November 9, 2026

The Honorable Mike Johnson
Speaker
U.S. House of Representatives

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives

The Honorable John Thune
Majority Leader
U.S. Senate

The Honorable Chuck Schumer
Minority Leader
U.S. Senate

Re: MGMA Legislative Priorities for the End of 2026

Dear Speaker Johnson, Majority Leader Thune, Minority Leader Jeffries, and Minority Leader Schumer:

On behalf of our member medical group practices, the Medical Group Management Association (MGMA) thanks you for your longstanding leadership in supporting medical group practices' ability to provide high-quality, cost-effective care. As we approach the end of 2026, and with government funding set to expire on December 11, we write to emphasize the urgent need for Congress to pass stabilizing legislation on key issues to medical groups in any end-of-year legislative package.

The recently finalized 2027 Medicare Physician Fee Schedule (PFS) includes additional cuts to Medicare physician payment, continuing the destabilizing downward trajectory of Medicare reimbursement from the past decades. Inadequate Medicare payment rates and the lack of inflationary update continue to undermine the financial viability of medical groups; Congress needs to prevent the scheduled 2027 cuts and pass lasting Medicare payment reform to ensure Medicare beneficiaries can access high-quality care in their communities. Further, congressional action is needed to support medical groups by stopping cuts to same-day services, extending Advanced Alternative Payment Model (APM) incentive payment, freezing the qualifying APM participant (QP) thresholds, extending the 1.0 work GPCI floor, passing prior authorization reform legislation, and preventing cuts to clinical laboratories.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical group practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following legislative recommendations.

Medicare Physician Payment

The Centers for Medicare & Medicaid Services (CMS) finalized its 2027 PFS that will cut the Medicare conversion factors by -1.83% for qualifying APM participants (QPs) and -2.31% for non-QPs over final 2026 rates beginning Jan. 1, 2027. These cuts are primarily due to expiration of the 2.5% increase that Congress temporarily passed for 2026. MGMA asks that Congress quickly pass legislation that would stop this cut by extending the 2.5% increase scheduled to expire through 2027.

This reduction in payment further erodes an already fragile payment system and intensifies the financial strain caused by years of inadequate Medicare reimbursement. Coupled with the current inflationary environment and other ongoing financial pressures — staffing shortages, increased administrative burden, and more — this policy is unsustainable for medical groups.

Physician practices have been warning for years about reimbursement failing to keep up with costs and its impact on current and future Medicare patient access. Eighty percent of medical practices report Medicare payment rates do not cover the cost of care in 2026, while 84% of medical groups report increased operating costs.[1] Medical groups continue to detail having to consider limiting the number of new Medicare patients, reducing charity care, reducing the number of clinical staff, and closing satellite locations should Medicare payment keep on this track. Increased consolidation has resulted from independent physician groups being unable to stay in operation due to these financial tensions and increasing regulatory burden.

While avoiding this impending cut is of foremost importance, permanent reform to the Medicare payment system is needed to sustainably support medical groups and avoid these yearly threats to their financial viability. Both the Republican and Democratic Doctors Caucuses recognize the severity of the problem and recently introduced the Patients First Act (H.R. 9693), comprehensive legislation that would include a yearly positive update to the Medicare conversion factor, modernize antiquated statutory budget neutrality requirements that have led to this dire situation, and reform MIPS. We urge Congress to work towards structural long-term reform to prevent these annual cuts to Medicare reimbursement.

0-Day Global Procedures and Modifier 25

Starting in 2027, CMS finalized a 20% reduction in payment to all services except the highest value service when an office/outpatient (O/O) evaluation and management (E/M) visit is performed on the same day with the same practitioner (or a practitioner of the same specialty in the same group practice) as a service with a 0-day global period. While CMS decreased this cut from the initially proposed 50% to 20% and removed 10-day and 90-day global procedures, this unwarranted reduction would still undermine many physician practices' ability to offer same-day care.

Modifier 25 is used to distinguish significant, separately identifiable work that goes beyond what is part of a 0-day global procedure. Current Medicare code valuation processes through the RUC and the misvalued code initiative address duplicative physician work and practice expenses for services normally furnished together. CMS can identify codes they believe include overlapping work or practice expense costs and address these through these established processes. A 20% reduction is not reflective of the current landscape and would actively undermine medical group operations.

The financial impact on a broad range of specialties would be detrimental and undermine patient access to care. There are numerous procedures that currently operate at or near break-even from a cost-accounting perspective. Further reductions in reimbursement for either the procedural component or the associated E/M service would require medical groups to carefully evaluate the long-term viability of continuing to offer certain services, ultimately impacting patient access to same-day care.

[1] MGMA Stat, Operating Costs Keep Climbing for Medical Practices in 2026, June 24, 2026, https://www.mgma.com/mgma-stat/operating-costs-keep-climbing-for-medical-practices-in-2026: MGMA Stat, 2026 Medicare Reimbursement Changes: Tracking What Matters, Feb. 26, 2026, https://www.mgma.com/mgma-stat/2026-medicare-reimbursement-changes.

We thank the nearly 80 members of Congress for urging CMS not to finalize the proposed 50% cut. We urge Congress to stop the finalized 20% cut to same-day services, or at minimum delay this policy by one year and work with CMS to take a targeted approach to address any potential overlapping costs using the tools already available to them.

Advanced APM Incentive Payment and QP Thresholds

The Advanced APM incentive payment has been essential to medical groups attempting to transition to value-based care models, allowing them to make the necessary infrastructure investments to succeed in these arrangements. The lapse of the incentive payment in 2025 and increased QP thresholds contributed to increased financial instability for practices and prevented them from making critical investments in value-based care operations and technologies. We appreciate Congress for extending the APM Incentive Payment at 3.1% and freezing the QP threshold level through the end of 2026 — we urge that these policies be extended through 2027 as it will become less feasible for practices to join and participate in APMs should they expire.

1.0 Work GPCI Floor

Physician practices in rural areas are subject to myriad financial pressures undermining their ability to operate and serve their communities. It is essential to keep the 1.0 work GPCI floor in place to avoid needless payment reductions and the associated negative repercussions for medical groups in these localities. Congress must not allow the 1.0 work GPCI floor to lapse on December 31, 2026, and extend this important policy while working towards a permeant solution.

Clinical Laboratory Cuts

We are thankful the Continuing Appropriations Act, 2026 (H.R. 7148), delayed harmful, scheduled cuts of up to 15% in the Medicare Clinical Laboratory Fee Schedule (CLFS) until December 31, 2026. This temporary measure was needed to avoid undercutting labs' ability to be appropriately reimbursed for their services. CMS recently released preliminary clinical laboratory rates for 2027, with an average reduction in reimbursement of 16%. This cut, in addition to ongoing reductions in Medicare reimbursement, further strains physician office laboratories and threatens their ability to offer important laboratory services.

Congress must act to continue preventing the scheduled lab cuts under The Protecting Access to Medicare Act (PAMA) by passing The Reforming and Enhancing Sustainable Updates to Laboratory Testing Services (RESULTS) Act (H.R. 5269; S. 2761), which will improve the data used to set sustainable rates for the CLFS and thereby support Medicare beneficiaries' access to laboratory testing and protect laboratory infrastructure and innovation. Enacting the RESULTS Act will help ensure that medical group practices can continue delivering efficient, high-quality lab testing and avoid disruptions that could delay diagnoses and treatment for America's seniors.

Prior Authorization Reform

Prior authorization requirements continuously rank as one of the most onerous regulatory burdens facing medical groups, as 90% of practices reported an increase in prior authorization burden in the last 12 months in MGMA's 2026 Regulatory Burden Report.[2] The widely supported Improving Seniors' Timely Access to Care Act (H.R. 3514, S. 1816) — which has 71 cosponsors in the Senate and 308 in the House of Representatives — would make long-needed changes to prior authorization and allow practices to

[2] MGMA's 2026 Regulatory Burden Report, April 9, 2026, https://www.mgma.com/federal-policy-resources/april-9-2026-regulatory-burden-report.

focus resources on clinical care instead of dealing with these administrative processes. This legislation unanimously passed two House committees earlier this year, and the current version has a preliminary Congressional Budget Office score of $0.

This legislation has the support of hundreds of healthcare organizations as it would implement commonsense changes to improve the transparency surrounding prior authorization utilization and expediate an often-laborious process. This bill should be included in any legislative vehicle before the end of the year to provide much-needed reform.

Conclusion

MGMA sincerely appreciates your enduring support for medical groups. We urge you to pass the above-referenced legislation to reinforce group practices' ability to provide high-quality, cost-effective care. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs