



7/21/25 WEDI FEDERAL UPDATE

CMS 2026 Medicare PFS Proposed Rule Includes Health IT Provisions. The [Calendar Year 2026 Medicare Physician Fee Schedule \(PFS\) Proposed Rule](#) was released by the Centers for Medicare & Medicaid Services (CMS) and includes numerous proposals for policy, payment, and other requirements, including provisions for health information technology (IT). The Proposed Rule also includes several requests for information (RFI) specific to Medicare reimbursement for physicians and other qualified health care providers. Overall, the aim is to reduce wasteful spending, re-evaluate quality measurement, and improve care management for beneficiaries with chronic diseases.

The Proposed Rule includes several potential changes to telehealth use and payment, including:

- Streamlining the process for adding services to the Medicare Telehealth Services List by removing the distinction between provisional and permanent services and limiting the review on whether the service can be provided using an interactive, two-way audio-video telecommunications system.
- Removing permanently the frequency limitations for later inpatient visits, nursing facility visits, and critical care consultations.
- Adopting permanently a definition of direct supervision that allows the physician or supervising practitioner to provide applicable supervision through real-time audio and visual interactive telecommunications (excluding audio-only), except for specific identified services.

The Proposed Rule calls on expanding the use of and access to remote patient monitoring and digital health services. One proposal is to expand payment policies for digital mental health treatment services to include payment for devices used in the treatment of attention deficit hyperactivity disorder. CMS is also requesting feedback on coding and payment policies for other digital therapy devices and a broader set of services describing digital tools as complements to mental health treatment plans of care.

In addition, several RFIs are included in the Proposed Rule, including those related to technology and data: (i) Transitioning to Fast Healthcare Interoperability Resources (FHIR)-based electronic clinical quality measure reporting; (ii) Assessing the status of and barriers to collecting and exchanging health care data; and (iii) Improving wellness, prevention, and

chronic disease management. CMS is hosting a webinar on July 23 at 10:00 am ET to provide an overview of the 2026 Quality Payment Program proposed policy updates. Register for the webinar [here](#). The deadline for submitting comments on the Proposed Rule is September 12.

Price Transparency Provisions Included in 2026 Hospital OPps and ASC Proposed Rule. CMS released the [Calendar Year 2026 Hospital Outpatient Prospective Payment System \(OPps\) and Ambulatory Surgical Center \(ASC\) Proposed Rule](#). Several provisions in the Proposed Rule relate to technology and data exchange. One section addresses the Hospital Price Transparency (HPT) regulations with a goal of improving the accuracy of the actual prices and limiting the use of estimates or algorithms. The HPT proposals include: (i) Adding more data to the machine-readable files about allowed amounts for a service; (ii) Using electronic remittance advice transaction data to calculate allowed amounts; (iii) Requiring hospitals attest that they have included all applicable payer-specific negotiated charges; (iv) Reporting the name of the hospital's chief executive officer, president, or senior official designated to oversee the data; and (v) Requiring hospitals include their Type 2 National Provider Identifier(s). Other proposed items in the overall rule include soliciting comments related to software as a service used to support clinical decision-making in the outpatient setting under the OPps; changes to the Hospital Outpatient Quality Reporting, Rural Emergency Hospital Quality Reporting, and Ambulatory Surgical Center Quality Reporting Programs to improve measurement and reporting in the outpatient setting; and requesting feedback on the quality reporting programs for future realignment of reporting. The deadline to submit comments is September 15.

CMS Announces New Payment Model Addressing Chronic Conditions. The CMS Innovation Center is proposing a new [Ambulatory Specialty Model](#) focused on the chronic conditions of heart failure and low back pain. The payment model will promote preventive care and disease management through better care coordination between primary and specialty care providers. The goal of the model is to reduce hospital admissions, improve patient outcomes, and lower costs. If finalized, the model will start in January 2027 and continue through December 2031.

ASTP/ONC Outlines TEFCA Priorities and Plans through 2025. The Assistant Secretary for Health Policy/Office of the National Coordinator for Health Information Technology (ASTP/ONC) posted a new [HealthITbuzz blog](#) outlining its priorities and plans related to the Trusted Exchange Framework and Common Agreement (TEFCA™) through the remainder of 2025. The first priority is to increase transparency, which will be accomplished through making more draft TEFCA work products available for public comment. The second priority is to drive participation and use of TEFCA by growing the exchanges for treatment and individual access services. They also plan to expand the use of the network for the other TEFCA authorized exchange purposes, including payment, operations, benefits determination, and public health. The third priority is to activate and support federal partners through the use of TEFCA in achieving goals of

interoperability. The blog also notes that ASTP/ONC is currently reviewing the public comments received from the recent joint RFI with CMS and plans to use the input received for policy and program implementation purposes.

DOJ-HHS Form Working Group to Combat Health Care Fraud. The Departments of Justice (DOJ) and Health and Human Services (HHS) [announced](#) the formation of a joint working group that will use the False Claims Act to fight health care fraud. The working group will be jointly led by the HHS General Counsel, Chief Counsel to HHS Office of Inspector General (HHSOIG), and the Deputy Assistant Attorney General of the Commercial Litigation Branch. Members of the working group will include designees from the HHS Office of General Counsel, CMS Center for Program Integrity, Office of Counsel to the HHSOIG, and DOJ's Civil Division, and representatives from the U.S. Attorneys' Offices. Priority areas for enforcement will include Medicare Advantage; drug, device, or biologics pricing; barriers to patient access to care; kickbacks related to drugs, medical devices, durable medical equipment, and other products; defective medical devices that impact patient safety; and manipulation of electronic health record (EHR) systems to drive inappropriate use of Medicare covered products and services. The intent of the working group is to use cross-agency collaboration to facilitate ongoing investigations and pursue new leads through enhanced data mining and analysis.

ASTP/ONC Reports Increase in Electronic Public Health Reporting by Hospitals. A [report](#) released by ASTP/ONC indicates that in 2024 hospitals were using electronic public health reporting at a higher rate than previous years. The highest usage reported was for required data reporting, including immunization registry, syndromic surveillance, laboratory reporting, and case reporting. While most data were being sent directly from the hospital's EHR, a portion of data was still being submitted using portals, flat files, and combination of electronic and manual processes. The electronic public health reporting was found to vary based on the type of hospital, with small, rural, independent, and critical access hospitals having lower rates of electronic reporting. A goal of ASTP/ONC is to improve public health agencies' access to essential data they need for public health decision-making.

CMS Alerts Medicare Providers and Suppliers of Phishing Scam. An [alert](#) posted by CMS warns Medicare providers and suppliers of phishing fraud schemes to steal patient information and provider money. The schemes involve a scammer impersonating a CMS employee via email or fax and requesting patient medical records or payment for an outstanding debt. In the alert, CMS reminds providers that they do not initiate audit activities via email or fax unless requested by the provider. Overpayment collection efforts are managed by the Medicare Administrative Contractors (MAC) using an established process. Providers with questions about recent audit or payment requests can contact their Medical Review Contractor or MAC.

Declaration of Emergency Allows Limited Waiver of HIPAA Penalties. The [Major Disaster Declaration and Public Health Emergency](#) (PHE) in Texas following the July 2 severe storms and flooding allows patient information to be shared to assist in disaster relief efforts and assist patients in receiving health care services. The HHS Secretary has exercised his authority and waived certain provisions of the HIPAA Privacy Rule. During the declared emergency and PHE, a covered hospital will not be sanctioned or penalized if it fails to obtain a patient's agreement to speak with family members or friends regarding the patient's care; honor a request to opt out of the facility directory; distribute a notice of privacy practices; allow the patient to request privacy restrictions; and allow the patient to request confidential communications. Additional resources and information on flexibilities during the PHE are available [here](#).