Illinois Health and Hospital Association

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

Re: CMS-1848-P: CY 2027 Medicare Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

On behalf of our more than 200 hospitals and over 30 health systems, the Illinois Health and Hospital Association (IHA) values the opportunity to comment on the calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule. IHA appreciates the Centers for Medicare & Medicaid Services' (CMS) efforts in developing this proposed rule, particularly provisions allowing clinical staff to work at top of license. These include greater payment flexibility for teaching physicians with a virtual presence and advanced care planning service delivery by clinical staff under supervision.

However, we are deeply concerned about certain proposals outlined by CMS, particularly as the statutorily required reduction in overall physician payment will already negatively affect beneficiary access. Accordingly, IHA asks CMS to address the following two issues:

- Revise the 340B-related proposal for mandated submission of targeted Part D claims data to the 340B claims data repository, instead permitting voluntary submission as previously planned to reduce administrative and financial provider burden; and
- Withdraw proposals to modify coding and payment policies for remote monitoring, which restrict access to care and provider reimbursement.

The comments below address each issue, explaining how the proposals affect provider operations, patient access, and financial sustainability. Hospital-employed physicians and advanced practice professionals are already facing significant cost pressures, including payment reductions arising from changes to Medicaid financing and the continued rising pharmaceutical, supply chain, and workforce costs. We urge CMS not to compound these challenges through additional payment reductions and access-impeding policies.

340B-Related Proposals
Beginning Jan. 1, 2027, CMS proposed requiring all 340B-covered entities to submit targeted Part D claims data to the 340B claims data repository, rather than voluntary submissions as currently planned. Although data submitted at this time would be for informational purposes only, failure to report data could constitute a violation of Medicare enrollment requirements, subjecting providers or suppliers to the loss of their Medicare billing privileges.

IHA opposes requiring all 340B covered entities to submit quarterly Part D claims data and linking Medicare billing privileges to data submission compliance, which would result in significant administrative burden and financial uncertainty for healthcare providers. By CMS' own estimates in the proposal, the requirement would create 462,000 administrative burden hours at a cost of $52.4 million annually. Realistically, rural and safety net hospitals may not have the administrative platforms or workflows to mobilize and implement the requirement to submit seven Part D claims-level data elements by January 2027. Specifically, the

identification and consolidation of all Part D prescription claims data into a single CMS-compliant submission from disparate platforms and third-party administrators will be incredibly challenging for these hospitals. Hospitals may have to divert resources away from clinical care to fulfill these requirements, which would impact Medicare beneficiary access to care and, for smaller hospitals, providers' financial sustainability. IHA also seeks clarification on how the proposed data will be used and disclosed. Distinct guardrails around data use, any future disclosures, and parameters for confidentiality, are critical for 340B providers.

IHA strongly urges CMS to revise the proposal for mandated submission of targeted Part D claims data to the 340B claims data repository, instead permitting voluntary submission as previously planned.

Remote Monitoring
CMS put forth four policies in the PFS proposed rule related to remote monitoring:

1. Requiring an established patient relationship and initiating visit for remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) services;
2. Only allowing payment for RPM or RTM services when performed by clinical staff employed by the practice and prohibiting services delivered by third-party contractors;
3. Reducing payment for certain devices and set-up codes by revising practice expense (PE) work relative value units (RVU) and eliminating PE inputs for treatment management codes; and
4. Bundling the 17 total RPM and RTM Current Procedural Terminology (CPT) codes to create four new Healthcare Common Procedure Coding System (HCPCS) G-Codes to describe remote monitoring services.

IHA opposes these remote monitoring proposals, which would restrict access to care for vulnerable Medicare beneficiaries who depend on remote monitoring services for the early detection of health declines, which enables proactive treatment adjustments for conditions like hypertension, diabetes, asthma, congestive heart failure and post-operative orthopedic recovery. Instead, beneficiary access will revert to preventable and more costly emergency department, inpatient, and clinic visits. These access barriers would be most acute in rural areas, restricting technological advancement where beneficiaries and healthcare providers most rely on it as the Rural Health Transformation Program is implemented.

Requiring the billing practitioner of remote monitoring services to have a face-to-face initiating visit creates an unnecessary care delay and financial burden on the patient. More commonly, a practitioner in a hospital or other healthcare setting may refer a patient to a separate practitioner for remote monitoring services, with the intent of those services beginning immediately to prevent more acute healthcare intervention. Based on standard healthcare practice, referrals should be permitted from someone within the billing practice or from an external healthcare provider with an existing relationship. Also, the justification that an initiating visit is required explicitly to obtain beneficiary consent for remote monitoring creates an administrative and financial restriction on these services that do not exist for other services. Remote monitoring consent can be obtained in writing like all other services, most commonly through a patient's electronic medical record or email.

In addition, the use of third-party contractors is critical for workforce flexibility to support the technological infrastructure and advancements necessary for 24-hour remote monitoring and patient engagement needs. Although healthcare providers often use employed staff for monitoring services, contractors may be used to supplement monitoring staff during off-hours or acute workforce shortages, or to direct and respond to calls that support scheduling, technical support, or patient education. Prohibiting contractors would create a separate standard for remote monitoring from other services, ignoring the stark reality that the national average turnover rate for clinical staff in U.S. hospitals stands at 18.5%. Prohibiting contractor use for remote monitoring would refuse to acknowledge workforce realities in the healthcare sector. It would also immediately restrict access to care that has been proven to prevent acute care interventions through the early detection of health decline, which enables proactive treatment adjustments outside of traditional, more costly healthcare visits.

Finally, the revaluation and bundling of codes will result in lower overall payment and programmatic insecurity for remote monitoring service providers. The justification contends that device and education costs are seen as overstated, and PE inputs are seen as not requiring clinical staff time beyond work RVUs. However, remote monitoring is a service that requires continued investment in new technology and workforce training to manage infrastructure demands, ensure practitioner and equipment

accuracy, and maintain high-quality programs. The proposed payment reductions act as a threat to long-term program sustainability for established healthcare providers using remote monitoring to support beneficiaries with chronic and acute conditions and integrate care across the continuum.

IHA strongly urges CMS to withdraw these remote monitoring proposals and work with stakeholders to develop responsible programmatic guardrails that maintain patient access to care and prevent more acute, costly interventions.

Dr. Oz, thank you again for the opportunity to comment on the CY 2027 Medicare PFS proposed rule. IHA urges CMS to permit voluntary 340B Part D claims data submission as previously planned and to withdraw the proposed remote monitoring coding and payment changes so that Medicare beneficiaries can continue to access timely, cost-effective care.

Sincerely,

A.J. Wilhelmi
President & CEO

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