American Society of Hematology
Helping hematologists conquer blood diseases worldwide

2026
President
Robert Negrin, MD
Stanford University
269 W. Campus Drive
Stanford, CA 94305
Phone: 650-868-8065

President-Elect
Cynthia Dunbar, MD
2127 California Street, NW
Washington, DC 20008
Phone: 202-819-6806

Vice President
Alison Loren, MD, MSCE
University of Pennsylvania
3400 Civic Center Boulevard
Philadelphia, PA 19104
Phone: 215-662-4859

Secretary
Jennifer Brown, MD, PhD
Dana-Farber Cancer Institute
450 Brookline Avenue
Boston, MA 02215
Phone: 617-632-5847

Treasurer
Joseph Mikhael, MD, FRCPC, MEd
Translational Genomics Research Institute
City of Hope Cancer Center
445 N. Fifth Street
Phoenix, AZ 85004
Phone: 602-343-8445

Councillors
Jennifer Holter-Chakrabarty, MD
Adam Cuker, MD, MS
Chancellor Donald, MD
Christopher Flowers, MD, MS
H. Leighton Grimes, PhD
Mary Horowitz, MD
Charlotte Niemeyer, MD
Mikkael Sekeres, MD, MS

Executive Director
Martha Liggett, Esq.

September 14, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies: CMS-1848-P

Submitted via Regulations.gov.

Dear Administrator Oz,

The American Society of Hematology (ASH) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid (CMS) Medicare Physician Fee Schedule (MPFS) proposed rule for CY 2027. Stakeholder feedback is vital to ensure proposed polices support the delivery of high-quality care without unintended consequences, while providing adequate payment for services provided by hematologists.

ASH represents more than 18,000 clinicians and scientists worldwide committed to studying and treating blood and blood-related diseases. These disorders encompass malignant hematologic disorders such as leukemia, lymphoma, and multiple myeloma, as well as classical hematology (non-malignant) conditions like sickle cell disease, as well as bleeding and clotting disorders. In addition, hematologists are pioneers in demonstrating the potential of treating various hematologic diseases and are innovators in the fields of stem cell biology, transfusion medicine, and gene and cell therapies. ASH membership is comprised of basic, translational, and clinical scientists, as well as physicians providing care to patients.

With this background in mind, we provide comments on the following topics of importance to hematologists and their patients.

- Conversion Factor for 2027
- Revision of G2211 with Modifier MOD1
- Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions
- The Future of the Care Management Services
- Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule
- Payment Implications of Technology Enablement of Primary Care
- Updates to Practice Expense Methodology
- Current Procedural Terminology (CPT) Request for Information (RFI)
- Proposed Changes to Payments Using Modifier -25

Conversion Factor for 2027

2027 marks the second year that there are two separate conversion factors: one for practitioners working in a qualifying advanced alternative payment model (APM) and the other for those not participating in a qualifying APM. The conversion factor for the former will be $33.17, a decrease of 1.19%, and the conversion factor for the latter will be $32.84, a decrease of 1.68%. The decreases reflect the expiration of the 2.5% adjustment to the 2026 conversion factor included in the One Big Beautiful Bill Act.

ASH appreciates that updates to the conversion factor require Congressional intervention, however the proposed policies in the rule, including changes to payment for same day services performed in the office setting, and changes to the indirect practice expense within the physician payment formula further undermine physician reimbursement and exacerbate continued downward pressure which affects the viability of physician practices. As the agency is aware, physician payment has been stagnant for nearly thirty years, with the current conversion factor set only a few dollars higher than it was 30 years ago. The MPFS conversion factor has not kept pace with inflation, and in fact, the MPFS is the only Medicare payment system that does not receive an annual inflationary update. We again reiterate that providing payment rate increases to hospitals, skilled nursing facilities, outpatient centers and ambulatory surgical centers while withholding comparable payment updates for the very physicians who provide care in those settings is unjustifiable.

We request the agency reconsider proposed policies that cut reimbursement, and we encourage the agency to work with Congress to develop solutions that provide certainty and stability for the MPFS. We will continue our congressional advocacy to support legislative solutions that create a sustainable reimbursement system for MPFS services including regular inflationary-based positive updates to the conversion factor, and in the meantime, we request the agency reconsider any policy in this rule that cuts physician payment.

Revision of G2211 with Modifier MOD1

The agency proposes to delete code G2211 (*Visit complexity inherent to evaluation and management associated with medical care services)* and replace it with a modifier. The modifier will have the exact same descriptor as G2211, and per the agency should be reported and billed in the same way as the G-code, except the new modifier is placed on the same claim-line as the CPT® code for the evaluation E/M service. Instead of a flat payment rate of approximately $17.00, CMS proposes to pay 16% of the total payment of the base E/M service. The revised payment rate for the services associated with new modifier will be higher when billed with higher level E/M services than the flat payment rate; however, the associated RVUs including a work RVU of .33 will no longer be applicable.

ASH does not support this proposal and recommends that the agency maintain G2211 to report services associated with complex, longitudinal care. The specialty of hematology/oncology comprises 5% of the total volume of G2211 provided to Medicare beneficiaries in 2024. The care our members provide keep patients out of the hospital, emergency room, and other sites of care by appropriately managing long-term hematologic conditions and diseases. Diseases like chronic lymphocytic leukemia, sickle cell disease, and thalassemia are all chronic diseases and disorders that require complex, longitudinal care, and code G2211 helps to capture the additional time, intensity, and cognitive expertise required to keep these patients stable.

The Society also believes the proposed change is premature. There is only one year of Medicare utilization data associated with G2211. Typically, three years of data is needed to determine if a service and its associated code is working as it should. CMS should allow additional time to evaluate actual utilization patterns, clinical use, payment implications, and the effects of the policy on physician practice and compensation before making a fundamental change to the reporting and payment methodology for G2211. Replacing an established and functioning code with a modifier after such a limited period of experience appears arbitrary in the absence of compelling evidence that the current code is not working as intended. ASH urges CMS to retain G2211 and its associated work RVUs and allow additional years of experience and data to inform any future changes to the policy.

The Society also questions whether replacing G2211 with a modifier would meaningfully advance CMS's stated goal of reducing administrative burden. The current process for reporting G2211 is relatively straightforward. When the service is provided to a Medicare beneficiary, and meets the applicable requirements and documentation, the physician reports the G2211 code in addition to the E/M service within the electronic health record. ASH does not believe there is a significant administrative burden associated with this process. Additionally, a fixed payment associated with a distinct HCPCS code may be more transparent and predictable than a percentage-based payment tied to the level of the underlying E/M service. CMS should therefore provide additional evidence demonstrating that the proposed modifier proposal would reduce administrative burden for physicians and other stakeholders.

While the change to a modifier may seem simple to the agency, it is far from simple for ASH members. CMS's proposal has significant unintended consequences for physicians, particularly those whose compensation and productivity are tied to work RVUs. Under the current policy, G2211 is associated with 0.33 work RVUs and losing the associated work RVUs will have far reaching implications. ASH appreciates the payment will increase based on the level of E/M reported with G2211; however, the loss of associated work RVUs is not worth the modest additional payment as further explained below.

Many physicians are employed under compensation models with RVU-based productivity targets. Eliminating the work RVUs by changing the G2211 code to a modifier could negatively affect physicians employed in these compensation models, even if Medicare payment for the same service increases under the proposal. The potential impact on physician productivity targets is particularly concerning because many institutions have established or increased RVU-based productivity expectations since G2211 became payable. ASH members report that their employers incorporated G2211 into productivity calculations and established compensation expectations based, at least in part, on the additional work RVUs associated with G2211. There is little reason to expect that employers will subsequently reduce those productivity targets if CMS eliminates the G2211 work RVUs; physicians may be required to see additional patients to achieve the same productivity targets if the work RVUs associated with G2211 are eliminated. As a result, physicians could lose an important source of work RVUs without a corresponding reduction in the productivity expectations against which they are evaluated and compensated. The Society is concerned that while the proposal may increase reimbursement at the institutional level, it could have a disproportionately negative impact on individual physicians whose compensation is directly tied to their productivity as measured by work RVUs.

The proposal also raises concerns related to physician benchmarking and compensation surveys. Productivity benchmarks and physician compensation surveys are generally retrospective and therefore will not immediately reflect a change in CMS policy. G2211 utilization and its associated

work RVUs may already be reflected in yearly compensation expectations and yearly productivity benchmarks based on historical data. If CMS removes the work RVUs associated with G2211, physicians could consequently experience a period of several years during which their compensation expectations continue to reflect prior utilization and productivity levels, while the work RVUs available to meet those expectations have been reduced.

In summary, ASH urges the agency not to finalize converting G2211 into a modifier. There is a premature understanding of how this code is currently working and no persuasive justification to make this change, and the loss of the associated work RVUs is not worth the modest payment increase.

Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions
The agency seeks comments on the potential development of a HCPCS G-code to capture the time, effort, work, and resources associated with physician-patient conversations regarding participation in clinical trials. The HCPCS G-code under consideration would reimburse physicians (or other qualified healthcare professionals) for spending a minimum of 20 minutes counseling patients on clinical trial eligibility, options, risks, and benefits. CMS also seeks comment on setting a work RVU between 1.00 and 1.50, whether the service may be provided as a telehealth service, and suggestions as to the types of documentation that would be required to bill for the service.

ASH appreciates CMS's recognition of the substantial physician work involved in discussions regarding clinical trial participation and generally supports the concept. Clinical trial conversations with patients require significant time and effort and include clinical trial education, the potential risks and benefits, addressing questions, and helping the patient understand how participation may fit within their overall treatment plan.

Regarding the work RVU and time requirement suggested by CMS, a work RVU between 1.00 and 1.50 seems reasonable, but ASH cannot make a clear determination until the associated activities and required documentation are developed by CMS. Only once CMS has fully defined the service and associated requirements can ASH objectively determine if the Society supports the development of the G code. CMS should also provide clear guidance as to whether the service would be limited to a single discussion or could be reported for multiple conversations, and whether it would be reportable when a patient ultimately declines to participate in the trial. Clinical trial discussions may evolve over time rather than occur as a single, discrete conversation depending on the course of the disease and a patient's response to treatment.

ASH also notes that beneficiaries will be responsible for cost-sharing associated with this service unless Congress removes the cost-sharing requirement through legislation. ASH believes that many patients will be dissatisfied once they learn they will incur cost-sharing for these discussions, particularly if the discussion does not lead to enrollment. The consideration of patient cost sharing for these discussions could also discourage reporting for the code and lead to underutilization, potentially canceling out the intention behind the code to reimburse for these important conversations. CMS may need to explore ways to ensure that these types of financial barriers do not prevent Medicare beneficiaries from learning about potentially life-saving clinical trials.

Prior to finalizing this service, CMS must also consider how a new separately reportable service will interact with existing clinical trial reimbursement mechanisms. The reimbursement arrangements and funding structures associated with clinical trials can differ significantly depending on whether the trial is industry-sponsored, government-sponsored, or investigator-initiated. In some circumstances,

clinical trial budgets may already include payment for physician activities related to patient identification, education, counseling, and enrollment.

The Future of the Care Management Services

ASH appreciates the agency's efforts to improve the adoption of care management services. The Society met with CMS staff on this issue in March 2026 and shared recommendations with the agency prior to the release of the CY 2027 MPFS proposed rule.

Hematologists primarily furnish evaluation and management (E/M) services to Medicare beneficiaries with classical and malignant hematologic conditions. To support the best health outcomes, ASH members spend significant amounts of time supporting their patients' care outside of office visits by providing ongoing longitudinal care management, extensive care coordination, and clinical decision-making between face-to-face visits. While the principal care management (PCM) and chronic care management (CCM) codes are designed to reimburse clinicians for this time-consuming work, this care frequently goes uncompensated for many reasons. The Society appreciates CMS's longstanding support for the PCM and CCM services and efforts to increase utilization. However, members consistently report that administrative and operational requirements create barriers to billing for these services, particularly when delivering team-based care, which is normal for patients with a hematologic condition.

Time-Tracking Requirements

CCM and PCM are time-based services requiring cumulative tracking of clinical staff and physician time across an entire calendar month. Unlike encounter-based services, these codes require practices to maintain an ongoing monthly accounting of time spent on care patient management activities. In practice, this creates a month-long documentation burden that is difficult for busy and often understaffed clinical practices to sustain. Physicians report that documenting time frequently takes longer than completing the clinical work and is more burdensome, resulting in unreimbursed care.

Hematology workflows illustrate this challenge. For example, bone marrow biopsy results are released incrementally, which prolongs the time to make a diagnosis and formulate a care plan over several days or even weeks. As noted in our conversation, flow cytometry, pathology, cytogenetic findings, and molecular diagnostic results are not returned together with some results returning within 24 hours and other results not returning until weeks later. Each result generates patient notifications and follow-up communications requiring physician review, interpretation, and discussion with patients. These interactions are clinically essential and directly inform treatment planning, yet they occur in short intervals throughout the month and are difficult to track accurately by the minute.

Similar patterns occur in classical hematology, where hemoglobinopathy, clotting, or bleeding disorder testing results arrive sequentially. Each update requires review, coordination, and patient communication. ASH members report that attempting to document multiple brief activities, such as five-minute patient calls, ten-minute care team discussions, or short care plan updates as administratively unsustainable. Over time, the burden contributes to burnout and abandonment of CCM and PCM billing despite physicians continuing to perform the work.

Documentation and Compliance Uncertainty

Documentation expectations for CCM and PCM create significant compliance concerns. Physicians frequently report uncertainty regarding the appropriate level of documentation required and how these requirements integrate into existing clinical workflows. ASH members indicate that their compliance

departments or practice administrators discourage billing for CCM or PCM services due to perceived audit risk, even when services are being performed and documented appropriately. The Society supports CMS's goal of ensuring that patients who are receiving care management services have comprehensive care plans, however, current documentation expectations including frequent updates and detailed time tracking requirements can exceed the administrative capacity of many practices. Finally, the administrative burden associated with care management services, coupled with low reimbursement levels is not worth the audit risk.

Care coordination activities such as phone calls, electronic communications, test review, and interdisciplinary collaboration are deceptively complex to document. As a result, physicians often perform care management activities aligned with CMS policy goals but forgo billing because requirements are difficult to operationalize. Streamlining care plan documentation while maintaining practitioner accountability would reduce burden, encourage participation, and allow clinicians to focus more directly on patient care and continuity for beneficiaries with complex conditions.

Single-Billing Practitioner Limitation

CCM and PCM recognize the complex work required to deliver specialty-based longitudinal care; however, the limitation allowing only one practitioner to bill CCM or PCM per patient per month does not reflect modern team-based hematology care.

Patients with hematologic diseases frequently receive coordinated care from multiple specialists and multidisciplinary teams. Diagnostic workflows further illustrate this collaboration: laboratory results may first reach the nurse practitioners or different physicians on the care team, yet clinical responsibility remains shared. Patients with sickle cell disease, bone marrow transplant histories, or complex hematologic malignancies commonly receive care from neurologists, cardiologists, pulmonologists, infectious disease specialists, psychiatrists, pain specialists, and others. Each specialty provides distinct and medically necessary management. Team-based care should not be of the mentality of "who gets there first" when it comes to billing for CCM or PCM services.

Finally, practices face challenges determining which physician should bill CCM or PCM each month. Tracking attribution within the same institution or medical practice is hard enough, and yet many patients are treated by interdisciplinary care teams spread across different organizations or institutions. This makes it nearly impossible to determine who is billing PCM and CCM. This leads to physicians providing meaningful care management who then may be unable to report those services, and the policy of one physician per month may unintentionally discourage collaboration among specialties. Refining CCM and PCM policies to better accommodate team-based care would improve coordinated management and access for beneficiaries with high-risk hematologic conditions.

To make PCM and CCM more accessible to billing clinicians while preserving safeguards, ASH respectfully recommends that CMS consider the following policy refinements. The agency should simplify documentation and time-tracking requirements. Reducing minute-level tracking expectations and streamlining care plan documentation would better align requirements with real-world clinical workflows and encourage broader adoption of care management services.

Additionally, CMS should consider revising the single-billing practitioner limitation to allow a hematologist and another specialist (e.g., cardiology, pulmonology, or infectious disease) to bill CCM and PCM for the same patient when each provides separate, medically necessary care management services. Patients with conditions such as sickle cell disease, beta thalassemia and acute leukemia

require coordinated multispecialty care, and physicians should not compete for reimbursement for services they independently furnish.

The Society also encourages the agency to consider the use of telehealth or asynchronous consent for these services without a preceding face-to-face visit for established patients. This would reduce administrative barriers, improve beneficiary access, and enable timely initiation of CCM or PCM when clinically appropriate.

Finally, beneficiaries frequently do not understand the cost-sharing obligations for services delivered outside traditional visits, which discourages adoption. While CMS's authority may be limited in this area, we are exploring potential Congressional solutions to reduce or eliminate cost-sharing for care management services that improve chronic disease outcomes.

Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule

CMS seeks feedback on whether the current office/outpatient E/M visit structure appropriately reflects the resources and complexity involved in providing primary care, particularly for patients who require ongoing, coordinated care. The agency notes that traditional E/M codes do not distinguish between different types of visits, such as one-time acute visits, specialty consultations, and longitudinal care provided through an ongoing relationship between a patient and clinician. ASH appreciates the agency's commitment to primary care; however, CMS should revisit how E/M services are structured and paid to also support specialties like hematology, not just primary care.

ASH has long advocated for improvements to payment for E/M services. Improvements have been made including revisions to the entire E/M code family, and the implementation of HCPCS code G2211. While these changes have helped, ASH believes that further refinements may be necessary. CMS seeks comment on creating payment policies or new codes that reflect the "purpose of the encounter" which it has described as longitudinal, acute, and consultative care visits.

ASH believes that a logical place to start with improving the accurate description and documentation of the E/M services is to reinstate payment for consultative visits represented by CPT codes 99242, 99243, 99244, and 99245 for office-based consultations, and 99252, 99253, 99254 and 99255 for inpatient consultations. It is important to note that Medicare stopped paying for consultations January 1, 2010. The agency cited longstanding concerns in the 2010 MPFS proposed rule regarding the documentation necessary to support reporting of consultation services, as well as questions about the definition of transfers of care and the broader scope of services encompassed by a consultation.[1] In this same rulemaking cycle, CMS finalized the elimination of the use of all consultation codes, stating "we believe the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services."[2]

ASH disagrees with CMS's 2010 decision and rationale. Documentation requirements are not similar across all E/M services, and it is not the documentation that determines the value of a service. It is the overall work, time, and intensity that determines value, and therefore, given the inherent differences between an E/M service and a consultation service, we believe CMS should reimburse physicians for consultations using established CPT codes. Consultations are vastly different from the typical E/M service. A consulting physician is asked to provide an expert assessment and opinion on

[1] Federal Register: Vol. 74, No. 132, Monday, July 13, 2009 pg. 33553
[2] Ibid.

a specific condition or disease, and then provide a recommendation to the requesting physician, who may then subsequently use the information to treat the patient. In contrast, an E/M service is used to assess a patient's condition, manage chronic illnesses, discuss surgical options, and provide follow-up care as needed. The E/M visit is generally an all-encompassing service, while a consult is meant to pointedly address a specific condition.

However, while only a specific condition is addressed during a consult, the time and effort associated with a consultation is extensive. The following is a non-exhaustive list of the activities required for a consultation:

- **Review and establish the purpose of the consultation**
  - Review the referring physician's or other Qualified Health Professional's (QHP) request for an expert opinion regarding evaluation and/or management of a specific medical problem.
  - Document the consultation request and clinical question in the medical record.
- **Review relevant clinical information**
  - Obtain and review prior medical records, laboratory results, imaging, and other diagnostic information.
  - Review patient-completed medical history forms and vital signs obtained by clinical staff.
  - Incorporate pertinent information into the medical record.
- **Obtain additional information and perform the clinical evaluation**
  - Obtain a medically appropriate history.
  - Perform a medically appropriate physical examination.
  - Order and review additional laboratory, imaging, or other diagnostic tests as clinically indicated.
- **Perform clinical assessment and medical decision making**
  - Synthesize the patient's history, examination findings, and diagnostic information.
  - Develop a differential diagnosis and assess the patient's condition using the appropriate level of medical decision making.
  - Determine appropriate recommendations for further evaluation and/or management.
- **Discuss findings and recommendations**
  - Discuss the findings, assessment, and recommendations with the patient and family or caregiver.
  - Answer questions and provide education regarding the condition and recommended management.
- **Communicate the consultation findings**
  - Prepare a written consultation report summarizing relevant findings, tests ordered and reviewed, test results, expert assessment, and recommendations for management.
  - Communicate the consultation findings and recommendations to the requesting physician.
  - Communicate with other members of the health care team as appropriate.
- **Complete documentation and follow-up**
  - Document the consultation, assessment, recommendations, and report these in the medical record.
  - Perform required electronic data capture and reporting associated with quality programs and other electronic mandates.
  - Respond to follow-up questions from the requesting physician, other QHP, patient, or family or caregiver.

All these activities equate to a service that is much different than a typical E/M service. E/M services are time intensive and complicated but are a completely different service from a consultation, which requires separate reimbursement.

CMS also requests comments on how primary care is delivered, and if there are changes that can be made to improve primary care for Medicare beneficiaries. While ASH agrees that primary care is an essential component of the Medicare program, CMS should also recognize that, in practice, specialists like hematologists frequently take on primary care responsibilities, particularly when caring for patients with complex, chronic, or serious conditions.

ASH recognizes the importance of disease prevention through lifestyle modification; however the Society urges CMS to also ensure appropriate treatment for diseases or disorders for which prevention and lifestyle modification may not be applicable. Many hematologic conditions simply cannot be prevented through changes in diet, exercise, or other lifestyle interventions. This is particularly true for patients with sickle cell disease and hemophilia, who live with inherited conditions that require ongoing medical management regardless of lifestyle, as well as for patients with hematologic malignancies that develop despite an individual's efforts to maintain a healthy lifestyle. A policy framework that focuses heavily on prevention and traditional primary care should not overlook these patients with serous hematologic conditions that are not driven by prevention or lifestyle and the substantial resources required to manage their conditions over time.

Hematologists frequently function as primary care providers for their patients, particularly during periods of active treatment. As an example, the hematologist and hematology care team may be the provider(s) the patient sees most often; and, when a new medical concern arises for a patient undergoing intensive treatment for a hematologic malignancy, it is the hematologist that the patient turns to for answers and additional clinical guidance. During active periods of treatment, the hematologist not only manages the underlying disease treatment protocols and complications of therapy, but may also manage any associated comorbidities, respond to patient questions about drug interactions, coordinate care with other clinicians, and provide ongoing follow-up. Although hematologists provide specialty care, the day-to-day reality for hematologists and their patients is such that these relationships also function like an ongoing primary care relationship.

This is especially important because patients often face significant challenges obtaining timely access to primary care. The primary care workforce shortage and the demands placed on primary care practices can make it difficult for patients to get an appointment when a question or concern arises. As a result, our members have informed us that patients frequently turn to their hematology care team instead, particularly when patients know that they can reach a nurse, QPP, or other member of the care team through their cancer center or hematology practice. When a patient undergoing complex treatment has a concern, being able to reach someone who knows the patient and understands the treatment plan can be critical to addressing the issue appropriately and avoiding unnecessary delays in care. Medicare payment policies should account for this reality and should not assume that primary care responsibilities are always provided separately from specialty care.

ASH also recognizes that electronic communications have become an increasingly important component of longitudinal physician/patient relationships. Patients routinely send questions and concerns through electronic messaging; responding to those messages can require meaningful medical decision making, particularly when the patient has a complex hematologic condition or is undergoing

active treatment. ASH understands that separately billing for patient messaging could result in additional cost-sharing for beneficiaries and that this issue therefore requires careful consideration. Nevertheless, the fact that communication occurs electronically rather than during an in-person encounter should not understate the value of the clinical work being performed.

CMS should ultimately ensure that its policies recognize the way care is delivered to Medicare beneficiaries with complex hematologic conditions. These patients need more than traditional preventive services, and the physicians caring for them often provide services that go beyond specialty treatment. Recognizing the primary care functions performed by hematologists, the substantial cognitive and communication work involved in longitudinal care, and the unique needs of patients with conditions that are not preventable or addressed through lifestyle modification will result in policies that better reflect the resources required to provide comprehensive, high-quality care.

Payment Implications of Technology Enablement of Primary Care

CMS requests stakeholder feedback on how advances in technology and clinical artificial intelligence (AI) are changing the delivery of primary care and how Medicare payment policies should evolve in response. The agency states that AI tools, such as AI documentation assistants and clinical decision-support tools, reduce administrative burden, improve workflows, and support clinical decision-making. CMS believes these technologies have the potential to shift primary care from reactive, manual processes to more proactive, data-driven, and personalized care. CMS also recognizes limitations in data to understand AI costs and infrastructure and to appropriately develop payment methodology for these technologies; the agency is seeking input on how to evaluate these tools and a payment methodology to support technology enabled care.

ASH's priorities related to AI-enabled care are grounded in core principles of appropriate governance, human-in-the-loop oversight, interoperability, data transparency, and health data security. The Society previously identified these principles as a foundation for evaluating AI tools in clinical care through comments on the HHS RFI on AI in Clinical Care.

Additionally, ASH cautions that while AI technologies may help reduce clerical burden or provide some support for clinical work, CMS should not assume that these tools reduce the complexity or value of physician work. ASH members note that the current state of AI does not yet decrease burden. Instead, the burden has shifted, requiring physicians to validate AI outputs, identify inaccuracies or errors, and interpret recommendations. This clinical work has not been eliminated but is occurring in a different form, and the efficiencies gained from certain technology-enabled tools, such as note-taking or documentation, should be considered in the broader context of care delivery. Even if technology-enabled clinical care improves significantly, clinicians will still need to interpret AI outputs, customize recommendations to the patient, and subsequently communicate this information with the patient. This is especially important in hematology, where conditions are often rare, clinically complex, and require understanding of the patient to make appropriate treatment recommendations. CMS should recognize that these tools require continued and necessary physician oversight as well as significant infrastructure investment.

Updates to Practice Expense Methodology

Within this year's rule, CMS requests comment on several topics related to the practice expense portion of the physician payment formula. Additionally, CMS proposes to eliminate certain steps, specifically steps 12-17 of the formula, which would remove the indirect practice cost index (IPCI). The IPCI is used to adjust indirect practice expenses based on specialty-level survey data because

indirect practice costs vary from one specialty to another, meaning some specialties incur remarkably high indirect practice costs, while others have relatively low indirect practice costs.

ASH supports the agency's goal to create a fair and equitable payment system and its desire to use empirical data to support policy changes. However, in recent years, including the CY 2026 implementation of the site of service payment differential policy which reduced the indirect practice costs of physician services performed in the facility setting, the agency's policies have not been supported by empirical evidence. The Society did not support last year's cut to indirect practice costs for services provided in the facility setting, as noted in the ASH Comments on the CY 26 MPFS, and we respectfully request CMS refrain from implementing changes to the physician payment formula in 2027 that would further cut practice expense costs, especially as the full impact of the 2026 policies are not yet understood.

CMS has stated that the agency believes the IPCI relies too heavily on outdated, specialty-specific survey data. The Society poses two arguments in response to this statement; one, the IPCI is designed to account for specialty-specific data, by calculating a payment amount that reflects the cost of service based on factors that vary like specialty type, and two, there are available, updated data that the agency could incorporate into the IPCI formula, like the AMA Physician Practice Information Survey (PPIS) data. The agency should model the impact of including the updated AMA PPIS in the IPCI and provide this information to the public for comment. CMS has rejected the very information it has been seeking by not using the updated, empirical evidence to support a fair and balanced payment system, nor has the agency produced data of its own to offer as an alternative. Simply cutting out a portion of the payment formula without evidentiary support will not improve the accuracy of physician payments, nor will it reflect "the resources required to furnish individual services."

ASH does not believe the agency should change the practice expense formula again without first understanding the effects of the site of service policy implemented only in this last year. Throughout the proposed rule, CMS has stated its objective to support small, independent physician practices to avoid consolidation, and to support access to care in rural areas. The continued payment cuts, whether through the physician payment formula or the lack of inflationary updates, have the opposite effect on practices. In fact, the constant downward pressure from these payment policies are driving physicians out of private practice. ASH recommends the agency not implement any further changes that cut physician payment and urges the agency to maintain the IPCI portion of the formula until the agency can fully assess the impact of the significant change made in 2026 and has evidence demonstrating that a revision is necessary.

Additionally, CMS seeks comment on how indirect practice expenses differ across physician specialties, particularly for physicians employed by hospitals or health systems. As ASH noted in our comment letter on the CY 2026 MPFS proposed rule, physicians incur indirect PE costs (rent, utilities, staff salaries) regardless of whether they are providing these services in the facility setting or non-facility setting. Additionally, based on feedback from ASH members, the Society believes that there is no set standard for how facility-based physicians might cover the costs of indirect practice expenses. ASH members have directly shared that even though their practice is physically located within the hospital, they must still pay rent for their office space and the salaries of their support staff. Additionally, scheduling a service or surgery to be performed in the facility setting consumes more time and resources than scheduling the same procedure in the physician office setting, requiring the coordination of operating room availability, nursing and surgical assistant staff, and physician availability. This scheduling activity equates to indirect costs that the physician bears and therefore

cutting payment for indirect costs would again impact physicians' ability to care for patients. ASH does not support this policy and requests that CMS provide the empirical data and associated methodology that was used to support it. If no such data exist, the Society recommends that the agency rescind the policy until such time that CMS can collect and provide the data and methodology for public review and comment.

Finally, CMS seeks comment on potential approaches to better identify hospital-employed physicians, including whether a new HCPCS modifier could distinguish services furnished by employed clinicians and allow more accurate allocation of indirect practice expenses. ASH supports the creation of a modifier to identify hospital-employed physicians. This would enable CMS to apply the indirect PE reduction only to those physicians who do not have separate administrative or clinical offices. Billing staff for facility-employed physicians could append this new modifier to claims. ASH recommends that CMS take a more measured approach, which using a modifier would allow. If CMS proposes to adopt a modifier in lieu of the current allocation method, CMS should first share specific specialty-level impact analysis in proposed rulemaking and allow for public review and comment.

Current Procedural Terminology (CPT) Request for Information (RFI)

CMS requests stakeholder feedback on whether the current physician coding and valuation system, the American Medical Association's (AMA) CPT coding system and the RVS Update Committee (RUC), continues to be the best option to describe and value Medicare services. CMS acknowledges that CPT codes and the RUC have formed the foundation of physician payment under the MPFS for many years, but the agency raises its longstanding concerns about reliance on a private organization, the AMA, to develop and value codes that directly influence physician reimbursement.

ASH is generally supportive of the CPT and RUC processes, while recognizing these processes have shortcomings. The Society is concerned that the valuation process tends to favor procedural services over non-procedural services. Much of the discussion in our comments from the above section on *Reconsidering Relative Primary Care Payment* regarding the valuation of primary care services is equally applicable here. ASH, therefore, refers the agency to that section of the letter. ASH also reiterates that the specialty of hematology may not always fit neatly within the MPFS framework that was originally built around procedures. When the Resource Based Relative Value Scale (RBRVS) was created, procedures were compared to each other based on their time and intensity. For example, the developers of the RBRVS assumed that the removal of a mole was much less intensive than open heart surgery. This type of comparison is not as easily made between an E/M visit and open heart surgery or removal of a mole. E/M services are "cognitive" in nature, and the intensity of an E/M visit is not as easily determined or comparable to other services in a system that relies on relativity.

However, even with these shortcomings, ASH supports the CPT and RUC process given the direct physician involvement on which these processes function. Physicians are best positioned in understanding how to describe a procedure or service through the CPT process and in helping to determine the subsequent value of a service in a system that relies on relativity. The processes in place now benefit from clinical expertise and physician input. The Society is concerned that if the agency were to take on this process, physician involvement and critical expertise would be lost. ASH notes that throughout the rule, CMS either proposed or sought comment on creating an increasing number of HCPCS G-codes outside the traditional CPT and RUC processes. While ASH is supportive of some of the proposed G codes, the Society encourages the agency to review comments and carefully consider the expertise provided to the agency from stakeholders. Comment letter feedback from

clinical experts is precisely the type of information that the agency needs in creating codes that reflect the work and valuation of a service.

Finally, ASH also believes it is important to accurately characterize the respective roles of the AMA and CMS, as both participate in the coding and valuation process. Physicians participating in the CPT and RUC process provide clinical expertise and recommendations concerning the definition and relative valuation of physician services; physicians do not establish Medicare payment rates. The RUC does not assign a payment value, as CMS states in the rule.[3] The RUC makes recommendations to CMS regarding payment values, and it is ultimately CMS that determines and finalizes Medicare payment for each service paid under the Physician Fee Schedule.

This distinction is important because characterizing physicians as determining their own Medicare payment levels creates a misleading impression of how the system operates. The physician-led nature of CPT and RUC, as previously stated, is a strength of this process because it ensures that clinical experts have an opportunity to inform the development of codes to describe a procedure or service and the valuation of clinical services. ASH therefore encourages CMS to preserve this important source of clinical expertise while recognizing that the final responsibility for Medicare payment policy rests solely with the agency.

Proposed Changes to Payments Using Modifier -25

CMS proposes to reduce payment when a separately identifiable E/M visit as indicated by modifier -25, is furnished by the same physician (or a physician in the same practice) on the same day as the procedure with a 0-, 10-, or 90-day global period. The most expensive service (either surgical procedure or E/M visit) will be paid at 100% and all other surgical procedure(s) or E/M visit furnished on the same day would be paid at 50%.

The agency states in the rule that "we continue to believe that there are efficiencies when the same physician (or a physician in the same group practice) provides an E/M service for the same patient in conjunction with a procedure with a global period, and that we are likely duplicating payment under the current payment methodology."[4] A payment cut of this magnitude should not be based on a belief or whether there is a likelihood of something occurring, but rather should be based on evidence and data of such occurrences.

This policy will have far-reaching consequences, particularly for small, independent practices, and is fundamentally inconsistent with CMS's stated commitment to these practices. Small, independent practices bear the full costs of clinical staff, supplies, equipment, and other infrastructure, and reductions of this magnitude could make it increasingly difficult for these practices to continue providing timely, accessible specialty care.

There are many instances when, for both patient convenience and timely care, procedures and E/M services are appropriately performed on the same day. For many patients, particularly those in rural areas, a hematologist may schedule a single visit to the clinic or office that includes several types of services, such as an E/M visit to follow up on a patient with acute lymphoblastic leukemia, while also performing a lumbar puncture to monitor possible spread of the disease. Coordinating services in this manner eliminates the burden of requiring patients to make additional trips to the office or clinic,

---

[3] Federal Register, Vol. 91, No. 135, pg. 43952

[4] Federal Register ,Vol. 91, No. 135, pg. 43908

which can be particularly challenging for Medicare beneficiaries who have limited mobility, rely on family members or public transportation, or must travel substantial distances to obtain specialty care.

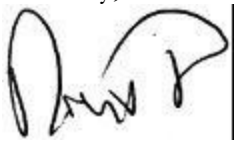
The direct practice expenses, including the supplies, clinical labor, and equipment needed for these two, separate, and distinct services are extremely different. For example, when comparing the direct practice expense inputs for 99214 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.*) and 62270 (*Spinal puncture, lumbar, diagnostic*), which are two services often performed on the same patient during the same encounter, the overlap of clinical labor inputs for these two services consists of total of four minutes captured by clinical labor codes CA013 (*prepare room, equipment and supplies*) and CA016 (*prepare, set-up and start IV, initial positioning and monitoring of patient*). The total clinical labor time for 99214 is 51 minutes, and the total clinical labor time for 62270 is 32 minutes. The supply input overlap is non-existent, and the overlap for the equipment is only for EF023 (table, exam). Therefore, using these two services as an example, a 50% payment reduction to either one is not justifiable based on the actual overlapping resources used for both services.

ASH urges the agency not to finalize this proposal and instead consider alternatives to address resource overlap, including processes that currently exist. For example, there is a process in place to address misvalued codes which CMS freely participates in through the RUC's Relative Assessment Workgroup. ASH also requests that CMS demonstrate, at the code level, that the assumed amount of resource overlap exists for the services to which the policy would apply. Payment adjustments should be based on evidence of actual resource efficiencies rather than the assumption that services furnished on the same day necessarily require substantially fewer resources, as demonstrated in the example above.

Finally, ASH notes that RUC's survey and valuation methodology is specifically designed to exclude the physician work and practice expense overlap associated with separately identifiable E/M services reported with modifier -25. This process has been used for decades, and CMS has implicitly accepted this methodology by historically accepting more than 90% of the RUC recommended work, practice expense, and malpractice RVUs for inclusion in the MPFS. Yet, CMS now believes, arbitrarily and without empirical evidence, that the process does not work, and that any overlap in practice expense has not been considered by the AMA RUC survey process. The proposed change in payment, outside of historical precedent and any evidence to support the change, will only add pressure on the delivery of care and may lead to greater inefficiencies.

ASH thanks CMS for the opportunity to share these comments on the Medicare Physician Fee Schedule (MPFS) proposed rule for CY 2027. Should you have any questions or require further information, please contact ASH Manager for Health Care Access Policy, Carina Smith at casmith@hematology.org.

Sincerely,



Robert Negrin, MD
President