AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

September 10, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1832-P
7500 Security Boulevard
Baltimore, MD 21244

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

Dear Administrator Oz:

On behalf of the more than 5,200 members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule. AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine (HPM). Our membership also includes nurses, social workers, spiritual care providers, and other health professionals deeply committed to improving quality of life for the expanding population of patients facing serious illness as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have access to high-quality palliative and hospice care.

Summary of Key Messages and Recommendations

AAHPM offers the following key messages and recommendations, which are further detailed in our comments below.

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Physician Fee Schedule Payment Provisions

- CY 2026 Conversion Factor. While AAHPM appreciates the modest increase for 2026, we continue to believe that major reforms are needed in how Medicare physician payment updates are made, and we urge CMS to work with Congress to achieve long-term reforms that provide positive payment updates consistent with inflation in practice expenses.
- Specialty Impacts and HPM Designation. CMS should include specialty code 17, Hospice and Palliative Care, in its specialty impact tables in the MPFS final rule and all future proposed and final rules going forward. CMS should also update the specialty code description to read "Hospice and Palliative Medicine" rather than "Hospice and Palliative Care."
- Practice Expense Methodology – Site of Service Payment Differential. CMS should not finalize its proposal to reduce PE relative value units (RVUs) for services valued in the facility setting.
- Efficiency Adjustment to Work Relative Value Units (RVUs). CMS should not finalize its proposal to apply an efficiency adjustment to non-time-based services. Instead, CMS should pursue a more methodologically rigorous approach for considering efficiency gains that considers each service independently and that relies on the experience of practicing physicians.
- Telehealth and Virtual Care
    - *Telehealth Services Review Process.* CMS should finalize its proposal to revise its review process for determining whether services can be added to the Medicare Telehealth Services List and to consider all services currently on the list to be included on a permanent basis.
    - *Frequency Limitations.* CMS should finalize its proposal to permanently remove frequency limitations for certain services furnished via telehealth.
    - *Virtual Direct Supervision.* CMS should finalize its proposal to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology.
    - *Teaching Physician Supervision.* CMS should retain existing flexibilities for teaching physician supervision, including to allow for teaching physician virtual presence if the service is furnished virtually in both urban and rural areas.
    - *Reporting of Home Address.* CMS should allow physicians to continue reporting their currently enrolled practice location when furnishing telehealth services from their homes.
    - *Statutory Telehealth Flexibilities.* CMS should work with Congress to permanently eliminate the geographic and originating site restrictions on Medicare telehealth services.
- Evaluation and Management Services: G2211. CMS should finalize its proposal to allow E/M complexity add-on code HCPCS G2211 to be reported with home and residence E/M visits.
- Request for Information (RFI) on Prevention and Management of Chronic Disease. CMS should pursue refinements to the PFS that would facilitate broader patient access to palliative care services, as further detailed in our comments below.

Quality Payment Program (QPP) Provisions

- MIPS Value Pathways (MVPs) General. CMS should maintain MVPs as a voluntary reporting option and prioritize the development of population-based MVPs that focus on specific patient populations rather than relying on a specialty-specific frameworks.
- MVP Subgroup Reporting. CMS should reverse its decisions to mandate MVP subgroup reporting in CY 2026. CMS should finalize its proposals to modify the definitions of single- and multi-specialty group (with modifications) and to exempt multi-specialty small practices from the subgroup reporting requirements.

- Addition and Modifications of MVPs. CMS should add the Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (*Heard and Understood)* measure to the measure sets for both the proposed Vascular Surgery and Neuropsychology MVPs, as well as the previously finalized Primary Care and Pulmonology Care MVPs.
- Core Elements MVP RFI. CMS should only include "core element" measures in MVPs on an optional basis in order to maintain flexibility for clinicians to select measures that are most relevant to their patients and practices. AAHPM also encourages the inclusion of the *Heard and Understood* measure as a core measure in applicable MVPs.
- Measure Procedural Codes RFI. CMS should not assign clinicians to MVPs based on procedural codes and instead preserve flexibility for clinicians to self-select MVPs.
- MIPS Quality Performance Category. CMS should work with specialty societies to identify and add more meaningful measures to both MIPS and MVPs. Additionally, CMS should add the Receiving Desired Help for Pain measure (*Help Wanted for Pain*) to the MIPS measure inventory.
- Specialty Measure Set. CMS should finalize its proposal to include the *Heard and Understood* measure in the Clinical Social Work, Neurology, Pulmonology, and Skilled Nursing Facility specialty measure sets.
- Total Per Capita Cost (TPCC) Measure. While AAHPM appreciates efforts by CMS to improve the attribution methodology for the TPCC measure, we remain concerned that the measure fails to align cost accountability with appropriate quality metrics and holds clinicians accountable for costs beyond their control.
- Informational-Only Feedback Period for New Cost Measures. CMS should finalize its proposal to allow for two-year informational-only feedback period for new cost measures.
- Query of Prescription Drug Monitoring Program (PDMP) Measure RFI. AAHPM urges caution in transitioning the Query of PDMP measure to a performance-based metric and urges CMS to adopt certain changes to the measure to exclude patients with serious or complex chronic illness and those at the end of life.
- Topped Out Measures. CMS should extend its recently finalized topped out measure policy to all clinicians impacted by limited measure choice and the scoring cap policy.
- MIPS Performance Threshold. CMS should finalize its proposal to maintain the MIPS performance threshold at 75 points for the CY 2026 through CY 228 performance periods.
- Well-being and Nutrition Measure RFI. AAHPM supports CMS incorporating measures addressing well-being into the QPP and continues to urge CMS to adopt the *Heard and Understood* measure into additional specialty measure sets and MVPs.
- Toward Digital Quality Measurement in CMS Quality Programs – RFI. CMS should adopt a thoughtful, long-term transition to digital quality measurement that recognizes the burden and operational challenges providers experience in adopting and updating electronic health record (EHR) systems that support interoperable data exchange.

Ambulatory Specialty Model (ASM)

- Overall Comments. CMS should not finalize the ASM. Rather, CMS should work with stakeholders to develop specialty care models that address identified concerns and provide meaningful opportunities for specialists to achieve Qualifying Alternative Payment Model (APM) Participant, or QP, status.
- Community-based Palliative Care Model. CMS should pursue APMs that would increase coverage for and access to community-based palliative care services to support patients with serious illness.

Physician Fee Schedule Payment Provisions

CY 2026 Conversion Factor

For CY 2026, CMS proposes a conversion factor (CF) of $33.5875 for items and services furnished by Qualifying Alternative Payment Model (APM) Participants, or QPs, and a CF of $33.4209 for all other items and services. These reflect increases of 3.84 percent and 3.32 percent, respectively, relative to the CF for CY 2025.

AAHPM appreciates that, for the first time after five years of reductions to the CF, payments under the MPFS will see a modest increase for 2026. However, we emphasize that such an increase is not sufficient to compensate for the declines that have occurred since 2021, and that the proposed CFs for 2026 are still well below that for CY 2020, before the first reductions took place. Further, we note that the increase for 2026 is largely driven by the temporary, one-time 2.5 percent assistance that Congress provided through the *One Big Beautiful Bill Act,* which will expire at the end of 2026, meaning that physicians will face another substantial payment reduction for 2027 without further Congressional action.

This state of affairs is not sustainable for physician practices, which rely on Medicare payments to operate their practices and furnish the care Medicare beneficiaries need. Physicians require consistent, predictable payment updates that provide adequate compensation for the costs they incur to run their practices. Instead, they have faced reductions year-after-year, and – despite nominal base payment increases required under the Medicare Access and CHIP Reauthorization Act – are threatened with future payment reductions as a result of short-term, short-sighted action by Congress.

AAHPM recognizes that structural problems with the statutory formulas for updating payments under the MPFS are responsible for the payment challenges that exist under the PFS, including the fact that payment updates are not tied to any indicators of inflation – unlike updates received for almost every other Medicare payment system – and that changes in relative value units (RVUs) are subject to budget neutrality adjustments. While temporary fixes enacted by Congress can help to provide much-needed immediate relief, they do not address the fundamental limitations of the current system.

AAHPM continues to believe that major reforms are needed in how Medicare physician payment updates are made. In particular, AAHPM believes annual MPFS conversion factor increases tied to changes in the Medicare Economic Index (MEI) are critical for ensuring that payments keep pace with costs. ***AAHPM therefore urges CMS to work with Congress to achieve long-term reforms that provide positive MPFS payment updates consistent with inflation in practice expenses, in order to protect the sustainability of physician practices and ongoing access for beneficiaries.***

Additionally, as we have requested for the last several years, ***we again urge CMS to include specialty code 17, Hospice and Palliative Care, in its Regulatory Impact Analysis (e.g., Table 92, Table 108) for the final rule, and for all future MPFS proposed and final rules going forward. We also request that CMS update the specialty code description to read "Hospice and Palliative Medicine" rather than "Hospice and Palliative Care;"*** such a change would align the physician specialty code description with the physician subspecialty recognized by the American Board of Medical Specialties.

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

With the goal of better recognizing the relative resources involved in furnishing services paid under the MPFS in facility versus non-facility settings, CMS proposes to reduce PE relative value units (RVUs) for each service valued in the facility setting under the MPFS, beginning in CY 2026. Specifically, under this proposal, CMS would reduce the portion of the indirect facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs.

While AAHPM appreciates CMS' interest in supporting private practices and reducing incentives for health care consolidation, ***we do not support this proposal, which we believe would undermine the facility-based work that a large proportion of our members perform.*** Notably, palliative care practitioners are commonly affiliated with academic medical centers and health systems. As a result, reducing payments for services furnished in facility settings could have a devastating impact on our field if these institutions reconsider whether investment in palliative care is warranted. We believe such an outcome would harm beneficiaries and be inconsistent with CMS' cost and quality goals, particularly given available evidence demonstrating that palliative care improves patient outcomes and reduces the use of unnecessary or preventable medical services and their associated costs. (Please refer to our comments in response to the Request for Information on Preventing and Managing Chronic Disease for additional information on the benefits of palliative care.)

Furthermore, this proposal would not accurately reflect the resource costs incurred by many physicians who furnish care in facility settings – particularly those who do not have any type of employment relationship with the facility. For example, our members routinely furnish care to seriously ill patients who have elected hospice or who are admitted to skilled nursing facilities. Those who operate independently incur the full set of practice costs, including for rent and utilities, clinical and administrative staff, office equipment and supplies, and more, which must be recouped across the full range of services they furnish. CMS' proposal to reduce indirect PE RVU for services furnished in facilities would fail to appropriately reimburse independent physicians for these costs.

We are also concerned that this proposal could have the unintended consequence of reducing beneficiary access to the Medicare hospice benefit if managing physicians reduce beneficiary referrals to hospice care, where their payments would be reduced under this policy. Hospice election rates are already low, with the National Alliance for Care at Home reporting that less than 50 percent of Medicare decedents used hospice in 2022, and of those, half were enrolled for 18 days or less. Any payment changes that reduce incentives for hospice referral could delay or prevent seriously ill patients from receiving the patient-centered physical, social, emotional, and spiritual support that hospice offers patients at the end-of-life.

We also highlight how this policy could harm hospitals that are already seeing payment reductions as a result of cuts to Medicaid programs that were included in the recently enacted reconciliation legislation. Payment reductions under this proposed policy would further threatening access to care for underserved patients, including patients in rural areas.

Finally, we question whether this proposal would truly support independent practice and reduce incentives for consolidation. For example, if independent physicians who routinely furnish care in facility settings receive insufficient payment under the policy, it could have the opposite effect of CMS' intent to

bolster private practice and lead to further consolidation. We therefore question how CMS will determine whether the policy is successful or whether further adjustments will be needed.

For all of the above reasons, ***AAHPM urges CMS not to finalize its proposals to implement site of service payment differentials through adjustments to indirect PE RVUs.*** Instead, CMS should consider alternative approaches for better targeting efforts to support private practice and for assessing the impacts of its policies on its intended goals.

Efficiency Adjustment to Work RVUs

Starting in CY 2026, CMS proposes to apply an efficiency adjustment to the work RVUs and corresponding intraservice portion of physician time for non-time-based services that are expected to accrue gains in efficiency over time. Time-based codes, such as evaluation and management (E/M) and care management services, would be excluded from the efficiency adjustment under CMS' proposal. Using a 5-year lookback of the Medicare Economic Index (MEI) productivity adjustment, CMS estimates the efficiency adjustment to be -2.5 percent. CMS also proposes to apply an efficiency adjustment every 3 years.

While utilization of affected services is not widespread among our members, ***AAHPM nonetheless has serious concerns with this efficiency adjustment proposal, which we urge CMS not to finalize.***

To begin, we underscore our support for physician input in setting values for individual services. We note that there is a rigorous, well-defined, multi-specialty process for determining the inputs for valuing services under the PFS, and that engagement of the physicians who furnish affected services is critical to that work. Failing to rely on the experience and expertise of these physicians to set valuation would reduce payment accuracy and undermine the integrity of the resource-based relative value scale upon which the MPFS relies.

We also highlight that the proposal is not supported by empirical data. In fact, a recent study published in the *Journal of the American College of Surgeons* analyzed surgical time data and found that overall operative times increased from 2019 to 2023, with 90 percent of CPT codes having longer or similar operative times in 2023 compared to 2019. This evidence clearly refutes CMS' premise that physicians have reduced the time required to perform the same services. Furthermore, it undercuts CMS' proposal to apply an efficiency adjustment every three years – a proposal that, if taken to its extreme conclusion, would end up resulting in no service being assigned any work RVUs over the long term.

We also disagree with the arbitrary, across-the-board nature of CMS' proposal, which CMS proposes to apply broadly – even to services that are new or that have recently been revalued. Such an approach is not resource-based and cannot be justified, particularly when recent data collection efforts that CMS has endorsed have identified the appropriate level of resources involved in furnishing services. It also does not account for the fact that different types of services have different potential to accrue efficiencies. For example, efficiencies gained for long surgical procedures will be very different than for minor procedures with short duration.

Finally, we object to the false correlation that CMS creates between efficiency, medical decision making (MDM), and risk. Even if physicians are able to perform procedures in a shorter time, MDM is not any easier, and the risk associated with performing the procedure is not any less. CMS' proposed approach

fails to recognize this complex dynamic, despite the fact that the work component of MPFS services takes into account both time and intensity of furnishing care.

In sum, CMS' proposal to apply an efficiency adjustment is arbitrary, misguided, and not supported by data or experience. ***Rather than finalize this policy, CMS should pursue a more methodologically rigorous approach for considering efficiency gains that considers each service independently and that relies on the experience of practicing physicians.***

Telehealth and Virtual Care

CMS proposes several policies that would create greater long-term certainty with respect to the delivery of services furnished via telehealth and the use of telecommunications technology to engage in direct supervision. These include proposals to:

- Revise its review process for determining whether services can be added to the Medicare Telehealth Services List, and in the process consider all services currently on the Medicare Telehealth Services List to be included on a permanent basis.
- Permanently remove the frequency limitations for furnishing subsequent inpatient and nursing facility services and critical care consultations when furnished via telehealth.
- Permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology for all "incident to" services, except for services that have a global surgery indicator of 010 or 090.

AAHPM supports these changes, which defer to physician judgement in determining whether services can be safely and effectively furnished or supervised using telecommunications technology, and we recommend that CMS finalize these policies as proposed. By making these policies permanent, CMS would offer greater clarity regarding its long-term policies, which would support providers' ability to engage in long-term planning and investment.

At the same time, ***we do not support CMS' proposal to revert to pre-pandemic rules regarding teaching physician supervision of resident services furnished within metropolitan statistical areas (MSAs).*** CMS proposes that – for services provided within MSAs – teaching physicians must maintain physical presence during critical portions of all resident-furnished services to qualify for Medicare payment. This policy backs away from flexibilities currently in place that allow for teaching physician virtual presence if the service is furnished virtually by the resident. We note that the existing flexibility for teaching physician supervision has been critical in increasing capacity of teaching programs, while managing patient safety concerns. Eliminating the flexibility will harm teaching programs' ability to recruit and retain qualified preceptors to train the next generation of physicians, and we believe the impact to the field of Hospice and Palliative Medicine will be particularly harmful, as there already exists a shortage of qualified HPM professionals. Rather than erecting barriers to entry for new HPM trainees, CMS should pursue strategies to grow the field, in order to maximize the benefits of palliative care in promoting efficiency and enhancing patient outcomes. In this case, ***we therefore urge CMS to retain existing flexibilities for teaching physician supervision, including to allow for teaching physician virtual presence if the service is furnished virtually in both urban and rural areas.***

We also raise concerns with CMS' silence on extending current flexibilities that allow physicians to report their current practice location when furnishing telehealth services from their homes without reporting their home address for purposes of Medicare enrollment. As we have previously stated, public reporting of home address information would raise significant physician privacy and safety risks. Furthermore,

reporting of home addresses – including through enrollment changes – would be a burdensome undertaking that would require substantial time for physicians to complete and contractors to process. ***AAHPM therefore urges CMS to allow physicians to continue rendering telehealth services as needed from their homes without having to report their home addresses.*** As with other flexibilities CMS is proposing, we support making this flexibility permanent.

Finally, while we acknowledge the importance of policies that CMS addresses through rulemaking, we underscore the need for statutory telehealth flexibilities, including elimination of the geographic and originating site restrictions on Medicare telehealth services. The temporary waiver of these requirements in response to the PHE for COVID-19 and in the ensuing months has been immensely beneficial to AAHPM members and their seriously ill patients by enabling patients to access care teams, receive timely assessment and management of pain and other symptoms, and receive follow-up care as medically necessary from their homes – even when they faced challenges related to pain, frailty, and medical instability. We are therefore troubled that these flexibilities are currently set to expire at the end of September. We note that the statutory geographic and originating site restrictions are outdated; do not reflect the current needs and technological capabilities to safely, effectively, and efficiently deliver care; and are not responsive to patients' and providers' preferences for receiving and delivering care with minimal burden. ***AAHPM therefore again urges CMS to work with Congress to permanently eliminate the geographic and originating site restrictions on Medicare telehealth services before the September deadline, to ensure that patients can continue to receive telehealth services wherever they are located in the country, including in their homes.***

Evaluation and Management (E/M) Services: G2211

AAHPM urges CMS to finalize its proposal to allow E/M complexity add-on code HCPCS G2211 to be reported with home and residence E/M visits, rather than limiting the use of the code to office and outpatient E/M visits only. If finalized, this code would support more accurate valuation of resources required to furnish E/M visits to patients who must be seen in their homes or residences. As noted above, patients with serious illness often face challenges in accessing care, including as a result of pain, frailty, medical instability, making home and residence visits an important component of the care our members furnish. In seeing these patients in such settings, our members regularly build longitudinal relationships with their patients that are consistent with the services originally envisioned for G2211. The ability to bill this add-on code for home and residence E/M visits will therefore contribute to enhanced care and care management, and in the process support the delivery of high-quality palliative care.

Request for Information (RFI) on Prevention and Management of Chronic Disease

In accordance with Executive Order 14212, "Establishing the President's Make America Health Again Commission," the Administration is directing its focus towards understanding and lowering chronic disease rates, including thinking on nutrition, physical activity, healthy lifestyles, over-reliance on medication and treatments, the effects of new technological habits, environmental impacts, and food and drug quality and safety. To that end, CMS seeks feedback on a number of questions designed to identify opportunities to support prevention and management goals through changes in the MPFS.

AAHPM appreciates the goals of CMS and this Administration to promote the health and well-being of the American people, including through the prevention and management of chronic disease. In support of these goals, we call attention to the value of palliative care in managing the nation's chronic disease burden, and ***we urge CMS to consider refinements to the PFS that would facilitate broader patient access***

to such services, as further detailed in our comments below. We also encourage CMS to partner with other agencies within the Department of Health and Human Services to bolster broader public health efforts, including through research and the development of evidence-based guidelines, patient and provider education, and health promotion programs.

Recognizing the Value of Palliative Care

Palliative care is an interdisciplinary model of care aimed at preventing and managing the debilitating effects of serious illness, including serious chronic illness. It can be provided from the time of diagnosis and involves the relief of pain and other symptoms that cause discomfort, such as shortness of breath and unrelenting nausea. Hospice is a type of palliative care for patients near the end life.

Additionally, palliative care is patient- and family-centered – it focuses on matching treatment to achievable patient goals to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients traverse throughout the course of a serious illness. High-quality palliative care also supports caregivers by offering education and information, emotional support, tools and strategies for supporting loved ones, social work assistance, and more.

A growing body of medical research has documented the benefits of high-quality palliative and hospice care for patients with serious and chronic illness and their families, by not only helping to relieve pain and other distressing symptoms but also addressing patients' psychosocial and spiritual needs and improving their capacity to contend with the stresses associated with their illness. Benefits also accrue for hospitals and payers, and for the health care system as a whole. To illustrate, evidence shows that high-quality palliative care services can provide significant benefits for patients, caregivers, and payers, including enhanced quality of life for patients, higher rates of patient and family satisfaction with medical care, reduced hospital expenditures and lengths of stay, and more. Furthermore, palliative care achieves these outcomes at a lower cost than usual care, by helping patients better understand and address their needs, choose the most effective interventions, and avoid unnecessary/unwanted hospitalizations and interventions. We also highlight the holistic, person-centered nature of palliative care, which focuses on understanding patients' needs and preferences – which often reflect patients' culture, history, community, and spiritual orientation – and considers psychosocial factors affecting patients' well-being.

Unfortunately, current policies and payment systems continue to pose numerous barriers that limit palliative care teams' ability to receive adequate reimbursement for providing comprehensive palliative care services, and therefore limit patients' ability to receive high-quality palliative care. However, improvements to payment under the MPFS – paired with broader regulatory and legislative reforms to bolster the palliative care workforce, increase funding for palliative care research, and protect access to multimodal pain management therapies – could serve to expand access to palliative care services nationwide.

To begin, AAHPM has supported payment changes in the MPFS that allow for increased access, including changes that allow for billing and payment of care management services, communication technology-based services, caregiver training services, community health integration (CHI), and principal illness navigation (PIN) services. Efforts to increase availability and utilization of these and similar services would expand palliative care teams' ability to support patients with serious illness. This could include policies

that would allow for provision of services comparable to CHI and PIN services to be furnished by clinical staff under physician supervision in institutional settings.

Perhaps even more impactful, however, would be the development of a code for home-based palliative care services furnished by an interdisciplinary care team under a monthly case rate that would cover comprehensive palliative care furnished in a manner consistent with the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care. The case rate would cover initial comprehensive assessments, ongoing patient education, development of care plans and goals of care, communication with other providers and coordination of related services, 24/7 availability to respond to requests for information or assistance, in-person and telehealth visits, symptom management, and more. Establishment of such a code and coverage through the MPFS would support comprehensive, team-based palliative care, reduce provider administrative burden, and facilitate care consistent with patients' goals and preferences.

Additionally, designing payment in this manner would help to address social isolation, as it would facilitate regular ongoing contact between patients and their palliative care teams. And while a payment bundle for comprehensive home-based palliative care would encompass social isolation screening, we also support the development of a standalone billing code to screen for social isolation, which would compensate physicians and care teams for work to identify a major risk factor for a wide range of physical and mental health conditions, as well as for increased mortality.

Finally, we encourage CMS to continue exploring separate coding and payment for digital therapeutics that treat or manage the symptoms of chronic diseases, as well as coding to support interpretation of data transmitted by such devices. We believe tools focused on cognitive behavioral therapy, digital coaching, and other behavioral interventions could help in the care of patients with serious chronic illness through assistance with symptom relief, psychological support, and more.

Updates to the Quality Payment Program (QPP)

MIPS Value Pathways (MVPs)

General

CMS continues to signal its intent to fully transition to MVPs and sunset the traditional MIPS program by performance year 2029. ***AAHPM remains deeply concerned about this approach and strongly urges CMS to maintain MVPs as a voluntary reporting option.*** The MVP framework, as currently designed, does not resolve fundamental flaws in the MIPS program, including the siloed structure of performance categories and the continued lack of meaningful linkage between quality and cost measures. As a result, clinicians often face redundant reporting requirements and are held accountable for duplicative measures. Additionally, MVPs are built on the existing MIPS measure set, which lacks clinical relevance for many specialties, including hospice and palliative medicine (HPM). Given the limited availability of MIPS measures that are clinically relevant to palliative care, we are concerned that HPM clinicians have few opportunities to be meaningfully assessed for the care they provide to patients with serious illness.

Additionally, AAHPM urges CMS to prioritize the development of population-based MVPs that focus on specific patient populations rather than relying on a specialty-specific frameworks. MVPs centered on specific patient populations, such as patients with serious illness, would support higher quality, higher-value care by holding group practices accountable for outcomes that matter most to their patients. When paired with clinically meaningful measures and designed to reflect the realities of team-based,

coordinated care, population-focused MVPs can reduce duplicative reporting, ease administrative burden, and promote alignment across care teams. This is particularly important for patients with serious illness, most of whom have multiple medical conditions, not just a single disease, which further complicates their care. Consequently, structuring MVPs around individual specialties may not fully reflect the comprehensive care these patients receive, particularly when multiple specialists are involved.

MVPs may offer a pathway to more meaningful performance measurement if they are redesigned to reflect patient-centered care, reduce administrative burden, and promote flexibility. Until that is achieved, AAHPM strongly urges CMS to maintain MVPs as voluntary as it continues to work with specialty societies to improve the reporting pathway.

Subgroup Reporting

Beginning in CY 2026, multi-specialty practices participating in MVPs will be required to form subgroups. In preparation for this change, CMS proposes to revise its definition of a single specialty group to mean a group consisting of clinicians in one specialty type or *clinicians involved in a single focus of care*, and to revise the definition of a multispecialty group to mean a group consisting of clinicians in two or more specialty types or *clinicians involved in multiple foci of care*. CMS also proposes to require groups to attest to their specialty composition during the MVP registration process. Finally, CMS proposes to exempt multi-specialty small practices from the subgroup reporting requirement.

While AAHPM is generally supportive of the proposed definitional changes (as discussed in greater detail below), we strongly urge CMS to reverse its decision to mandate MVP subgroup reporting in CY 2026. As we have stated previously, this requirement places significant administrative burden on multi-specialty group practices that already struggle with the complexity and frequent changes within MIPS policies. While optional subgroup reporting could enhance focused quality reporting, especially if combined with other program reforms, mandatory subgroup reporting should be deferred until technology enables seamless submission of discrete data elements and CMS can automatically calculate performance at the clinician, subgroup, and group practice levels. Until then, practices should have the flexibility to determine subgroup composition based on their unique structures and patient populations.

We are also concerned that CMS lacks a sufficient data foundation and measure inventory to justify a subgroup mandate at this time. The 2023 QPP Experience Report illustrates these limitations: 20,484 clinicians submitted MVP data during performance year (PY) 2023, yet only 6,790 received a final score, and only 101 clinicians participated via subgroups. This represents just 0.02 percent of all MIPS-eligible clinicians in PY 2023, underscoring that subgroup reporting remains largely untested at scale. To that end, CMS should maintain subgroup reporting as a voluntary option while it gathers additional data on reporting patterns, practices, and challenges. A delay would also allow CMS time to develop additional MVPs across specialties and subspecialties, expand the pool of measures available for MVPs, and address scoring methodologies that continue to discourage the use of more specialized measures.

AAHPM supports CMS' proposal to revise the definitions of single- and multi-specialty groups, particularly the recognition that clinical focus should play a role in group classification. This approach ensures that multi-specialty groups unified by a single clinical focus, such as palliative care, would not be unnecessarily required to form subgroups. ***To ensure clarity and consistency, however, we recommend further refinement of these definitions to ensure they are mutually exclusive.*** As currently proposed, a group that consists of two or more specialties involved in a single focus of care would be considered both a single-specialty and a multi-specialty group. ***Specifically, we recommend that CMS make the following***

modifications to the proposed definitions to more accurately capture what we believe is CMS' intent under this proposal:

- *Single specialty group means a group that consists of one specialty type or consists of clinicians in two or more specialties involved in a single focus of care.*
- *Multispecialty group means a group as defined at § 414.1305 that consists of clinicians in two or more specialty types NOT involved in a single foci of care or clinicians in two or more specialty types involved in multiple foci of care.*

Finally, AAHPM supports CMS' proposal to exempt multi-specialty small practices from the subgroup reporting requirement. This exemption is consistent with prior recommendations from AAHPM and appropriately recognizes the unique challenges these practices face. Small practices already struggle to meet case minimums and would be disproportionately disadvantaged if required to report as smaller subgroups.

Addition and Modification of MVPs

CMS proposes to adopt six new MVPs for CY 2026, including the Vascular Surgery and Neuropsychology MVPs. Additionally, CMS proposes modifications to all 21 previously finalized MVPs.

AAHPM recommends that CMS add the Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Heard and Understood; Quality ID #495) to the measure sets for both the Vascular Surgery and Neuropsychology MVPs.

The *Heard and Understood* measure was developed by AAHPM in coordination with the National Coalition for Hospice and Palliative Care and RAND Health under a CMS-awarded cooperative grant. This patient-reported outcome performance measure focuses on patient experience, which is a high priority area for MIPS and CMS' Meaningful Measures 2.0 initiative. The measure offers patients living with serious illness, their families, and caregivers a way to share feedback about the desired care they receive, as well as enables physicians, health systems, and payers to better understand how well the care they provide meets patients' needs and preferences. While other patient-reported experience measures exist, the *Heard and Understood* measure is the first one to focus on palliative care in physicians' offices and clinics.

Studies have shown that adding palliative care to the plan of care for patients with serious illness results in better symptom management and communication with health care providers, as well as decreased strain on family members or other caregivers.[1,2] By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve the quality of medical care for patients with serious

[1] Teno JM, Clarridge BR, Casey V, et al. Family perspectives on end-of-life care at the last place of care. *Journal of the American Medical Association* 7 January 2004; 291(1):88-93.

[2] Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly* September 2011; 89(3):343-380.

illness[3,4,5] and quality of life[6,7,8] both during and after disease-directed treatments.[9] Furthermore, integrating palliative care into the care of patients living with serious illness delivers value to the health care system. Palliative care reduces utilization of emergency department and hospital services by avoiding care that is inconsistent with a patient's goals and values, thus resulting in overall cost savings.[10,11,12]

Palliative care has expanded rapidly in recent years across inpatient, ambulatory, home-based, and facility settings; yet there is much work to be done, both within and outside of specialist palliative care service delivery models. Studies show that seriously ill persons often report feeling silenced, ignored, and misunderstood in medical institutions.[13] Feeling heard and understood is a critical component of patient-centered decision-making, which reinforces dignity and is one of the key factors in patient-reported quality care.[14] It is important to measure how heard and understood patients feel in order to promote more universal adoption of key practices of shared decision making and generalist palliative care skills. Because of rapidly growing public demand for high quality palliative care (from patients, but also from both specialist palliative care providers and from other providers focused on serious disease management), measuring patients' experiences in shared decision-making is critical to advancing person-centered care.

CMS has previously recognized the importance of the *Heard and Understood* measure and included this patient-report experience measure in several MVPs, including Advancing Cancer Care, Advancing Care for Heart Disease, Coordinating Stroke Care, Optimal Care for Kidney Health, and Neurological Conditions. AAHPM believes that including the *Heard and Understood* measure in both the Vascular Surgery and

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[6] Davis MP, Temel JS, Balboni T, Glare P. A review of the trials which examine early integration of outpatient and home palliative care for patients with serious illnesses. Ann Palliat Med. 2015;4(3):99-121. http://www.ncbi.nlm.nih.gov/pubmed/26231807

[7] Rabow M, Kvale E, Barbour L, Cassel JB, Cohen S, Jackson V, Luhrs C, Nguyen V, Rinaldi S, Stevens D, Spragens L, Weissman D. Moving upstream: a review of the evidence of the impact of outpatient palliative care. J Palliat Med. 2013 Dec;16(12):1540-9. http://www.ncbi.nlm.nih.gov/pubmed/24225013

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[9] Delgado-Guay MO, Parsons HA, Li Z, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 15 January, 2009, *Cancer*; 115(2):437-45.

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[11] Lustbader D, Mudra M, Romano C, Lukoski E, Chang A, Mittelberger J, Scherr T, Cooper D. The impact of a home-based palliative care program in an accountable care organization. *J Palliat Med.* 2016 Aug 30 [Epub ahead of print]. https://www.ncbi.nlm.nih.gov/pubmed/27574868

[12] May P, Garrido MM, Cassel JB, et al. Cost analysis of a prospective multi-site cohort study of palliative care consultation teams for adults with advanced cancer: Where do cost savings come from? *Palliat Med.* 2017; 31(4):378-386. https://www.ncbi.nlm.nih.gov/pubmed/28156192

[13] Frosch, D. L., May, S. G., Rendle, K. A., Tietbohl, C., & Elwyn, G. (2012). Authoritarian physicians and patients' fear of being labeled 'difficult' among key obstacles to shared decision making. *Health Affairs*, 31(5), 1030-1038

[14] Gramling, R., et al., Feeling heard and understood: A patient-reported quality measure for the inpatient palliative care setting. Journal of Pain and Symptom Management, 2016. 51(2): pp. 150–154.t

Neuropsychology MVPs will support advancing person-centered care by giving MVP participants the option to measure whether their patients' needs and preferences are being met. As noted above, measuring the experiences of patients, families, and caregivers is critical to advancing person-centered care and will promote more universal adoption of best practices to support shared decision making.

Additionally, including the *Heard and Understood* measure in both MVPs will further encourage inclusion of palliative care teams in the care of patients, helping to support more comprehensive care and facilitate delivery of care consistent with what matters to patients. In the context of Vascular Surgery, palliative care can be essential to providing holistic care, particularly in patients with complex or advanced vascular conditions where surgical options may be limited. For these patients, palliative care can facilitate shared decision-making, helping patients and their families navigate care that aligns with the patients' values and goals. Similarly, integrating palliative care with neuropsychology can enhance the overall care of patients with serious neurological conditions, such as dementia, by ensuring symptom management and psychosocial support are tailored to the needs of the patients and their families. This can lead to improvements in daily functioning and can provide critical support to families as they navigate difficult decisions about treatment and end-of-life care.

The *Heard and Understood* measure recognizes that patient-centered care and complex shared decision-making conversations are provided in a variety of practice types and among a variety of physicians specialties. Some physicians have their own well-developed palliative care departments where they address all aspects of serious illness, while others are embedded within specialty centers. Some may not be palliative care specialists, but integrate generalist palliative care skills into their primary care or specialist practice. The *Heard and Understood* measure is specified in a manner that allows non-palliative care specialists who treat patients with serious illness to report the measure. No matter the structure for integrating palliative care, responsiveness to seriously ill patients' needs and preferences is important in supporting effective team-based care.

AAHPM continues to urge CMS to add Heard and Understood to the previously finalized Value in Primary Care MVP. We believe that responsiveness to seriously ill patients' needs and preferences is important in supporting effective team-based care, and that expanding the understanding of primary care to include primary palliative care would help to increase access to palliative care, support more comprehensive primary care, and facilitate delivery of care consistent with what matters to patients.

Finally, AAHPM recommends that CMS add the *Heard and Understood* measure to the previously finalized Pulmonology Care MVP, which captures a broad range of pulmonology conditions, including chronic conditions like COPD. As noted above, this measure is highly responsive to the needs and preferences of seriously ill patients, helping to strengthen team-based care, promote more comprehensive treatment, and ensure that care is delivered in alignment with what matters most to patients.

Core Elements MVP RFI

CMS seeks comment on potentially requiring MVP participants to select at least one quality measure from a subset of measures in each MVP, referred to as "core elements," as part of their four required quality measures. While MVPs are intended to focus on defined types of care and patient populations, the introduction of "core elements" appears to run counter to that goal. Instead of mandating broad, cross-cutting measures, CMS should incentivize the development and use of more patient-centered measures that directly reflect the care being provided. Inclusion of overly broad measures risks adding reporting burden without yielding improvements in patient outcomes or providing patients with meaningful information.

AAHPM believes that cross-cutting measures should only be included in MVPs on an optional basis, thereby maintaining flexibility for clinicians to select measures most relevant to their patients and practice settings. However, we appreciate CMS' interest in promoting cross-cutting measures that enable more direct comparisons across clinicians. To that end, if CMS continues to pursue "core elements," we suggest that CMS explore assigning greater weight to core element measures, while maintaining voluntary reporting, rather than mandating their reporting. This approach would encourage the adoption of core elements while still allowing clinicians the flexibility to report other quality metrics if the core element measures are not relevant to their practice.

Should CMS move forward with "core elements," (either on a voluntary or mandatory basis), we encourage the inclusion of the *Heard and Understood* measure as a core measure in appliable MVPs. As discussed above, this measure captures the experiences of patients with serious illness and their families by assessing whether care aligns with their needs and preferences. Including measures like *Heard and Understood* would advance person-centered care within MVPs by evaluating clinicians on whether the care they furnish truly meets patients' goals and values.

Measure Procedural Codes RFI

CMS seeks comment on a future policy that would require clinicians to report a specific MVP based on the procedural codes they bill, and to potentially require specialists to report specific measures within an MVP.

AAHPM urges CMS to not assign clinicians to MVPs based on procedural codes, which are an imprecise reflection of a clinician's scope of practice. Relying on procedural codes to assign MVPs or measures risks significant misalignment. As CMS itself acknowledges in its discussion of subgroup reporting, claims data have serious limitations and often fail to capture the nuances of clinical practice. In its discussion around its proposal to allow clinicians to self-attest as part of MVP registration, CMS noted that using claims analyses to determine group specialty composition could result in misclassification. Forcing measure assignment through claims data would add burden without improving the accuracy or value of performance measurement.

Instead, CMS should preserve flexibility by continuing to allow clinicians to self-select MVPs and to choose the measures and activities within each MVP that are most relevant to their practice. This approach will ensure that MVP participation yields more meaningful results for patients while maintaining the integrity of quality reporting.

Finally, AAHPM reiterates the importance of moving toward population-based MVPs that emphasize patient populations rather than specialty silos. MVPs focused on populations, such as patients with serious illness, would provide a stronger foundation for meaningful performance measurement, reduce duplicative reporting, and promote accountability for outcomes that matter most to patients.

MIPS Quality Performance Category

General

To make the MIPS program more meaningful to HPM practitioners, CMS must introduce improved quality and cost measures beyond those currently available in the MIPS inventory and provide incentives for their development and testing. AAHPM recognizes the Administration's commitment to reducing regulatory burden on providers and appreciates these efforts. However, unlike in other quality reporting programs,

the addition of measures to MIPS does not increase clinician burden, as it does not expand the number of measures required for reporting. Rather, expanding the set of available measures provides clinicians with greater flexibility to select those that best reflect the care they deliver and that are most relevant to their patient population. Conversely, removing measures may inadvertently increase burden by leaving clinicians with fewer relevant options, forcing them to report on measures that are less applicable to their practice and that do not capture the value of the care they deliver. ***To that end, AAHPM continues to encourage CMS to work with societies to identify and add more meaningful measures to both MIPS and MVPs.***

As noted above, the *Heard and Understood* aligns with CMS' priorities to include more patient experience measures in its quality programs and provides essential feedback on how well care aligns with the needs and preferences of those living with serious illness. ***AAHPM supports recent action by CMS to incorporate the Heard and Understood measure into additional specialty measure sets, as well as MVPs.***

AAHPM also recommends that CMS add the measure "Receiving Desired Help for Pain" (Help Wanted for Pain; CBE ID #3666) separately to the MIPS measure inventory. Developed alongside *Heard and Understood*, this measure evaluates the percentage of patients who report receiving the pain management support they desire during ambulatory palliative care visits. Including both *Help Wanted for Pain* and *Heard and Understood* in MIPS, including in MVPs, would enable more accurate assessment of providers caring for patients with serious illness by capturing distinct, patient-centered aspects of palliative care quality.

Specialty Measure Sets

CMS proposes to add *Heard and Understood* to the following specialty measure sets:

- Clinical Social Work
- Neurology
- Pulmonology
- Skilled Nursing Facility

AAHPM supports the addition of the Heard and Understood measure to these measure sets, which AAHPM has previously advocated for. Similar to other measure sets where the *Heard and Understood* measure has already been adopted, these specialties provide care to patients with serious illness who would benefit from improved responsiveness to their needs and preferences. As noted above, measuring the experiences of patients, families, and caregivers is critical to advancing person-centered care and will promote more universal adoption of best practices to support shared decision making. Additionally, we believe that responsiveness to seriously ill patients' needs and preferences is important in supporting effective team-based care.

MIPS Cost Performance Category

Total Per Capita Cost (TPCC) measure

Beginning with the 2026 performance period, CMS proposes substantive changes to the TPCC measure that are designed to limit instances in which the measure is attributed to highly specialized groups based solely on billing by advanced care practitioners (ACPs). Specifically, CMS proposes requiring that both services in a candidate event be furnished by the same clinician group and by a clinician whose specialty is eligible for attribution. This change is intended to ensure that attribution more accurately reflects ongoing care relationships. Under the proposed modification, a MIPS-eligible clinician would be attributed beneficiaries only if they or another eligible clinician within their group have furnished at least two

qualifying visits, and only if services in the candidate event are provided by clinicians not excluded from TPCC attribution under specialty criteria.

CMS further proposes excluding ACPs (e.g., physician assistants, nurse practitioners, and certified clinical nurse specialists) from TPCC attribution when they are part of clinician groups composed entirely of excluded specialties. This change would reduce the likelihood that highly specialized clinician groups are assessed solely on the basis of ACP billing patterns within the clinician group.

AAHPM appreciates CMS's efforts to improve the methodology of this flawed measure. While the measure is designed to emphasize the role of primary care in managing overall healthcare costs and most specialties are technically excluded from the TPCC measure, specialists are nonetheless often unexpectedly pulled into the measure and held accountable for total patient costs due to attribution flaws. As a result, specialists frequently receive disproportionately low scores, even though they are not the intended focus of the measure. AAHPM has continued to highlight that the measure suffers from persistent attribution challenges and inadequate risk adjustment and provides little actionable feedback for both clinicians and patients.

Despite these proposed refinements, AAHPM remains concerned that TPCC measure continues to hold clinicians accountable for spending that is often beyond their control and does not reflect the realities of care delivery in many specialties, including HPM. The continued use of total-cost-of-care metrics places significant reporting and accountability burdens on clinicians without delivering meaningful data to improve care. Cost measures should reflect only the spending that physicians can reasonably influence and to which they can be appropriately attributed. Additionally, the TPCC measure fails to align cost accountability with patient outcomes or quality metrics and risk discouraging the appropriate integration of palliative care, especially for patients with serious illness or near the end of life. A shift away from broad, imprecise metrics toward more targeted, actionable approaches is essential to reduce administrative burden and support informed clinical decision-making.

In the absence of full removal, AAHPM generally supports CMS' proposed modifications to address attribution challenges with the TPCC measure. However, we are concerned that the proposed exclusion of ACPs only when all physicians in a group are specialty-excluded sets too high a threshold. This "all-or-nothing" approach could still result in non–primary care practices being inappropriately assessed under the measure if even one non-excluded specialty is present. Instead, we urge CMS to adopt a more reliable method of excluding specialists, such as the use of patient-relationship codes or similar attestations. This approach would align with CMS's own proposal on subgroups, where the agency recognizes the importance of accounting not only for the specialty composition of a group but also for its clinical focus through self-attestation.

Finally, we strongly encourage CMS to implement any finalized improvements beginning with the 2025 performance period rather than waiting until 2026. Because cost measures are based on performance-year benchmarks and this policy would be finalized before the conclusion of the 2025 performance year, we believe it is both feasible and appropriate for CMS to move forward on this earlier timeline.

Informational-Only Feedback Period for New Cost Measures

CMS proposes that, beginning with the CY 2026 performance period/2028 MIPS payment year, all new cost measures would be scored for informational purposes only during the first two years after initial finalization. Scores generated during this informational-only period would not be incorporated into a MIPS

eligible clinician's cost performance category score or final MIPS score. In addition, CMS proposes that performance on cost measures during this period would not be publicly reported.

AAHPM supports this proposal, as it will allow clinicians time to understand and adapt to new cost measures, assess their performance, and make necessary practice adjustments before the measures are used in scoring or public reporting.

MIPS Promoting Interoperability Performance Category

Query of Prescription Drug Monitoring Program (PDMP) Measure RFI

Similar to the Fiscal Year (FY) 2026 Inpatient Prospective Payment System (IPPS) Proposed Rule, CMS seeks public comment to potentially inform future rulemaking to change the Query of PDMP measure from its current status as an attestation-based measure ("yes" or "no") to a performance-based measure (numerator and denominator), as well as alternative measures designed to more effectively assess the degree to which participants are utilizing PDMPs. CMS cites progress in the integration of PDMPs with electronic health records (EHRs) or health information exchange systems (HIEs), pharmacy dispensing systems (PDSs), or both, among other factors, in supporting broader use of the Medicare Promoting Interoperability Program to incentivize use of PDMPs.

AAHPM continues to have serious concerns that performance-based assessment on the PDMP measure could pose significant challenges for hospitals and other providers that may routinely prescribe controlled substances. Notably, AAHPM members – as palliative care practitioners – rely upon opioids and other treatment options to alleviate pain for patients with serious illness as part of a comprehensive, patient-centered plan of care. We are concerned that transitioning to performance-based assessment would create incentives to reduce opioid prescriptions – even for patients with debilitating pain resulting from advanced disease progression for whom the benefit of opioid treatment outweighs any potential risk.

Additionally, while we understand the interest in utilizing EHR technology to prevent misuse and abuse of controlled substances, we disagree that performance assessment on this measure advances this goal. Data show that use of prescription opioid medications has decreased nationwide while overdose deaths have skyrocketed, with synthetic opioids, excluding methadone, accounting for the vast majority of overdose deaths in recent years. These data suggest that opioid prescriptions are not a major contributor to the overdose epidemic that the nation continues to experience. It is therefore not clear that increasing emphasis on the Query of PDMP measure by transitioning to performance measurement is clinically relevant.

As a result, AAHPM urges caution in transitioning the Query of PDMP measure to a performance-based measure. Most importantly, we recommend that, prior to effectuating such a change, CMS incorporate appropriate denominator exclusions for patients with serious or complex chronic illness and those at the end of life. This should include patients who are in a hospice election or who are discharged to hospice, as well as those who are receiving palliative care. These patients are more likely to require concurrent prescribing of multiple opioids to address pain associated with their terminal illnesses or other serious conditions. Additionally, we believe other patients with serious illness – for example patients with advanced stages of diseases including cancer, AIDS, dementia and other incurable neurodegenerative diseases, chronic lung disease, end stage renal disease, cirrhosis, heart failure, hemophilia, or sickle cell disease – should also be excluded. Many such patients may lack access to hospice or formal, specialized palliative care, for example due to barriers such as culturally-linked patient preferences, residence in rural or underserved communities, or physician failure to refer. Yet, these patients may require multiple opioid

prescriptions to manage pain and provide symptom relief, for example as a result of palliative care services provided by primary care clinicians. Other patient groups that should also be excluded from the denominator include patients who are receiving opioids for the treatment of addiction. We are concerned that the failure to incorporate appropriate denominator exclusions under performance-based assessment could raise access barriers to appropriate medications for these high-need populations.

Addressing Topped Out Measures

As part of CY 2025 rulemaking, CMS finalized a policy to exempt certain topped out measures frequently used by certain specialties reporting with limited measure choice in their specialty measure sets from the 7-point scoring cap. CMS proposes to modify this policy for identifying measures impacted by limited measure choice by applying the analysis and criteria to MVPs, in addition to the analysis of specialty measure sets.

AAHPM continues to urge CMS to extend the CY 2025 approach to all clinicians affected by the scoring cap policy. Many clinicians in specialties, such as HPM, do not have access to a defined specialty measure set and instead rely on a limited number of broadly applicable measures. Current scoring policies reduce points for clinicians who consistently deliver high-quality care, creating a system in which excellence is not rewarded but penalized. These effects are especially pronounced in specialties with a limited number of relevant measures, where topped-out measures may represent the only viable reporting options. When these measures become topped out and are capped or removed, clinicians are penalized for sustained high performance without any meaningful alternatives. To that end, we urge CMS to apply the policy universally to all topped-out measures. If universal application is not feasible, CMS should at minimum conduct a detailed and comprehensive review of how each specialty and subspecialty is affected by measure availability and MIPS scoring policies.

MIPS Performance Threshold

AAHPM supports CMS' proposal to maintain the MIPS performance threshold at 75 points for the CY 2026 performance period through the CY 2028 performance period, and we encourage CMS to finalize the policy as proposed. Maintaining the performance threshold at 75 points will provide stability and avoid any additional burden that a higher performance threshold would impose.

Well-being and Nutrition Measures RFI

CMS is seeking input on the potential incorporation of well-being and nutrition measures into the QPP in future years. CMS defines well-being as a comprehensive, patient-centered approach to disease prevention and health promotion that integrates mental and physical health while emphasizing preventive care to address potential health issues proactively. The agency requests feedback on tools and measures that evaluate overall health, happiness, and life satisfaction, including domains such as emotional well-being, social connections, sense of purpose, and fulfillment. CMS also invites comments on the applicability of tools and frameworks that assess complementary and integrative health, skill building, and self-care within the context of the QPP.

AAHPM agrees that the adoption of measures into the QPP that address well-being could be beneficial in supporting high-quality care for Medicare patients. We note that such a measure's emphasis on mental, social, and physical health aligns well with a palliative care approach and would reflect on the extent to which care is being delivered in accordance with patients' and caregivers' needs, goals, and preferences. In particular, we believe that an assessment such as a distress thermometer could identify the extent to which patients' well-being is impaired as a result of psychological distress. Distress scales have been

validated across different populations and geographies in measuring and quantifying levels of distress.[15,16,17,18]

The *Heard and Understood* measure, which is discussed in greater detail above, focuses on palliative care patients' experience and encompasses physical, mental, social, and emotional aspects of well-being and aligns with CMS' priorities to include more patient experience measures in its quality programs. As a result, AAHPM urges CMS to explore adoption of this measure into additional specialty measure sets and MVPs.

AAHPM also appreciates consideration of a future measure focused on nutrition. To the extent that CMS considers a measure in this domain, we suggest that CMS should focus on whether patients have the information they need and/or sufficient support to address any nutrition-related concerns.

Toward Digital Quality Measurement in CMS Quality Programs – RFI

CMS seeks comments on its anticipated approach to the use of Health Level Seven® (HL7®) Fast Healthcare Interoperability Resources® (FHIR®) in electronic clinical quality measure (eCQM) reporting for the MIPS quality performance category. CMS notes its intention of transitioning to a fully digital quality measure (dQM) landscape using standardized data and the FHIR model to drive interoperability, improve reporting value, and support a data-driven healthcare system

AAHPM appreciates CMS' interest in transitioning to the use of FHIR to collect quality data, which we agree would likely enable greater care coordination and information sharing. However, fully transitioning to eCQMs, and eventually dQMs, will demand investments in technology, infrastructure, and workforce training, posing challenges for many organizations.

AAHPM is therefore concerned that CMS is considering mandating the use of FHIR standards for MIPS quality data reporting; any such requirement would likely impose substantial costs to implement or upgrade HIT systems, which would serve as a significant barrier to success for many clinicians across the country. As we have previously noted, HPM physicians have experienced challenges with adoption of certified electronic health record technology (CEHRT) due to the limited availability of CEHRT that is tailored towards the delivery of palliative care. We note that incentives to adopt CEHRT were not provided to hospice programs, where many AAHPM members practice. Even where CEHRT is used, our members face challenges related to direct electronic extractions of data to registries for purposes of MIPS reporting.

As a result, AAHPM cautions against CMS moving forward with FHIR-based data exchange without addressing these barriers. We urge CMS to work with Congress to secure funding for a new incentive program that supports hospices in adopting CEHRT. Such incentives would not only level the playing field and support hospices' quality assessment and improvement efforts but also lead to improvements in interoperable data exchange that could facilitate seamless care coordination and more effective care management. Until such time that hospices receive such incentive payments and have sufficient time to

[15] Donovan KA, Grassi L, McGinty H, Jacobsen PB. "Validation of the distress thermometer worldwide: state of the science." Psychooncology, 2014. 23(3):241-50.
[16] Baken DM, Woolley C. "Validation of the distress thermometer, impact thermometer and combinations of these in screening for distress." Psychooncology, 2011. 20(6):609-14.
[17] Ransom S, Jacobsen PB, Booth-Jones M. "Validation of the distress thermometer with bone marrow transplant patients." Psychooncology, 2006. 15(7):604-12.
[18] Mitchell AJ, Morgan JP, Petersen DP, et al. "Validation of simple visual-analogue thermometer screen for mood complications of cardiovascular disease: the Emotion Thermometers." J Affect Disord, 2012. 136(3):1257-63.

adopt modernized systems, CMS should refrain from imposing new CEHRT-related requirements on hospices and the HPM physicians who rely on their medical record systems, such as through quality reporting programs.

Further, even when that time comes, ***we urge CMS to adopt a thoughtful, long-term transition that recognizes the burden and operational challenges providers experience in updating their EHR systems to support interoperable data exchange.*** CMS should undertake these efforts in a transparent manner that offers providers sufficient lead time for preparation and minimizes unnecessary burden on the provider community.

Ambulatory Specialty Model (ASM)

CMS proposes a new Ambulatory Specialty Model (ASM) that would be a mandatory alternative payment model (APM) focused on enhancing quality of care and reducing costs for Medicare beneficiaries with heart failure or low back pain. The model would link participating specialists' payments to performance on measures related to quality, cost, care coordination, and meaningful use of CEHRT, building on the MVP framework under MIPS. As part of the model parameters, CMS proposes the following:

- To achieve savings by retaining 15 percent of the amount available for incentive payments, rather than distributing the full amount through payment adjustments;
- To put at risk up to 12 percent of PFS payments for poor performing physicians under the model;
- To assess performance at the individual level, rather than at the group level, with individuals' performance compared against all the other specialists treating the same condition; and
- To exempt participants from MIPS reporting requirements. However, QPs and other clinicians already exempt from MIPS would not be exempt from model participation.

Additionally, while CMS does not specify in the proposed rule, we understand that the model would not qualify as an Advanced APM, meaning participation in the model could not support a participating physician's ability to achieve QP status.

We recognize that the ASM would not apply to HPM physicians. However, we believe the proposed model would set alarming precedents for models that apply to physicians, and we offer our concerns on the parameters below.

- Mandatory participation requirements. AAHPM is concerned with the mandatory nature of the proposed model, which we believe places participants at significant financial risk regardless of their readiness for participation or their opportunities for success. Mandatory models for physician practices, in particular, pose challenges that many practices will find difficult to overcome. Successful participation in APMs often requires new infrastructure investments and technical capabilities – for example, sophisticated data management and analysis capabilities, dedicated resources to continually assess and refine performance, and updates to electronic medical records – along with the development and implementation of new care management practices. Such demands would be challenging, if not impossible, to meet for many practices, especially smaller practices, thereby setting them up for failure. We also question the appropriateness of implementing mandatory models that do not have strong evidence of success. Such an approach places significant risk on participating physicians to strive for outcomes that

may not be meaningful or achievable. Instead, we suggest that models should first be tested on a voluntary basis to develop the evidence base in support of mandatory interventions.[19]

- Financial parameters. AAHPM objects to CMS' proposal to achieve savings at the expense of physicians – even those with strong performance under the model – and to require greater risk than what is specified under MIPS. By retaining 15 percent of the amount available for incentive payments, CMS would simply be reducing funding to participating physicians, whose payments have already been subject to five years of reductions and whose annual increases are not expected to keep pace with rising practice costs. This is on top of allowing for penalties that can be as high as 12 percent starting in 2031 – a level of risk significantly higher than the maximum penalties under MIPS. Physicians require Medicare payment relief, not the penalties and payment rescissions that the ASM would impose.
- MVP chassis. AAHPM disagrees with CMS' decision to build the ASM on the MVP framework, given the concerns we noted in our QPP comments above. In particular, we are concerned that the MVP framework is flawed, much like the underlying traditional MIPS program it seeks to replace, and we do not believe it offers a meaningful pathway for measuring performance of Medicare physicians on metrics that matter to patients. Building a model on top of the MVP framework would only amplify the drawbacks of the MVP framework rather than support performance improvement and high-value care.
- Individual-level performance assessment. AAHPM objects to CMS' proposal to assess performance of participating physicians at the individual level. This is in contrast to policies within MIPS that allow for assessment at the group, virtual group, and APM group levels, in addition to individual-level assessment. Requiring participation and performance assessment at the individual level will drastically increase burden for participating physicians, many of whom have likely relied on group reporting methods for participation in MIPS, while also reducing incentives to provide effective team-based care.
- Lack of exemptions for QPs. Per statute, an important benefit of achieving QP status is exemption from the burdensome reporting requirements under MIPS. Through achieving significant participation levels in Advanced APMs, QPs have demonstrated their commitment to care transformation, as well as embraced the cost and quality incentives applicable to their respective Advanced APMs. Requiring QPs to participate in the ASM would create disincentives for achieving QP status, while also subjecting QPs to performance incentives that may conflict or interfere with the incentives under their Advanced APMs.
- Non-designation as an Advanced APM. AAHPM disagrees with CMS' decision to implement a specialty care model that does not support participants' ability to achieve QP status by virtue of not qualifying as an Advanced APM. Like many other stakeholders, AAHPM has been disappointed in the dearth of APMs that offer opportunities for specialists to achieve QP status. The absence of relevant Advanced APMs has left specialists at a disadvantage – with little opportunity to qualify for the now-expired QP bonuses or to benefit from higher physician payment updates reserved for QPs starting in 2026. Further, it reflects missed opportunities to engage specialists in care transformation efforts. It is therefore confounding that the ASM would not qualify as an Advanced APM, particularly given the financial stakes involved.

[19] While the model builds on the MVP framework, which is currently voluntary, MVP reporting is still relatively new and untested in the QPP. The recent 2023 QPP Experience Report highlights that only a small proportion of clinicians submitted MVP data in PY 2023, and among those, few received a final score based on their performance in the pathway.

For all of these reasons, ***AAHPM urges CMS not to finalize the ASM. Rather, CMS should work with stakeholders to develop specialty care models that address the concerns raised above and provide meaningful opportunities for specialists to achieve QP status.*** Broad availability of such specialty-focused Advanced APMs would help transform the care landscape and support the delivery of high-quality, high-value care.

Finally, in support of such a goal, we remind CMS that AAHPM has long advocated for a robust Medicare APM that would support increased access to community-based palliative care services, including submitted a proposed model to the Physician-Focused Payment Model Technical Advisory Committee (PTAC) and working with other stakeholders to inform CMS about critical elements that should be incorporated into such a model. While those efforts have yet to result in a model focused on community-based palliative care, ***we continue to believe that increased coverage for and access to community-based palliative care services is necessary to support patients with serious illness, and we urge CMS to pursue options for achieving these outcomes through APMs***.

* * * * * *

Thank you, again, for the opportunity to provide feedback in response to the CY 2026 Medicare Physician Fee Schedule proposed rule. AAHPM would be pleased to work with CMS to address our feedback and recommendations above. Please direct questions or requests for additional information to Wendy Chill, Senior Director of Health Policy and Government Relations, at wchill@aahpm.org.

Sincerely,

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