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September 14, 2026

Submitted electronically via: https://www.regulations.gov/

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

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1848-P)

Dear Administrator Oz,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule regarding the calendar year (CY) 2027 Physician Fee Schedule (PFS), Medicare Shared Savings Program, and Prescription Drug Inflation Rebate Program (CMS-1848-P) (hereinafter, "Proposed Rule"). Many of the topics in the Proposed Rule will have a significant impact on our provider clients and the patients they serve, particularly proposals related to the conversion factor, practice expense, and sunset of the traditional Merit-Based Incentive Payment System (MIPS).

Background

Vizient® enables healthcare providers to deliver better, more affordable care by improving financial sustainability, enhancing system performance, and accelerating strategic growth. More than two-thirds of the nation's acute care providers and more than one-third of ambulatory providers rely on Vizient solutions and services. By combining the nation's most influential healthcare leader networks with industry-leading data and analytics, comprehensive solutions, and advisory services through Kaufman Hall, Vizient helps providers achieve financial, clinical, and operational excellence. Headquartered in Irving, Texas, Vizient has offices throughout the United States. Learn more at vizient.com.

Recommendations

In our comments, Vizient responds to various issues, proposals provided in the Proposed Rule and offers recommendations to constructively improve the Final Rule.

Calculation of the Proposed CY 2027 PFS Conversion Factor

For CY 2027, CMS proposes that the qualifying Advanced Alternative Payment Model (qualifying APM) conversion Factor (CF) is 33.1693 and the non-qualifying APM CF is 32.8409.[1] Both conversion factors are a decrease from the CY 2026 conversion factors and are largely driven by the expiration of the 2.5% statutory boost to the CF.[2] However, Vizient also notes that Medicare physician payment has not adequately accounted for inflation and increasing practice costs. For example, Vizient's Supply Market Outlook highlights by spend category projected price increases for 2027, including a 3.39% average increase for certain supply chain categories. Considering the proposed payment reduction and continued growth in health-related costs, Vizient is concerned that providers will face even greater financial challenges in CY 2027 absent action by CMS or Congress. Vizient encourages CMS to continue working with Congress to support legislative efforts that establish a stable, predictable, and adequate payment update framework beyond CY 2027, so that providers can continue to deliver high-quality care to their patients.

Practice Expense

Indirect Practice Expense (PE) Methodology

Allocation

CMS proposes to allocate indirect PE using the work relative value unit (RVU) and the clinical labor RVU for all services, with the exception of codes with 010- and 090-day global periods. CMS provides limited justification for this change, citing a RAND report noting that global triplet services[3] are advantaged over non-triplet services because of differences in the allocation of indirect PE RVUs.[4] However, CMS does not demonstrate that the proposed allocation approach more accurately reflects the resources involved in furnishing the impacted services. Vizient suggests CMS refrain from finalizing the proposal due to these accuracy concerns.

Phase-Out of the Indirect Practice Cost Index (IPCI)

CMS proposes to remove steps of the PE RVU methodology that rely on the IPCI (steps 12-17) over a two-year period. In the first year, only half of the measured variation in the IPCI will be applied to the indirect allocator. In the second year, the IPCI will no longer be applied. By removing the IPCI, CMS will be utilizing less data to determine each specialty's overhead costs. The proposal to phase out the use of the IPCI in the PE methodology will result in significant

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[1] Since CY 2026, as required by statute (Section 1848(d)(1)(A) of the Social Security Act), there have been two separate conversion factors (CFs): one items and services furnished by a qualifying Advanced Alternative Payment Model participant (qualifying APM CF) and another for other items and services furnished by a non-qualifying APM participant (referred to as the nonqualifying APM conversion factor).

[2] https://www.congress.gov/bill/119th-congress/house-bill/1/text

[3] As outlined in the RAND report, triplet services can be billed in three ways: a technical component (TC), a professional component (PC) or a global service (i.e., the TC and PC together). For triplet services, the PFS currently allocates indirect PE RVUs to TCs using clinical labor PE RVUs and to PCs using physician work RVUs. The global service receives indirect PE RVUs allocated from the sum of both clinical labor and physician work. To avoid financial incentives to bill for a separate PC and TC when a provider furnishes the global service, the RVUs for the global service are equal to the sum of the RVUs for the TC and PC. Non-triplet services, which can only be billed as the entire service, receive indirect PE RVUs based only on the greater of physician work RVUs and clinical labor PE RVUs (rather than the sum).

[4] https://www.rand.org/pubs/research_reports/RRA4720-2.html

changes to PE RVUs, even though CMS proposes a stabilization factor to ease this adjustment. Vizient is concerned that in deciding to remove the IPCI, the agency may not be weighing enough specialty-specific insights to set payment rates. Vizient encourages CMS to work more closely with providers to identify opportunities to capture indirect practice costs in the PE methodology. Should the agency finalize the proposal, we similarly encourage the agency to carefully monitor implementation to ensure that specialties facing reimbursement reductions can continue providing care and that patient access is not jeopardized.

Stabilization Factor
To prevent volatility in PE RVUs, CMS proposes to apply a PE stabilization factor for each code's PE RVU. As a result of the PE stabilization factor, annual changes in code PE RVUs would be capped at 5%. As noted above, Vizient has concerns that the change to the PE methodology could be particularly harmful to certain practices and that this could have downstream impacts on patient care. While Vizient appreciates that CMS recognizes that there is a need to prevent volatility, we are concerned that capping annual changes at 5% may be inadequate to prevent harm, especially as these changes would accumulate year over year. Vizient encourages CMS to consider changes to the stabilization factor that would be less disruptive to providers, including potential payment enhancements. Should CMS finalize this policy, we urge CMS to closely monitor implementation to ensure that providers are able to continue operating on a long-term basis as reimbursement reductions continue.

Site of Service Payment Differential

CMS proposes to equalize the rate for nursing facility visits without regard to the beneficiary's status by setting the facility PE RVU equal to the non-facility PE RVU for certain nursing facility related CPT codes. The agency is proposing this policy in response to a consequence of the CY 2026 PFS Final Rule policy to allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated to services furnished in the non-facility setting. As noted in Vizient's CY 2026 PFS comments, we oppose CMS arbitrarily reducing the indirect PE for facility-based services and continue to believe the policy adds financial pressure that could limit patient access to care. While we appreciate that CMS is proposing policy to correct one consequence of the proposal, we encourage CMS to more broadly identify other aspects of the policy that are disruptive to care in facility settings. Vizient suggests CMS consider reversing the 2026 Final Rule policy to limit ongoing harm.

In the Proposed Rule, CMS seeks comment on the amount of indirect PE hospital-employed physicians incur when they furnish care within a facility (e.g., for these physicians, is the 50% indirect PE allocation accurate or could it possibly be less than 50%, such as 0%?). Costs associated with a physician's care delivery persist, even if the hospital employs the physician. For example, the physician will still require billing and coding infrastructure, scheduling, credentialing and enrollment, administrative personnel, quality reporting, cybersecurity and information technology, among other expenses. These additional expenses are not already

accounted for under the Outpatient Prospective Payment System (OPPS), are costly and can lead to operational inefficiencies, particularly if the hospital struggles to standardize procedures across newly acquired practices.[5] Additionally, current reimbursement structures fail to adequately recognize the growing costs of information technology, quality program participation, and mandatory payment model requirements, among other expenses, potentially forcing independent physicians to pursue employment-based practice arrangements to remain financially viable and continue providing care. Vizient discourages CMS from making unsupported assumptions regarding the indirect PE of hospital-employed physicians.

Vizient also notes that hospitals continue to lose money employing their physicians – an estimated $312,528 per physician indirect costs the first quarter of 2025, up 6% from the same period last year, according to a recent Kaufman Hall Physician Flash Report.[6] While CMS seeks feedback related to the indirect PE, to prevent unintended consequences, Vizient cautions CMS in arbitrarily shifting reimbursement without considering other expenses that may be incurred as employment trends evolve.[7] Vizient discourages CMS from arbitrarily adjusting the indirect PE allocation of hospital-employed physicians.

Also, CMS requests comment on whether a new Healthcare Common Procedure Coding System (HCPCS) modifier for employed physicians would be a reasonable way to identify and reduce facility PE from the services they perform in the facility setting, or whether there are other methods CMS could consider. While there are various types of relationships that a hospital may have with a physician, the agency also does not provide support to demonstrate that a physician's employment status dictates their practice expenses.[8] Vizient is concerned that CMS assumes that all hospital employed physicians should have their facility PE reduced without appreciating the different types of relationships that may exist and variability in how those relationships may be structured.

In addition, requiring a modifier for employed physicians would impose significant administrative burden as hospitals would have to determine which clinicians need to use the modifier, modify billing, and more closely monitor employment changes. As noted above, identifying which physicians are employed for purposes of the policy would also be challenging and a topic which CMS would need to detail. As such, Vizient discourages CMS from requiring a modifier to identify hospital-employed physicians as this would impose significant administrative burden and add unnecessary operational complexity.

Strategies to Improve Payment Transparency, Accuracy, and Congruency Across Payment Systems

Professional and Technical Components

[5] https://www.vizient.com/insights/articles/hospitals-keep-losing-money-on-physicians-is-there-another-way
[6] https://www.vizient.com/insights/articles/a-strategic-guide-to-primary-care-physician-employment-alternatives
[7] Physicians Advocacy Institute > PAI Research > PAI-Avalere Health Report on Physician Employment Trends and Practice Acquisitions: 2018-2026
[8] https://www.vizient.com/insights/articles/a-strategic-guide-to-primary-care-physician-employment-alternatives

Although CMS does not propose policy for services that are not currently billable with technical component (TC)/ professional component (26) modifiers, the agency developed a public use file that displays RVU amounts that aim to reflect the relative resources involved in furnishing professional and technical aspects of the services. CMS indicates that this file provides a foundation for future rulemaking and seeks comment on how the agency could develop methodologies to more clearly identify and, where appropriate, disaggregate the underlying components of services paid as globals. While Vizient is not addressing the values provided in the public use file, the agency's approach to create the file appears to be arbitrary and does not reflect allocations based on a thorough review of each service. Due to these concerns, Vizient discourages CMS from advancing future payment policy that relies on the public use file.

In addition, CMS notes that the agency created the public use file to facilitate more consistent comparisons across services and settings. As noted above, Vizient has concerns with the methodology the agency used to create the file, which calls into question the accuracy of such comparisons. In addition, Vizient notes that there are often justifiable reasons for cost variation between different sites of care, including patient acuity variability, different staffing, resources, and regulatory requirements, among others. Vizient is concerned that CMS may not be appreciating these differences, particularly if the agency intends to use the file in future years to equalize rates across sites of care. As noted in Vizient's OPPS comments, we are strongly opposed to site-neutral payment policies which result in hospitals being under-reimbursed for care and would oppose future policies that aim to have a similar effect.

Global Surgical Packages

CMS proposes to pause certain data collection efforts required by Medicare Access and CHIP Reauthorization Act of 2015 related to valuation of global surgical packages to reduce burden.[9] Also, CMS questions whether a more robust data collection effort would be more appropriate. Easing data collection requirements will help reduce provider burden, however, replacing one data collection initiative for another, more burdensome approach does not reduce burden. Should CMS pursue alternative data collection, we encourage CMS to ensure that such data collection is not unnecessarily burdensome to providers.

Evaluation and Management (E/M) Visits

E/M Visit Complexity Add-On (HCPCS Code G2211)

Modifier MOD1

CMS proposes replacing the E/M Visit Complexity add-on code G2211 with a new modifier, referred to as MOD1, beginning in CY 2027. MOD1 would be reported under the same circumstances as G2211 and would continue to recognize visits in which the practitioner serves

[9] https://www.cms.gov/medicare/payment/fee-schedules/physician/global-surgery-data-collection

as the continuing focal point for the patient's healthcare needs or provides ongoing care for a serious or complex condition. As G2211 is still a relatively new code, based on data from the Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, provided in Figure 1, provider utilization of the G2211 code has increased over the past year. Should CMS finalize the proposal to shift to MOD1, Vizient encourages the agency to provide additional outreach and education to stakeholders to ensure there is not inadvertent billing of only G2211.

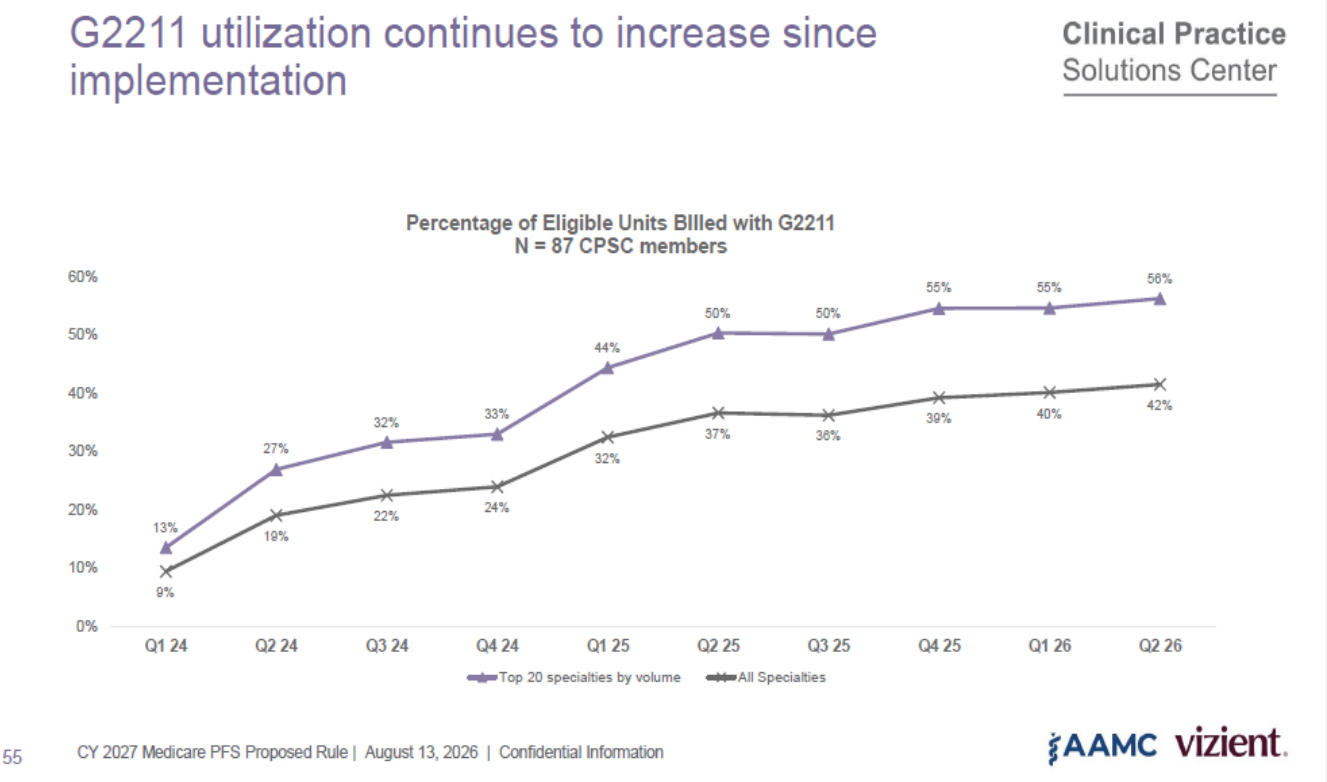

Figure 1. Graph showing the percentage of eligible units billed with G2211 (Medicare only) among Clinical Practice Solutions Center members which includes faculty practice organizations.

Also, CMS proposes valuing MOD1 at 16% of the underlying E/M service because the current fixed G2211 payment produces different proportional increases depending on the level of the E/M visit. CMS calculated the proposed 16% adjustment using a utilization-weighted average of G2211's value relative to associated E/M services, adjusted for budget neutrality. Based on the methodology, Vizient understands that the proposed valuing of MOD1 should not significantly impact overall payments to providers, which Vizient appreciates. If CMS finalizes the proposal, we encourage the agency to monitor utilization considering the agency's methodology, should future adjustments be needed.

As noted above, CMS proposes transitioning from a fixed add-on code with an assigned work RVU value to a modifier-based percentage payment without an assigned work RVU. Vizient notes that

this proposed shift may create implementation challenges for physician practices. Physician compensation and productivity models are frequently based on work RVUs. Providers may experience difficulty incorporating the proposed 16% payment adjustments into existing compensation arrangements and productivity calculations. To help address this potential challenge, Vizient encourages CMS to provide a crosswalk or methodology that translates MOD1 percentage-based payments into equivalent work RVU values for the applicable E/M services.

Modifier MOD2
In addition to MOD1, CMS proposes creating a second modifier, MOD2, available only to Accountable Care Organization (ACO) participants to be paid at 32% of the corresponding E/M code value. While Vizient appreciates the agency's efforts to enhance reimbursement for codes that are more resource-intensive, we encourage the agency to continue to monitor MOD1 and MOD2 to ensure reimbursement is adequate for both modifiers. Similarly, Vizient encourages CMS to consider whether additional opportunities could be made available to enable more providers to bill for MOD2.

Also, CMS clarifies that utilization and claims of either modifier will be included in ACOs' expenditure calculation for benchmarking and performance year expenditures and used in the determination of total cost of care. Since MOD2 reimbursement would be greater, some ACOs may be reluctant to report MOD2 as the historical expenditure data used to establish financial benchmarks does not account for these additional payments. Vizient encourages CMS to monitor utilization of MOD2 and assess whether any aspects of the policy create unintended disincentives to use MOD2.

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

CMS proposes to reduce payment when a separately identifiable E/M visit is furnished by the same physician, or another physician in the same group practice, on the same day as a 0-, 10-, or 90-day global surgical procedure. Under the proposal, the highest-paid service would continue to be paid at 100%, while all other same-day E/M visits and procedures would be paid at 50%. Separately identifiable E/M visits often represent medically necessary services that require their own clinical assessment, decision-making, and management and should not be presumed to overlap with the procedure being performed. This proposal inappropriately assumes duplicative physician work between these services and the proposed reimbursement reductions to separately identifiable E/M visits appear to be arbitrary. In addition, the proposal may have unintended consequences for care delivery and patient access.

For example, this proposal may discourage the provision of clinically appropriate surgical procedures and separately identifiable E/M services on the same day, including when provided by multiple practitioners within the same group practice, resulting in more appointments spread over multiple days. This concern is particularly significant for patients with chronic conditions, mobility limitations, transportation challenges, or who must travel significant distances to access

specialty care. As patients often benefit from receiving comprehensive services in one day, Vizient recommends that CMS withdraw the proposal to prevent disruptions to care delivery and minimize patient burden.

Payment for Medicare Telehealth Services

Changes to the Medicare Telehealth Services List

For CY 2027, CMS proposes adding five new HCPCS G-codes to the Medicare Telehealth Services List.[10] Telehealth continues to be an important tool for improving access to care, particularly for patients in rural and underserved communities, and for patients seeking timely access to specialty care, behavioral health services, chronic disease management, and other essential healthcare services. Vizient supports CMS's proposal to add five hew HCPCS G-codes, which address a range of needs, to the Medicare Telehealth Services List.

Proposals Implementing Consolidated Appropriations Act, 2026

Proposed Extension of Existing Telehealth Flexibilities
The Consolidated Appropriations Act, 2026 (CAA, 2026)[11] extends existing telehealth flexibilities by temporarily removing geographic restrictions, allowing a broad range of originating sites, allowing audio-only telehealth services, and permitting different types of practitioners to furnish Medicare telehealth services until December 31, 2027. In the Proposed Rule, CMS proposes to implement the CAA, 2026's telehealth policies that extend existing flexibilities. Vizient appreciates the measures the agency took during the COVID-19 Public Health Emergency (PHE) to expand access to telehealth services which helped ensure continuous access to care in more locations. A March 2023 report from the Clinical Practice Solutions Center (CPSC), developed by the Association of American Medical Colleges (AAMC) and Vizient, highlighted effective strategies for sustaining and optimizing telehealth in primary care, but also indicates that legislative and regulatory uncertainty remains a significant barrier to broader telehealth adoption by more providers.[12] As such, Vizient encourages CMS to finalize the proposal and urges CMS to work with Congress to permanently extend the COVID-19 PHE-related telehealth flexibilities that will, without congressional intervention, expire in 2027.

The CAA, 2026 also delays the in-person visit requirement for mental health services furnished through telehealth until January 1, 2028, and CMS proposes implementing this provision of the law. This extension is critical for mental health telehealth services because the Consolidated Appropriation Act, 2021 (CAA, 2021), which permanently expanded access to telehealth for mental health services by easing geographic and originating site restrictions, also requires that

[10] These codes are outlined in the Proposed Rule (pgs. 43901-43902) and include: 1) GACP1 and GACP2 – Advance care planning, 2) GSMAS – Group-based medical sessions for patients with common medical conditions; 3) GSLPP – Pediatric speech, language, voice, communication, and auditory processing disorder treatment; and 4) GADV1 – Evaluation and management services related to vaccine adverse effects.
[11] https://www.congress.gov/bill/119th-congress/house-bill/7148/text
[12] https://vizientinc-delivery.sitecorecontenthub.cloud/api/public/content/f554e03fac1f4922b9f7a43420bf0ab9

in-person (non-telehealth) visits be furnished to the beneficiary six months before the initial telehealth service. The CAA, 2021, while still a significant improvement to support access to telehealth services, is stricter than policies provided during the PHE. As a result of the CAA, 2026's extension, stakeholders have more time to prepare for the in-person visit requirement to go into effect. Vizient encourages CMS to work with providers to identify challenges that patients may face when attempting to meet this in-person requirement. To the extent those challenges can be addressed through more flexible regulations, we encourage the agency to take such steps to prevent care disruption.

Proposed Telehealth Billing Modifiers

The CAA, 2026 also requires CMS to establish new telehealth billing modifiers to identify telehealth services furnished through certain virtual telehealth platform arrangements and telehealth services furnished incident to a physician or practitioner's professional service. To implement this policy, CMS proposes creating modifiers BB and BC, effective January 1, 2027. CMS indicated that implementation instructions would be provided through future website postings and additional subregulatory guidance but did not specify when such guidance will be released. As these modifiers are intended for claims-reporting purposes, clear and timely operational guidance will be critical to ensure consistent implementation. In addition, such guidance will help promote consistent reporting, reduce administrative burden, and minimize potential claim submission errors. For example, additional clarification regarding how ownership and payment arrangements are to be identified in complex organizational structures, including joint ventures, reseller and white-label arrangements, enterprise software licensing agreements, bundled information technology contracts, and shared-service models may be needed to support appropriate modifier use. Vizient encourages CMS to work closely with providers when developing subregulatory guidance to identify key issues that should be clarified and to ensure such guidance is not disruptive or burdensome to providers.

Also, as noted above, the requirement to use the telehealth modifiers goes into effect January 1, 2027. As the effective date rapidly approaches, Vizient suggests CMS ensure the subgregulatory guidance is promptly released to allow sufficient time for provider education, system modifications, claims processing updates, and compliance planning.

Telehealth Critical Care Consultations

In the CY 2026 PFS Final Rule, CMS permanently removed the limitation of one telehealth critical care consultation per day.[13] Following this policy change, CMS received questions about whether the terms "initial" and "subsequent" in the critical care consultation code descriptors continued to imply frequency restrictions, creating uncertainty for providers about when each code may be reported. To clarify billing requirements, CMS proposes revising the descriptors to align with time-based critical care coding conventions, with G0508 describing the first 30 to 74 minutes of a telehealth critical care consultation and G0509 describing each additional 30

[13] https://www.federalregister.gov/documents/2025/11/05/2025-19787/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other

minutes. Vizient supports providing greater clarity regarding how telehealth critical care consultation codes should be billed.

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

For CY 2027, CMS is proposing a modification to previously finalized policy that allows teaching physicians to have a virtual presence in teaching settings during three-way telehealth visits. Under the proposal, teaching physicians would be permitted to bill for telehealth services involving residents when either the teaching physician or the resident is physically present with the patient, rather than requiring the teaching physician, resident, and patient to all be in separate locations. The proposed approach enables patients to receive in-person care from either provider while still benefiting from the expertise and participation of the broader care team through telehealth. The proposal also increases flexibility by reducing barriers related to provider location and supporting more efficient use of clinical workforce resources. Vizient supports CMS's proposal which more accurately reflects care delivery in academic medical centers and other teaching settings.

Remote Therapeutic Monitoring (RTM) and Remote Physiologic Monitoring (RPM)

Established Patient Requirements for RTM

CMS proposes that, beginning in CY 2027, RTM services may only be furnished to established patients who have an existing clinical relationship with their practitioner before the practitioner can bill Medicare for RTM services.[14] Imposing an additional requirement before care can be delivered may limit or prevent access to care. In addition, while CMS has implemented a similar policy for RPM services, the agency has not clarified how patient care has been impacted. Before adding this requirement to RTM, we encourage the agency to clarify how patient care was impacted once an existing clinical relationship was required before care could be delivered for RPM services.

Initiating Visit Requirements for RPM and RTM Services

CMS proposes that, beginning in CY 2027, RPM and RTM services must be started through a separate initiating visit with the billing practitioner to ensure the practitioner evaluates whether remote monitoring is clinically appropriate for the patient, discusses the service, obtains the patient's consent, and establishes the care plan needed for effective monitoring. CMS clarifies

[14] RPM represents the remote monitoring of parameters such as weight, blood pressure, and pulse oximetry to monitor a patient's condition and inform their management. The remote physiologic monitoring code set currently includes CPT codes 99091, 99445, 99453, 99454, 99457, 99458, 99470, 99473, and 99474. For RTM, there are distinct device supply codes for three types of therapeutic monitoring: respiratory system, cognitive behavioral therapy, and musculoskeletal system monitoring. The remote therapeutic monitoring code set currently includes CPT codes 98975, 98976, 98977, 98978, 98979, 98980, 98981, 98984, and 98985 (code descriptors in Table A-D6). There are three components of RPM and RTM services: education and setup, device supply, and treatment management.

that the initiating visit must be a face-to-face encounter, either in person or via telehealth, and cannot be a service that is not separately billable under Medicare. The established patient requirement for RPM already ensures that the billing practitioner has an existing clinical relationship with the patient, familiarity with the patient's medical history and care needs, and responsibility for ongoing care management. If finalized for RTM, the established patient requirements would have a similar effect. Therefore, requiring an additional initiating visit alongside may be unnecessary as it could consume limited appointment capacity and delay access to remote monitoring services. In addition, requiring the initiating visit may delay access to care by imposing unnecessary burdens on providers and patients in range of clinical scenarios, including upon discharge. To help support patient access to care, Vizient encourages CMS to maintain the existing policy and refrain from requiring an initiating visit before RTM and RPM services can be furnished.

If CMS finalizes the initiating visit requirement for RPM and RTM services, Vizient encourages CMS to consider providing additional flexibility related to this requirement. RPM and RTM services are frequently deployed following hospital discharge, especially for patients with chronic conditions or those at elevated risk of readmission. In many cases, these patients have already undergone a comprehensive clinical evaluation, patient education, and care planning process during their hospitalization, establishing both the patient-provider relationship, and the clinical need for RPM or RTM services. Requiring an additional initiating visit following discharge would be duplicative, could delay access to clinically appropriate monitoring services, and is unlikely to provide meaningful additional clinical benefit. Therefore, Vizient recommends that the agency provide additional flexibilities to the initiating visit requirement, such as exempting patients discharged from inpatient hospitals and other facility settings or allowing a discharge encounter to satisfy the initiating visit requirement.

RPM and RTM Services Furnished by Third-Party Companies

CMS proposes that, beginning January 1, 2027, Medicare will only reimburse for RPM and RTM services when they are furnished by clinical staff who are direct employees of the billing practitioner or practice due to concerns that certain RPM and RTM services are provided by third-party companies that have limited relationships with patients and limited involvement from the billing practitioner. Many hospitals and health systems rely on qualified third-party vendors to furnish RPM and RTM services because they do not have the staffing capacity or operational bandwidth to perform these functions internally. These vendor-supported arrangements enable providers to expand remote monitoring capabilities and maintain access to these services despite ongoing workforce shortages. Further, the proposed employment requirement may disproportionately affect rural and small practices that do not have sufficient patient volume or resources to support dedicated monitoring teams. Requiring all clinical staff involved in RPM and RTM services to be directly employed by the billing practitioner or practice could make it difficult for some organizations to continue offering these programs, disrupting care for patients who currently benefit from these programs. Vizient urges CMS not to finalize this proposal.

Further, this proposal could unintentionally undermine CMS's broader efforts to expand access to care in rural and underserved communities, such as through the Rural Health Transformation (RHT) Program. Through the RHT Program, states are working to broaden access to RPM and RTM services.[15] In some arrangements, the academic medical center or hospital may provide the clinical infrastructure, technology, and staffing necessary to support remote monitoring, effectively serving as a third-party partner that enables rural practices to offer these services to their patients. Prohibiting the use of qualified third-party companies could undermine these collaborative models and limit the ability of rural providers to offer RPM and RTM services to their patients. While Vizient agrees that addressing inappropriate billing practices is important, we have concerns that imposing excessively broad restrictions may jeopardize access to care and disrupt initiatives that aim to broaden access to RTM and RPM.

Valuation of Codes

CMS proposes reducing Medicare payment for certain RPM and RTM device-related services through modifications related to the PE because the agency is concerned that the current PE inputs may overstate the actual costs of the monitoring equipment.[16] To do this, CMS proposes removing the direct PE inputs from the RPM and RTM treatment management codes, as the agency believes the associated resource costs of furnishing these services are already reflected in the physician work RVUs and that the typical clinical workflow does not involve clinical staff time. Vizient is concerned that CMS has not provided sufficient information demonstrating that the proposed PE changes are accurate. Vizient recommends CMS withdraw the proposals and work with providers to consider alternative approaches to valuation of these codes.

Request for Comment on Simplification of RPM and RTM Billing Codes

CMS is considering updates to simplify the RPM and RTM billing codes and help ensure patients receive the full remote monitoring service. CMS is considering replacing the current 17 RPM[17] and RTM billing codes with four new HCPCS G-codes[18] to simplify billing, reduce administrative burden, and ensure patients receive all required components of remote monitoring services. CMS clarifies these new HCPCS G-codes would adopt all current conditions of payment for the remote therapeutic and remote physiologic codes finalized in prior rulemaking, if finalized. As CMS is aware, the current code set reflects variations in the technologies used and the resources required to furnish different remote monitoring services, and those differences are reflected in the

[15] https://www.cms.gov/files/document/rht-program-state-provided-abstracts.pdf

[16] For RPM and RTM set-up and patient education codes (99453 and 98975), CMS proposes crosswalks to those used for self-measured blood pressure training services (CPT 99473). For RPM and RTM device supply codes (CPT 99454, 98976, 98977, 98978, 98984, 98985, and 98986), CMS proposes crosswalks to other existing monitoring services that CMS believes more accurately reflect the resources used in practice.

The current codes include: 99453, 99445, 99454, 99091, 99470, 99457, 99458, 98975, 98984, 98976, 98985, 98977, 98986, 98978, 98979, 98980, and 98981.

[18] The proposed G codes include: GRPM1- (RPM initial setup and patient education); GRPM2 - (Remote monitoring of physiologic parameters); GRTM1 - (RTM initial setup and patient education); and GRTM2 - (Remote monitoring of physiologic parameters)

current valuations. Consolidating the existing 17 codes into four G-codes does not adequately capture the range of RPM and RTM services furnished in practice and risks overlooking meaningful differences in how these services are valued. As CMS works to simplify codes for remote monitoring services, Vizient recommends the agency to work with stakeholders to ensure that any revisions preserve meaningful distinctions among services that vary in technology, resource utilization, and clinical application.

Proposed Terminology for Software as a Medical Service

For CY 2027, CMS proposes to rename the term Software as a Service (SaaS) as Software as a Medical Service (SaMS) to better distinguish software-based technologies that support clinical decision-making through algorithmic analysis from general cloud-based computing service models. CMS would use SaMS to describe technologies that include diagnostic or clinical functionality, including certain technologies regulated by the FDA as medical devices. To provide greater clarity and consistent with Vizient's OPPS comments, we recommend CMS provide detailed examples illustrating which technologies qualify as SaMS and which do not. Clear delineation will be particularly important for hybrid technologies that include both clinical and administrative components.

Shared Medical Appointment (HCPCS code GSMAS)

CMS proposes to establish coding and payment for Shared Medical Appointments (SMAs) provided "for medical conditions that are modifiable with lifestyle change."[19,20] In addition, CMS seeks comment on how to determine when SMAs would be appropriate, including identifying which medical conditions would be considered modifiable with lifestyle change. CMS indicates diabetes mellitus, obesity, hypertension, and hyperlipidemia are examples of conditions that are modifiable with lifestyle change but does not list examples that would not be modifiable with lifestyle change, making the distinction difficult to identify. Many additional medical conditions, including heart failure, cancer survivorship, and kidney disease, may also be appropriate for SMAs, but how CMS would determine whether these conditions would qualify is unclear. Vizient encourages CMS to make clear that providers can broadly interpret "medical conditions that are modifiable with lifestyle change" for purposes of conditions that may be eligible for SMAs.

In addition, Vizient notes that a narrow interpretation of the term "medical condition" could unnecessarily limit patient access to SMAs by restricting the range of conditions for which providers may furnish for SMAs, particularly given the increasing complexity of chronic disease management. For example, a patient participating in an SMA for diabetes nutrition management may also have chronic kidney disease and may gain value from the SMA that extends beyond the

[19] https://www.federalregister.gov/d/2026-14327/p-580

[20] CMS proposes that each SMA include: 1) an individualized E/M assessment documented in each patient's medical record; 2) evidence-based education, counseling, and discussion of self-care and disease management; and 3) lifestyle and behavior change counseling, with medication management when clinically appropriate. Sessions would be 60 minutes, limited to 10 patients, led and billed by a physician or qualified nonphysician practitioner, and require an established patient relationship, patient consent, and individualized documentation.

primary condition being addressed. A recent Vizient Research Institute study found that one in five patients with multiple chronic conditions would rather seek care in the emergency department than wait for an appointment with their physician, underscoring the importance of expanding access to innovative care delivery models.[21] Vizient recommends that CMS provide additional flexibility regarding the use of the GSMAS code to support a broad range of clinically appropriate chronic conditions and avoid overly restrictive requirements that could limit patient access to care.

CMS also proposes several operational requirements for GSMAS, including a 60-minute session duration. SMAs can vary considerably in complexity depending on patient populations, clinical needs, care team composition, and the conditions being addressed. A standardized 60-minute session may be sufficient for some patient populations but may not adequately accommodate more complex patients who require additional counseling, education, care planning, or clinical management. For example, patients participating in an SMA focused on diabetes management may also have hypertension, obesity, cardiovascular disease, or other comorbidities that require additional discussion and care coordination. As 60 minutes may not be sufficient for more complex patient populations, Vizient recommends that CMS consider establishing an add-on code for extended group visits when additional time is medically necessary to provide patient education, care planning, behavioral support, or management of multiple chronic conditions**.**

Maternity Care

CMS requests comment on whether to adopt new CPT codes for maternity care that the American Medical Association (AMA) developed or create 15 new G codes for CY 2027 that retain the previous global code structure for maternity care services.[22] As CMS is aware, other payers may use the AMA's new CPT codes or seek to align with the PFS. Therefore, if the agency were to retain the previous global code structure for maternity care services by creating new G codes, there would be parallel coding structures that would be extremely difficult for providers to navigate due to payer variation. Patient care may vary depending on insurance coverage since the new AMA codes shift away from the current global approach that assumes a standard number of prenatal visits for pregnancies. In addition, providers would need to navigate different coding, billing, and payer requirements depending on the patient's coverage, creating additional administrative burden and financial uncertainty, particularly as more billing errors or claim denials may occur. Due to these concerns, Vizient encourages CMS to adopt the new maternity CPT codes and not finalize implementing the proposed HCPCS G codes.

Medicare Shared Savings Program (SSP)

Vizient generally supports CMS's proposals to strengthen participation in and operation of the SSP through targeted policies designed to encourage ACO participation, improve beneficiary

[21] https://www.vizient.com/insights/articles/the-chronic-care-reckoning-redesign-or-absorb-the-cost
[22] The proposed G codes are detailed in Table A–D3 in the Proposed Rule (pg. 43882).

engagement, and promote long-term program sustainability. These include proposals to ease quality reporting requirements, modify beneficiary assignment methodology, and improve beneficiary communications.

Proposal To Modify the Methodology and Use Description for Advance Investment Payments

CMS proposes to modify the methodology for calculating Advance Investment Payments (AIPs), which are quarterly payments available to certain new, low-revenue ACOs that are inexperienced with performance-based risk and new to the SSP, beginning on January 1, 2028. Specifically, CMS proposes replacing the Area Deprivation Index (ADI) component of the AIP methodology with a new rural residency adjustment intended to encourage participation by low-revenue, risk-inexperienced ACOs, particularly those serving rural communities.[23] CMS indicates that the agency aims to improve representation of rural populations in the SSP and notes that rural populations face specific barriers such as geographic isolation, provider shortages, transportation challenges, limited broadband infrastructure, and fewer local healthcare resources.

Consistent with prior comments, Vizient has raised concerns about the limitations of using the ADI and applauds CMS's proposal to remove the ADI component of the AIP methodology. In addition, Vizient appreciates that the agency recognizes how factors such as limited broadband and transportation challenges can be a barrier to care. However, these challenges are apparent for a variety of geographies. To effectively identify those beneficiaries whose geographic location can serve as a barrier, Vizient encourages CMS to consider utilizing the Vizient Vulnerability Index™[24] instead of the proposed rural residency adjustment. The Vizient Vulnerability Index™ identifies neighborhood-level social needs and barriers to care that may not be captured through geographic or rural classifications alone, providing a more comprehensive assessment of the population in a specific location. The Vizient Vulnerability Index™ is publicly available, utilizes publicly available data sources, and includes nine domains (i.e., economic, education, healthcare access, neighborhood resources, housing, clean environment, social environment, transportation, and public safety). Vizient continues to welcome the opportunity to further discuss and partner with CMS on potential opportunities to use the Vizient Vulnerability Index™, including for purposes of the AIP.

[23] Under the proposal, CMS would determine rural status using beneficiaries' mailing addresses and county classifications using federal Census and Office of Management and Budget data. Beneficiaries living in micropolitan or noncore counties would be considered rural for purposes of the calculation. CMS would then incorporate the number of assigned rural beneficiaries into the formula used to determine an ACO's maximum quarterly AIP. Under this proposal, ACOs would receive $45 per beneficiary per quarter for beneficiaries who are enrolled in the Low-Income Subsidy (LIS), are dually eligible for Medicare and Medicaid, or live in a rural area. For all other beneficiaries, ACOs would receive $25 per beneficiary per quarter.

[24] The Vizient Vulnerability Index™ is patented technology and protected by U.S. Patent No. 12,430,367.

Updates to the Quality Payment Program (QPP)

Proposal to Update Timeline for Full Merit-based Incentive Payment System (MIPS)- Value Pathways (MVPs) Implementation

CMS proposes sunsetting the traditional Merit-Based Incentive Payment System (MIPS) reporting option, leaving the MVP as the only reporting option for MIPS beginning with the CY 2029 performance period/2031 MIPS payment year.[25] While CMS indicates in the Proposed Rule that the agency is considering future alternatives and flexibilities for specialties that lack sufficient measures or an applicable MVP, these alternatives have not yet been developed or finalized. As a result, Vizient is concerned that there are insufficient MVPs currently available to sunset traditional MIPS without significant disruption and that doing so could disadvantage certain providers by requiring them to report under an MVP that does not appropriately reflect their practice or scope of services. Further, while the number and variety of MVPs continue to grow, the availability of an MVP does not necessarily make it a suitable reporting option for every provider, given differences in clinical focus, patient populations, and reporting capabilities. Vizient encourages CMS to maintain traditional MIPS as a reporting option until the agency demonstrates that MVPs provide comprehensive and practical reporting pathways for all providers.

In addition, Vizient notes that MVPs are a relatively new reporting option, and anecdotal information suggests providers have had mixed experiences. Consistent with our prior comments, Vizient encourages CMS to provide more information regarding providers who have voluntarily transitioned to MVP reporting before mandatory reporting should occur.

Applying QP Determinations at the TIN/NPI Level

CMS proposes to modify the application of the Qualifying APM Participant (QP) and Partial QP status. Under the proposal, only Tax Identification Numbers (TINs) participating in Advanced APMs receive additional incentive payments, including both the APM Incentive Payment and the qualifying APM conversion factor. Currently, if a clinician achieves QP status through participation in an Advanced APM, that QP status applies to the clinician's entire NPI, regardless of whether all of the clinician's practice affiliations (i.e., TINs) participate in an Advanced APM. While CMS indicates that relatively few clinicians will be affected, Vizient recommends CMS refrain from finalizing the proposal to prevent disruption to existing practices. Should the agency finalize the proposal, we encourage CMS to monitor implementation to ensure the policy does not create unintended administrative complexity or disincentives for clinicians.

[25] CMS clarifies that beginning in the CY 2029 performance period/2031 MIPS payment year, eligible clinicians participating in MIPS, and not reporting the APM Performance Pathway (APP), would be required to report the measures and activities in a selected MVP for MIPS. CMS also proposes including virtual groups in MVP reporting to ensure all eligible clinicians can report MVPs.

Ambulatory Specialty Model (ASM)

CMS makes clear the agency's ongoing plan to continue the ASM by proposing several changes to ASM participation policies intended to clarify participant responsibilities and requirements, provide targeted exceptions in specified circumstances, and strengthen model oversight. In addition, CMS is leaving MVPs as the only MIPS reporting option beginning with the CY 2029 performance period. While the ASM and MVPs are currently distinct programs, they share similar goals related to specialty-focused care transformation, quality measurement, and accountability. Therefore, the potential benefits of testing the ASM, which continues to be a mandatory model, are limited because of the substantial similarity between ASM and MVPs. As CMS has proposed the transition to MVPs in CY 2029, Vizient encourages withdrawing the ASM.

Medicare Prescription Drug Inflation Rebate Program

In the CY 2026 PFS Final Rule, CMS established policy for a 340B repository to receive voluntary submissions from covered entities (CEs) of certain data elements associated with Part D claims for which the CE dispensed (directly or indirectly, including via retrospective replenishment and contract pharmacy arrangements) units of a drug for which a manufacturer provides a discount under the 340B Program. CMS proposes to require the submission of certain Part D 340B data to the 340B repository beginning with claims with a date of service on or after January 1, 2027. As noted in the Proposed Rule, the agency is still working to operationalize the 340B repository, which is expected to launch in Fall 2026 for voluntary reporting. Stakeholder perspectives may evolve as they interact with the repository and technical challenges may emerge. For example, stakeholders have already raised concerns regarding ambiguity related to the entity that is required to report to the 340B repository. As the repository has not been functional and no CE are able to voluntarily report at this time, Vizient recommends CMS withdraw the proposal to mandate CE reporting of certain data elements associated with Part D claims.

In addition, CMS indicates that while reporting to the 340B repository is mandatory, the data submitted to the repository would not be used to calculate inflation rebates. Rather, CMS will continue to use the previously finalized Prescriber-Pharmacy Methodology to remove 340B units from Part D inflation rebate calculations. Since CMS has not identified use for the data and the agency has already established a voluntary reporting option which has yet to be tested, requiring CE to report this information is unnecessary and imposes undue burden on 340B providers. Vizient urges CMS to withdraw the proposal to mandate reporting to the 340B repository.

In the Proposed Rule, CMS indicates that the agency reserves the right to revoke a currently enrolled provider or supplier's Medicare enrollment and any corresponding provider agreement or supplier agreement for failure to comply. As a result, a CE that does not comply could face an extreme penalty for noncompliance, as their Medicare enrollment could be revoked. Vizient is concerned that the potential penalty is excessive, especially as CMS will not be using the data in CY 2027 and could jeopardize patient access to care should provider enrollment be revoked.

Vizient urges CMS to clarify and significantly ease the potential consequences of not reporting to the 340B repository.

Should CMS finalize the proposal to require mandatory reporting, it is unclear what level of technical support and flexibilities will be available to CEs. As noted above, the 340B repository has not yet launched, and CEs are only learning of a reporting mandate through the Proposed Rule, leaving them with extremely limited time to comply. As a result, CEs will be in a challenging position of needing to register for reporting, identify workflows to ensure reporting occurs and coordinate with third-party administrators and other stakeholders to ensure reporting is completed. These steps will take significant time and resources during the time when CEs' resources will be strained further due to reimbursement reductions proposed in the Outpatient Prospective Payment System proposed rule and the upcoming 340B Rebate Model Pilot Program.[26,27] While Vizient believes withdrawing the proposal is the best policy option, if CMS does finalize the proposal, the agency should provide significant technical support and flexibilities to CEs, including delaying the reporting mandate.

Conclusion

Vizient thanks CMS for the opportunity to comment on the Proposed Rule. Vizient's membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. Additionally, many are specialized, including academic medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top health care providers. In closing, on behalf of Vizient, I would like to thank CMS for providing us the opportunity to comment on this important Proposed Rule. Please feel free to contact me or Jenna Stern at jenna.stern@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

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[26] https://www.federalregister.gov/documents/2026/07/07/2026-13656/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment
[27] https://www.hrsa.gov/opa/340b-model-pilot-program