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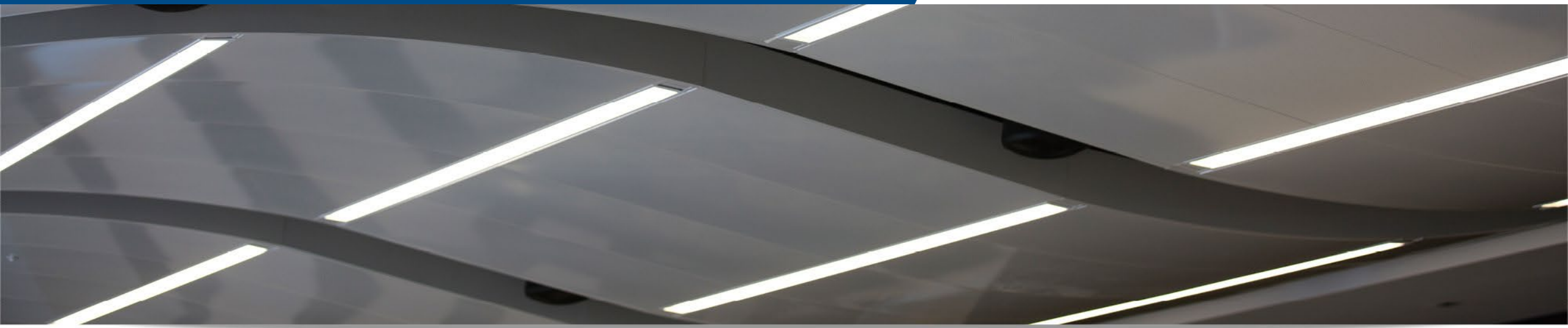

Calendar Year 2027 Medicare Physician Fee Schedule Proposed Rule

Alston & Bird Summary

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Background

- On July 14, 2026, the Centers for Medicare & Medicaid Services (CMS) released its *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* proposed rule
- The annual proposed rule includes key policy proposals, including proposals to revise payment policies under the Medicare Physician Fee Schedule (PFS) and make other changes to Medicare Part B payment policies
- **Comments are due by <u>September 14, 2026</u>**

Background [cont'd]

- The proposed rule is available here
- The press release is available here
- The general fact sheet is available here
- The Medicare Shared Savings Program (MSSP) proposals fact sheet is available here
- The Quality Payment Program (QPP) proposals fact sheet is available here

Rate Setting and Conversion Factor

- As required by statute, beginning in 2026, there will be two separate conversion factors (CFs): one for items and services furnished by a qualifying alternative payment model (APM) participant (QP) ("qualifying APM CF") and another for other items and services furnished by clinicians who are not QPs ("nonqualifying APM CF"), equal to the respective CF for the previous year multiplied by the update established in statute for such respective CF for such year
- Under CMS's proposals:
  - The **qualifying APM CF** is **33.1693**
    - This CF represents a decrease of $0.40 (-1.19 percent) from the current CY 2026 CF of 33.4009
    - This reflects a 0.53 percent positive budget neutrality adjustment required by statute and the 0.75 percent update adjustment factor specified in statute
  - The **nonqualifying APM CF** is **32.8409**
    - This CF represents a decrease of $0.56 (-1.68 percent) from the current CY 2026 CF of 33.5875
    - This reflects a 0.53 percent positive budget neutrality adjustment required by statute and the 0.25 percent update adjustment factor specified in statute

Determination of Practice Expense (PE) Relative Value Units (RVUs) – PE Methodology

- CMS proposes to allocate indirect PE RVUs using both the work RVU and the clinical labor RVU for ALL services, with the exception of codes with 010- and 090-day global periods, instead of just applying that methodology to those services that can be reported using technical, professional, and global components (typically diagnostic and imaging services)
  - Under current policy, CMS allocates a larger share of indirect PE RVUs to services that can be reported using technical, professional, and global components than to those that cannot
  - The agency states that it would be more accurate to use the same allocation methodology for all PFS services
- CMS also proposes to remove the indirect practice cost index (IPCI) from the calculation of PE RVUs over a two-year transition period
  - In the first year, only half of the measured variation in the IPCI would be applied
  - In the second year, the IPCI would no longer be applied
- According to CMS, the IPCI favors aggregate specialty-level survey data over code level inputs and allocators, and consequently limits the influence of improvements to inputs and allocation methodologies

Determination of PE RVUs – PE Methodology [cont'd]

- To minimize volatility in PE RVUs following the proposed removal of the IPCI, the agency proposes a PE stabilization adjustment in the form of a cap to annual changes to the PE RVU
  - This cap would be calculated after the application of the cognitive services floor and any adjustments that occur outside the PE methodology will be subject to a cap and will not increase or decrease more than five percent each year
  - The cap would be applied prior to the statutory phase-in of significant RVU reductions required by Section 1848(c)(7) of the *Social Security Act* (SSA), which limits all codes that are not new or revised to a 19 percent decrease in total RVUs in an individual calendar year so that a code may be impacted by both the PE stabilization adjustment and the statutory phase-in
  - The adjustment would not apply to new or revised codes or codes formerly contractor priced that are newly nationally priced
    - While CMS believes that the benefits of the PE stabilization adjustment would ideally apply to new and revised codes and newly nationally priced codes, CMS seeks comment on an approach that would allow it to expand the PE stabilization adjustment to those categories of codes
  - The proposed PE stabilization adjustment also would not apply to revalued codes because the statutory phase-in sufficiently limits large reductions to individual codes undergoing review and/or revaluation and limits the amount of time a revalued code would remain overvalued by being significantly constrained from reductions found to be appropriate through revaluation

Determination of PE RVUs - PE Methodology [cont'd]

- CMS proposes to modify its methodology for adjusting volume and time to account for payment modifiers and other special payment rules
- Specifically, for each paid claim line, CMS would calculate the ratio of allowed charges to the national PFS amount
  - This proposal would account for differences resulting from payment modifiers and special payment rules as well as geographic differences
  - The agency proposes to use the same ratio to adjust time, rather than a separate calculation under its current methodology, with the exception of anesthesia, for which CMS calculates time using only procedures with modifiers indicating they are personally performed
- The agency proposes to continue to use the current PE incurred per hour (PE/HR) and 2006-based Medicare Economic Index (MEI) cost shares for CY 2027 instead of using the 2017-based MEI cost shares
- With respect to updates to direct PE input prices, CMS further proposes to update the prices of nine supplies and two equipment items based on publicly submitted invoices; *see* Table A-D9 for a full list of applicable items

Determination of PE RVUs – Site of Service Payment Differential

- In the CY 2026 PFS final rule, CMS finalized a policy that allocated half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated in the non-facility setting
- CMS subsequently heard from stakeholders that this policy resulted in an unintended and significant site of service differential for physician visits in a nursing facility based solely on whether a beneficiary's stay is covered by Part A
  - A service furnished to a patient in a skilled nursing facility (SNF) during a Part A stay is a "facility" setting; a service furnished to a patient in a nursing facility during a Part B stay is a "non-facility" setting
  - Under the 50 percent reduction policy, the site of service differential became based on the status of the beneficiary, not the setting of care

Determination of PE RVUs – Site of Service Payment Differential [cont'd]

- Because the resources required to furnish an evaluation and management (E/M) service are not expected to vary based on whether the beneficiary is on a Part A stay or not, CMS proposes for CY 2027 to set the facility PE RVU equal to the non-facility PE RVU for the following nursing facility E/M codes:
  - Current Procedural Terminology (CPT) codes 99304, 99305, and 99306 (initial nursing facility care at three levels of medical decision making)
  - CPT codes 99307, 99308, 99309, and 99310 (subsequent nursing facility care at four levels of medical decision making)
  - CPT codes 99315 and 99316 (nursing facility discharge management at two-time thresholds)

Determination of PE RVUs – Site of Service Payment Differential [cont'd]

- CMS continues to have concerns about the current site of service differential and noted that stakeholders specifically said that the facility PE reductions have a disparate impact on hospital medical groups and hospitalists
- In the CY 2026 PFS final rule, CMS said that the 50 percent reduction policy was a starting point and that it intended to further examine its methodology and consider additional refinements based on feedback received or any studies or data sources identified
  - CMS remains open to more specific data that addresses the variability as well as feedback on how to update the valuation and payment methodologies to better reflect the relative resources involved in furnishing the services, both across settings of care, and within the context of an evolving ecosystem of care models and business arrangements
- CMS acknowledges it has historically relied on specialty-specific PE/HR survey data and the binary site of service differential to reflect variable PE costs
- While acknowledging that physician practices maintain some indirect PE costs for physicians who are solely facility-based, CMS continues to be concerned about the growth of exclusively facility-based physicians and that potential overpayments for indirect PE costs could be a driver of clinician movement to higher cost settings without creating commensurate clinical value

Determination of PE RVUs – Site of Service Payment Differential [cont'd]

- To better inform its consideration of how to account for PE under the PFS methodologies, including the current differentials that are effectuated based on the binary 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 is seeking information that will help illuminate to what extent these costs are truly incurred when the professionals are employed by the hospital and/or practice primarily in the hospital and are not already accounted for in the existing Outpatient Prospective Payment System (OPPS) payments:
  - If a physician is employed by and practicing in a hospital, what portion of the indirect PE is associated with the PFS service, versus costs that are associated with the payment to the hospital, such as those paid under the OPPS?
  - What is the amount of indirect PE hospital-employed physicians incur when they furnish care within a facility? For these physicians, is the 50 percent indirect PE allocation accurate or could it possibly be less than 50 percent, such as 0 percent?
  - In consideration of the accuracy of the current 50 percent indirect PE allocation for services furnished in the facility setting, how can the agency 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 PEs

Determination of PE RVUs – Site of Service Payment Differential [cont'd]

- CMS is seeking information that will help illuminate to what extent these costs are truly incurred when the professionals are employed by the hospital and/or practice primarily in the hospital and are not already accounted for in the existing OPPS payments [cont'd]:
  - Whether a new Healthcare Common Procedure Coding System (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
  - What are the primary variables CMS should consider to continue to improve its data sources, allocation methodologies, and payment rates across settings of care, to best reflect the resources involved in furnishing PFS services by professionals and suppliers operating in a complex marketplace, across settings of care
  - If there is 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
    - This would help CMS understand and improve how PE is allocated across settings of care, both in general and for specific kinds of services

Determination of PE RVUs – Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems – Professional and Technical Components

- CMS notes that the structure of the PFS can make it difficult for interested parties and the agency to compare payment rates, underlying resource costs, and value across settings of care
- To facilitate more consistent comparisons across services and settings, CMS developed a public use file that displays, for services that are not currently billable with TC/26 modifiers, RVU amounts that reflect the relative resources involved in furnishing professional and technical aspects of the services
- The file is meant to improve transparency on how PFS payments may be conceptually divided between professional and technical components
- In particular, it is intended to illuminate differences between technical aspects of PFS services and facility fees across settings of care
  - The file excludes 010- and 090-day global surgery services because their bundled nature obscures how each component of the service contributes to the total valuation
    - CMS seeks comment on how to address this issue, either in possible improvements to the global surgery packages (referred to as “globals”) or, at least, in the best way to make their component pieces transparent
  - The file also excludes codes subject to the cognitive services floor and the statutory phase-in of significant RVU reductions, due to technical challenges with how these policies are implemented that hinder the disaggregation of their component parts

Determination of PE RVUs – Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems – Professional and Technical Components [cont'd]

- CMS seeks comment on:
  - The utility of displaying RVUs associated with professional and technical aspects of services not currently billable with TC/26 modifiers, 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
  - Methodologies CMS could develop to more clearly identify and, where appropriate, disaggregate the underlying components of these services
  - 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

Determination of PE RVUs – Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems – Global Surgical Packages

- In the CY 2015 PFS final rule, CMS finalized a policy to transition all 10-day and 90-day globals to 0-day globals. However, the *Medicare Access and CHIP Reauthorization Act* (MACRA) prohibited CMS from doing so and directed CMS to collect data on how to best value globals
- As part of this effort, CMS collects data via reporting of CPT code 99024 (a no payment code used solely for data collection indicating that a post-operative E/M service was performed during the global period), limited to practices with 10 or more practitioners in nine states
- CMS explained in the CY 2019 PFS final rule, only four percent of reviewed 10-day globals and 67 percent of reviewed 90-day globals had one or more post-operative visits occurring during the global period
- CMS continues to explore steps to improve accountability and more accurate payment for global services

Determination of PE RVUs – Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems – Global Surgical Packages [cont'd]

- CMS proposes to pause the data collection required by MACRA
  - CMS remains interested in how best to use and collect this data going forward and ways it might consider improving this data collection
  - CMS currently has several years of data that continued to illustrate what it believes is the issue with the post-operative visits during the global period and how these visits are not occurring, yet providers are still being paid for these visits under the current global payment policy
  - Additionally, CMS believes that the current data collection may impose an undue burden to providers and that pausing the data collection would reduce burden on practitioners

Determination of PE RVUs – Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems – Global Surgical Packages [cont'd]

- CMS questions whether a more robust data collection would be appropriate and if it should have all providers report CPT code 99024
- CMS also seeks comment on other data sources it might consider to more accurately value the globals
- CMS is posting a public use file to display the imputed RVUs associated with both the 10- and 90-day post-operative visits based on a purely arithmetic approach to understand the valuation of the services based on the data that was analyzed
  - This public use file shows the current work RVUs, the number of post-operative visits that are reported to CMS using no-pay HCPCS code 99024, and the work RVUs remaining if all postoperative visits are removed
  - CMS seeks comment on potential revaluation strategies that it may consider through future rulemaking

Payment for Medicare Telehealth Services – Changes to the Medicare Telehealth Services List

- CMS notes it did not receive any requests to add or remove services from the Medicare Telehealth Services List for CY 2027
- CMS proposes adding the following new HCPCS codes to the Medicare Telehealth Services List:
  - G-code GACP1 *(Advance care planning [ACP] including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), directed by a treating physician or other treating qualified health care professional [QHP])*;
  - GACP2 *(ACP including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s), directed by a treating physician or other treating QHP (List separately in addition to code for primary procedure))*;
  - GSMAS *(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 QHPs, clinical staff, or auxiliary personnel under the direction of the supervising physician or other 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)*;
  - GSLPP *(Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual; for the pediatric population up to age 18 or 21)*; and
  - GADV1 *(Office or other outpatient E/M service(s) for the diagnosis and treatment of vaccine adverse effects, new or established patient; each 15 minutes personally performed by the physician or QHP (list separately in addition to CPT codes 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350))*
- CMS clarifies that, if finalized, these services will be separately payable under the PFS and will be subject to requirements related to payment for telehealth services as they are inherently face-to-face services and would serve as a substitute for an in-person encounter
- The agency also believes that these services are capable of being furnished using an interactive telecommunications system

Payment for Medicare Telehealth Services – Telehealth Flexibilities and Modifiers

- Beginning January 1, 2027, Section 6209(g) of the *Consolidated Appropriations Act, 2026* (CAA, 2026) requires CMS to establish modifiers for telehealth services in certain instances
  - These modifiers do not affect payment and are required for claims for telehealth services that are provided through a virtual telehealth platform by a provider that contracts with an entity that owns such virtual platform; or for which a provider has a payment arrangement with an entity for use of such virtual platform; and for claims for telehealth services that are provided incident to a provider's professional service
- CMS is therefore creating modifiers BB and BC
  - The agency notes that guidance on use of these modifiers will be available on the CMS website

Payment for Medicare Telehealth Services – Telehealth Critical Care Consultations

- In the CY 2026 PFS final rule, CMS finalized permanently removing frequency limitations of one critical care consultation service furnished via telehealth per day
- Since its removal, CMS has received questions about language in the code descriptors for HCPCS codes G0508 (*Telehealth consultation, critical care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth*) and G0509 *(Telehealth consultation, critical care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth)* describing "initial" and "subsequent" consultations and questions regarding the language about the typical time spent on the service
- CMS is proposing the following revised code descriptors for clarity:
  - G0508: *Telehealth consultation, critical care; first 30 to 74 minutes*
  - G0509: *Telehealth consultation, critical care; each additional 30 minutes (List separately in addition to code for primary service)*
- CMS seeks comment on its proposal

Payment for Medicare Telehealth Services – Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

- In the CY 2026 PFS final rule, CMS finalized permanently allowing teaching physicians to have a virtual presence in all teaching settings, only in clinical instances when the service is a three-way telehealth visit, with the teaching physician, resident, and patient in different locations
- CMS has received feedback that its finalized policy can cause logistical complexities, in rare cases, when either the teaching physician or resident is in the same physical location as the beneficiary
- To address this, CMS is proposing a modification to permit teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary (rather than requiring the teaching physician, resident, and patient to each be in a different location)
- The agency notes it would generally interpret physical presence to be defined as either the teaching physician or resident in the same room as the beneficiary but is seeking comment on other scenarios in which this may be appropriate
  - CMS further clarifies that this would only apply to services on the Medicare Telehealth Services List
- CMS seeks comment on its proposal

Payment for Medicare Telehealth Services – Telehealth Originating Site Facility Fee Payment Amount Proposed Update

- The telehealth originating site facility fee is increased by the percentage increase in the MEI
- The proposed MEI increase for CY 2027 is 2.5 percent and is based on the expected historical percentage increase of the 2017-based MEI
- CMS proposes to update the MEI increase for CY 2027 based on historical data through the second quarter of 2026
- Therefore, for CY 2027, CMS proposes the payment amount for HCPCS code Q3014 *(Telehealth originating site facility fee)* to be $32.65
- *See* Table A-C1 for the Medicare telehealth originating site facility fee and the corresponding MEI percentage increase for each applicable time period

Valuation of Specific Codes, Including Potentially Misvalued Codes – Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

- CMS proposes to reform the use of RPM and RTM services due to two Office of Inspector General (OIG) reports that found some practices did not have a prior relationship with patients for whom they billed remote monitoring, that companies were "cold calling" beneficiaries to solicit them for services they may not need, and that 43 percent of enrollees who received RPM did not receive all three components of the service, raising questions about whether monitoring is being used as intended
- Accordingly, with respect to RPM or RTM services, CMS proposes to require:
  - RTM services only be furnished to established patients
    - RPM services are already subject to this requirement per the CY 2021 PFS final rule
  - Practitioners reporting RPM or RTM services would have to furnish a separately reportable initiating visit in association with the onset of RPM or RTM services
    - The initiating visit must be conducted face-to-face; CPT codes that do not involve a face-to-face visit by the billing practitioner or are not separately payable under Medicare cannot be used as the visit for RPM or RTM initiation
    - If RPM or RTM is not discussed with the patient at that visit, that visit cannot count as the initiating visit for RPM or RTM
    - The RPM or RTM initiating visit can be separately billed

Valuation of Specific Codes, Including Potentially Misvalued Codes – RPM and RTM [cont'd]

- Accordingly, with respect to RPM or RTM services, CMS proposes to:
  - Allow payment for RPM or RTM services only when furnished by clinical staff employed by the practice
    - Clinical staff would have to be a direct employee of the practitioner or the practitioner's practice
    - RPM and RTM codes could not be billed if performed by contracted third parties
    - Clinical staff would not have to be physically located within the practice nor would the beneficiary have to be on site
    - Time spent by the 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 at 42 CFR 410.26 are met, and the clinical staff are direct employees of the practitioner or the practitioner's 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

Valuation of Specific Codes, Including Potentially Misvalued Codes – RPM and RTM [cont'd]

- With respect to proposed PE input changes for RPM or RTM services, CMS proposes:
  - For CPT codes 99453 and 98975 (RPM and RTM initial set up and patient education on the use of equipment, respectively), crosswalk the direct PE inputs from CPT code 99473
    - CMS seeks comment on this proposal, specifically information regarding the typical clinical workflow for the initial set-up and patient education on use of equipment services used in furnishing RPM or RTM and their associated costs
    - CMS believes the existing valuation may be overstated due to lack of information about the typical device

Valuation of Specific Codes, Including Potentially Misvalued Codes – RPM and RTM [cont'd]

- With respect to proposed PE input changes for RPM or RTM services, CMS proposes:
  - For CPT codes 99445 and 99454 (device supply with daily recording/programmed alert transmission codes for RPM), crosswalk direct PE inputs from CPT code 99474 (self-measured blood pressure report to clinician)
  - For CPT codes 98976, 98977, 98978, 98984, 98985, and 98986 (device supply for data access or data transmission codes for RTM), crosswalk direct PE inputs from CPT code 93270 (external patient electrocardiographic rhythm recording)
- CMS seeks comments on this proposal, specifically:
  - Information regarding the typical devices used in furnishing RPM or RTM, not just their associated costs and invoices, but robust evidence detailing what providers are actually paying for these devices, including discounts or other typical pricing details
  - 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

Valuation of Specific Codes, Including Potentially Misvalued Codes – RPM and RTM [cont'd]

- With respect to proposed PE input changes for RPM or RTM services, CMS proposes:
  - For CPT codes 99470, 99457, 99458, 98979, 98980, and 98981 (treatment management codes), eliminate PE inputs for these codes entirely, believing resource costs are accurately captured in work RVUs and that the typical clinical workflow does not involve clinical staff time beyond what is already reflected in the work valuation
    - CMS proposes maintaining the current work RVUs and work times
    - The agency also requests information on the typical clinical workflow for these services
- CMS solicits comments, requesting robust evidence on what providers are actually paying for devices, including discounts and typical pricing details; whether costs include software, hardware, or both; and more information about typical devices

Valuation of Specific Codes, Including Potentially Misvalued Codes – RPM and RTM [cont'd]

- CMS is concerned about the administrative burden of the current code structure with numerous remote monitoring codes and is considering bundling all 17 RPM and RTM codes into four new HCPCS G-codes that would describe initial set up and monthly monitoring/management for RPM and RTM, respectively:
  - GRPM1: RPM initial set-up and patient education
  - GRPM2: Remote monitoring of physiologic parameter(s) (e.g., 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; and treatment management services requiring at least one real-time interactive communication with the patient/caregiver totaling at least 20 minutes
  - GRTM1: RTM initial set-up and patient education
  - GRTM2: Remote monitoring of therapeutic parameter(s) (e.g., 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; and treatment management services requiring at least one real-time interactive communication with the patient or caregiver totaling at least 20 minutes

Valuation of Specific Codes, Including Potentially Misvalued Codes – RPM and RTM [cont'd]

- CMS seeks comment on:
  - The proposed G-codes
  - Any other revisions needed to the code descriptors to reflect the necessary service elements for this code family
  - Implementing the proposed G-codes in rural health clinics (RHCs) and federally qualified health centers (FQHCs)
- CMS could finalize payment for these codes after consideration of public comment
- If finalized, these G-codes would adopt all current conditions of payment for these codes finalized in past rulemaking, as well as any relevant proposals in this proposed rule
- All service elements outlined in the new G-codes would be required each calendar month
- CMS identifies two key benefits of consolidation: (1) reducing administrative burden from 17 codes to four, and (2) ensuring that beneficiaries always receive treatment management services when receiving remote monitoring, addressing the OIG finding that 43 percent of enrollees did not receive all three components
  - By incorporating device supply, data transmission, and treatment management into a single code, CMS could ensure all elements are always provided

Valuation of Specific Codes, Including Potentially Misvalued Codes – RPM and RTM [cont'd]

- CMS suggests crosswalking:
  - GRPM1 and GRTM1 (PE-only setup codes) to the direct PE inputs from CPT code 99473 (education and training for self-measured blood pressure readings)
    - CMS seeks comments 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
  - GRPM2 to the work RVU of 0.61 from CPT code 99457 and the direct PE inputs from CPT code 99474 (self-measured blood pressure report to clinician)
  - GRTM2 to the work RVU of 0.62 from CPT code 98980 and the direct PE inputs from CPT code 93270 (external patient electrocardiographic rhythm recording)

Valuation of Specific Codes, Including Potentially Misvalued Codes – E/M Visit Complexity Add-On (HCPCS code G2211)

- In the CY 2024 PFS final rule, CMS finalized separate payment for the office/outpatient (O/O) E/M visit complexity add-on code, HCPCS code G2211, which is meant to recognize the longitudinal relationship between patient and practitioner
- However, CMS now believes that the resource costs of providing longitudinal care are not best characterized as a separate service requiring a separate code. Rather, CMS believes it is an inherent part of the visit, which would be more accurately valued as a modifier to the base E/M code
- Accordingly, the agency proposes to replace HCPCS code G2211 with a modifier (referred to as MOD1), which would be replaced with a two-digit HCPCS modifier, if finalized
  - Use of the MOD1 modifier would have the same requirements as billing G2211 now
  - This modifier would have the same code descriptor as G2211, with technical changes
- CMS proposes to value MOD1 at 16 percent of the base E/M code
  - This percentage was established by using a weighted average of the percentage increase that G2211 comprised relative to the O/O E/M code, weighted by HCPCS code G2211 utilization and adjusted to maintain budget neutrality
  - The agency believes that the current flat rate of G2211 does not reflect the variation of work in the various E/M visit levels

Valuation of Specific Codes, Including Potentially Misvalued Codes – E/M Visit Complexity Add-On (HCPCS code G2211) [cont'd]

- CMS proposes to create modifier MOD2 for services furnished in an Accountable Care Organization (ACO) that would be valued at 32 percent of the E/M visit
  - Use of this modifier would only be applicable to E/M visits when performed by Shared Savings Program ACO participants, ACO professionals, ACO providers and suppliers (defined at 42 CFR 425.20) and participant providers in the LEAD Model when visit complexity criteria are met
  - The provider furnishing this service must be one who can bill O/O E/M visits or home visit services, regardless of specialty
  - ACO Primary Care Flex Model participants can also use the MOD2 modifier
  - LEAD Participant providers billing under a Participant tax identification number (TIN) that is in a LEAD ACO may bill modifier MOD2

Valuation of Specific Codes, Including Potentially Misvalued Codes – E/M Visit Complexity Add-On (HCPCS code G2211) [cont'd]

- CMS proposes to create modifier MOD2 for services furnished in an Accountable Care Organization (ACO) that would be valued at 32 percent of the E/M visit [cont'd]
  - The agency explains that serving as a focal point of care for all necessary services within an accountable care relationship is inherently more complex, and therefore should include additional resource costs
  - Use of this modifier is voluntary, and a provider can append MOD1, MOD2, or no modifier as appropriate
  - CMS emphasizes that simply providing an E/M visit while being part of an ACO would not necessarily meet the threshold of inherent complexity and should be used for visits that have an increased visit complexity that required an increased valuation
  - Qualifying providers for MOD2 can bill this modifier for all beneficiaries to whom they provide care, regardless of whether that beneficiary is assigned, aligned, or attributed to an ACO
  - Utilization and claims of either modifier will be included in ACOs' expenditure calculations for benchmarking and performance year expenditures and used in the determination of total cost of care

Valuation of Specific Codes, Including Potentially Misvalued Codes – E/M Visit Complexity Add-On (HCPCS code G2211) [cont'd]

- Regarding the impact on assignment of beneficiaries of Medicare Shared Savings Program (MSSP) ACOs:
  - Despite CMS proposing to delete G2211, it would remain in the regulations at 42 CFR 425.400(c) for the purposes of determining the population of Medicare fee-for-service (FFS) beneficiaries for whose care the ACO is accountable under 42 CFR subpart F, and for determining whether an ACO has achieved savings under 42 CFR subpart G, and will continue to be used for assigning beneficiaries to an ACO in benchmark years during which HCPCS code G2211 was still an allowable service
    - If the proposal is finalized, G2211 will no longer be payable, and there will be no impact on future calculations of allowed charges used for purposes of assignment
  - The allowed charges associated with O/O or home or residence E/M services billed with or without modifiers MOD1 or MOD2 will be used in determining beneficiary assignment
    - Since the CPT codes identified as O/O or home or residence E/M services are included in the definition of primary care services used for purposes of assignment as defined in 42 CFR 425.400(c), CMS does not believe that changes to the regulatory text are required
    - Certain operational changes will be implemented via Change Request, Medicare Learning Network (MLN) Matters article, or other sub-regulatory guidance

Valuation of Specific Codes, Including Potentially Misvalued Codes – E/M Visit Complexity Add-On (HCPCS code G2211) [cont'd]

- Regarding the impact on assignment of beneficiaries to LEAD ACOs:
  - If finalized, CMS will handle the deletion of HCPCS code G2211 and the transition to the modifiers similarly to the Shared Savings Program
  - CMS will continue to use G2211 allowable charges to conduct claims-based alignment in LEAD when G2211 was an allowable service in the requisite claims look back period
  - Once the claims-based alignment look-back period rolls forward to include 2027 and future years, the LEAD alignment methodology will include the allowed charges associated with MOD1 and MOD2 when conducting claims-based alignment
  - LEAD ACOs will be accountable for expenditures incurred by using either modifier MOD1 or MOD2, and expenditures associated with modifier MOD1 and MOD2 will be included in total Medicare Parts A and B expenditures when CMS conducts financial settlement for LEAD ACOs

Valuation of Specific Codes, Including Potentially Misvalued Codes – E/M Visit Complexity Add-On (HCPCS code G2211) [cont'd]

- In the CY 2025 PFS final rule, CMS finalized that it would allow payment of G2211 with modifier -25 when the O/O E/M base code is reported by the same practitioner on the same day as an annual wellness visit (AWV), vaccine administration, or any Medicare Part B preventative service when furnished in the office or outpatient setting
- CMS proposes to maintain these same limitations for MOD1 and MOD2 with modifier -25
- Note that as described below, CMS is proposing changes to when modifier -25 is appended
  - In light of these proposed changes, CMS is seeking comment 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

Valuation of Specific Codes, Including Potentially Misvalued Codes – Shared Medical Appointment (HCPCS code GSMAS)

- Consistent with the administration's goal of supporting healthcare delivery approaches that enable multidisciplinary support, foster beneficiary engagement, and encourage sustainable lifestyle and behavioral changes, CMS proposes to create coding and valuation for shared medical appointments (SMAs) (HCPCS code GSMAS), which are voluntary group-based sessions where multiple patients with a common chronic condition, such as Type 2 diabetes mellitus, receive medical care together
- With respect to SMAs, CMS proposes that:
  - SMAs be limited to beneficiaries who have received a professional service from the billing physician or other QHP or another physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice within the previous 12 months
  - Beneficiaries consent to SMA participation (since they can elect individual care instead) and to confidentiality terms (since personal health information would be discussed in a group setting)
  - SMAs be 60-minute sessions with a maximum of ten beneficiaries per session
  - SMAs be permitted to be held either in-person or via telehealth and SMA services be added to the Medicare Telehealth list

Valuation of Specific Codes, Including Potentially Misvalued Codes – Shared Medical Appointment (HCPCS code GSMAS) [cont'd]

- With respect to SMAs, CMS proposes that [cont'd]:
  - Each SMA session be documented in each participating beneficiary's medical record, reflecting the specific services that the individual beneficiary received during the SMA session
    - The services provided to the group as a whole would also need to be captured in the medical record
    - If the beneficiary requires a level of individualized care beyond what can be appropriately provided within the group session of an SMA, that care should be provided in a separate individual medical appointment
    - CMS seeks comment on additional guardrails to consider to prevent fraud, waste, and abuse (FWA) when billing SMAs
      - Examples include: 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

Valuation of Specific Codes, Including Potentially Misvalued Codes – Shared Medical Appointment (HCPCS code GSMAS) [cont'd]

- With respect to SMAs, CMS proposes that [cont'd]:
  - SMAs only be provided for medical conditions that are modifiable with lifestyle change
    - CMS seeks comment on how to determine when SMAs would be appropriate, including which medical conditions qualify as modifiable with lifestyle change
      - The agency suggests that it would typically consider conditions with medical guidelines that include lifestyle change as part of prevention and treatment as qualifying conditions for SMAs
      - Such conditions include diabetes, obesity, hypertension, and hyperlipidemia
    - The exact content of the SMA and desired behavioral change would vary
      - For example, improving diet and exercise supports both prevention and management of Type 2 Diabetes
      - CMS would not consider medication adherence or titrating medications for Type 2 Diabetes to be appropriate for an SMA, but would consider SMAs focused on improving nutrient composition to be an appropriate SMA activity, for example

Valuation of Specific Codes, Including Potentially Misvalued Codes – Shared Medical Appointment (HCPCS code GSMAS) [cont'd]

- With respect to SMAs, CMS proposes that [cont'd]:
  - SMAs must be billed and led by a physician or qualified nonphysician practitioner, and may include other QHPs, clinical staff, or auxiliary personnel
  - HCPCS code GSMAS would be billed once per patient, per session
  - CMS would accept any documentation demonstrating the care was rendered, provided that the physician's or qualified nonphysician practitioner's co-signature is included
  - When another QHP, such as a registered dietitian, provides a service during the SMA session, such as CPT code 97804 (Medical nutrition therapy (MNT); group (2 or more individual(s)), each 30 minutes), that service is considered part of the SMA and should not be billed separately

Valuation of Specific Codes, Including Potentially Misvalued Codes – Shared Medical Appointment (HCPCS code GSMAS) [cont'd]

- With respect to SMAs, CMS proposes that [cont'd]:
  - Each SMA include the following components:
    - E/M elements, consistent with the complexity of the beneficiary's condition
    - 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
  - If it is medically necessary for a beneficiary to receive an E/M visit on the same day as an SMA by the same physician or other QHP (or another physician or other QHP of the exact same specialty and subspecialty who belongs to the same group practice), CMS proposes that any time and effort cannot be counted more than once
    - CMS proposes not to treat this as two E/M same-day visits and seeks public comment on this proposal
  - Additionally, CMS seeks comment on what components must be required for each SMA session

Valuation of Specific Codes, Including Potentially Misvalued Codes – Shared Medical Appointment (HCPCS code GSMAS) [cont'd]

- CMS proposes that the valuation of HCPCS code GSMAS would use a building block methodology that sums up the values associated with two reference codes
- Using this methodology, CMS proposes a combined work RVU of 1.73 for GSMAS with a total work time of 45 minutes (calculated by adding pre-service evaluation time of 7 minutes, an intraservice time of 30 minutes, and a post-service time of 8 minutes)
  - For the individualized patient clinical assessment, CMS incorporates the work RVUs, work time, and direct PE inputs associated with a level 3 O/O visit for an established patient (CPT code 99213) which has a work RVU of 1.30 and a total work time of 30 minutes (5 minutes pre-service, 20 minutes intraservice, 5 minutes post-service)
  - For the group education, counseling, and peer support elements, CMS incorporates CPT code 96202 which has a work RVU of 0.43 and a total work time of 15 minutes (2 minutes pre-service, 10 minutes intraservice, 3 minutes post-service)
  - The agency notes that while an SMA may include up to 10 beneficiaries in a 60-minute session, the individualized care for each beneficiary may vary as some may receive more or less than others
  - The proposed valuation reflects a typical SMA session and is not intended to represent the exact time distribution for every beneficiary in every SMA
  - The proposed total work time is for valuation purposes only and is not a billing requirement
  - CMS seeks comment on this valuation

Valuation of Specific Codes, Including Potentially Misvalued Codes – Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

- Surgical procedures with a global surgery period include all necessary services normally provided by the practitioner before, during, and after a procedure, including pre-operative visits, typical intra-operative services, post-operative follow-up visits, supplies, and other services
- Because global packages already account for E/M resource costs, standalone E/M codes are not billable on the same day as a procedure code unless they are "significant and separately identifiable" from the procedure, as indicated by appending modifier -25 to the claim
- In the CY 2019 PFS final rule, CMS proposed a 50 percent payment reduction for the least expensive 0-day global procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim by an appended modifier -25
  - Following public comment, CMS did not finalize this proposal mainly because it had concerns about balancing appropriate valuation with potential disruption to patient care, and the American Medical Association (AMA) and CPT Editorial Panel's stated plans to revisit O/O E/M coding
  - CMS noted in that final rule that it continues to have concerns about 0- and 10-day global periods on the same day as E/M visits and that it is likely duplicating payment

Valuation of Specific Codes, Including Potentially Misvalued Codes – Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods [cont'd]

- CMS proposes to reduce payment when a separately identifiable O/O 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-, or 90-day global procedure
  - The most expensive service (either surgical or E/M visit) would be paid at 100 percent
  - All other surgical procedure(s) or E/M visit(s) furnished on the same day would be paid at 50 percent
- CMS explains that the 50 percent value is aligned with its previous proposal from CY 2019 and matches the multiple procedure payment reduction (MPPR)
  - CMS seeks comment on the value of the adjustment, such as if it should match a different MPPR value, such as 25 percent
    - Under MPPR, Medicare reduces payment by 50 percent for the second and subsequent surgical procedures furnished on the same day to the same patient largely based on the efficiencies in PE and pre- and post-surgical physician work
- CMS proposes to apply this policy only to O/O E/M visits at this time, but seeks comment on whether it should apply to other E/M visits, such as inpatient E/M visits
- CMS reiterates it does not find it appropriate to schedule medical services to maximize payment, which would create undue burden and potential medical risk for beneficiaries
  - CMS has data analysis tools to monitor for potentially problematic utilization patterns, including distinct claims editing, comparative billing reports to identify outlier providers, and medical review capabilities
  - CMS seeks comment on whether or not it is necessary to revise the conditions of payment to mitigate such payment abuses

Valuation of Specific Codes, Including Potentially Misvalued Codes – Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods [cont'd]

- CMS separately seeks comment on how this policy might apply to an E/M visit reported on the same day as an intravitreal eye injection, such as CPT code 67028, a high-volume 000-day global code
  - Since new injectable medications were developed to treat retinal diseases, there has been a new focus from auditors (including the OIG), Medicare Administrative Contractors (MACs), professional eye associations, and the AMA to better understand when same-day eye examinations are clinically indicated and separately identifiable from the injection
- CMS seeks comment on the clinical circumstances involved and any overlap with resources already accounted for in valuation of the global procedure, specifically:
  - Established patients without symptoms in the fellow eye
  - Established patients with symptoms in the fellow eye (whether prior or newly reported)
  - New patients
  - Whether it varies according to diagnosis and exam findings
  - Whether injections in the fellow eye are always deferred to another day
  - How CMS might confirm or ensure the visit is significant and separately identifiable absent a medical record review (e.g., should a new or different diagnosis code be expected on the claim)
- CMS also seeks to better understand whether the E/M work associated with new patients is typically included in the valuation of minor procedures, or whether there is extra work for new patients that is significant and separately identifiable enough to always warrant separate payment

Valuation of Specific Codes, Including Potentially Misvalued Codes – Revisions to Teaching Physician Policy Related to the Primary Care Exception

- Medicare reimburses O/O E/M codes of lower and mid-level complexity provided by a resident without the presence of a teaching physician
  - This exception applies only in specific outpatient primary care centers and when certain conditions are met
- CMS proposes to expand this exception so that all levels of an O/O E/M service provided in primary care centers that meet the requirements in 42 CFR 415.174 may be provided under direct supervision of the teaching physician when they believe such care is clinically appropriate and without the presence of a teaching physician
- Specifically, CMS is proposing to modify:
  - The requirements for certain E/M codes to allow PFS payment for a service furnished by a resident provided under direct supervision
  - 42 CFR 415.174(a) to state that certain E/M codes (as specified by CMS in program instructions) may be paid under the PFS 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
- CMS would continue to monitor the visit levels over time and welcomes comments on this proposal

Valuation of Specific Codes, Including Potentially Misvalued Codes – Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions

- CMS explains that providers rarely initiate conversations with patients about clinical trials, primarily because of the time and administrative burdens
- CMS seeks comment on whether it should establish payment for the resource costs associated with clinical trial counseling provided by a physician or other QHP
  - If effectuated, CMS would establish an HCPCS G-code for clinical trial counseling for a minimum of 20 minutes
- CMS also seeks comment on:
  - How to accurately value this service, including inputs for work and PE
    - Interested parties suggested a work RVU value between 1.00 and 1.50 RVUs
  - Whether the service should be available as a Medicare telehealth service
  - What documentation requirements CMS should consider for such a service

Request for Information (RFI): Redesigning Primary Care to Make America Healthy Again

- CMS is interested in how Medicare FFS could incorporate more incentives to invest in high-value care to reduce costs of care in the long-term within the PFS
- To support broader “Make America Healthy Again” (MAHA) priorities and reconcile with how technology innovation is reshaping primary care delivery for beneficiaries and clinicians, CMS seeks comment on how to re-imagine and improve the relative valuation of primary care services
- CMS wants to understand how that re-imagination might occur within the current construct of O/O E/M services and via alternatives to Medicare FFS payment, including through outcomes-based payment and/or the expansion of prospective primary care payment (PPCP)
- CMS is also considering first establishing PPCP permanently in the MSSP. CMS is seeking suggestions on how to implement PPCP within the broader Medicare FFS program with appropriate guardrails

RFI: Redesigning Primary Care to Make America Healthy Again [cont'd]

- Specifically, CMS seeks comment on three main topics:
  - Reconsidering relative primary care payment in the Medicare PFS: CMS is increasingly concerned about the relative undervaluation of primary care services and seeks feedback on:
    - How to reconsider this relative undervaluation in the PFS under the current paradigm of O/O E/M visits, the Annual Wellness Visit (AWV), and care management codes
    - Updating this code set, and how or if CMS should consider a "two-track" approach to care management services with one track focused on technology enabled care and the other track focused on "traditional" care management
  - The payment implications of technology–enablement of primary care: CMS seeks comment on:
    - How technology and clinical AI are impacting primary care, both broadly and more narrowly within the care management codes and the AWV
    - How CMS might update its approach to paying for technology-enabled care given the potentially transformative effects on the beneficiary and clinician experience
    - If the agency were to approach paying for technology-enabled primary care differently, how should it consider the relative valuation, in terms of time and intensity of services
    - How else could these services be valued
    - How should CMS consider evidence of the impact or outcome of technology-enabled services in primary care
  - Establishing PPCP in the MSSP: Given the series of CMS Innovation Center (CMMI) PPCP model tests, CMS seeks comment on:
    - How CMS should approach establishing PPCP in the MSSP, and more broadly across Medicare FFS
- For more details *see* pages 43936-43946 of the proposed rule

Comprehensive Outpatient Rehabilitation Facility (CORF) Services and KX Modifier Thresholds – Technical Corrections of CORF Regulations

- During previous rulemaking, CMS made several revisions and redesignations at 42 CFR § 410.100 without changing a related provision (§ 410.105) for the requirements for coverage of CORF services
- CMS also created a new subpart M at 42 CFR § 414.1105 for payment of CORF items and services that references § 410.100 without making the corresponding revisions to the sections that were amended during previous rulemaking
- CMS is now proposing to revise § 410.105(b)(3)(ii) for the home environment evaluation to indicate that the home environment evaluation is specified at § 410.100(l) and not § 410.100(m)
- CMS is also proposing to amend § 414.1105(c) for CORF supplies and durable medical equipment (DME) to indicate that supplies and DME that are CORF services are specified at § 410.100(k) instead of § 410.100(l)
- The agency is also proposing to remove from § 414.1105(c) language that relates to CORF drugs and biologicals because the provisions relating to payment for drugs and biologicals that are CORF services are at § 414.1105(d)
- CMS requests comments on these proposals

CORF Services and KX Modifier Thresholds – KX Modifier Thresholds

- For CY 2027, CMS proposes to increase the CY 2026 KX modifier threshold amount (formerly referred to as the "therapy cap" amount) by the most recent forecast of the 2017-based MEI
  - For CY 2027, the proposed MEI increase is estimated to be 2.5 percent and is based on the expected historical percentage increase of the 2017-based MEI
  - Multiplying the CY 2026 KX modifier threshold amount of $2,480 by the proposed CY 2027 percentage increase in the MEI of 2.5 percent ($2,480 x 1.025) and rounding to the nearest $10.00 results in a proposed CY 2027 KX modifier threshold amount of $2,540 for physical therapy and speech-language pathology services combined and $2,540 for occupational therapy services
- CMS also proposes to update the MEI increase for CY 2027 based on historical data through the second quarter of 2026, and proposes to use such data, if appropriate, to determine the final MEI percentage increase and the CY 2027 KX modifier threshold amounts in the CY 2027 PFS final rule
- CMS states that the threshold for targeted medical review (MR) is $3,000 for services through CY 2027
  - Thus, for CY 2027, the MR threshold is $3,000 for physical therapy and speech-language pathology services combined and $3,000 for occupational therapy services
- Per statute, effective beginning with CY 2028, the MR threshold levels will be annually updated by the percentage increase in the MEI

Supporting Beneficiaries Planning for Future Medical Decisions – Advance Care Planning (ACP) Services (HCPCS Codes GACP1 and GACP2)

- CMS proposes to create two new HCPCS codes to describe ACP services furnished by clinical staff under the direct supervision of the billing physician or other practitioner (and incidental to their professional services) and proposes that the existing CPT codes 99497 and 99498 would only be used to report time personally spent by the billing practitioner
- Specifically, CMS proposes the following new HCPCS codes:
  - GACP1 *(ACP including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), surrogate directed by a treating physician or other treating QHP)*
  - GACP2 *(ACP including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), each additional 20 minutes with the patient, family member(s), surrogate directed by a treating physician or other treating QHP (List separately in addition to code for primary procedure))*

Supporting Beneficiaries Planning for Future Medical Decisions – ACP Services (HCPCS Codes GACP1 and GACP2) [cont'd]

- GACP1
  - CMS proposes a work RVU of 1.00 for HCPCS code GACP1, based on a crosswalk to the work time of CPT code 99490 *(Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; first 20 minutes of clinical staff time directed by a physician or other QHP, per calendar month)*
  - For direct PE, CMS proposes 20 minutes of clinical labor (L037D) in the service period
- GACP2
  - CMS proposes a work RVU of 0.7 for HCPCS code GACP2, based on a crosswalk to the work time of CPT code 99439 *(Chronic care management services with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, comprehensive care plan established, implemented, revised, or monitored; each additional 20 minutes of clinical staff time directed by a physician or other QHP, per calendar month (List separately in addition to code for primary procedure))*
  - For direct PE, CMS proposes 20 minutes of clinical labor (L037D) in the service period
- Under this proposal, the new G codes and CPT codes 99497 and 99498 could be reported together, if time thresholds by the billing practitioner and clinical staff were each met with these respective code sets

Supporting Beneficiaries Planning for Future Medical Decisions – ACP Services (HCPCS Codes GACP1 and GACP2) [cont'd]

- CMS seeks comment on whether it would be better for the new G codes to represent, and be valued for, the combined time of a billing practitioner and their clinical staff within a single code, in case, for example, the billing practitioner and staff did not meet time thresholds for separate reporting of their respective times, but might meet the threshold for a code combining their time
- CMS notes that for both the existing codes (describing physician time but allowing use for clinical staff time) and newly proposed ACP codes (describing clinical staff time) to be paid "incident to," the reporting practitioner must furnish a prior professional service to which the services of the clinical staff are incidental
- CMS seeks comment about whether these "incident to" criteria (the requirement for the billing practitioner to perform initial and subsequent services reflecting their participation in and management of the course of treatment) are typically met for beneficiaries needing ACP services, by a separately billed E/M visit (whether the same day as the ACP services or prior), or might best be included in a new code inclusive of combined time spent by both a reporting practitioner and their clinical staff
  - CMS states that if the billing practitioner is by definition participating and managing by performing part of the ACP code itself, there would not be a need to require a prior initiating visit as CMS does for care management services provided "incident to"
- To help CMS craft new coding that reflects typical clinical practice and "incident to" rules governing payment for services by clinical staff, CMS seeks comment that specify or clarify for the alternative new coding, the typical care team structure; how much time is typically spent by the billing practitioner and spent by their staff, and when; and the clinical circumstances of patients, for example, the care settings and whether the patient is typically a well patient or is doing ACP in conjunction with a particular illness
- Further, for CY 2027, CMS is proposing to add both HCPCS codes GACP1 and GACP2 to the Medicare Telehealth list

Supporting Beneficiaries Planning for Future Medical Decisions – RFI on Community-based Palliative Care

- In coordination with requests for information in the FY 2027 Hospice and 2027 End-tage Renal Disease (ESRD) proposed rules, CMS is additionally seeking comment on the specific requirements it should consider given the prior CMMI model tests focused on complex and serious illness care
- CMS seeks comment on where it should focus on potential FWA in community-based palliative care
- Note: In response to this RFI (described on this slide and proceeding slides), CMS asks that commenters support their statements with peer-reviewed evidence or evidence from its institution

Supporting Beneficiaries Planning for Future Medical Decisions – RFI on Community-based Palliative Care [cont'd]

- Eligibility for Serious Illness Care: CMS recognizes that defining which beneficiaries are eligible for serious illness care is challenging in palliative and supportive care and seeks feedback on eligibility and care management services:
  - For any future supportive or palliative care service for Medicare beneficiaries, should eligibility be restricted to certification of a likely life expectancy duration?
  - If eligibility is restricted to those beneficiaries with a terminal prognosis, is there evidence to suggest a reasonable interval (i.e., less than one year of life expectancy as in some States' Medicaid programs)?
- Eligibility for Palliative Services: CMS recognizes that defining eligibility for palliative services beyond the potential criterion of a terminal prognosis is likely necessary to understand who is eligible for serious illness care and seeks feedback on the following:
  - For any future supportive or palliative care service for Medicare beneficiaries, how could CMS consider impact on the daily functions of life or activities of daily living as part of who is eligible for the service?
  - Would eligibility best be based on impact on daily function, on caregiver strain, or both?
  - How can CMS avoid overly burdensome requirements for defining eligibility for services?

Supporting Beneficiaries Planning for Future Medical Decisions – RFI on Community-based Palliative Care [cont'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 between visit care (in addition to E/M services for outpatient or home visits) and seeks feedback on the following:
  - How should CMS differentiate the care management requirements for seriously ill beneficiaries from other Medicare beneficiaries?
  - What are the essential service elements that must be included? (e.g., 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?
- Advanced Primary Care Management: For Advanced Primary Care Management (APCM) services (HCPCS codes G0556-G0558), CMS requires physicians to report to the Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) for primary care. If CMS elects to develop additional care management services for seriously ill beneficiaries, however, the agency may define serious illness in the future. CMS seeks feedback on the following:
  - Should care management services for seriously ill beneficiaries also require reporting to an MVP? Which quality measures should be reasonably included?
  - If no viable MVP reporting mechanism is found, what are the essential quality elements required for palliative care management? Is sole reporting of ambulatory palliative care patients feeling heard and understood (CBE 3665) sufficient? Should other measures be considered?

Supporting Beneficiaries Planning for Future Medical Decisions – RFI on Intensive Lifestyle Interventions to slow progression of Alzheimer's disease

- As follow-up to the Prevention and Management of Chronic Disease RFI in the CY 2026 proposed rule, CMS is requesting additional information to better understand the resource costs and requirements for developing intensive lifestyle interventions to reduce the risk of Alzheimer's disease and Alzheimer's disease-related dementias (AD/ADRD) for Medicare beneficiaries and seeks comment on the following:
  - Given the discussion of the evidence to date on the effectiveness of intensive lifestyle interventions for CMS to pursue, CMS is particularly interested in demonstrations of cost-savings associated with these and other interventions. Please cite any evidence available in your discussion
  - Given CMS' concern for addressing FWA throughout the Medicare program, please comment on any potential or observed FWA in diagnosis, treatment, or management of AD/ADRD
  - Given the emerging role of biomarker diagnostic testing (e.g., p-tau217, et. al) for AD/ADRD leading to early diagnosis, please provide any evidence supporting earlier detection and its role in supporting improving AD/ADRD care and any potential role in identifying eligibility for an intensive lifestyle intervention focused on AD/ADRD
  - What are the essential domains to address in a multi-domain intensive lifestyle intervention to reduce the risk of cognitive decline for older adults at risk for developing AD/ADRD that would be appropriate to include under Medicare?
  - Should these interventions be made available as a one-time service (i.e., to teach older adults how to make changes in their lifestyle to help reduce AD/ADRD risk) or on a recurring (e.g., annual) basis?
  - Should the eligibility for these services be restricted to beneficiaries with a diagnosis of mild cognitive impairment (MCI), or early-stage dementia? If so, how should this diagnosis be made or confirmed?

Supporting Beneficiaries Planning for Future Medical Decisions – RFI on Intensive Lifestyle Interventions to slow progression of Alzheimer's disease [cont'd]

- CMS notes that responses to the general intensive lifestyle intervention question in the RFI from the CY 2026 proposed rule focused on the differentiation between intensive lifestyle interventions (ILIs) and intensive behavioral therapy (IBT) where ILIs are more multi-domain, longitudinal, and comprehensive and typically incorporate a multi-disciplinary team and are delivered in a community setting, and noting these are needed flexibilities that current IBT coding does not currently accommodate
- To better under the resource costs and requirements for future AD/ADRD ILI services, CMS seeks comment on the following:
  - Given ILI's are multi-domain, and likely include physical activity, nutrition, potentially additional domains such as sleep and stress management, who are the essential interdisciplinary team members that CMS should account for in developing appropriate resource costs for future services?
  - How should supervision be determined for AD/ADRD ILI's? Is general supervision sufficient for ensuring clinical safety and oversight? Is direct supervision required?

Supporting Beneficiaries Planning for Future Medical Decisions – RFI on Intensive Lifestyle Interventions to slow progression of Alzheimer's disease [cont'd]

- CMS notes that while there are many variations of ILI's focusing on AD/ADRD that are delivered, the essential "dose" of intervention or minimum frequency and duration of a future service and the modality (i.e., must this intervention be delivered purely in person, can it be delivered virtually) are all important to consider. CMS therefore seeks comment on the following:
  - What is the minimum frequency of sessions for an AD/ADRD ILI per week? What is the minimum number of weeks that will be necessary?
  - Should CMS require a future AD/ADRD ILI to be delivered in person? Can it be delivered virtually?
- Finally, while CMS is accepting applications for MAHA ELEVATE (a CMMI payment model to generate evidence associated with lifestyle interventions), including potentially intensive lifestyle interventions focused on reducing risk and/or slowing progression of AD/ADRD, CMS has no endorsement process for specific interventions. In development of the CMS Health Technology Ecosystem and the library of applications, CMS seeks comment on the following:
  - How should CMS support the development of our Health Technology Ecosystem to support older adults reducing their risk for developing AD/ADRD using intensive lifestyle changes?

CPT RFI

- CMS discusses concerns about federal reliance on the CPT coding system, owned by the AMA and licensed for CMS use
- AMA maintains and distributes all CPT codes, and new CPT codes are introduced by the CPT Advisory Committee and are assigned a payment value by the Relative Value Scale Update Committee (RUC)
- CMS notes concerns about federal reliance on a private organization with a conflict of interest, particularly stemming from the influence of the AMA RUC to value services and the CPT coding system's limited emphasis on prevention and lifestyle modifications

CPT RFI [cont'd]

- CMS seeks comments on a number of areas regarding the influence of the CPT coding system and AMA process on physician payment policy such as:
  - What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT-4 licenses for health care entities? Please cite potential improvements to patient care diverted or delayed due to AMA'S monopoly over CPT codes, including inhibited innovations and acquisition or maintenance costs of CPT® licensure.
  - What, if any, evidence is there that the generation of CPT-4 codes follows a process of identification of medical necessity? What opportunities or examples from other populations, sites of care, or international health systems could instruct a process of identification of medical necessity in the CPT-4 code development process?
  - A combination of CPT-4 and [Healthcare Common Procedure Coding System] codes were formally adopted by [the Department of Health and Human Services] as the legal standard for national coding for physician and other services as part of implementing [the *Health Insurance Portability and Accountability Act of 1996*] HIPAA (45 CFR 162.1002(a)(5)). If CMS were to revisit this standard in future rulemaking, which if any alternatives exist to CPT-4 for CMS to consider as part of the national coding standard for physician services? Would CMS need to specify a separate legal standard, or could CMS allow for private competition to supplement the existing CPT-4 coding standard?
  - What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?
  - What are the benefits and drawbacks of paying for physician procedural services on the basis of the underlying International Classification of Diseases, 10th Revision (ICD-10) procedure code, as an alternative to CPT-4 code? How could the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) services be grouped or bundled into payment categories, similar to Medicare Severity Diagnosis Related Groups (MS DRGs), or OPPS Ambulatory Payment Classifications (APCs)? What other alternatives exist for bundling or grouping procedural services?

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

- RHCs are paid under an all-inclusive rate (AIR) methodology for a limited number of qualified preventive health services furnished by an RHC practitioner
- FQHCs are paid under the FQHC PPS for qualified preventive health services and preventive primary health services
- Preventive services that do not constitute a separate billable RHC or FQHC visit must be furnished as part of a qualified RHC or FQHC visit to be billable to Medicare

RHC and FQHC Payment for Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT)

- To increase access to DSMT and MNT services in RHCs, CMS proposes to recognize DSMT and MNT services as qualified preventative services that are covered and paid the AIR as stand-alone billable visits under the RHC benefit
  - Such services would need to be furnished by a certified provider under direct supervision of RHC professional staff
  - When DSMT or MNT is furnished on the same day as another qualified visit, Medicare would pay one AIR for that encounter to the RHC
- CMS seeks public comments on these proposals

RHC and FQHC Payment for Telecommunication Technology Services

- Payment for an encounter furnished by RHCs and FQHCs using interactive, real-time, audio/visual telecommunications technology or for certain audio-only interactions in cases where the patient is not capable of, or does not consent to, the use of certain video technology services is subject to the national average payment rates for comparable services under the PFS
  - Associated costs may not be used in determining payments under RHC AIR or FQHC PPS
- Payment for mental health visits in RHCs and FQHCs furnished via interactive, real-time, audio/visual or audio-only telecommunications technology is paid under the RHC AIR and FQHC PPS rates, subject to certain in-person visit requirements
- The CAA, 2026 extended:
  - (1) CMS's authority to pay for FQHC and RHC non-behavioral health telecommunication technology services as Medicare telehealth services, and
  - (2) the delay of the RHC and FQHC mental health in-person requirements
- CMS proposes to make conforming regulatory changes to reflect that in-person visit requirements for mental health visits would not apply to any services furnished through December 31, 2027
- CMS does not propose any modifications to existing regulations for non-behavioral health telecommunication technology services because regulations already authorize CMS to pay for such services as Medicare telehealth services

Proposed CY 2027 FQHC PPS Market Basket Update for RHCs and FQHCs

- For CY 2027, CMS proposes to use an estimate of the percentage increase in the 2022-based FQHC market basket to update payments to FQHCs
  - The final CY 2027 FQHC update would be based on the four-quarter moving-average percent change of the 2022-based FQHC market basket through the second quarter of 2026
  - Since CMS does not have the second quarter of 2026 historical data for the proposed rule, the proposed CY 2027 FQHC update is based on the most recent projection available at this time
  - A productivity adjustment is included in the 2022-based FQHC market basket
- For CY 2027, CMS proposes to update the CY 2026 FQHC PPS base rate by the historical percentage increase through the second quarter of 2026 of the productivity-adjusted FQHC market basket (the FQHC market basket update)
  - The proposed FQHC market basket update is estimated to be 2.5 percent and is based on the expected historical percentage increase of the productivity-adjusted 2022-based FQHC market basket
  - Multiplying the CY 2026 FQHC PPS base rate amount of $207.72 by the proposed CY 2027 FQHC market basket update of 2.5 percent ($207.72 x 1.025) results in a proposed CY 2027 FQHC PPS base rate amount of $212.91
- CMS also proposes that the CY 2027 market basket update and the productivity adjustment will be updated to reflect historical data through the second quarter of 2026

Proposed Technical Changes for RHCs and FQHCs

- CMS proposes technical changes to the regulations to:
  - Update references for appropriate paragraphs or sections
  - Correct erroneous terms to be consistent with existing authority
  - Revise and align the descriptions of permissible telecommunications modalities in two regulations describing the same in-person mental health visit requirement, to clarify that the use of audio-only interactions is permissible in cases where the patient is not capable of, or does not consent to, the use of video technology

Proposed Changes to the Ambulatory Specialty Model (ASM)

- CMS proposes to:
  - Modify the definition of "ASM beneficiary" to clarify that the term means a Medicare FFS beneficiary being treated by an ASM participant for an ASM targeted chronic condition
  - Revise the definition of "Dual eligible proportion" to clarify that it means the share of an ASM participant's beneficiaries who are dually eligible Medicare beneficiaries
- CMS seeks comment on these proposed revisions
- CMS proposes that a clinician selected as an ASM participant for at least one performance year is an ASM participant for the duration of the ASM test period unless CMS terminates the ASM model or terminates the ASM participant
- CMS proposes to clarify that not meeting ASM participant eligibility criteria for an ASM performance year would not nullify the application of ASM payment adjustments
  - CMS proposes to reorganize those regulatory provisions to reflect:
    - The specified model requirements that an ASM participant would not be required to meet for the applicable ASM performance year
    - The specific model requirements not applicable for the corresponding ASM payment year
    - An ASM participant’s ineligibility for waivers provided under the model for the applicable ASM performance year
- CMS proposes that an ASM participant who does not meet eligibility criteria for an ASM performance year would not be eligible for the CMS-sponsored model arrangements and patient incentives safe harbor for the applicable ASM performance year

ASM Participant Exceptions: TIN Changes

- CMS proposes to revise existing text to refer to "exceptions" rather than "exclusions" and to add new provisions for additional exception circumstances, and describes the effect and duration of an exception due to a change in TIN or redesignation of primary specialty type
- CMS propose the following regarding exceptions due to TIN change:
  - An ASM participant who stops reassigning billing rights to the TIN used to select them and satisfies notification requirements may be excepted from specified ASM requirements
  - An ASM participant who stops reassigning billing rights to the selected TIN before the performance year must notify CMS in writing no later than 60 days after the start of the performance year; CMS may then determine if an exception applies
  - An ASM participant who stops reassigning billing rights during an ASM performance year need not reassign billing rights to a new TIN that year to be potentially eligible for an exception, and must provide written notice within 30 days of stopping reassignment

ASM Participant Exceptions: Heart Failure Specialty Redesignations

- CMS proposes that ASM heart failure participants who redesignate their primary specialty type through Provider Enrollment, Chain, and Ownership System (PECOS) or CMS-855 form and demonstrate proof of board certification may be excepted from specified model requirements
- CMS proposes to allow an exception for the following redesignated specialty types: cardiac electrophysiology, cardiac surgery, interventional cardiology, advanced heart failure and transplant cardiology, and adult congenital heart disease
  - CMS proposes that participants provide written notification and board certification verification within 30 days of the effective date of the approved redesignation
- CMS considered limiting specialty redesignation exceptions to the 2027 and 2028 performance years, but concluded that allowing the exception beyond 2028 would provide more consistent treatment of clinicians whose specialty redesignations occur later
- CMS seeks comment on:
  - The proposed timeline and documentation requirements for notifying CMS of a heart failure participant specialty type redesignation
  - The proposed specialty types to which a heart failure participant may redesignate to be considered for an exception
  - The proposed requirement to provide direct evidence of board certification in a proposed specialty type
  - The alternative to only consider exceptions for redesignations that occur during the 2027 and 2028 performance years
  - Whether CMS should consider ASM low back pain participant exceptions based on primary specialty type redesignations

ASM Participant Exceptions: Effect, Duration, and Terminations

- CMS proposes that ASM participants with an approved exception would not be subject to performance assessment, data submission, final scoring, and payment adjustments for the corresponding payment year, and not be eligible for waivers or safe harbors for the applicable exception period
- CMS proposes that a TIN-change exception would be effective on the CMS-determined date and apply only for the applicable performance year, thereby allowing CMS to reselect the same National Provider Identifier (NPI) should it reassign billing rights to the original TIN and otherwise meet ASM participant eligibility criteria
- CMS proposes that a specialty-redesignation exception would be effective on the CMS-determined date and apply for the applicable performance year and all remaining ASM performance years
  - CMS believes it is unlikely that the ASM participant would revert to the previous primary specialty type during the remainder of the ASM test period
- CMS proposes to include an additional remedial action whereby CMS could terminate an ASM participant upon determining one or more grounds for remedial action has occurred, including:
  - failure to comply with terms of the ASM or applicable Medicare program requirements
  - taking action to threaten the health or safety of a patient
  - submitting false data or making false representations in connection with the Model
  - undergoing a change in control that presents a program integrity risk
- CMS proposes to terminate an ASM participant upon determining grounds for remedial action exist or continued participation would be inconsistent with ASM or applicable law

ASM Data Submission Requirements

- CMS proposes removing and clarifying quality reporting flexibility for small practices, including clarifying that small practices may submit quality data at either the group (TIN) or individual (TIN/NPI) level
- CMS proposes to allow a participant to submit improvement activities data at either the group (TIN) or individual (TIN/NPI) level
- CMS proposes that if any group level quality submission is received from a small practice, CMS would score the group (TIN) level submission and assign that score to all ASM participants in the small practice (meaning individual [TIN/NPI] level submissions would not be scored if group-level data is received)

TABLE B-D1: PROPOSED TREATMENT OF MULTIPLE DATA SUBMISSIONS FOR THE QUALITY ASM PERFORMANCE CATEGORY

ASM Participant in a Small Practice	Multiple Quality Data Submissions Received	Source of Multiple Quality Data Submissions	Group-level Quality Data Submission Received	Quality Data Submission Scored
No	No	N/A	Not Permitted	Individual-level (TIN/NPI)
	Yes	Multiple Organizations	Not Permitted	Highest Individual-level (TIN/NPI)
		Single Organization	Not Permitted	Most Recent Individual-level (TIN/NPI)
Yes	No	N/A	Yes	Group-level (TIN)
			No	Individual-level (TIN/NPI)
	Yes	Multiple Organizations	Yes	Highest Group-level (TIN)
			No	Highest Individual-level (TIN/NPI)
		Single Organization	Yes	Most Recent Group-level (TIN)
			No	Most Recent Individual-level (TIN/NPI)

Quality ASM Performance Category: MRI Lumbar Spine for Low Back Pain Measure

- CMS proposes to add the "Magnetic Resonance Imaging (MRI) Lumbar Spine for Low Back Pain (modified for ASM)" measure to the ASM low back pain quality measure set
- To improve the reliability and clinical validity of the proposed MRI Lumbar Spine for Low Back Pain measure, CMS would revise the previously existing measure (Hospital Outpatient Quality Reporting Program OP-8) denominator exclusions to better align with current evidence-based low back pain imaging guidelines and the ASM performance period (rolling 24-month measurement period)
- CMS proposes a multiple-participant attribution methodology (i.e., assign the MRI to all physicians who provided qualifying services for low back pain)
  - CMS believes this attribution method "provides a more complete and accurate understanding of imaging practices"
- CMS considered assigning each MRI to a single clinician based on who provided the most qualifying visits, but concluded the approach would be less reflective of real-world care patterns and produce less reliable performance measurement

Quality ASM Performance Category: Low Back Pain Quality Measure Set Updates

- CMS proposes a minimum case count threshold of 20 cases, which aligns with the ASM participant eligibility criteria that the participant should have historically been attributed at least 20 low back pain episodes
- CMS considered using a lower minimum case threshold of 10 MRIs, which would allow more low back pain specialists, particularly those with lower imaging volume, to be scored, but would result in less reliable performance measurement than the proposed 20-case threshold
- CMS proposes a 365-day attribution lookback period for MRI studies, which aligns with the ASM annual performance period and CMS believes improves consistency across quality measures
- CMS considered using a shorter 120-day attribution window, which would focus attribution on clinicians more directly involved in imaging decisions immediately preceding the MRI, but would reduce the number of attributed cases and provide a less comprehensive view of MRI utilization patterns
- CMS proposes to remove Functional Status Change for Patients with Low Back Impairments (MIPS Q220) from the ASM low back pain quality measure set as the measure steward no longer intends to maintain this measure or the key operational components (i.e., online portal)
- CMS proposes to replace MIPS Q220 with Functional Outcome Assessment (MIPS Q182), which CMS states promotes the routine assessment of functional status and requires clinicians to document a care plan when functional outcome deficiencies are identified
  - While this measure does not require the use of a specific instrument, there are examples of appropriate, validated tools, including the Modified Oswestry Disability Index and the Patient-Reported Outcomes Measurement Information System (PROMIS)

Quality ASM Performance Category: General Quality Scoring Policies

- CMS proposes to score all administrative claims-based quality measures at the individual TIN/NPI level
- CMS proposes to separately describe scoring requirements for non-administrative claims-based and administrative claims-based quality measures
- CMS proposes to exclude quality measures lacking a benchmark from the quality performance category score calculations (removing its total [numerator] and available [denominator] measure achievement points)

Quality ASM Performance Category: Voluntary Patient-Reported Outcome Data Submission

- To support the development of patient-reported outcome-based performance measures (PRO-PMs), CMS proposes to establish a voluntary data submission opportunity and scoring incentive for ASM participants to report PRO data
  - CMS proposes to add five points to an ASM participant's quality ASM performance category score for submitting beneficiary-level PRO data meeting CMS criteria
  - CMS considered several alternatives, including:
    - A larger or smaller PRO data submission incentive but concluded that more points could overvalue voluntary reporting relative to quality performance, while fewer points may not adequately encourage participation
    - Automatically awarding full credit (10 points) on a PROM-related quality measure for participants that voluntarily submit PRO data, but concluded the approach would overvalue data submission relative to actual performance
    - Scaling PRO data submission incentives based on the amount and completeness of data submitted, but concluded a single incentive better supports consistent, high-quality submissions
    - Using operational support rather than bonus points to encourage PRO data submission, but concluded a direct scoring incentive would be more effective at driving participation
    - Allowing PRO data submission incentives to increase quality scores above the category maximum, but concluded this would distort the model's scoring framework and weighting of quality relative to cost
    - Adding PRO data submission bonus points directly to participants' final scores, but concluded the incentive should remain tied to the quality performance category rather than affect overall model scoring
  - CMS seeks comment on the proposed 5-point scoring incentive and on all alternative incentive structures considered

Requirements for Successful Voluntary PRO Data Submission

- To support the development of a valid, reliable, and feasible PRO-PM, CMS proposes:
  - That participants submit baseline assessment data for at least 20 ASM beneficiaries during the first data collection period, then follow-up assessment data for at least 20 ASM beneficiaries with prior baseline assessments
  - That participants submit all CMS-specified PRO data elements
  - That participants submit minimum CMS-specified risk variables for each beneficiary from whom PRO data is collected
  - That PRO data be submitted by the generally applicable ASM data submission deadline (March 31 or later as specified by CMS) following the close of the performance year
  - To allow correction and resubmission of PRO data until the applicable submission deadline
- CMS considered several alternatives, including:
  - PRO data submission thresholds, including percentage-based requirements, but concluded a 20-beneficiary minimum would provide sufficient data for measure development
  - Quarterly or biannual PRO data submissions to improve data quality and feedback opportunities, but favored annual submission to reduce administrative burden
  - Requiring baseline and follow-up PRO assessments within the same performance year, but concluded the approach would increase burden and provide less flexibility for measuring meaningful outcome changes
  - Requiring ongoing baseline PRO data collection for newly eligible beneficiaries in future reporting periods to support PRO-PM development
  - Additional PRO data submission requirements including sampling, response-rate, completion-rate, and documentation standards, but did not propose them because requirements will likely vary based on the measure under development

Promoting Interoperability (PI) Performance Category

- CMS proposes to revise the Health Information Exchange (HIE) objective and add the Electronic Prior Authorization (EPA) measure (PI_HIE_7) as an optional measure beginning in 2027 with no scoring penalty for non-reporting
  - CMS proposes to adopt the same measure specifications for this measure as those used under MIPS
- CMS proposes starting in the 2028 performance year, to require the EPA measure (via "yes" attestation or applicable exclusion) and to apply the same exclusions available under MIPS for the EPA measure
- CMS proposes starting in the 2028 performance year to require the new EPA for Prescription Drugs measure (PI_HIE_8) and align its specifications and exclusions with MIPS
- CMS proposes to adopt a measure exclusion policy for measures within the Public Health and Clinical Data Exchange objective, consistent with MIPS
- CMS proposes to remove the requirement to report the security risk analysis measure through attestation
- CMS proposes to remove Office of the National Coordinator for Health Information Technology (ONC) direct review required attestations
- CMS proposes to retain the requirement to avoid knowingly and willfully limiting/restricting certified electronic health record technology (CEHRT) interoperability
- CMS proposes to adopt a measure suppression policy aligning with the MIPS policy
- *See* Table B-D2 for Proposed ASM PI objectives and measures for the 2027 ASM performance year

Promoting Interoperability (PI) Performance Category: Exclusions and Measure Suppression

- CMS proposes to clarify that exclusions are available for the Immunization Registry Reporting and Electronic Case Reporting measures, and to adopt the same exclusion criteria as MIPS
- CMS proposes to remove the Security Risk Analysis attestation requirement beginning with the 2027 ASM performance year
- CMS proposes to remove the ONC Direct Review attestation and ONC-Authorized Certification Bodies (ONC-ACB) Surveillance attestation from the PI ASM performance category starting in the 2027 performance year (this is consistent with changes in the MIPS PI performance category)
- CMS proposes adopting a PI measure suppression policy starting in the 2027 ASM performance year, excluding an affected measure from the objective score or from the meaningful EHR user status determination
  - CMS proposes to evaluate measure suppression using MIPS-based criteria, including reporting barriers, health IT limitations, technical standards issues, and circumstances that could undermine the accuracy of performance measurement
  - CMS proposes to provide ASM participants advance notice when a PI measure is suppressed and, consistent with MIPS, apply suppression for the full performance year, with potential continuation in future years if issues remain unresolved

ASM Final Score Methodology

- CMS proposes to revise the ASM's final score methodology but does not propose any substantive changes to scoring or payment adjustment policies
- CMS proposes to include a rural scoring adjustment in the calculation of an ASM participant's final score
- CMS proposes to define “rural area” using the same definition used under MIPS
- CMS proposes to add five points to the final score of an ASM participant located in a rural area who otherwise qualifies for a final score greater than zero and to make corresponding revisions to the final score formula
  - CMS considered restricting the rural scoring adjustment to providers that do not receive a small-practice adjustment, but concluded that both small and large rural practices face unique barriers and therefore proposes making the adjustment available to all eligible rural participants
  - CMS states that eligible participants could receive the rural, small practice, and complex patient scoring adjustments

ASM Performance Report and Payment Adjustments

- CMS proposes to update the annual ASM performance report to include information on whether the ASM participant received the proposed new scoring incentives and adjustments, including the proposed PRO data submission incentive and rural scoring adjustment; the changes are intended to improve transparency and participant feedback rather than alter payment or scoring methodologies
- CMS proposes technical revisions to the policies governing how ASM payment adjustments are applied when participants move between practice affiliations, without modifying the underlying payment methodology to more clearly describe using the highest ASM payment multiplier calculated for an NPI selected as an ASM participant under multiple TINs
- CMS proposes to condition access to ASM safe harbor protections on active participation in the model: if an ASM participant becomes ineligible for ASM or receives an exception from ASM requirements, the protections would not apply to arrangements associated with that period

Collaborative Care Arrangements (CCAs)

- CMS proposes to permit one or more ASM participants to enter into the same CCA with a primary care practice if all participating ASM participants bill through the same TIN and are expressly named in the agreement
- CMS seeks comment whether CMS should allow multiple ASM participants from the same practice to share a single CCA and whether that approach could create any disadvantages for solo practitioners or single-participant practices
- CMS proposes to maintain the requirement that at least one shared ASM beneficiary exists between the primary care practice and at least one ASM participant party to the CCA
- CMS proposes to eliminate the requirement that a shared ASM beneficiary be an "established" patient before an ASM participant and primary care practice may satisfy the shared patient requirement for a CCA
- CMS seeks comment on whether one shared ASM beneficiary should be enough to support a CCA involving multiple ASM clinicians and whether CMS should remove the requirement that the beneficiary be an "established" patient

Collaborative Care Arrangements (CCAs) [cont'd]

- CMS proposes to allow ASM participants to use the existence of a shared ASM beneficiary as a factor when selecting a primary care partner for a CCA, provided the arrangement is intended to advance care coordination rather than drive referrals
- CMS seeks comment on this proposal and whether the approach is sufficiently clear and accommodates operational realities
- CMS proposes to apply CCA requirements and protections to both monetary and in-kind support, including shared technology, staffing, and care coordination resources
- CMS proposes to reorganize CCA requirements by grouping all remuneration-related rules in one place, making it easier for providers to determine which requirements apply when financial or in-kind support is exchanged
- CMS proposes to require that any financial or in-kind support exchanged under a CCA be tied to a legitimate care coordination purpose

CCAs: Limitation on Remuneration and Documentation Requirements

- CMS proposes to continue limiting the amount of remuneration that may be exchanged under a CCA, but to calculate that limit using Medicare Part B covered professional services payments from the ASM performance year rather than the ASM payment year; CMS also proposes a reconciliation and repayment process to ensure compliance with the remuneration limit
  - CMS proposes that the limitation would be calculated using the ASM participant's payment adjustment factor for the applicable performance year, multiplied by the amount otherwise paid to the ASM participant during that performance year
  - CMS proposes to calculate remuneration limits separately for each ASM participant that is a party to a CCA
- CMS proposes to require CCAs that exchange remuneration to specify a methodology for valuing remuneration, determine whether the arrangement exceeds the applicable remuneration limit, reconcile amounts after the limit is calculated, and repay any excess remuneration; CMS proposes to value in-kind support based on either the provider's costs (using any reasonable accounting methodology) or fair market value

CCAs: Limitation on Remuneration and Documentation Requirements [cont'd]

- CMS proposes to require remuneration exchanged under a CCA to occur directly between the parties and to require any monetary payments to be made through traceable payment methods (e.g., check, electronic funds transfer, or other traceable transaction)
- CMS proposes to expand documentation requirements for CCAs by requiring participants to maintain contemporaneous records of all remuneration exchanged, including the type and value of remuneration, the methodology used to value any in-kind support, and the date of each exchange for all CCAs entered into
  - CMS also proposes to require documentation identifying all ASM participants that are parties to the arrangement
- CMS considered requiring ASM participants to maintain documentation demonstrating that all ASM participants that are parties to the same CCA reassign billing rights to the same TIN, but did not propose this requirement because CMS believes it can verify this information using data already available to the agency

Medicare Program Waivers

- CMS proposes to update the MIPS reporting waiver policy so it reflects both ASM participants that do not meet eligibility requirements and ASM participants that receive an approved exception from ASM requirements

Limiting Medicare Coverage of Certain Individuals

- The *One Big Beautiful Bill Act* (OBBBA)/*Working Families Tax Cut* (WFTC) legislation added Section 1899C of the SSA, which limits Medicare eligibility to an individual who is (1) a citizen or national of the U.S.; (2) an alien lawfully admitted for permanent residence under the *Immigration and Nationality Act* (INA); (3) an alien who has been granted the status of Cuban and Haitian entrant (CHE); or (4) an individual who lawfully resides in the U.S. in accordance with a Compact of Free Association (COFA migrant)
  - Previously, Medicare eligibility depended on whether the individual was "lawfully present", a broader standard that includes asylees, refugees, and certain parolees
    - The "lawfully present" standard also applies to Title II benefits (e.g., Social Security retirement, survivors, and disability insurance benefits) so the Social Security Administration used a common eligibility system
  - Since OBBBA/WFTC did not change eligibility for Title II benefits, CMS proposes to establish Medicare-specific definitions and enrollment/criteria regarding citizenship, nationality, and immigration status

Limiting Medicare Coverage of Certain Individuals [cont'd]

- CMS proposes to establish a new definition of "eligible noncitizen" that includes the noncitizens eligible for Medicare under Section 1899C of the SSA
  - The proposed definition does not apply to:
    - Noncitizen U.S. nationals who are expressly eligible for Medicare per the SSA
    - Those eligible for Title II benefits
- CMS proposes to amend the following regulations to incorporate this proposed definition, effective July 4, 2025:
  - Premium-free Part A: 42 CFR 406.5, 406.10, 406.11, 406.12, 406.13
  - Premium Part A: 42 CFR 406.20
  - Part B: 42 CFR 407.10
  - Part B-Immunosuppressive Drug Benefit: 42 CFR 407.55

Limiting Medicare Coverage of Certain Individuals [cont'd]

- Individuals who were entitled to or enrolled in Medicare as of July 4, 2025 but do not satisfy the requirements of SSA Section 1899C(a) would have their coverage terminated effective February 1, 2027 (18 months after enactment of OBBBA/WFTC)
- Under this "grace period", CMS proposes that:
  - The Social Security Administration would provide a termination notice towards the end of December 2026 explaining that the individual does not satisfy the enrollment provisions and that their enrollment termination will be effective February 1, 2027
    - The notices would inform individuals of their appeal rights under existing regulations
    - All terminations would be at the end of the calendar month

Limiting Medicare Coverage of Certain Individuals [cont'd]

- CMS proposes a different framework for individuals whose eligibility is impacted by OBBBA/WFTC's provisions outside of the grace period; this includes individuals:
  - Enrolled in Medicare after July 4, 2025, but before the Social Security Administration implements screening procedures (expected in 2026)
  - Enrolled in Medicare, not eligible due to Section 1899C(a), and was not notified as part of the grace period
    - This category includes individuals whose immigration status changed
- All terminations would be prospective
- CMS proposes the following notification framework for non-grace period individuals:
  - The Social Security Administration would send a termination notice explaining the individual does not satisfy SSA Section 1899C(a)
  - Medicare entitlement or enrollment would terminate at the end of the month following the month in which the notice is dated (e.g., notice dated in March 2027 leads to termination effective at end of April 2027)
  - The Social Security Administration would not terminate an individual's enrollment before providing notice
  - No termination would occur prior to the proposed effective date of January 1, 2027
  - Individuals would receive appeal rights information in the notice
  - Notices would be sent on an ongoing basis as the Social Security Administration receives information indicating an individual no longer meets requirements

Limiting Medicare Coverage of Certain Individuals [cont'd]

- CMS proposes to establish a special enrollment period (SEP) for individuals who initially did not meet the eligibility requirements of section 1899C(a) of the SSA at the time they met all other Medicare eligibility requirements, but subsequently satisfy those requirements
  - This SEP would also apply to individuals whose Medicare entitlement or enrollment is terminated because they do not or no longer meet the requirements in section 1899C(a) of the SSA, but who subsequently experience a change that allows them to satisfy those requirements
  - CMS has the authority to establish SEPs for exceptional conditions; CMS believes the enactment of OBBBA/WFTC to be an exceptional condition
- With respect to this SEP, CMS proposes:
  - That the general rule that an individual must have missed an enrollment period due to the exceptional condition would not apply
  - The SEP would be available to individuals who later meet, or again meet, the requirements of Section 1899C(a) of the SSA, regardless of whether an enrollment period was missed
  - The SEP would begin in the month in which the individual, upon contacting the Social Security Administration, provides sufficient documentation to establish eligibility, and the proposed special enrollment period would end six months later
  - CMS proposes that entitlement and enrollment would be prospective for premium Part A and Part B, beginning with the first day of the month following the month of enrollment
    - CMS believes a prospective-only approach is the most practical and administrable method for implementing this SEP for premium Part A and B
  - For premium-free Medicare Part A, that entitlement may be retroactive for up to six months, but not earlier than the first month in which the individual met the Section 1899C eligibility requirements
- Under this proposal, if acceptable evidence establishes the month in which the individual first satisfied the citizenship, nationality, or immigration status requirements, the Social Security Administration would use that month, subject to the applicable retroactivity limit. If the earliest month of eligibility cannot be established based on acceptable documentary evidence, entitlement would instead begin on the first day of the month in which the Social Security Administration verifies that the individual satisfies the citizenship, nationality, or immigration status requirements

Limiting Medicare Coverage of Certain Individuals [cont'd]

- Eligibility for MA plans, Part D plans, and cost plans depends on underlying Part A/Part B entitlement; individuals losing Part A/Part B eligibility under Section 1899C of the SSA must also be disenrolled from these plans
- CMS proposes a separate involuntary disenrollment process for section 1899C-related terminations (distinct from the existing loss-of-entitlement process) to better track impact and create new technical processes with the Social Security Administration
  - Disenrollment effective the first day of the calendar month following the last month of Part A or Part B entitlement
  - CMS processes these automatically through the MARx system; plans are not required to provide separate notification since the Social Security Administration provides the loss-of-entitlement notice
  - CMS proposes to make numerous confirming changes to regulations effectuate this proposal
- CMS proposes to replace the existing SEP for gaining lawful presence status with a new SEP for individuals who become eligible noncitizens:
  - MA SEP:
    - Is available as soon as the individual is entitled to Part A and enrolled in Part B
    - Lasts two months after the individual becomes entitled to Part A and enrolled in Part B
    - Effective the first day of the calendar month following the election
  - Part D SEP:
    - Lasts two months after either the individual's Part A or Part B entitlement date (whichever is earlier)
    - Effective the first day of the calendar month following the election

Medicare Prescription Drug Inflation Rebate Program – Medicare Part D Claims Data 340B Repository

- In the CY 2026 PFS final rule, CMS established a 340B repository through which covered entities may voluntarily submit certain data elements for Part D claims involving drugs dispensed under the 340B Drug Pricing Program (340B Program)
  - The repository is meant to assess the data for potential use in identifying units of Part D rebatable drugs for which the manufacturer provided a discount under the 340B Program
  - In that final rule, CMS strongly encouraged all covered entities to submit data elements to the 340B repository during the 2026 testing period to test the data quality and completeness and provide an opportunity for covered entities to familiarize themselves with it
  - CMS expects the repository to launch in fall 2026

Medicare Prescription Drug Inflation Rebate Program – Medicare Part D Claims Data 340B Repository [cont'd]

- CMS now proposes to make 340B repository reporting mandatory
- Beginning with claims that have a date of service on or after January 1, 2027, a provider or supplier that is a 340B covered entity must submit the data elements associated with each claim for a covered Part D drug billed to Medicare Part D for which the covered entity or its contractors (such as contract pharmacies) dispensed units of a drug for which a manufacturer provides a 340B discount to the covered entity
  - This requirement would apply to claims for units of a drug covered under Part D and:
    - Dispensed by contract pharmacies that the covered entity, its contractors, or its third-party administrators (TPAs) identify as 340B-eligible and for which the covered entity obtains a 340B discount, including through retrospective replenishment models
    - Dispensed by the covered entity's in-house pharmacy

Medicare Prescription Drug Inflation Rebate Program – Medicare Part D Claims Data 340B Repository [cont'd]

- The data elements must include, in addition to its 340B ID and name as designated in the 340B Office of Pharmacy Affairs Information System (OPAIS) database:
  - Date of Service (i.e., the date the prescription was filled by the pharmacy)
  - Prescription or Service Reference Number
  - Fill Number (i.e., the code indicating whether the prescription is an original or a refill; if a refill, the code indicates the refill number)
  - Dispensing Pharmacy NPI
  - NDC-11
- CMS would reserve the right to revoke, consistent with 42 CFR 424.535(a)(10), a currently enrolled provider or supplier's Medicare enrollment and any corresponding provider agreement or supplier agreement for failure to comply with the requirements for maintaining and providing access to documentation related to the data elements

Medicare Prescription Drug Inflation Rebate Program – Medicare Part D Claims Data 340B Repository [cont'd]

- 340B providers would have to report data on a quarterly basis within one calendar quarter following the close of the applicable calendar quarter
  - Example: claims with a date of service between October 1, 2027 through December 31, 2027 should be submitted to the 340B repository no later than March 31, 2028
- CMS states that the proposed data elements, information, and reporting timelines are the same as those established for voluntary submissions in the CY 2026 PFS final rule
- More information regarding how to submit data to the 340B repository can be found in Collection of Information CMS-10930
- CMS would not use the 340B repository data to calculate inflation rebates

Medicare Prescription Drug Inflation Rebate Program – Medicare Part D Claims Data 340B Repository [cont'd]

- Any future proposal to use the data reported to the 340B repository to remove 340B units from Part D inflation rebate calculations would undergo notice-and-comment rulemaking
  - CMS would analyze the data submitted to determine if it could be reliably used in the future to remove 340B units from Part D inflation rebate calculations
  - With this data, CMS would match data elements to Prescription Drug Event (PDE) transactions for each Part D rebatable drug dispensed during the applicable period and would evaluate 340B repository data for data integrity and submission frequency and completeness across covered entity types and geographies, including through comparison to claims identified under the Prescriber-Pharmacy Methodology
- The agency notes that the data submitted to the 340B repository would be confidential and will not be made available to anyone, including manufacturers and Part D plan sponsors

Medicare Prescription Drug Inflation Rebate Program – Medicare Part D Claims Data 340B Repository [cont'd]

- With respect to submitting data, CMS proposes to:
  - Rely upon the completeness and accuracy of the submitted, certified data to the 340B repository to verify the 340B status of a claim
  - Require, as part of every submission, that 340B providers (or an individual or contractor with delegated authority as an authorized representative of the 340B provider to perform the certification) certify three things:
    - The data elements from all claims submitted to the 340B repository are from verified 340B claims
    - To the best of the 340B provider's knowledge, its submissions include all Part D 340B claims for the 340B provider at the time of submission for the relevant period
    - The submitter is authorized to submit on behalf of the 340B provider
  - Allow 340B providers to arrange for TPAs or other vendors to submit the required data elements to the 340B repository on their behalf
    - 340B providers would still be ultimately responsible for the accuracy of the data submitted to the 340B repository even if a 340B provider has an arrangement with a vendor to submit on its behalf

Medicare Prescription Drug Inflation Rebate Program – Medicare Part D Claims Data 340B Repository [cont'd]

- With respect to submitting data, CMS proposes to [cont'd]:
  - Permit 340B providers additional time to submit data to reflect a revision to the 340B determination of claims with dates of service throughout an applicable period
    - The revision could be either (1) a resubmission of data for a claim that the 340B provider previously submitted to the repository in error or with errors in the requested data fields, or (2) a new submission of data for a claim for a drug that the 340B provider had previously determined was not purchased under the 340B Program, but later identified as having been purchased under the program
    - In instances where the 340B provider submits data that is either incomplete or contains invalid data, CMS may inform the 340B provider of the error and request that the provider resolve and resubmit the data in order to process the submission successfully
      - CMS will provide details on the process and timing for covered entities to submit revised data to the 340B repository after the end of the reporting period in the future
- The proposed regulatory text states that CMS would specify the form and manner of resubmitting the data

Changes to the Regulations Associated with the Ambulance Fee Schedule (AFS)

- Medicare provides the following add-on payments:
  - A three percent increase for covered ground ambulance transports that originate in a rural area or in a rural census tract of a metropolitan statistical area
  - A two percent increase for covered ground ambulance transports that do not originate in a rural area or in a rural census tract of a metropolitan statistical area
  - A 22.6 percent increase for ground ambulance services that originate in a qualified rural area (as described by statute)
- Section 6203 of the *Consolidated Appropriations Act, 2026* extends these add-on payments to services provided through December 31, 2027
- CMS explains that this requirement is self-implementing

Changes to the Regulations Associated with the AFS

- CMS expects to address the ongoing data collection requirements for the Medicare Ground Ambulance Data Collection System in the CY 2028 PFS rulemaking cycle
  - In doing so, it expects to include findings from the Medicare Payment Advisory Commission's (MedPAC) June 2026 Report to Congress
- For CY 2027, CMS proposes to use the geographic area delineations for the AFS described in OMB Bulletin No. 23-01, along with the geographic areas based on the most recent version of the Goldsmith Modification, to more accurately identify urban and rural areas for AFS payment purposes
  - CMS currently uses Office of Management and Budget's (OMB) standards published on June 29, 2010 and 2010 Census Bureau data
  - AFS data has historically used the same geographic area designations as the Inpatient Prospective Payment System (IPPS) and other Medicare payment systems
    - CMS began using OMB Bulletin No. 23-01 for the IPPS beginning in FY 2025

Changes to the Regulations Associated with the AFS [cont'd]

- CMS also proposes to adopt the most recent modifications of the Rural-Urban Commuting Area (RUCA) codes beginning in CY 2027, to recognize levels of rurality in census tracts located in every county across the nation, for purposes of payment under the AFS
  - If CMS adopts the most recent RUCA codes, many counties that are designated as urban at the county level based on population would have rural census tracts within them that would be recognized as rural areas through the use of RUCA codes
  - CMS proposes to continue its current policies of:
    - Designating any census tract falling at or above RUCA level 4.0 as rural areas for the purposes of AFS payment
    - Not designating as rural areas census tracts that fall at RUCA levels 2 or 3 that are at least 400 square miles in area with a population density of no more than 35 people
      - The agency explains that it is not feasible to implement this guideline due to the complexities of identifying these areas at the ZIP code level
      - CMS seeks comments on this proposal
- CMS estimates that geographic designations for approximately 95.87 percent of ZIP codes would be unchanged by these proposals
  - *See* Table B-H1 for the state-by-state impacts of the proposed policy
- CMS seeks comment on these proposals to use OMB Bulletin No. 23-01 and the most recent modifications of the RUCA codes

Modifications to the Quality Payment Program (QPP) Reporting and Data Submission

- CMS proposes several changes to the QPP starting January 1, 2027, including:
  - Expanding the MIPS MVPs portfolio to include Diabetic Disease and Hypertension MVPs that address the prevention of chronic illnesses and aim to reduce the incidence and impact of long-term conditions
  - Adding new improvement activities under the "Advancing Health and Wellness" subcategory within the improvement activities performance category to address nutrition, implement lifestyle approaches to disease management, and support patient wellness
  - Sunsetting the traditional MIPS reporting option and transitioning to MVPs as the only reporting option for MIPS beginning with the CY 2029 performance period/CY 2031 MIPS payment year

QPP – Transitioning MIPS to MVP-Only Reporting

- CMS proposes to phase out traditional MIPS reporting for MIPS eligible clinicians not participating in the Advanced Alternative Payment Models (APM) Performance Pathway (APP) and to sunset traditional MIPS reporting in the CY 2029 performance period/2031 MIPS payment year, to fully transition to MVP reporting
- Beginning in the CY 2029 performance period/2031 MIPS payment year, CMS proposes that eligible clinicians participating in MIPS, and not reporting the APP, would be required to report the measures and activities in a selected MVP
  - Clinicians may continue to report through either traditional MIPS or via MVPs through the CY 2028 performance year/2030 MIPS payment year
  - CMS proposes to revise the definition of an MVP participant to include virtual groups so that virtual groups would be included in MVP reporting
    - CMS recognizes that virtual groups would have to register both to form a virtual group and for MVP reporting and is exploring options to mitigate the need for a second registration
    - CMS also states that clinicians in virtual groups would be unable to participate as subgroups
- CMS believes the timing is appropriate given the current proposed inventory of MVPs offers the opportunity for approximately 98 percent of MIPS eligible clinicians based on self-reported specialty designations to report through an MVPCMS also proposes to develop policies supporting MVP-only reporting for MIPS
  - CMS will continue to develop new MVPs and alternative reporting options for subspecialists without many applicable and available MIPS measures to support the transition to full MVP reporting

QPP – MVPs Development and Maintenance

- CMS proposes three new MVPs (*see* Appendix 3 of the proposed rule for full details)
  - Diabetic Disease
  - Hypertension
    - These two MVPs are designed to address the prevention of chronic illnesses by including measures and activities aimed at reducing incidence and impact of these long-term conditions
  - Hospitalist
- CMS also proposes MVP maintenance updates to the MVP inventory, aligned with the MVP development criteria. Currently, the MVP inventory includes 27 MVPs. CMS proposes several modifications (*see* Appendix 3 of the proposed rule for full details):
  - Modify 23 MVPs to expand upon clinical concepts, advance health and wellness, address maintenance requests from interested parties, and remove measures and activities that would either be replaced by more robust measures or activities or are being proposed for removal from their respective MIPS inventory
  - Rename “Rehabilitative Support for Musculoskeletal Care MVP” to “Rehabilitative Support MVP”
- CMS further proposes to make updates to all 27 MVPs to include MIPS core measures
  - CMS would modify the current MVP quality reporting requirements by replacing an outcome/high priority measure with one MIPS core measure included in the MVP

QPP – APM Performance Pathway (APP)

- CMS proposes to align quality measures in the APM Performance Pathway (APP), original quality measure set, and the APP Plus quality measure set to reflect CMS's proposed changes to measures specified for the quality performance category
- Specifically, CMS proposes to adopt measure specification changes to the following measures in the APP and APP Plus quality measure sets (*see* Appendix 1, Table Group D, of the proposed rule for full details):
  - Diabetes: Glycemic Status Assessment Greater Than 9% (Quality ID: 001) (electronic clinical quality measures [eCQMs] collection type)
  - Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID: 134)
  - Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Quality ID: 479)
- CMS also proposes to remove the following measures that were scheduled to be added to the APP Plus quality measure set in CY 2027 or later, due to operational issues and concerns by ACOs with increasing the number of measures in the APP Plus quality measure set each year (*see* Tables C-BC2 in the proposed rule):
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment measures (Quality ID: 305)
  - Adult Immunization Status (Quality ID: 493)

QPP – MIPS Quality Performance Category

- For the CY 2027 performance period/2029 MIPS payment year, CMS proposes to establish a measure set inventory of 180 MIPS quality measures: 177 would be available in traditional MIPS, while three would be available only for MVPs
- CMS proposes to modify the measure set inventory as follows (*see* Appendix 1 of the proposed rule for full details):
  - 20 measure removals
  - 10 measure additions for CY 2027
  - One measure addition for CY 2028
  - 43 substantive changes to existing measures
- CMS explains that these modifications would:
  - Remove measures with low bar or topped-out status, duplicative measures, measures with limited adoption or lacking robustness, and measures that would no longer be maintained
  - Add measures for measuring patient-reported outcomes and chronic disease management
  - Make substantive changes to ensure that measures continue to be meaningful and drive improvements in quality of care

QPP – MIPS Quality Performance Category [cont'd]

- CMS also proposes to amend the definition of "collection type" to include the proposed Medicare eCQMs for ACOs Participating in the MSSP, as proposed in the proposals relating to the MSSP
- Beginning with the CY 2027 performance period/2029 MIPS payment year, CMS proposes to:
  - Implement the MIPS core measure designations for quality measures in traditional MIPS and MVPs
  - Remove the high priority designation from MIPS quality measures and the MVP inventory
  - Stop using the high priority designation as one of the quality measure retention criteria and replace it with the requirement to report a MIPS core measure, and require an attestation process when a MIPS core measure is not available and applicable, except for clinicians in small practices
  - Amend the quality performance category data submission criteria to require MIPS core measure reporting with an attestation process
  - Amend and establish data submission and data completeness criteria for the Medicare eCQMs collection type

QPP – Modifications to MIPS Quality Data Submission Criteria

- CMS proposes to establish a list of MIPS core measures and to modify the quality performance category data submission criteria for traditional MIPS and MVPs
- For each MVP, CMS proposes to select a minimum of three MIPS core measures per MVP from the list of MIPS quality measures already assigned to the MVP, based on the following factors:
  - Whether the measure is outcome-based
  - Measure collection type availability and the clinician's ability to meet reporting requirements
  - Measure adoption and current and historic performance rates
  - Whether the measure is most reflective of the care that is central to the clinical focus of the selected MVP, represents best practices essential to the MVP's specialty or medical condition, or addresses important areas for improving care

QPP – Modifications to MIPS Quality Data Submission Criteria [cont'd]

- CMS proposes that the MIPS core measure designation would apply to quality measures in both traditional MIPS and MVPs
  - Clinicians reporting through the traditional MIPS reporting option would select from the complete inventory of available MIPS core measures for the performance period
  - Clinicians reporting through the MVP reporting option would select the applicable MIPS core measures from the core measures identified within their chosen MVP
- Beginning with the CY 2027 performance period/2029 MIPS payment year, CMS proposes to establish a MIPS core measure designation applicable to selected quality measures
- CMS also proposes to remove the "high priority measure" designation from the MIPS quality measure inventory and the MVP inventory to implement the proposed MIPS core measure designation and, accordingly, to no longer include the use of a high priority measure designation as one of the considerations for retaining a MIPS quality measure beginning with the CY 2027 performance period/2029 MIPS payment year

QPP – Modifications to MIPS Quality Data Submission Criteria [cont'd]

- CMS proposes to remove the current quality measure data submission requirement of one outcome measure for traditional MIPS and MVPs and replace the requirement with a MIPS core measure data submission requirement to emphasize the reporting on the proposed MIPS core measures
  - MIPS eligible clinicians reporting via traditional MIPS must submit data on at least six measures, including at least one MIPS core measure
  - Clinicians reporting a specialty measure set in traditional MIPS must report at least six measures and choose an applicable MIPS core measure, if available, within that specialty measure set
    - If less than six measures are available or applicable, clinicians must report on each available and applicable measure
  - An MVP participant must select and report, if applicable, four quality measures, including at least one MIPS core measure from those available for the selected MVP

QPP – Modifications to MIPS Quality Data Submission Criteria [cont'd]

- If there is no available and applicable MIPS core measure, for either traditional MIPS or MVP reporting, CMS proposes to establish an self-attestation process under which the clinician would be required in good faith to attest during the data submission period that there was not an available and applicable MIPS core measure for them to report, and to choose another measure to report in place of the MIPS core measure
- CMS would exempt clinicians in small practices from these requirements
  - Clinicians in small practices would continue to report six quality measures for traditional MIPS or four quality measures as currently required for MVPs

QPP – Modifications to Data Submission and Completeness Criteria for Medicare CQMs

- CMS proposes to amend and establish the data submission criteria for the Medicare CQMs collection type by including the availability of Medicare CQMs within the APP Plus measure set, as applicable
  - The data submission criteria for Medicare CQMs would be met by a MIPS eligible clinician, group, and APM Entity reporting on the Medicare CQMs within the APP measure set or APP Plus measure set (as applicable) and administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey as required under the APP
- In alignment with the proposal to extend the availability of the Medicare CQMs collection type and to sunset the Medicare CQMs collection type starting with the CY 2030 performance period/2032 MIPS payment year under the MSSP, CMS proposes to amend the data completeness criteria for the Medicare CQMs collection type by eliminating the current limit on duration of availability for the Medicare CQMs collection type as a means for meeting data completeness criteria requirements
  - This timing aligns with when FHIR-based reporting becomes mandatory
- CMS also proposes to establish a data completeness criteria threshold for the Medicare eCQMs collection type of submission of at least 75 percent of the APM Entity's applicable beneficiaries eligible for the Medicare eCQM who meet the measure's denominator criteria

QPP – Addition of New MIPS Quality Measures

- For CY 2027 performance period/2029 MIPS payment year, CMS proposes a set of 180 MIPS quality measures, including the following changes (*see* Appendix I of this proposed rule for full details):
  - Addition of 10 new measures, including measures focused on patient-reported outcomes and chronic disease management (*see* Table Group A of Appendix 1 of the proposed rule for full details)
  - Updates to specialty sets, including adding new measures or existing measures already in the MIPS quality measure inventory, removing measures, and making substantive changes to existing measures (*see* Table Group B of Appendix 1 of the proposed rule for full details)
  - Removal of 20 existing quality measures that are extremely topped out or have reached the end of the topped-out lifecycle, are no longer maintained, are duplicative, have limited adoption, are a low bar process measure, or lack robustness (*see* Table Group C of Appendix 1 of the proposed rule for full details)
  - Substantive changes to 43 existing measures (*see* Table Groups D and DD of Appendix 1 to the proposed rule for full details)

QPP – MIPS Cost Performance Category

- CMS proposes to update the operational list of care episodes and patient condition groups and codes to reflect coding changes identified through CMS's annual maintenance process for MIPS cost measures
  - Proposed revisions are available for review on CMS's QPP Cost Measure Information page at *https://www.cms.gov/medicare/quality/value-based-programs/costmeasures/about*
  - CMS seeks feedback on the service and diagnosis codes used in MIPS care episode and patient condition groups to inform any non-substantive changes to the operational list in tandem with CMS's annual maintenance efforts for the CY 2027 performance period/2029 MIPS payment year
- CMS is not proposing to adopt any new MIPS cost measures, remove any existing MIPS cost measures, or make substantive changes to any existing MIPS cost measures for the CY 2027 performance period/2029 MIPS payment year

QPP – MIPS Improvement Activities Performance Category

- Beginning with the CY 2027 performance period/2029 MIPS payment year, CMS proposes to update the MIPS Improvement Activity Inventory by:
  - Adding six new improvement activities in two subcategories (*see* Table F-B1 in Appendix 2 of the proposed rule for full details):
    - (1) Care Coordination
      - Use of Data to Improve Practice Workflows and Understand and Improve Diagnostic Performance
    - (2) Advancing Health and Wellness (*see* Table F-B1 in Appendix 2 of the proposed rule for full details)
      - Systematic Screening and Intervention for Nutrition and other Health-Impacting, Non-Clinical Issues, Advance Care Planning Conversations, Clinician Use of Artificial Intelligence (AI), and Lifestyle Approaches to Diabetes Remediation
  - Modifying the descriptions of the following improvement activities (*see* Table F-B2 in Appendix 2 of the proposed rule for full details)
    - Depression screening, Implementation of documentation improvements for practice/process improvements, Implementation of practices/processes for developing regular individual care plans, and Glycemic management services (which will be combined with elements of similar improvement activities to make descriptions more robust)
    - "Use decision support" improvement activity would be modified to explicitly incorporate AI-enabled decision support and strengthen oversight requirements
  - Removing 11 improvement activities for being duplicative or obsolete (*see* Table F-B3 in Appendix 2 of the proposed rule for full details)

QPP – MIPS PI Performance Category

- Beginning with the CY 2026 performance period/2028 MIPS payment year, CMS proposes to remove the ONC Direct Review attestation and the ONC-ACB Surveillance attestation to reduce administrative burden
  - MIPS eligible clinicians would not be required to report on the ONC Direct Review attestation but would have the option of reporting on the ONC-ACB Surveillance attestation in the CY 2026 performance period/2028 MIPS payment year
  - The proposed removal of these attestations would not affect a MIPS eligible clinician's score for the MIPS PI performance category for the CY 2026 performance period/2028 MIPS payment year
- Beginning with the CY 2027 performance period/2029 MIPS payment year, CMS proposes to:
  - To align with relevant ONC Health IT Certification Program proposed updates as set forth in the Health Data, Technology, and Interoperability: ASTP/ONC Deregulatory Actions to Unleash Prosperity proposed rule (90 Fed. Reg. 60970), CMS proposes to update the definition of CEHRT by removing the certification criteria for the following:
    - Family health history; patient health information capture; automated numerator recording; automated measure calculation; and clinical quality measures – filter
    - CMS notes that this proposal is not contingent upon ONC's final actions on the proposed updates in the proposed rule
  - Update the EPA measure description and make the measure optional for CY 2027
    - Currently, MIPS eligible clinicians must report this measure to be considered a meaningful EHR user
    - As an optional measure, it would be eligible for 10 bonus points for those who submit a "Yes" response; "No" responses would have no effect on the PI performance category
  - Remove the Security Risk Analysis measure to reduce reporting burden
    - MIPS eligible clinicians would still be required to comply with applicable cybersecurity requirements but would not be required to report the measure

QPP – MIPS PI Performance Category [cont'd]

- Beginning with the CY 2028 performance period/2030 MIPS payment year, CMS proposes to:
  - Update the EPA measure description with additional requirements and make the measure required for CY 2028 onwards
    - MIPS eligible clinicians would be required to use certified Health IT modules where necessary to support the EPA processes
    - CMS proposes to take a step-wise approach to the certified health IT capabilities necessary to complete the measure
    - Clinicians would attest that they are using CEHRT to electronically request and process prior authorization documentation through a Prior Authorization API that conforms to each of the three certified Health IT modules
    - Reporting on this measure would be optional for the CY 2027 performance year/2029 MIPS payment year and required beginning with the CY 2028 performance year/CY 2030 MIPS payment year (i.e., a "No" response would mean the MIPS eligible clinician would receive a score of zero and would not be considered a meaningful EHR user)
  - Add a new measure, EPA for Prescription Drugs, as a required measure under the Health Information Exchange objective
    - This would measure the use of standards-based EPA for prescription drugs as part of CMS's assessment of meaningful use of CEHRT by MIPS eligible clinicians
    - Excludes clinicians who do not prescribe drugs that require the applicable EPA or who prescribe fewer than 100 permissible drugs during the performance period
    - Clinicians would be required to attest to the measure or claim an applicable exclusion to earn a score for the PI performance category
- CMS would also make conforming amendments to implement these proposals
- Additional details on these proposals can be found in Tables C-G 2 through C-G 8 of the proposed rule

QPP – MIPS Scoring

- Beginning in the CY 2027 performance period/2029 MIPS payment year, CMS proposes that for clinicians (except those in small practices) who do not submit a MIPS core measure and do not attest during data submission that they do not have an available and applicable MIPS core measure, CMS would assign zero measure achievement points for one quality measure
- CMS proposes to apply the defined topped out measure benchmark for:
  - Certain topped out measures for clinicians impacted by limited measure choice, for the CY 2027 performance period/2029 MIPS payment year (*see* Table C-H1 of the proposed rule for full details)
    - CMS seeks feedback on the proposed list of topped out measures impacted by limited measure choice in specialty measure sets and MVPs to be subject to the defined topped out measure benchmark
  - MIPS core measures that are topped out for two or more consecutive years, beginning in the CY 2027 performance period/2029 MIPS payment year
  - If a measure is topped out, it would not be subject to the seven-point topped out measure scoring cap
  - If a measure is no longer topped out, it would be scored using its historical benchmark instead of the topped-out measure benchmark

QPP – MIPS Scoring [cont'd]

- CMS proposes to modify the publishing location of topped out measures impacted by limited measure choice and scored according to the defined topped out benchmark
  - Instead of publishing the list in the Federal Register, CMS would publish the list annually on the QPP website at https://qpp.cms.gov
- CMS proposes to modify the benchmarking methodology for MSSP ACOs reporting the Medicare CQMs collection type by extending the use of flat benchmarks and to establish a flat benchmarking methodology
  - CMS would use flat benchmarks to score all Medicare CQMs for the CY 2025 performance year and subsequent performance years and retroactively apply flat benchmarks beginning with the CY 2026 performance period/2028 MIPS payment year to Quality IDs 001, 134, and 236
- CMS would also use flat benchmarks to score the newly proposed Medicare eCQMs beginning with the CY 2027 performance year and subsequent years

QPP – Third Party Intermediaries

- CMS proposes to remove the additional requirements for health IT vendors beginning with the CY 2025 performance period/2027 MIPS payment year because health IT vendors are no longer permitted to submit MIPS data as a third-party intermediary
  - The additional requirements for health IT vendors only apply for the CY 2021 performance period/CY 2023 MIPS payment year through the CY 2024 performance period/2026 MIPS payment year
- CMS proposes to update the requirements for third-party intermediaries related to the conditions for approval of Qualified Clinical Data Registries (QCDRs) and qualified registries (*see* the following slide for details)
- CMS proposes to revise the remedial action and termination policies to terminate third-party intermediaries that do not submit data for one year and that cannot submit appropriate documentation of their intent to submit MIPS data

QPP – Third Party Intermediaries [cont'd]

- CMS proposes that QCDRs and qualified registries would be required to provide the performance feedback at the level at which the data was or will be submitted (for example, individual, group, virtual group, subgroup, APM entity).
- CMS would update the existing two policies regarding a third party intermediary's annual data validation audit, to require that:
  - A third party intermediary with fewer than 10 QPP participants submitting MIPS data must audit all QPP participants
  - A third party intermediary submitting data for QPP participants with fewer than five patient records must audit all patient records
- CMS would also update the timeframe available for submission of self-nomination plans to require third party intermediaries that do not submit data for one year (instead of two years) to submit a self-nomination participation plan
  - The plan must include the QCDR's and/or qualified registry's detailed plans about how the QCDR or qualified registry intends to encourage clinicians to submit MIPS data to CMS through the QCDR or qualified registry

QPP – Third Party Intermediaries [cont'd]

- CMS would modify the qualified postings' policy to prohibit third party intermediaries from making changes to the information submitted after the qualified posting is publicly posted on the QPP Resource Library page
- CMS would revise existing policies to specify a QCDR or a qualified registry must be able to submit to CMS data for at least six quality measures including at least one MIPS core measure to align with the proposed removal of high priority designation from MIPS quality measures and the proposed MIPS core measure reporting requirements beginning in the CY 2027 performance period/2029 MIPS payment year

QPP – Calculating MIPS Final Score

- Beginning with the CY 2027 performance period/2029 MIPS payment year, CMS proposes to use the most current and reliable data to determine if an individual MIPS eligible clinician is located in an area that has been identified as being affected by an extreme and uncontrollable circumstance (EUC)
  - For example, CMS may use zip codes on billed claims that identify the location of service
- Beginning with the CY 2025 performance period/2027 MIPS payment year, CMS proposes to adjust the deadline by which clinicians would be able to submit reweighting requests for the performance categories where a third-party intermediary did not submit data on their behalf in accordance with the applicable data submission deadlines, from November 1st to December 31st of the year preceding the relevant MIPS payment year

QPP – Public Reporting

- CMS proposes to remove the requirement preventing public reporting of any performance data reported through an MVP on a new improvement activity or PI measure, objective, or activity during the first year in which it is included in such MVP
  - Performance information for new improvement activities and PI measures would be publicly reported on CMS Compare Tools during the first year in which the measures and activities are included in the program, regardless of reporting option

QPP – Advanced APM Proposals

- CMS proposes to modify the Qualifying APM Participant (QP) and Partial QP determination policies by applying QP and Partial QP status strictly to an eligible at the TIN and NPI level
  - QP and Partial QP status would only apply to the clinician at the TIN that is participating with the APM Entity in the Advanced APM, to ensure that only TINs participating in Advanced APMs receive additional incentive payments
    - The APM Incentive Payment and the qualifying APM conversion factor would apply to the NPI's claims only with participating TINs
    - A Partial QP's ability to opt into or out of MIPS would be at the TIN/NPI level
  - CMS notes that the majority of clinicians in Advanced APMs are already participating with an APM Entity in an Advanced APM with all of their TIN reassignments and therefore the QP status would apply at each of their TINs
    - For others, CMS believes this would provide a meaningful incentive to increase participation in an Advanced APM
  - CMS also states that this aligns with MIPS, which already operates on a TIN/NPI basis

QPP – Advanced APM Proposals [cont'd]

- CMS proposes to remove a clerical error in regulatory text to clarify when QP status is lost as a result of an APM Entity terminating participation from an Advanced APM to align with Partial QP regulation text and remove any potential for confusion with respect to the intended timeframe for APM Entity terminations before financial risk is borne in the Advanced APM
- CMS proposes to clarify that, for certain APMs that do not require or generate a participation list for its APM Entities, CMS would not include these APMs for MIPS scoring or QP determinations
- CMS proposes to codify the provision of the CAA, 2026 that provided a 3.1 percent APM Incentive Payment for payment year 2028 and make a conforming change to the definition of "APM Incentive Payment"
- CMS proposes to revise the Medicare Option and All-Payer Combination Option QP and Partial QP thresholds – both payment amount and patient count – for determining QP and Partial QP status in alignment with the CAA, 2024

QPP Requests for Information

- The QPP section includes the following RFIs:
  - Fast Healthcare Interoperability Resources®-Based Digital Quality Measurement in the Quality Payment Program and Other CMS Quality Programs – Request for Information
  - Request for Information on Future Potential Performance-Based Measures of Electronic Prior Authorization
  - MVP Scoring Request for Information
  - Request for Information: Star Rating Assignment Methodology for Administrative Claims Quality Measures

Please contact us if you have any questions or if you would like additional information.