that no longer meet program needs based on established measure-retention criteria. CMS states that measure removal is intended to maintain a focused, clinically meaningful, and manageable measure set by eliminating measures that are outdated, duplicative, topped out, low value, or otherwise no longer support quality improvement objectives. The agency also describes the factors it considers when evaluating measures for removal and outlines how measure inventory maintenance supports its broader goals of reducing reporting complexity, improving measure relevance, and aligning quality measurement across CMS programs.

AAFP Response

The AAFP supports CMS' ongoing efforts to maintain a meaningful and streamlined quality measure inventory and agrees that obsolete, duplicative, outdated, or low-value measures should be considered for removal. However, the AAFP urges CMS to ensure that measure removal decisions do not inadvertently eliminate important measures that address persistent

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gaps in primary care measurement. Family physicians remain concerned that reliance on benchmarking performance, reporting volume, or topped-out status alone may disadvantage measures that capture prevention, care coordination, continuity, patient-centeredness, and other foundational elements of comprehensive primary care. CMS should retain additional safeguards for measures that address important care gaps, promote meaningful patient outcomes, or reflect aspects of care that remain underrepresented in federal quality programs. Furthermore, if CMS finalizes the proposed removal of the high-priority measure designation, the agency should establish alternative retention considerations to ensure that important prevention, outcome, patient experience, and care coordination measures continue to receive appropriate protection within the MIPS measure inventory. In summary, measure reduction is appropriate, but measure removal should not come at the expense of capturing the value of comprehensive, longitudinal, relationship-based primary care.

(iii) Inventory of Quality Measures

CMS provides an updated inventory of quality measures available for reporting under the MIPS quality performance category and describes proposed additions, removals, and maintenance activities affecting the measure set. The agency explains how these changes are intended to support ongoing measure inventory refinement, improve the clinical relevance of available measures, reduce duplication, and align quality measurement with broader CMS priorities. CMS also discusses the role of the quality measure inventory in supporting traditional MIPS reporting, MIPS Value Pathways (MVPs), and future quality measurement initiatives, including efforts to streamline reporting and advance digital quality measurement. As part of this inventory review, CMS seeks to maintain a measure set that is meaningful, actionable, and responsive to evolving clinical practice and program needs

AAFP Response

The AAFP supports CMS' ongoing efforts to maintain a meaningful, evidence-based, and clinically relevant MIPS quality measure inventory. We appreciate the Agency's focus on improving measure relevance through the addition of measures addressing chronic disease management and patient-reported outcomes, as well as its efforts to remove outdated, duplicative, or low-value measures. However, family physicians remain concerned that measure inventory changes may inadvertently reduce the availability of measures that capture the unique value of comprehensive, longitudinal, relationship-based primary care. The AAFP encourages CMS to carefully evaluate the impact of proposed measure removals and specification changes on primary care and to preserve measures that address continuity, prevention, care coordination, patient-centeredness, and whole-person care. This includes retaining the Person-Centered Primary Care measure (PCPCM), a unique measure of relationship-based, longitudinal primary care. CMS should also continue pursuing measure

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alignment and inventory simplification while ensuring that changes do not increase administrative burden or accelerate transitions to digital reporting approaches before adequate testing and readiness have been demonstrated.

d. MIPS Performance Category Measures and Activities

(3) Improvement Activities Performance Category

CMS proposes six new improvement activities:

- IA_CC_XX – Use of Data to Improve Practice Workflows
- IA_CC_XX – Understand and Improve Diagnostic Performance
- IA_AHW_XX – Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues
- IA_AHW_XX – Advance Care Planning Conversations to Support Patient Wellness and Care Preferences
- IA_AHW_XX – Clinician Use of Artificial Intelligence to Improve Patient Care
- IA_AHW_XX – Lifestyle Approaches to Diabetes Remediation

AAFP Response

The AAFP is generally supportive of the proposed new improvement activities. However, we encourage CMS to combine “Advance Care Planning Conversations to Support Patient Wellness and Care Preferences” with the existing “Advance Care Planning (IA_PM_21)” activity. The activities are similar in their intent, and it does not seem necessary to maintain them as separate activities.

(4) MIPS Promoting Interoperability Performance Category

(b) Proposal to Modify the Definition of Certified Electronic Health Record Technology in the MIPS Promoting Interoperability Performance Category

CMS proposes modifying the definition of CEHRT to align with the applicable ONC proposals to remove and revise certain ONC health IT certification criteria proposed in the HTI-5 proposed rule.

Beginning with the 2026 performance year, CMS proposes to eliminate the ONC direct review and ONC-authorized certification bodies' surveillance attestation requirements. CMS also proposes to eliminate the security risk analysis attestation requirements. Although practices will no longer be required to attest that they have conducted an analysis for the

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purposes of MIPS, they will still be required to complete an analysis to maintain HIPAA compliance.

CMS is proposing modifications to the Electronic Prior Authorization (ePA) measure, as well as a new ePA for Prescription Drugs measure. Specifically, CMS proposes to update the existing ePA measure to align with current federal interoperability and prior authorization (PA) initiatives by requiring the use of standards-based ePA transactions and expanding the measure's applicability to a broader range of PA requests. CMS also proposes refinements intended to improve consistency with the CMS Interoperability and Prior Authorization Final Rule and to encourage greater adoption of automated ePA processes across the health care system. In addition, CMS proposes a new ePA for Prescription Drugs measure that would assess the use of ePA for medications subject to PA requirements.

AAFP response

The AAFP supports the burden-reducing elements of this proposal and supports the direction of ePA, with important conditions. We support removing the Direct Review and ACB Surveillance attestations and aligning the CEHRT definition with ONC's certification program updates, provided the changes are coordinated with ONC's final HTI-5 rule and do not degrade physicians' ability to calculate and report quality measures. The AAFP has [consistently supported](#) CMS and ONC efforts to align health IT requirements and implementation timelines across federal programs, and we believe maintaining consistency between certification requirements and CMS reporting programs can reduce unnecessary administrative burden for both EHR developers and the physicians they serve. As CMS considers finalizing these changes, we urge the agency not to proceed unless ONC finalizes the same provisions in the HTI-5 final rule. Advancing divergent certification and reporting requirements across federal programs would create confusion, increase implementation complexity, and undermine the burden reduction goals of this proposal. We therefore encourage CMS and ONC to continue coordinating closely to ensure any changes to the definition of CEHRT are implemented consistently across programs, provide adequate transition time for developers and end-users, and preserve the functionality necessary to support quality measurement and true interoperability.

We do not object to removing the Security Risk Analysis measure as a reporting item, but we urge CMS and ONC to sustain cybersecurity education and technical assistance for physician practices. While eliminating the measure may reduce reporting burden under MIPS, it does not lessen physicians' underlying obligations to protect electronic protected health information under HIPAA, nor does it diminish the increasingly sophisticated cybersecurity threats facing the health care sector. Family physicians continue to serve as stewards of highly sensitive patient information, and maintaining patient trust depends on ensuring that

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physician practices have the resources necessary to safeguard that data. As the AAFP has [previously noted](#), many smaller practices lack dedicated IT staff and often rely on external vendors or part-time contractors to support cybersecurity functions. Consequently, compliance challenges and implementation costs can disproportionately affect smaller and independent practices.

CMS and ONC should therefore pair this burden-reduction proposal with continued investments in physician-focused cybersecurity initiatives, including educational resources, technical assistance programs, implementation guidance, and tools specifically designed for small and rural practices. We encourage the agencies to build upon successful support models that provide hands-on assistance and practical implementation guidance to physician practices that may lack in-house cybersecurity expertise. We also urge continued coordination across HHS to ensure physician practices are not held responsible for cybersecurity failures that stem from vendor-controlled systems or technology infrastructure outside of their direct control. Eliminating a reporting requirement may be appropriate, but maintaining a strong culture of cybersecurity awareness and preparedness remains essential to protecting patients, supporting physician practices, and preserving confidence in an increasingly interconnected health care system.

Regarding ePA, AAFP strongly supports moving prior authorization to standards-based electronic workflows, but we also strongly urge parity and readiness. Family physicians continue to experience significant administrative burden associated with PA, and we believe broader adoption of interoperable, standards-based ePA transactions has the potential to reduce reliance on phone, fax, portal-based, and other manual processes that disrupt clinical workflows and unnecessarily delay patient care. We support CMS' efforts to align ePA requirements with broader federal interoperability initiatives and encourage continued use of standardized FHIR-based approaches that facilitate more automated, workflow-integrated PA processes.

However, the success of these policies depends on coordinated implementation across the entire health care ecosystem. Physicians should not be required to meet ePA performance expectations unless the corresponding certified health IT capabilities are broadly available without additional programming or expense required by end-users and payers are subject to equivalent requirements to support the necessary FHIR-based PA APIs and related interoperability functions. Consistent with the AAFP's long-standing interoperability principles, implementation timelines should be [aligned](#) across physicians, health IT developers, and payers to avoid creating situations where clinicians are held accountable for technologies or workflows that remain outside their control. We therefore support making the ePA measure optional for CY 2027.

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We appreciate CMS' recognition that implementation challenges will vary across practice settings. Small, independent, rural, and safety-net practices frequently depend on EHR vendors, clearinghouses, and other external entities for health IT functionality and may have limited ability to independently address interoperability gaps. Accordingly, we urge CMS not to advance the CY 2028 required measure proposals, including the new ePA for Prescription Drugs measure, without evidence of payer-side readiness, demonstrated vendor implementation, and successful real-world adoption across diverse practice environments. PA reforms should reduce administrative burden, not simply replace existing manual processes with new electronic requirements that remain fragmented or incomplete.

The AAFP further [encourages](#) CMS to maintain robust exclusions and hardship accommodations for physicians who order few or no applicable items or medications; lack access to the required certified functionality; or face vendor, payer, or connectivity barriers beyond their control. We appreciate that CMS proposed an exclusion for clinicians who do not order prescription drugs requiring PA, and we recommend that any required measure retain and expand these protections. CMS should also continue monitoring implementation of ePA standards and work with ONC to ensure that certified health IT supports seamless integration of PA workflows into routine clinical practice. Implemented correctly, ePA can advance interoperability, improve transparency, and meaningfully reduce burden for family physicians and their care teams. Implemented prematurely, it risks introducing new administrative complexity while failing to deliver the intended benefits to physicians and patients.

B. MIPS Final Score Methodology

1. Performance Category Scores

b. 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 Measures and Administrative Claims Measures

(1) Proposal for Scoring of MIPS Core Measures

CMS proposes updates to the quality performance category scoring methodology to account for the newly proposed MIPS Core Measure framework. Under the proposal, clinicians and groups that report an applicable MIPS Core Measure would receive full credit for satisfying the core measure reporting requirement, while those without an available or applicable core measure could utilize a self-attestation process and would not be subject to a scoring penalty. CMS also proposes that small practices remain exempt from the core measure reporting requirement. The agency states that these scoring policies are intended to support implementation of the MIPS Core Measure framework, improve comparability across

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participants, and align quality scoring with its broader strategy of emphasizing measures that reflect essential aspects of care within a specialty, condition, or episode of care.

AAFP Response

The AAFP appreciates CMS' efforts to align quality reporting and scoring policies and supports the continued exemption for small practices and the availability of an attestation pathway. However, the AAFP remains concerned that the proposed scoring policy relies on a Core Measure construct that may not adequately reflect the breadth and complexity of comprehensive primary care. Family physicians care for diverse patient populations across the lifespan, and a limited set of Core Measures may not appropriately represent that work. The AAFP urges CMS to broaden the flexibility available through the attestation process, avoid scoring penalties during the initial implementation period, and evaluate the applicability and burden associated with Core Measure reporting before incorporating such measures into scoring methodologies that directly affect physician performance results.

(2) Small Practice Scoring Exemption Clarification for MIPS Core Measures

CMS proposes to clarify how the small practice exemption would apply under the proposed MIPS Core Measure scoring methodology. Consistent with its proposal to exempt small practices from the Core Measure reporting requirement, CMS proposes that small practices would not be required to report a MIPS Core Measure, submit a self-attestation, or incur a scoring penalty for failing to satisfy the Core Measure requirement. The agency states that this policy is intended to reduce administrative burden and recognize the operational and resource constraints often faced by small practices while maintaining flexibility for those that choose to voluntarily report applicable Core Measures. CMS believes this approach will support implementation of the broader MIPS Core Measure framework while preserving existing accommodations for small practice participants.

AAFP Response

The AAFP does not support the proposed core measure requirement. However, if it is implemented, then we strongly support CMS' proposal to exempt small practices from the MIPS core measure scoring requirement and associated attestation process. Family physicians practicing in small, rural, independent, and physician-owned practices continue to face unique administrative, operational, and health IT challenges that make additional reporting requirements particularly burdensome. By clarifying that small practices will not be required to report a Core Measure, submit an attestation, or face scoring penalties for failing to do so, CMS appropriately recognizes these realities and preserves reporting flexibility. The AAFP encourages CMS to maintain this exemption in future years and to continue evaluating whether broader applicability and feasibility concerns associated with the core measure

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framework warrant additional refinements before expanding related reporting and scoring requirements.

(3) Scoring Topped Out Measures

(a) Background on Scoring Topped Out Measures

CMS discusses its current approach to scoring topped out quality measures and the challenges that can arise when clinicians, specialties, or MVPs have limited alternative measure options available. The agency acknowledges that certain topped out measures may continue to address clinically meaningful aspects of care despite high levels of performance and describes existing policies that allow some of these measures to remain available for reporting and scoring. CMS explains that the goal of its topped-out measure policies is to balance the need to encourage continuous quality improvement with the need to maintain meaningful reporting options for clinicians in specialties or clinical areas where measure choice may be limited. As part of this discussion, CMS outlines how topped out measure scoring fits within the broader quality performance category scoring framework and ongoing efforts to maintain a relevant and clinically meaningful measure inventory.

AAFP Response

The AAFP supports CMS' continued efforts to address the unintended consequences of topped-out measure scoring for physicians who face limited measure choice. Physicians should not be disadvantaged simply because high-performing measures remain among the most clinically relevant options available within their specialty. The AAFP appreciates CMS' recognition that certain specialties, measure sets, and MVPs may have insufficient alternatives to topped-out measures and supports policies that allow continued use of appropriate benchmark-based scoring in these circumstances. However, CMS should continue exercising caution when considering the removal of topped-out measures, particularly those that address prevention, chronic disease management, care coordination, continuity, and other foundational elements of comprehensive primary care. Overall, high performance should not be interpreted as evidence that a measure is no longer meaningful, especially when the measure continues to reflect important patient outcomes or established standards of care. We also encourage CMS to acknowledge that aggregate performance may overlook persistent disparities in care. Before retiring a measure, CMS should conduct and publicly share stratified analyses by race, ethnicity, language, geographic location, and other relevant demographic characteristics to determine whether significant performance gaps remain for specific patient populations. Measures that continue to identify disparities or opportunities for improvement should not be considered topped out simply because overall performance is high.

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(b) Proposal of Measures Impacted by Limited Measure Choice to be Subject to Defined Topped Out Benchmark for the CY 2027 Performance Period/2029 MIPS Payment Year

CMS proposes to continue using defined topped out benchmarks for certain quality measures affected by limited measure choice during the CY 2027 performance period/2029 MIPS payment year. The agency recognizes that some specialties, measure sets, and MVPs have a limited number of applicable quality measures available and that removing or restricting topped out measures in these circumstances could reduce meaningful reporting options. CMS proposes to identify measures that meet its limited measure choice criteria and allow them to be scored using a defined topped out benchmark in order to preserve reporting flexibility while continuing to differentiate performance among clinicians reporting those measures.

AAFP Response

The AAFP supports CMS' proposal to apply defined topped-out benchmarks to measures affected by limited measure choice. Physicians should not be disadvantaged when clinically relevant topped-out measures remain among the few applicable reporting options available within a specialty measure set or MVP. At the same time, the need for these accommodations highlights persistent measure gaps across MIPS and MVP reporting pathways, particularly those focused on specialty care. CMS should support the development of specialty-focused meaningful measures while ensuring that clinically important measures are not removed solely because they achieve aggregate high-performance rates.

(c) Proposal to Score Topped Out MIPS Core Measures According to Defined Topped Out Benchmark

CMS proposes that MIPS Core Measures designated as topped out be scored using the defined topped out benchmark methodology rather than being subject to the standard 7-point scoring cap applied to most topped out measures. CMS states that this policy is intended to ensure that clinicians are not disadvantaged when reporting a Core Measure that CMS has designated as essential but that has also achieved topped out status. Under the proposal, eligible topped out Core Measures would remain eligible to earn up to the maximum achievement points available under the quality performance category scoring methodology.

AAFP Response

The AAFP does not support the proposed core measure requirement. However, if it is implemented, then we support CMS' proposal to score topped-out MIPS Core Measures using the defined topped-out benchmark rather than applying the traditional 7-point scoring cap. Physicians should not be disadvantaged for reporting a required measure that has

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already reached topped-out status. Allowing these measures to continue earning up to 10 achievement points promotes scoring fairness and helps mitigate unintended consequences associated with limited measure choice. **However, the AAFP notes that the need for this policy underscores broader concerns regarding the proposed Core Measure framework, including limited measure availability and specialty applicability. CMS should continue evaluating whether the proposed Core Measure inventory provides sufficient flexibility and meaningful options for all types of physicians before expanding reliance on Core Measures within MIPS and MVP reporting.**

(d) Clarification Regarding Scoring Non-Topped Out Measures According to Historical Benchmark

CMS proposes to clarify that measures previously scored using a defined topped out benchmark would return to scoring based on historical benchmarks if they no longer meet the criteria for topped out status. The agency explains that benchmark methodologies should reflect current measure performance characteristics and that special scoring accommodations should only apply while a measure remains topped out. CMS states that this clarification is intended to promote consistent application of quality scoring policies and ensure that measures are scored using the methodology most appropriate to their current performance distribution.

AAFP Response

The AAFP supports CMS' clarification that measures previously identified for scoring under the defined topped-out benchmark should return to historical benchmark scoring when they are no longer considered topped out. Scoring methodologies should reflect current measure performance characteristics, and special benchmark treatment should be reserved for circumstances in which topped-out status continues to limit meaningful performance differentiation. The AAFP appreciates CMS' efforts to apply scoring policies consistently and transparently. However, CMS should provide timely communication regarding benchmark status changes and continue working to simplify quality scoring methodologies so that physicians can better understand how their performance is assessed and scored with adequate time to impact their scores before it's too late.

c. Scoring the Quality Performance Category for Medicare Shared Savings Program ACOs

(1) Proposal to Use Flat Benchmarks to Score Medicare Shared Savings Program ACOs Reporting Medicare CQMs

CMS proposes to continue using flat benchmarks to score Medicare Clinical Quality Measures (Medicare CQMs) reported by Shared Savings Program ACOs for the CY 2027 performance period/2029 MIPS payment year. Under this proposal, performance on

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Medicare CQMs would continue to be assessed against fixed performance benchmarks rather than benchmarks derived from historical performance data. CMS states that maintaining flat benchmarks would promote stability and predictability during the ongoing transition to digital quality measurement and would help avoid scoring volatility that could result from methodological changes. The agency believes this approach will support consistent quality reporting and performance assessment for ACOs while CMS continues to refine its broader benchmarking strategy for Medicare CQMs, Medicare eCQMs, and other emerging digital quality measurement approaches.

AAFP Response

The AAFP supports CMS' proposal to continue utilizing flat benchmarks for Medicare CQMs and appreciates the agency's efforts to provide greater stability and predictability during the ongoing transition to digital quality measurement. Family physicians and MSSP ACOs continue to navigate significant operational changes related to evolving quality reporting requirements, and a consistent benchmarking methodology may help reduce uncertainty. The AAFP particularly appreciates CMS' efforts to minimize unintended scoring volatility for measures highly relevant to primary care, including depression screening, blood pressure control, and diabetes management. However, CMS should provide additional justification regarding its decision to move away from the previously finalized transition to historical benchmarking and should clearly communicate its long-term benchmarking strategy for Medicare CQMs, Medicare eCQMs, and future FHIR-based reporting approaches. The AAFP also encourages CMS to ensure that flat benchmarks continue to support meaningful performance differentiation and ongoing quality improvement.

(2) Proposal to Use Flat Benchmarks to Score Medicare Shared Savings Program ACOs Reporting Medicare eCQMs

CMS proposes to use flat benchmarks to score Medicare electronic Clinical Quality Measures (Medicare eCQMs) reported by Shared Savings Program ACOs. Because Medicare eCQMs are a newly established collection type, CMS proposes to assess performance against fixed benchmarks rather than historical performance benchmarks. The agency states that this approach is intended to provide scoring stability, predictability, and a consistent methodology as organizations begin adopting Medicare eCQMs and as CMS collects sufficient performance data to inform future benchmarking approaches. CMS believes the use of flat benchmarks will facilitate implementation of the new collection type while supporting the broader transition toward digital quality measurement within the Shared Savings Program.

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AAFP Response

The AAFP supports CMS' proposal to utilize flat benchmarks for the newly established Medicare eCQM collection type. Given the absence of historical Medicare eCQM performance data, a flat benchmark methodology provides a reasonable and predictable approach for assessing performance during the initial implementation period. The AAFP appreciates CMS' efforts to provide MSSP ACOs with additional quality reporting options and to support a measured transition toward digital quality measurement. However, CMS should clearly articulate its long-term benchmarking strategy for Medicare eCQMs, including whether flat benchmarks are intended to be temporary or permanent. The AAFP further urges CMS to maintain Medicare eCQMs as a voluntary reporting option until interoperability, vendor readiness, and data exchange capabilities are sufficiently mature across diverse practice settings. Any future transition to mandatory Medicare eCQM or FHIR-based reporting should occur only after demonstrated feasibility and evidence that these approaches reduce, rather than increase, administrative burden for physicians and care teams.

e. MVP Scoring Request for Information

CMS is assessing whether an MVP score normalization is needed within an MVP to ensure scoring fairness across MVPs. They are also considering timing for implementing a new MVP scoring methodology – beginning with the CY 2029 performance period or an earlier pilot rollout.

AAFP Response

The AAFP understands CMS' concern that some MVPs may be inherently easier or harder than others and agrees that comparability across MVPs warrants additional study. However, any normalization methodology should be thoroughly modeled and tested before implementation. CMS should demonstrate that normalization improves fairness without increasing volatility, reducing transparency, or penalizing physicians who achieve high levels of performance. It is difficult to provide detailed feedback and accurately assess the impact of such a policy without additional data and information. The AAFP requests that CMS model a scoring normalization for MVPs and share their findings with stakeholders before moving forward with a proposal.

Regardless of whether CMS includes scoring normalization, we recommend offering protections from negative payment adjustments for practices that voluntarily report MVPs. As stated earlier, we believe the uncertainty created by changing MVP policies will deter practices from reporting MVPs. This would allow practices to become more familiar with any

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new MVP scoring policies while also assuring them that doing so does not put them more at risk than reporting through traditional MIPS.

D. Calculating Final Score

2. Proposal to Use Alternative Data Sources to Determine Clinician Eligibility for the Automatic EUC

CMS generally relies on PECOS data to determine if an individual in an area is affected by an extreme and uncontrollable circumstance (EUC). However, CMS has found that the data may incorrectly exclude physicians from the EUC policy because the PECOS address data may be inaccurate or outdated. CMS proposes using the most current and reliable data to determine if an individual MIPS EC is in an area that has been identified as being affected by an EUC.

AAFP Response

The AAFP supports these proposals and appreciates CMS' efforts to ensure ECs are protected from negative payment adjustments for circumstances beyond their control.

3. Proposal to Update the Deadline for Clinicians to Inform CMS that a Third Party Intermediary Did Not Submit Data Due to Reasons Outside the MIPS Eligible Clinician's Control

CMS proposes adjusting the deadline for ECs to request reweighting for the quality, improvement activities, or promoting interoperability categories due to scenarios where a third party did not submit data on their behalf. Beginning with the 2025 performance period/2027 MIPS payment year, MIPS ECs would be able to request reweighting on or before December 31 of the year preceding the relevant MIPS payment year.

AAFP Response

The AAFP supports these proposals and appreciates CMS' efforts to ensure ECs are protected from negative payment adjustments for circumstances beyond their control.

E. Public Reporting

2. Proposal to Remove the Public Reporting Requirements for the MIPS Value Pathway Requirement at § 414.1395(c)(2)

CMS proposes to remove the existing public reporting limitation that prevents newly adopted Improvement Activities and Promoting Interoperability measures, objectives, and activities included in an MVP from being publicly reported during their first year of use. CMS states that this change would align public reporting policies across MVPs and allow performance information associated with newly incorporated measures and activities to be publicly

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displayed without a one-year delay. The agency believes removing this provision would simplify public reporting requirements and increase the amount of information available to patients and other stakeholders regarding clinician performance within MVPs.

AAFP Response

The AAFP has concerns regarding CMS' proposal to remove the first-year public reporting protection for newly introduced Improvement Activities and Promoting Interoperability measures within MVPs. We support public reporting of meaningful, accurate, and reliable physician performance information but it is important to note that newly implemented measures often require operational refinement, physician education, and validation before they are suitable for public comparison. The existing policy provides an important transition period that helps ensure reported information accurately reflects physician performance rather than implementation challenges related to data exchange or collection. The AAFP recommends that CMS retain the current first-year public reporting delay or establish objective criteria demonstrating measure reliability, validity, and stability prior to public reporting.

3. Request for Information: Star Rating Assignment Methodology for Administrative Claims Quality Measures

CMS requests feedback on potential revisions to the methodology used to assign star ratings for publicly reported administrative claims-based quality measures. The agency discusses options for improving the consistency, interpretability, and usefulness of star ratings and seeks stakeholder input on approaches that would better distinguish performance while making quality information more accessible to patients and other users. CMS also requests feedback on whether a revised star rating methodology could be applied more broadly to other measure types, including cost measures, and seeks input on factors that should be considered when evaluating future public reporting methodologies. The agency states that any future changes would be intended to improve the transparency and usability of publicly reported performance information while maintaining meaningful distinctions in clinician performance.

AAFP response

The AAFP supports CMS' efforts to improve the transparency, usefulness, and interpretability of publicly reported physician performance information. However, before proposing a new star rating assignment methodology for administrative claims measures, CMS should conduct comprehensive testing to assess its impact on all types of eligible physicians. Any revised methodology should accurately reflect meaningful performance differences, avoid overemphasizing statistically insignificant variations, and be understandable to patients.

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We urge CMS to consider that star ratings can oversimplify quality. Family physicians care for:

- Patients with multiple chronic conditions
- Socially vulnerable populations
- Complex behavioral health needs
- Diverse patient populations across the lifespan

Reducing performance to a simple star rating risks oversimplifying care quality. We oppose public reporting approaches that fail to adequately account for patient complexity and social risk.

The AAFP is also concerned about the potential expansion of star ratings to cost measures.

We strongly oppose applying the proposed methodology to cost measures . As we have raised in previous AAFP comments, cost measures do not fully or fairly reflect factors outside physicians' control, including:

- Specialist utilization
- Hospital use
- Community resources
- Patient complexity

The AAFP strongly opposes public reporting of cost-measure performance, including within star ratings at this time. Presenting cost performance through a simplified rating system could mislead patients into assuming that lower-cost care is inherently higher quality or that higher-cost care reflects poor quality. In many cases, higher spending may reflect clinically appropriate, evidence-based care for patients with greater medical complexity, social risk factors, or barriers to accessing preventive and supportive services. Until cost measures are valid, reliable, appropriately attributed, and adequately risk adjusted for clinical complexity and relevant social factors, public ratings unfairly penalize physicians who care for higher-need populations. They may also create pressure to avoid necessary services out of concern for cost performance. Given the measures' methodological limitations and the significant risk of misinterpretation, CMS should not publicly report cost-measure performance until these concerns are fully addressed.

Instead, we encourage CMS to carefully evaluate whether cost measure performance can be fairly attributed to individual physicians and interpreted appropriately by patients. CMS should also ensure that any future public reporting methodology adequately accounts for patient complexity, social risk factors, and the comprehensive nature of primary care.

5. Advanced APMs

CMS proposes applying QP status and Partial QP status strictly to a TIN/NPI combination. Under this proposal, QP status and Partial QP status would only apply to the clinician at the TIN that is participating in the APM Entity in the AAPM. Both the APM Incentive Payment and the QP conversion factor would apply to the NPI's claims only with those TINs, as would the ability of a Partial QP to opt into MIPS. If an EC participates in multiple APM entities and attains QP status at the individual level, CMS would apply the QP status at each of the clinician's TINs participating across those APM entities. If the EC attains QP status as part of a specific APM Entity-level determination, QP status would only apply at the TINs associated with the APM Entity(ies) that collectively attained QP status.

CMS notes that this proposal is likely to have minimal effect as most ECs in AAPMs already participate with an APM Entity in an AAPM with all their TIN reassignments. Additionally, in their experience, it is more operationally feasible for practices to report MIPS for ECs in their practice rather than removing select ECs who are not subject to MIPS.

AAFP Response

While the AAFP understands CMS' desire to direct the QP conversion factor to the TIN(s) under which the EC earned QP status, the AAFP notes that section 1848(d)(A)(1) simply states that the conversion factor applies to, "items and services furnished by a qualifying APM participant (as defined in [section 1395l\(z\)\(2\) of this title](#))."

It does not specify that the conversion factor is limited to the TIN(s) associated with the APM Entity participating in the AAPM. As such, the AAFP questions whether it is within CMS' current statutory authority to limit how the QP conversion factor is applied.

CMS is concerned that applying the higher conversion factor to TIN(s) not associated with the AAPM would disincentivize them from joining an AAPM. The AAFP believes it may actually serve as an inducement to participate in an AAPM since there would be a greater financial benefit for them if all their ECs received the QP conversion factor. Since 2026 is the first year the split conversion factor was in effect, the AAFP recommends that CMS continue to monitor the financial impact as well as the number and types of clinicians who would be impacted by implementing this policy and reassess whether it is warranted in future rulemaking.

Appendix 1: MIPS Quality Measures

CMS proposes a series of updates to the MIPS quality measure inventory, including the addition of new quality measures, modification of existing measures, and removal of measures that no longer meet the agency's measure-retention criteria. The proposed changes are intended to improve the clinical relevance of the inventory, align measurement

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with current evidence and CMS priorities and support ongoing refinement of the Quality Payment Program. CMS proposes new measures addressing areas such as cardiovascular disease management, chronic kidney disease treatment, and cancer screening follow-up, while also proposing the removal of certain existing measures based on factors such as benchmark availability and other measure-retention considerations. The agency states that these inventory updates are intended to maintain a meaningful, streamlined, and clinically relevant set of quality measures available for MIPS reporting.

AAFP Response

Support for Addition of LDL-C Monitoring and Management Measure in MIPS

The AAFP supports CMS' proposal to add the **LDL-C Monitoring and Management** measure to the MIPS quality measure inventory. Cardiovascular disease remains a leading cause of morbidity and mortality, and family physicians play a critical role in identifying, treating, and managing patients with atherosclerotic cardiovascular disease (ASCVD). This measure addresses a clinically meaningful aspect of care, aligns with current evidence-based guidelines, and has the potential to improve patient outcomes by encouraging appropriate lipid monitoring and management.

While supportive of the measure's inclusion, the AAFP encourages CMS to ensure implementation is feasible and equitable. Factors such as medication affordability, access to specialty therapies, patient adherence, and social drivers of health can affect a patient's ability to achieve LDL-C targets despite appropriate clinical management. CMS should continue to monitor measure performance, provide clear implementation guidance, and consider flexibility for patients who achieve substantial LDL-C improvement but may not reach a specific treatment threshold.

Overall, the AAFP believes this measure represents an important opportunity to advance evidence-based cardiovascular care and supports its inclusion as an optional measure in MIPS for the CY 2027 performance period.

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

The AAFP supports the addition of this measure as an optional measure within family medicine, cardiology, endocrinology, geriatrics, internal medicine and nephrology specialty sets in traditional MIPS. We support the overall goal of the measure to promote the prevention and slow the progression of chronic kidney disease. However, successful implementation depends on patients having affordable and reliable access to the medications required to meet the measure. CMS should ensure that these therapies are adequately covered under Medicare, placed on affordable formularies, and accessible to

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beneficiaries without excessive cost-sharing or administrative barriers. Physicians should not be held accountable for measure performance when patients are unable to obtain clinically appropriate medications due to affordability, coverage, or access challenges.

Person-Centered Primary Care Measure (PCPCM)

The AAFP opposes the proposed removal of the Person-Centered Primary Care Measure (PCPCM) (Quality Measure #483) from MIPS. Although CMS cites the absence of a national benchmark as justification for removal, this circumstance is not unique to the PCPCM and affects more than 30 percent of measures currently retained in the program. Removal at this stage would be premature for a relatively new measure that is still building adoption and generating performance data.

The PCPCM is uniquely positioned to assess aspects of primary care that are central to CMS' broader vision for delivery system reform, including longitudinal relationships, whole-person care, wellness and prevention, and chronic disease management. As a patient-reported outcome measure, it provides important insight into whether patients experience the foundational functions of high-quality primary care that CMS seeks to promote through HHS's Make America Healthy Again initiative, as well as through more specific pathways such as the Value in Primary Care MVP and the ACO Primary Care Flex Model.

AAFP encourages CMS to retain the PCPCM in MIPS and consider alternative scoring approaches, such as a defined scoring floor during the continued maturation of the measure. Maintaining the measure will help ensure that physicians, patients, and policymakers have a meaningful way to assess and advance patient-centered primary care.

Q205: Sexually Transmitted Infection (STI) Testing for People with HIV

The AAFP recognizes the importance of routine STI screening for people living with HIV and believes this measure may be appropriate for family physicians who provide comprehensive HIV care. However, HIV management is not uniformly provided across family medicine, and many patients receive HIV-specific care from infectious disease specialists or dedicated HIV clinics. Accordingly, CMS should ensure appropriate attribution and recognize the measure's limited applicability across the broader family medicine specialty.

Q340: HIV Annual Retention in Care

The AAFP supports efforts to improve outcomes for people living with HIV **but opposes the addition of Q340: HIV Annual Retention in Care to the Family Medicine Specialty Set.**

This measure is not broadly applicable to most family physicians, as many patients with HIV receive their HIV-specific care from infectious disease specialists or dedicated HIV clinics. The AAFP is concerned about attribution, as family physicians are often not the clinicians

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primarily responsible for managing HIV treatment and follow-up. Patients should be attributed to the clinician providing HIV care, and primary care physicians should not be held accountable when they are not the treating physician for the condition.

Further, specialty sets should prioritize measures that are broadly relevant to the scope of family medicine and reflect areas where physicians can meaningfully influence performance. Adding highly condition-specific measures with limited applicability reduces the usefulness of the Family Medicine Specialty Set and may not provide meaningful information about the quality of care delivered by most family physicians. For these reasons, the AAFP urges CMS not to add Q340 to the Family Medicine Specialty Set.

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@aaafp.org.

Sincerely,

A handwritten signature in black ink, appearing to read "J Brull, MD", is positioned above the typed name.

Jen Brull, MD, FAAFP
Board Chair
American Academy of Family Physicians

ⁱ Chung, H., et al. (2023). *Medicaid costs and utilization of collaborative versus colocation care for patients with depression*. *Psychiatric Services*, 74(11).

ⁱⁱ Watkins, K. E., Ober, A. J., Lamp, K., et al. (2017). *Collaborative care for opioid and alcohol use disorders in primary care: The SUMMIT randomized clinical trial*. *JAMA Internal Medicine*, 177, 1480–1488.

ⁱⁱⁱ Bowman Family Foundation. (2025). *Mounting Evidence that Use of the Collaborative Care Model Reduces Total Healthcare Costs*.

^{iv} <https://www.cms.gov/data-research/statistics-trends-reports/medicare-fee-service-parts-b/medicare-utilization-part-b/top-200-level-i-cpt-codes-ranked-charges-reports>

^v <https://www.aaafp.org/assets/image/upload/v1/Migrated%20-%20AEM%20DAM/AAFP/documents/advocacy/payment/medicare/lt-cms-2025mpfs-090924-pdf.pdf>

^{vi} <https://www.aaafp.org/assets/image/upload/v1/Migrated%20-%20AEM%20DAM/AAFP/documents/advocacy/payment/medicare/lt-cms-2025mpfs-090924-pdf.pdf>

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^{vii} Health Care Payment Learning & Action Network. *The Future of Primary Care: A Framework for the Future and a Foundation for Health Care Reform*. (2021).

^{viii} See the Determination of PE RVUs section, section II.B., above.

^{ix} <https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/state-of-primary-careworkforce-2023.pdf>

^x David Katerndahl, Robert Wood, Carlos Roberto Jaén, Complexity of ambulatory care across disciplines, *Healthcare*, Volume 3, Issue 2, 2015, Pages 89-96, ISSN 2213-0764, <https://doi.org/10.1016/j.hjdsi.2015.02.002>.

(<https://www.sciencedirect.com/science/article/pii/S2213076415000184>)