

September 14, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Attention: CMS-1848-P

Submitted electronically via Regulations.gov

RE: Comments on Calendar Year 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:

The Massachusetts Health & Hospital Association (MHA), on behalf of our member hospitals and health systems, physician organizations, and allied healthcare providers, appreciates this opportunity to comment on the Calendar Year 2027 Medicare Physician Fee Schedule Proposed Rule (CMS-1848-P).

Our organizations care for Medicare beneficiaries in urban, rural, underserved, and medically complex communities. MHA strongly supports the Centers for Medicare & Medicaid Services' (CMS's) continued efforts to modernize Medicare payment policy to reflect advances in clinical practice and technology-enabled care. MHA particularly appreciates the proposals that support beneficiary access to telehealth, recognize the growing role of digital tools in clinical care, and establish a new framework for Software as a Medical Service.

At the same time, MHA is opposed to the proposed changes to remote patient monitoring (RPM) and remote therapeutic monitoring (RTM). These changes would disrupt clinically integrated care models, reduce beneficiary access, impose significant operational burdens, and undermine CMS's broader goals for rural health transformation, chronic disease management, care in the home, and value-based care.

And for CMS's recently enacted Rural Health Transformation Program (RHTP), the proposed RPM/RTM policies are especially problematic because the RHTP is intended to promote innovative, community-based care models that extend access beyond traditional clinical settings. RPM serves as a foundational tool for achieving the program's goals of improving population health, enhancing care coordination, and supporting rural providers facing workforce shortages and geographic barriers. By limiting flexibility in staffing and reducing reimbursement for remote monitoring services, the proposed rule risks discouraging investment in digital health infrastructure and impeding the very care transformation strategies that the RHTP seeks to accelerate, ultimately threatening access, quality, and sustainability for rural patients and providers alike.

MHA respectfully recommends that CMS:

1. Finalize the proposed policies that enhance beneficiary access to telehealth and virtual care;
2. *Not* finalize the proposed direct-employment, initiating-visit, established-patient, code-consolidation, and payment-reduction policies for remote patient monitoring and remote therapeutic monitoring;
3. Address program-integrity concerns through focused, evidence-based safeguards rather than broad restrictions on legitimate care delivery models;
4. Develop a coherent Medicare payment framework for technology-enabled care that reflects clinical value, provider resources, patient outcomes, and differences among technologies; and
5. Finalize the new Software as a Medical Service category with clear definitions, appropriate differentiation among clinical software products, and consistent guidance for Medicare Administrative Contractors.

Support Medicare Beneficiaries' Continued Access to Telehealth and Virtual Care

Telehealth is now an integral component of healthcare delivery across nearly every setting and specialty. It enables Medicare beneficiaries to obtain primary care, specialty care, behavioral health services, rehabilitation, chronic disease management, post-discharge follow-up, and care coordination without unnecessary geographic, transportation, or mobility barriers.

For providers across the continuum, telehealth is not a separate healthcare system. It is a clinical modality that allows care teams to match the method of delivery to the beneficiary's condition, preferences, location, and clinical needs.

MHA supports CMS's proposals to add five Healthcare Common Procedure Coding System (HCPCS) codes to the Medicare Telehealth Services List, including services involving advance care planning, speech-language services for children, vaccination side-effect management, and shared medical appointments for group education, counseling, and peer support. MHA also appreciates the proposed teaching-physician flexibility and CMS's clarification of critical-care telehealth consultation descriptors.

MHA encourages CMS to continue working with Congress to make the broader Medicare telehealth flexibilities permanent. Predictable, long-term policy is necessary for providers to invest in clinical staff, platforms, training, cybersecurity, workflow redesign, and integration with electronic health records.

CMS should apply the following principles as it implements telehealth policy:

- Care should be reimbursed based on clinical appropriateness, professional responsibility, and value, rather than assumptions that a virtual interaction is inherently less resource-intensive or less effective than an in-person interaction.
- Providers should retain flexibility to determine whether an in-person, synchronous virtual, asynchronous, or hybrid care model is most appropriate for a particular beneficiary.
- Telehealth policies should support, rather than fragment, longitudinal relationships among beneficiaries, primary care providers, specialists, hospitals, and post-acute providers.
- New claims requirements should be narrowly tailored and should not create unnecessary burdens for traditional providers that use telehealth as one component of an integrated care model.
- CMS should protect the privacy and safety of virtual-only practitioners who do not maintain a separately enrolled physical practice location.

Telehealth Claims Modifiers

MHA urges CMS to implement any congressionally required telehealth modifier in a focused and administratively workable manner. The modifier should principally identify virtual-only providers or telehealth platform arrangements where additional information would provide meaningful program-integrity insight.

Traditional hospitals, health systems, physician groups, community providers, post-acute providers, and other organizations that use telehealth as one modality within an established care relationship should not be subjected to unnecessary modifier requirements. CMS should also clearly define the arrangements captured by the proposed BB and BC modifiers and provide concrete examples before requiring their use.

At a minimum, CMS should consider excluding from these modifier uses telehealth services that are provided:

- By a clinician or provider organization that also offers in-person care;
- To an established patient as part of a course of care that includes in-person services; or
- Through an organization that has a clinical or contractual relationship with an in-person or facility-based provider treating the same condition.

These exclusions would help CMS distinguish between virtual-only delivery arrangements and telehealth used as an integrated component of longitudinal care.

Opposition to Proposed RPM and RTM Restrictions

RPM and RTM allow providers to maintain clinical connections with beneficiaries between traditional encounters. Depending on the condition and program, these services can include monitoring blood pressure, weight, oxygen saturation, symptoms, medication response, musculoskeletal function, respiratory status, and other clinically relevant information.

These services can be especially important following hospitalization, after a medication change, following a new diagnosis, or when a patient's chronic condition is worsening. They give care teams an opportunity to recognize changes and intervene before a condition becomes an emergency.

Opposition to the Direct-Employment Requirement for RPM / RTM

MHA strongly opposes the proposal to permit payment for RPM and RTM only when the clinical staff furnishing the services are directly employed by the billing practitioner or practice.

High-quality remote monitoring requires more than acquisition of a connected device. Depending on the care model, it may require:

- Patient enrollment, consent, education, and onboarding;
- Device acquisition, configuration, logistics, replacement, and technical support;
- Connectivity and secure data transmission;
- Software and electronic health record integration;
- Clinical review of transmitted information;
- Patient outreach and engagement;
- Alert management and escalation;
- Documentation and treatment management;
- Billing, compliance, quality assurance, and auditing infrastructure; and
- After-hours or geographically distributed staffing capacity.

Smaller physician practices, rural providers, safety-net organizations, and specialty practices may not have the staff or capital necessary to build all these functions internally. Qualified clinical partners allow providers to access specialized infrastructure and scalable support while retaining responsibility for the beneficiary's care plan, monitoring parameters, escalation protocols, and treatment decisions. Many rural providers here in Massachusetts and across the country see RPM/RTM as a tool to increase access in rural areas and as an integral part of the RHTP. But they will only be able to do so with the help of qualified clinical partners and third-party vendors.

The proposed employment test would also affect arrangements that are not conventionally understood as third-party vendor models. In many health systems, the billing practitioner may be employed by a medical group or faculty practice plan, while nurses, advanced

practice professionals, pharmacists, therapists, or centralized virtual-care staff are employed by an affiliated hospital or another entity within the same system. These professionals may work within an integrated clinical program, use the same health record, and operate under provider-approved protocols, but be associated with a different taxpayer identification number.

Centralized monitoring teams also allow health systems to support multiple hospitals, practices, specialties, or geographic regions. Requiring every monitoring professional to be employed by each billing entity would require significant restructuring and could make otherwise integrated programs ineligible for reimbursement.

MHA therefore recommends that CMS retain the general supervision framework and permit RPM and RTM services to be supported by qualified clinical personnel employed by an affiliated entity or accountable clinical partner, provided that:

- The billing practitioner orders and remains responsible for the service;
- Medical necessity is documented;
- Patient consent and onboarding are documented;
- Monitoring parameters and escalation protocols are approved by the responsible provider;
- The clinical partner operates under the provider's oversight;
- Required communications and clinical responses are documented;
- Data are available for audit; and
- Claims are submitted only when all applicable service requirements have been satisfied.

Revalue RPM/RTM Reimbursement with Reliable Resource-Cost Data

MHA is also concerned about the proposed changes to the valuation of RPM and RTM services. Medicare payment should reflect the full resources required to deliver compliant, clinically integrated monitoring, not merely the retail cost of a consumer device; it should also balance the simplification of payment while recognizing the differences in clinical intensity, patient complexity, and resources required for each patient.

Connected monitoring may involve hardware, cellular connectivity, data transmission, software, electronic health record integration, technical support, device replacement, patient education, clinical labor, alert review, beneficiary outreach, documentation, and compliance infrastructure. The cost of a basic, off-the-shelf device does not capture these program inputs.

And notably, while this proposal only addresses Medicare patients, the broader impact of coverage and reimbursement will affect other non-Medicare populations as well. Pediatric remote monitoring differs significantly from adult models because children require age-, size-, and developmentally appropriate equipment to ensure safe and effective care. For example, an adult-sized blood pressure cuff may not appropriately fit a young child. CMS acknowledges limited device cost data yet proposes to crosswalk valuation to a single-

parameter, patient-operated blood pressure cuff – an approach that fails to reflect the range and cost of equipment required in pediatric programs, including pulse oximeters, infant scales, and home spirometers. CMS should ensure that valuation reflects the distinct equipment and clinical resources required for all programs, including pediatric remote monitoring, and MHA welcomes the opportunity to provide CMS with additional information on the devices and resources used in pediatric programs.

The proposal to reduce or remove clinical staff time from the valuation of treatment-management services is difficult to reconcile with the simultaneous proposal to require practices to employ the clinical staff furnishing those services. CMS should not require providers to internalize additional clinical labor while reducing recognition of that labor in the payment methodology.

MHA also has strong concerns with eliminating direct practice expense inputs from CPT codes 99470, 99457, and 99458, among other codes. Additional patient populations, including pediatric treatment management, involves substantial clinical staff time for caregiver training, device troubleshooting, and family communication and education furnished under general supervision, and the valuation of these codes should continue to reflect that resource investment.

MHA recommends that CMS:

- Refrain from finalizing RPM and RTM payment reductions until it has collected reliable information on device, technology, connectivity, clinical labor, and program-delivery inputs;
- Consider the results of the forthcoming Relative Value Scale Update Committee review before revising the code family;
- Evaluate RPM and RTM in the broader context of chronic care management, principal care management, behavioral health integration, advanced primary care management, and technology-enabled longitudinal care; and
- Ensure that payment is sufficient to support access in rural, safety-net, small-practice, and post-acute settings.

Use Targeted Safeguards to Address Program-Integrity Concerns

MHA supports CMS's efforts to prevent fraud, waste, abuse, beneficiary solicitation, medically unnecessary device distribution, and billing for services that were not furnished. However, focusing principally on the employment relationship between the clinical professional and billing practitioner does not directly address those activities. While program-integrity oversight is essential, the policies in the proposed rule are not sufficiently targeted to the conduct CMS seeks to address. They would instead affect a much broader range of legitimate, provider-directed, clinically integrated programs.

Instead, MHA recommends safeguards that focus on clinical validity and actual delivery of the service. CMS should consider:

1. Requiring the ordering practitioner to be identified on the claim; include documentation of medical necessity, consent, and patient onboarding; and require the billing provider to review and approve clinical and escalation protocols;
2. Identifying the clinical information or health data being monitored; include auditable records of device transmission, clinical review, beneficiary communication, and treatment-management time; and require documentation of abnormal findings and the clinical response, when applicable;
3. Identifying clinical partners that furnish monitoring support, monitor organizations and billing providers with anomalous billing patterns, and conduct focused audits where claims data indicate potentially duplicative or implausible billing; and
4. Providing clear education to practitioners concerning Medicare's RPM and RTM requirements.

These safeguards are more closely aligned with the oversight measures described in federal remote-monitoring reports, including identification of the ordering provider, identification of the data being monitored, provider education, and scrutiny of entities involved in remote monitoring.

CMS and the Office of Inspector General should also distinguish suspicious billing patterns from clinically explainable utilization. For example, multiple devices may be medically necessary for some patients, and different practices may monitor different conditions for the same beneficiary. Certain codes may also be absent during a month because of global surgical billing rules or because a particular component, such as device setup, is furnished only at the outset of an episode. Oversight should be sufficiently sophisticated to recognize these distinctions before CMS makes structural changes affecting beneficiary access.

Provide Flexibility in Satisfying the Initiating Visit Requirement

MHA encourages CMS to consider providing flexibility to clinicians for the proposed initiating-visit requirements when a qualifying clinical encounter has already occurred.

RPM is frequently initiated during or immediately following an inpatient stay, emergency department encounter, surgical episode, post-acute transition, or other documented clinical encounter. In these circumstances, a treating clinician may have already evaluated the beneficiary, determined that monitoring is necessary, established the relevant care plan, and ordered the service.

Requiring another, separately billable initiating visit with the practitioner who will bill for monitoring could duplicate work already performed and documented; delay monitoring during a high-risk transition; increase beneficiary and program costs; create scheduling and handoff problems; and impede bedside enrollment and device education before discharge.

CMS should not finalize the requirement as proposed. If it adopts an initiating-encounter requirement, CMS should allow for flexibility and recognize a documented inpatient

encounter, hospital discharge, emergency department discharge, post-acute transition, or other relevant clinical encounter as satisfying the requirement. CMS should also confirm that a qualifying evaluation and management encounter may be furnished through telehealth.

Recognize the Downstream Impacts on Pediatric Populations

While the focus of this letter addresses the provisions in the proposed Medicare Physician Fee Schedule, it is also important to remember that changes to Medicare will also affect coverage by other payers and other populations of patients. Pediatric remote monitoring is not simply a lower-volume version of adult RPM. The clinical workflow, caregiver role, patient complexity, device requirements, and resources required to successfully implement and sustain monitoring can differ substantially from adult programs. CMS should ensure that changes to RPM and RTM requirements and payment methodologies recognize these differences and do not unintentionally reduce access to remote monitoring for children.

Provide a Meaningful Implementation Period If Any Changes Are Made

Each RPM and RTM proposal would require more than a billing update. The combined changes could affect staffing, employment relationships, contracting, patient intake, scheduling, informed consent, electronic health record configuration, coding, compliance systems, and overall program economics.

If CMS finalizes any structural change, it should provide a meaningful phase-in period extending well beyond January 1, 2027. CMS should also publish detailed operational guidance sufficiently in advance of implementation.

Modernize Medicare Reimbursement for Technology-Enabled Care

MHA supports CMS's broader effort to consider how technology is changing care management, primary care, patient monitoring, diagnostics, clinical decision-making, and longitudinal treatment.

Medicare's existing payment structure can make it difficult to account for technology-enabled services that occur between traditional visits or that combine software, data, clinical review, patient communication, and care-team intervention. The challenge is not simply whether Medicare should pay for technology; the more important question is how Medicare should recognize the healthcare service, clinical responsibility, resources, risks, and outcomes associated with technology-enabled care.

CMS should develop a framework that: 1) Focuses on the clinical service and beneficiary value; 2) avoids assuming that technology automatically reduces clinician work; 3) uses a multi-dimensional payment framework; and 4) preserves distinct pathways for clinically different services.

Focus on Clinical Service and Beneficiary Value

Payment should not be triggered merely because a technology is used. Nor should payment be denied merely because software or a connected device is integral to the service. CMS should evaluate:

- The clinical purpose and function of the technology;
- The condition or population served;
- The degree of practitioner involvement and accountability;
- The intensity and frequency of clinical review;
- The resources required for patient engagement and care coordination;
- The technology's effect on clinical workflow;
- The level of clinical and regulatory risk;
- Evidence of safety and effectiveness;
- Patient access, experience, and outcomes;
- Interoperability and integration with health records;
- Effects on avoidable utilization and total cost of care; and
- Effects on clinician workload and the capacity of the healthcare workforce.

Use a Multidimensional Payment Framework

A one-size-fits-all formula will not reflect the variation among digital health technologies. CMS should at least consider:

1. **Clinical functionality:** Whether the software assists, augments, or autonomously performs a clinical function;
2. **Clinical risk:** The potential consequences of an incorrect or missed output;
3. **Regulatory status:** The applicable Food and Drug Administration pathway and evidence requirements;
4. **Professional involvement:** The extent of practitioner review, interpretation, oversight, and intervention;
5. **Workflow intensity:** Implementation, integration, monitoring, patient communication, and documentation requirements;
6. **Payment unit:** Whether per-service, per-use, episode-based, monthly, prospective, or outcomes-based payment is most appropriate; and
7. **Demonstrated value:** Effects on safety, quality, access, patient experience, clinician experience, utilization, and total cost.

Fee-for-service payment may remain appropriate when a discrete technology-supported service and the associated professional work can be identified. Prospective or longitudinal payment may be more suitable when technology is embedded in broader care management, population health, or home-based care.

Avoid Assuming That Technology Automatically Reduces Clinician Work

Technology may improve efficiency over time, but implementation can initially increase work. Providers may need to redesign workflows, integrate new systems, train staff, educate patients, review and validate outputs, resolve technical issues, and monitor the technology's performance.

Some technologies produce new information that requires additional interpretation and action. Predictive alerts, continuous monitoring information, clinical decision support, medication-titration recommendations, and patient-engagement tools may increase the number of clinically relevant issues identified between visits.

Payment policy should therefore be based on demonstrated workflow effects and resource use, rather than an across-the-board assumption that use of software reduces professional time.

Preserve Distinct Pathways for Clinically Different Services

CMS should avoid collapsing remote monitoring, digital therapeutics, digital mental health treatment, care management, clinical decision support, and diagnostic software into a single technology category.

These services may differ in clinical purpose, evidence, professional responsibility, regulatory status, practice expense, hardware requirements, and the relationship between the software and practitioner. Medicare should preserve distinct pathways where those differences are material.

Support the New Software as a Medical Service Category With Clarifications

MHA applauds CMS for proposing the concept of Software as a Medical Service, or SaMS. Moving beyond generic references to “software” can help Medicare distinguish software that performs or supports a clinical function from lower-risk consumer health, wellness, or administrative applications.

CMS proposes to define SaMS as software-based technologies that support clinical decision-making through algorithmic analysis, including technologies that provide clinical or diagnostic functionality. This is an important starting point, but the definition and payment methodology require additional clarity, including identification of the specific codes and supplies to which CMS intends the category to apply. Without clear boundaries, providers and Medicare Administrative Contractors may apply the new category inconsistently or inadvertently move established therapeutic, diagnostic, or monitoring services into an inappropriate payment pathway.

SaMS should also not be subject to a uniform payment amount or valuation formula. Products cleared or authorized as medical devices may be subject to evidence and regulatory requirements that are not applicable to general consumer health applications. Payment policy should recognize these differences and should not establish parity

between products that have materially different clinical functions, regulatory requirements, and evidence bases.

The SaMS category should complement, not replace, established pathways for services such as RPM, RTM, digital mental health treatment, digital therapeutics, and laboratory analyses. CMS should explicitly affirm that creation of SaMS does not automatically authorize Medicare Administrative Contractors to crosswalk clinically distinct therapeutic or diagnostic products to remote-monitoring payment rates or to treat those products only as ancillary software inputs. Clear distinctions are especially important for FDA-authorized digital therapeutics that deliver an intervention rather than merely collect information or support general wellness.

Support Responsible Use of Artificial Intelligence in Technology-Enabled Care

MHA appreciates CMS's requests for information concerning artificial intelligence and the proposed Merit-Based Incentive Payment System improvement activities involving clinician use of AI and interoperable clinical decision support. Artificial intelligence can support information-intensive activities such as documentation, chart review, patient communication, triage, risk identification, remote-monitoring data review, and longitudinal care management. It may also support clinical decision-making and identification of patients who require intervention.

CMS should evaluate AI-enabled care using a patient- and provider-centered framework that considers:

- Safety and effectiveness;
- Transparency and explainability;
- Appropriate human oversight;
- Data privacy and security;
- Clinical accountability;
- Integration into care team workflows;
- Patient access and experience;
- Clinician workload and experience;
- Interoperability;
- Avoidable utilization; and
- Total cost of care.

Payment should focus on the healthcare service delivered, the associated professional responsibility and resources, the clinical risk, and the value generated, rather than establishing payment merely for the presence of AI. CMS should also avoid presuming immediate efficiency gains during the implementation of AI-enabled tools in healthcare.

MHA appreciates CMS's continued commitment to advancing access, innovation, and high-quality care. MHA looks forward to working with the agency to ensure that Medicare beneficiaries can benefit from safe, effective, accountable, and sustainable technology-

enabled care. Should you have any further questions or concerns, please do not hesitate to contact MHA at adelmolino@mhalink.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Adam J. Delmolino'.

Adam J. Delmolino
Senior Director, Virtual Care & Clinical Affairs
Massachusetts Health & Hospital Association