

September 12, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS–1832–P, 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 (Vol. 90, No. 134), July 16, 2025.

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') hospital outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) payment system proposed rule for calendar year (CY) 2026.

HAP is pleased that CMS, as directed by Congress, is proposing a positive payment update for physicians, marking the first such update in several years. However, HAP will continue to monitor:

- The impact of the proposed efficiency adjustment and changes to PE RVUs, as these adjustments may redistribute payments in ways that could inadvertently disadvantage certain providers, particularly those who are hospital-based.
- CMS's consideration of the complexities tied to the agency's proposals for identifying Medicare Part D drug units purchased under the 340B drug pricing program for the purposes of removing them from Medicare inflation rebate calculations, and any approach by CMS that would impose unnecessary burdens on 340B hospitals or allow sensitive 340B data to be used outside the scope of the Medicare drug rebate program.
- CMS's proposals for additional flexibilities in the delivery of telehealth services and behavioral health services.
- CMS's proposal to introduce another mandatory payment model, the Ambulatory Specialty Model.



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PROPOSED PAYMENT UPDATE AND RATE ADJUSTMENTS

Pennsylvania hospitals and health systems are pleased by the agency's proposal for a positive Physician Fee Schedule payment update. Physician payment rates have remained flat for several years despite increases in inflation and the rising cost of care. However, we join the American Hospital Association (AHA) in voicing our concerns that the proposed efficiency adjustments and changes to the practice expense methodology significantly diminish the value of the proposed payment updates and disadvantage physicians who are largely hospital-based, including physicians providing specialty care.

The proposed efficiency adjustments, however, are far-reaching and ill-informed. In the rule, CMS proposes an efficiency adjustment of –2.5% to the work relative value units (RVUs) that physicians use to bill Medicare with the expectation that a provider will spend less time providing a service to a patient as they develop expertise in performing the service. This adjustment would apply to more than 7,000 services subject to PFS rates despite new data showing that operative times are not decreasing. In fact, recent studies indicate that operative overall actually increased by 3% between 2019 and 2023 (Childers CP, Foe LM, Mujumdar V, et al. [Longitudinal Trends in Efficiency & Complexity of Surgical Procedures](#). *J Coll. Surg.* 2025). The regulated community has significant concerns that the proposed changes would disadvantage certain providers, including those that are largely hospital-based, that routinely perform certain procedures, diagnostic imaging and radiology services.

HAP also opposes the agency's proposal to reduce allocations for practice expenses by half for services provided in facility settings. All physicians, regardless of where they practice, have overhead costs. Some examples include administrative staff support (scheduling and billing), rent, depreciation and utilities – all of which have become more expensive over the last five years. HAP would strongly recommend that CMS not move forward with this proposal in light of the significant cuts providers will see in the coming years because of provisions in OBBBA.

TELEHEALTH SERVICES

CMS proposes changing its review process for the Medicare Telehealth Services List by removing the distinction between provisional and permanent services. It also would limit its review to whether the service can be furnished using an interactive, two-way audio/video telecommunications system. The proposed rule would make changes to several telehealth waivers, including the permanent removal of frequency limitations for subsequent inpatient visits, and the permanent adoption of a definition of direct



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supervision to include virtual presence via audio/video real-time communications technology. ***We at HAP appreciate CMS's proposal to extend or make certain telehealth flexibilities permanent, such as removing frequency limitations for subsequent inpatient visits and critical care consultations.***

However, Pennsylvania's hospitals and health systems are disappointed that the agency did not propose extending a waiver that would allow providers to report practice addresses instead of home addresses when delivering telehealth services from their homes. In light of increases in violence against healthcare workers, we believe that it is important to protect the safety of providers delivering services from home. ***HAP encourages CMS to consider extending the preexisting waiver in the OPPS final rule.***

Additionally, for services rendered in metropolitan statistical areas (MSAs), the proposal does not include the continuation of allowing virtual supervision of residents for virtual services across teaching settings. Instead, this would only be permitted for services provided outside of MSAs, which limits hospitals' ability to deliver quality follow-up services for telehealth appointments to patients in rural areas and areas of low access to care otherwise delineated as part of an MSA. ***HAP would recommend CMS include the continuation of allowing virtual supervision of residents for virtual services within MSAs, as well.***

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM

HAP understands that under the Inflation Reduction Act of 2022 (IRA), CMS was required to develop a new methodology for ensuring that drugs purchased under the 340B program were not included in the calculation of Medicare inflation. However, the regulated community has concerns regarding the agency's proposal to use a claim-based methodology to determine the volume of Medicare Part D drugs purchased under the 340B program to achieve the goals laid out in the IRA.

We strongly caution the administration against an approach that would add unnecessary burden on 340B hospitals, particularly in light of the HRSA Rebate Model Pilot Program beginning in January 2026. If the pilot program moves forward, covered entities will be under considerable strain over the next year as they attempt to transition from the current upfront drug discount model to a claims-based rebate model. HAP strongly encourages CMS to delay implementation of this proposal while covered entities recover from the seismic programmatic changes being made to the 340B program. We would also caution the agency from any requirements that would allow sensitive 340B data to be used outside the scope of the



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Medicare drug inflation rebate program to diminish the value of the program to hospitals and their patients.

BEHAVIORAL HEALTH SERVICES

CMS proposes updates intended to enhance integration of behavioral health into primary care. First, the agency clarifies that marriage and family therapists and mental health counselors can bill Medicare directly for Community Health Integration and Principal Illness Navigation services. Next, CMS proposes creating add-on codes for Advanced Primary Care Management services that complement previously established Behavioral Health Integration or psychiatric Collaborative Care Model services. The agency also proposes updates to previously established payment codes for services provided using digital mental health treatment (DMHT) devices, including expanding payment for use of DMHT for attention deficit hyperactivity disorder.

HAP supports efforts to expand the integration of behavioral health into primary care. We welcome moves by CMS to foster collaboration between behavioral health and primary care providers. Integrating services enhance early detection, reduce symptoms, prevent worsening conditions, and improve long-term health and functioning. The proposed updates would reduce the administrative burden on providers and enhance the ability of behavioral health professionals to receive due compensation for the care they provide.

MEDICARE SHARED SAVINGS PROGRAM

One of several changes proposed the Medicare Shared Savings Program (MSSP) includes reducing the time an accountable care organization (ACO) can participate in an upside-only arrangement for the BASIC track from seven to five years.

While Pennsylvania hospitals are committed to providing high quality, efficient health care, ***we urge CMS to allow the full seven years for ACOs to establish the infrastructure necessary to successfully take on risk in the MSSP.***

Participants in the MSSP are at varying levels of sophistication and an across-the-board reduction in the time allowed to transition to risk may unintentionally impact providers' willingness to engage and/or their ability to be successful.

PROPOSED MANDATORY VALUE-BASED AMBULATORY SPECIALTY PAYMENT MODEL



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In the rule, CMS is proposing the creation of a new, mandatory Ambulatory Specialty Model (ASM) beginning January 1, 2027, and running through December 31, 2031. The model is intended to focus on low back pain and congenital heart failure and would include specialists who focus on these conditions.

As in other mandatory CMS models, CMS will be selecting specific core-based statistical areas or metropolitan divisions for inclusion in the model. Specialists within these areas who have treated at least 20 fee-for-service Medicare patients with either low back pain or congenital heart failure over a 12-month period will be included in the model.

Low back pain specialists would include anesthesiology, pain management, interventional pain management, neurosurgery, orthopedic surgery, and physical medicine and rehabilitation. Heart failure specialists would include cardiology.

Participants will be assessed individually, not at the practice level across four categories: quality, cost, care improvement activities, and improving interoperability. Performance will indicate payment adjustments on future Medicare Part B claims in the range of -9 percent to +9 percent.

While HAP appreciates the overall goal of a model such as ASM, ***we urge CMS to refrain from mandating participation at this time.*** Similar to our comments on the MSSP, individual physicians are also at varying levels of readiness to assume risk and we are concerned that mandating participation may have unintended consequences further reducing access to these critical specialists.

We appreciate your consideration of these comments. Please contact us if you have questions.