Medical Group Management Association®

September 14, 2026

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

Re: Medicare and Medicaid Programs; CY 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

Dear Administrator Oz:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the calendar year (CY) 2027 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 16, 2026.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 medical groups comprising more than 350,000 physicians. These groups range from small independent practices in remote and other underserved areas to large regional and national health systems that cover the full spectrum of physician specialties.

Key Recommendations

MGMA appreciates the Centers for Medicare & Medicaid Services' (CMS') leadership in overseeing the Medicare program and working to make improvements for patients and providers. We respectfully offer the following comments in response to the CY 2027 PFS proposed rule. CMS should:

- **Work with Congress to provide a positive update to the Medicare conversion factors in CY 2027 and all future years and reform outdated budget neutrality requirements.** MGMA maintains its position that the continued decline of Medicare payment is undermining the financial viability of medical groups and leading to myriad negative consequences for practice operations. These ongoing cuts,

coupled with a lack of an inflationary update, further exacerbate administrative burdens and undermine the ability of physician practices to provide high-quality care. The current situation is untenable and must be remedied immediately through Congress extending the 2.5% increase to Medicare payment scheduled to expire at the end of 2026 and passing the *Patients First Act* that would make comprehensive reforms.

- **Withdraw its proposal to reduce payment by 50% when a separately identifiable E/M visit (billed with a -25 modifier) is furnished by the same physician, or a physician in the same practice, on the same day as a 0-, 10-, or 90-day global procedure.** This unwarranted reduction is not supported by evidence and would have substantial financial and operational consequences for physician practices' ability to offer same-day care, negatively impacting patient access to these services. CMS should use its current tools to address any duplicative costs and not institute a punitive across-the-board cut.
- **Rescind extensive proposed remote patient monitoring changes, such as requiring employees of physician practices to offer these services.** These widespread proposals would impede medical groups' ability to offer necessary remote monitoring services that help treat chronic conditions and ultimately undermine beneficiary access to care.
- **Delay implementation of Practice Expense (PE) RVU methodological changes due to the lack of clarity into the effect of these policies.** These complex and lasting changes to PE RVU methodology should be made alongside robust specialty-level analysis to allow the healthcare community to appropriately understand what is shifting and its real-world impact.
- **Avoid transitioning HCPCS complexity add-on code G2211 to two modifiers given issues related to administrative complexity, need for additional education, and potential unintended consequences.**
- **Finalize many proposed changes to the Medicare Shared Savings Program to promote new participation in higher-risk arrangements while continuing to support established participants.** CMS should finalize proposals to help newer value-based care participants take on more risk and ensure proposals to address the ratcheting effect will not have unintended consequences.
- **Withdraw the proposal to evaluate Qualified Advanced Alternative Payment Model (APM) participant (QP) status at the TIN/NPI level.** This policy would create new financial and administrative burdens for practices and could undermine the agency's efforts to grow value-based care.
- **Delay implementation of the Ambulatory Specialty Model (ASM) and modify unnecessarily burdensome exemption request requirements.** MGMA opposes the mandatory nature of ASM and remains strongly opposed to the model's redistribution structure where only 85% of redistributed funds go to participants and CMS keeps the other 15%.
- **Maintain Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) as a voluntary reporting option under the Quality Payment Program and do not**

sunset MIPS following the 2028 performance period. Mandating MVPs starting in 2029 would amplify the structural problems in MIPS and introduce additional administrative concerns given the current design of the program. CMS should work to reform MVPs while keeping them voluntary to ensure physician practices can succeed in the program.

Physician Fee Schedule

Conversion Factors

CMS proposal: CMS instituted two conversion factors starting in 2026 as required by the *Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)* – one for QPs, including a +0.75% adjustment, and one for non-QPs, consisting of a +0.25% adjustment. CMS proposes the following 2027 Medicare PFS conversion factors: $33.1693 for QPs and $32.8409 for non-QPs (-1.19% for QPs and -1.68% for non-QPs over final 2026 rates). This reflects +0.75% for QPs and +0.25% for non-QPs, a statutory budget neutrality adjustment of 0.53%, and the expiration of a temporary 2.5% increase to 2026 Medicare payment passed by Congress as part of the *One Big Beautiful Bill Act*.

MGMA comment: MGMA recognizes that CMS is constrained by statutory budget neutrality requirements, however, we remain deeply concerned about the impact of the estimated reductions to the conversion factors in CY 2027. The downward trajectory of Medicare reimbursement over the past decades is a destabilizing force on this nation's healthcare system. These proposed cuts for 2027, coupled with the current inflationary environment and other ongoing financial pressures — staffing shortages, increased administrative burden, and more — are 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 percent of medical groups report increased operating costs.[1] Practices 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.

The 2026 Medicare Board of Trustees' annual report maintained its language from previous years detailing the inadequacy of Medicare payment and its potential impact on

[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.

Medicare participation: "While the physician payment system put in place by MACRA avoided the significant short-range physician payment issues resulting from the SGR system approach, it nevertheless raises important long-range concerns that will almost certainly need to be addressed by future legislation … Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term."[2] Moreover, the Medicare Payment Advisory Commission (MedPAC) recommended that Congress implement a permanent positive update to the PFS.[3] With the Medicare Economic Index (MEI) predicted to be 2.5% for 2027, these cuts — coupled with the lack of an inflationary update — push Medicare reimbursement further away from adequately covering the cost of care, again undermining practices' 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 strongly urge CMS to work with Congress to pass this vital legislation and make long-overdue stabilizing changes to Medicare payment.

Practice Expense (PE) RVU Methodology

CMS proposal: CMS proposes making significant updates to its PE RVU methodology due to concerns about relying on outdated survey data that is not reflective of current practice. CMS intends to eliminate the Indirect Practice Cost Index (IPCI) from its PE calculations, which would eliminate steps 12 through 17 of its 18-step process for determining PE. CMS would phase in this change with half of the IPCI being removed in year one and the rest being removed in year two. CMS also proposes changes to the allocation of indirect PE by creating a new indirect PE allocator formula to align with work and clinical labor RVUs. Further, the agency would create a new PE stabilization adjustment to limit annual increases or decreases in PE RVUs to +/- 5% for most services.

MGMA comment: Given the complexity of PE RVU calculations and its multi-step process, the ultimate impact on medical groups due to these proposed changes is difficult to discern. Amplifying this opacity is the lack of specialty-level analysis from CMS detailing each change. This is a break with historical precedent as CMS typically includes specialty-level analysis for significant PE RVU changes.

These proposals will have a disproportionate impact on certain specialties, but again CMS' discussion of their impact overlaps with other proposed changes in the PFS, making it difficult to understand each change and their lasting impact. We urge CMS not to move

[2]Medicare Board of Trustees, 2026 Annual Report, June 9, 2026, https://www.cms.gov/oact/tr/2026.
[3] MedPAC, March 2026 Report to Congress: Medicare Payment Policy, https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_MedPAC_Report_To_Congress_v2_SEC.pdf.

forward with these PE changes and to provide the appropriate analyses needed for medical groups and the public to understand each proposed change and have an opportunity to comment. Making sweeping, highly technical changes that have a lasting impact with little discussion of their effects does not foster confidence in their long-term viability and could lead to numerous unintended consequences to medical group operations.

Site of Service Payment Differential

CMS proposal: CMS finalized a policy in the 2026 PFS to allocate half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting compared to those allocated to services furnished in the non-facility setting. CMS proposes to make changes specific to nursing facilities related to this policy, while soliciting comment more broadly about data and ways to update the valuation and payment methodologies to better reflect the relative resources involved in furnishing services.

MGMA comment: MGMA continues to believe that this change to indirect practice expense does not accurately reflect the cost of providing services in a facility setting and is working to undermine private practices providing services in facility-based settings. We support many of CMS' goals of bolstering private practice and accurately reflecting the current landscape, but the agency should examine alternative policies to facilitate accurate payment rates.

The reduction to the indirect practice expense for facility settings decreases reimbursement for private practices that offer services in the facility setting as their administrative costs are paid through the professional claim. Cutting this reimbursement while shifting it to the facility fee would fail to account for these real costs and leave them uncompensated, weakening their financial viability. MGMA has heard from members highlighting the real-world negative impact this policy is having on their practices. While there has been increased consolidation over the past years, there are still many practices who offer these services in facilities while maintaining a private practice. CMS' policy has unintended consequences for many services such as cutting surgical global codes with bundled postoperative office visits. This policy is potentially increasing consolidation by failing to account for real costs.

CMS should withdraw its 2026 indirect PE RVU policy and work with the healthcare community to address site of service issues to avoid duplicative payments in a more tailored manner. The 2024 AMA Physician Practice Information (PPI) Survey was designed to reflect the relatively higher indirect practice expense costs for non-facility-based specialties compared to indirect expenses for specialties that are largely facility-based. The survey allocates more of the total practice expense to the office-based setting to account for the costs of operating a private practice, yet CMS chose not to incorporate it. The agency should reexamine this decision and further collaborate with stakeholders to fill gaps in data for certain specialties.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

CMS proposal: Starting in 2027, CMS proposes to reduce payment when a separately identifiable E/M visit (billed with a -25 modifier) is furnished by the same physician, or a physician in the same practice, on the same day as a 0-, 10-, or 90-day global procedure. The most expensive service, whether surgical or E/M visit, would be paid at 100% and all other surgical procedures or E/M visits furnished on the same day would be paid at 50%. CMS had proposed a similar policy in the 2019 PFS but did not finalize it at that time.

MGMA comment: MGMA strongly opposes CMS' proposal to cut same-day services by 50% as this unwarranted reduction is not supported by evidence and will debilitate many physician practices' ability to offer same-day care. CMS proposed a similar policy in 2019 but did not finalize it following extensive feedback from the public. The proposed rule does not cite new evidence as a reason for reviving this policy, yet the impact is still the same – the cumulative effect to a broad range of specialties would be detrimental and undermine patient access to care.

Modifier -25 is used to distinguish significant, separately identifiable work that goes beyond what is part of a 0-, 10-, or 90-day global procedure. CMS points to Multiple Procedure Payment Reduction (MPPR) policies as a reason for this proposed cut, while ignoring that those policies are meant to address efficiencies for multiple services of the same or similar type. Further, 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 50% cross-the-board reduction is not reflective of the current landscape and would actively undermine medical group operations.

The range of clinical scenarios where distinct and separately identifiable E/M services are performed on the same day as a procedure are myriad: dermatology, otolaryngology, family medicine, podiatry, rheumatology, ophthalmology, orthopedic surgery, and many more specialties appropriately utilize modifier -25 to provide valuable same-day care. This reach of this cut is vast and does not reflect the current realities of clinical care. It would also have knock-on effects with commercial insurers moving to adopt this reduction, further destabilizing medical groups.

The financial impact on practices of all sizes would be significant. 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 E/M service would require medical groups to carefully evaluate the long-term viability of continuing to offer certain services. Numerous MGMA members, from mid-size rheumatology to OB/GYN practices, have illuminated to us potential financial losses of hundreds of thousands of dollars just from this cut alone.

Practices in rural communities, where beneficiaries have long commutes, have detailed the negative consequences this would have on their ability to offer certain services. “Do we provide care or make payroll,” is how one rural practice described the tradeoff of this proposal. This proposal would potentially limit beneficiary access to same-day services by perversely incentivizing practices to offer procedures on a separate day due to an arbitrary cut. Even though CMS states that it will monitor utilization rates, this potential result should prevent the agency from moving forward.

Choosing to finalize this change would undermine independent practices' financial viability and contribute to them either closing their doors or selling to larger entities, in contravention of the agency’s stated intentions. CMS should not move forward with this proposal and instead take a targeted approach to address any overlap in services using already available tools rather than an arbitrary 50% across-the-board reduction.

Remote Patient Monitoring

CMS proposal: CMS previously established payment for two code families for certain remote monitoring services – remote physiologic monitoring (RPM) and remote therapy monitoring (RTM). In response to Office of Inspector General (OIG) reports on fraud, waste, and abuse related to these services, CMS proposes substantial changes. Starting in 2027, CMS would require RTM services be furnished only to established patients, a policy that has been in place for RPM services since the end of COVID-19 public health emergency (PHE). Further, CMS proposes that practitioners reporting RPM or RTM services must furnish a separately reportable face-to-face (telehealth or in-person) initiating visit in association with the onset of RPM or RTM services. This is meant to align with current requirements for chronic care management services and is intended to ensure the practitioner assesses the clinical appropriateness of remote monitoring and obtain beneficiary consent.

CMS proposes to allow payment for RPM or RTM services only when performed by clinical staff employed by the practice and not when those services are delivered by contractors. Clinical staff providing RPM or RTM services can be counted if that time is spent under the general supervision of the billing practitioner and “incident to” requirements are met. This policy change is in response to OIG findings that outsourcing to third parties may have limited association with the billing practitioner.

The agency also proposes to revalue numerous RPM and RTM codes that would result in a reduction in their reimbursement rates due to concerns about reliable pricing data and overvaluation. Further, CMS is seeking comment on bundling the RPM and RTM CPT codes and creating four new HCPCS G-Codes to describe remote monitoring services.

MGMA comment: MGMA strongly urges CMS to withdraw its extensive proposed changes to remote monitoring services to avoid unnecessarily disrupting Medicare beneficiaries’

access to these vital services. CMS should work with stakeholders to evaluate a more targeted approach to address the concerns highlighted in the OIG reports without impacting beneficiary access to care.

CMS is proposing to require a separately identifiable initiating visit for RPM and RTM services, which would introduce unnecessary complexity. It's unclear if the definition of separately identifiable would require a totally separate visit to discuss RPM/RTM services, or if that visit would be included in, for example, a discharge visit from the hospital. CMS should not introduce additional administrative hurdles to patients receiving these services.

Further, CMS should not move forward with reimbursement cuts to RPM and RTM codes due to the belief it lacks data on devices used for these services. Instead, the agency should work with the RUC and stakeholders to obtain more information related to these RVU changes to capture the actual work involved with billing these codes instead of instituting an arbitrary cut. Given that CMS only started paying for RPM codes in 2019, with additional coding changes made thereafter, reversing course and devaluing these services without working to ascertain more information would be shortsighted.

Due to the significant costs associated with remote monitoring services, such establishing the infrastructure needed to monitor patients and training clinical staff, many medical groups partner with third-party vendors who are able to provide these services through economies of scale. Requiring direct staff of the medical group to deliver RPM or RTM services would prohibit many clinical arrangements across health systems and practices of all sizes.

MGMA has heard from numerous practices about how this policy would make it impossible for them to continue offering RPM and RTM services and would ultimately limit patients' access to care. Cardiology practices have expressed concerns about being able to utilize remote monitoring devices that track a patient's cardiac rhythms and require 24-hour monitoring. Certain practices would not be able to bring these services in-house due to their already stretched thin clinical and administrative staff on top of the costs of establishing their own remote monitoring workflows.

Intensifying these concerns is the quick implementation of this change starting in 2027, only two months following the publication of the final rule, expected in November 2026. This will require physician practices to make swift decisions to attempt to bring these services in-house or discontinue offering them. Ultimately, it is the beneficiary who will be impacted the most by these changes — disrupting vital remote monitoring services will undermine the ability of practices to address chronic conditions and would increase the likelihood of complications and hospitalizations that would have otherwise been prevented. The Trump Administration has focused on improving preventive care, these policies serve to undermine this goal.

The OIG recommended that CMS monitor companies that bill for remote patient monitoring, not outright ban all of them. Instead of prohibiting remote monitoring services offered by third-party vendors, CMS has numerous levers it can pull to address concerns outlined by the OIG. There are targeted enforcement options, or the agency can establish a special registration process for vendors similar to other federal programs, to address these issues.

We urge CMS to withdraw these proposed changes and work with stakeholders to balance program integrity concerns with maintaining access to necessary services for Medicare beneficiaries.

Evaluation & Management (E/M) Services

HCPCS Complexity Add-on Code G2211

CMS proposal: For 2027, CMS proposes to transition HCPCS complexity add-on code G2211 to a modifier that can be appended to the associated E/M base code. This modifier, MOD1, would increase payment of the associated E/M code by 16%. This policy change is meant to address CMS' belief that the current code boosts lower-intensity visits relative to higher-intensity ones.

CMS also proposes a second modifier (MOD2) for E/M visits for practitioners in the Medicare Shared Savings Program (MSSP) or participating providers in ACO LEAD. The modifier could increase payment of the associated E/M visit by 32%. This is meant to reflect the additional costs of providing longitudinal care in ACOs. The use of MOD2 in the MSSP would be voluntary and available to be billed to all beneficiaries (not just MSSP-assigned beneficiaries). MOD2 would also be voluntary for the ACO LEAD model and could be billed for all beneficiaries (not just LEAD-assigned beneficiaries). Claims submitted with this modifier would be included in beneficiary assignment calculations, historical benchmark expenditures, and performance year expenditures for the MSSP.

MGMA comment: MGMA has historically agreed with CMS that reimbursement for E/M visits may not always adequately reflect the resources associated with primary care and certain types of specialty visits. Since finalizing G2211 in 2024, the agency has made numerous changes to billing requirements (expanding its ability to be billed with annual wellness visits and preventative services) while releasing guidance to help educate the provider community. While we appreciate much of CMS' discussion examining how to better capture visit complexity in E/M visits, given the newness of the code, we caution CMS from transitioning away from an add-on code to modifiers given the generally low utilization of G2211 compared to CMS estimates.

Medical groups have spent years working with physicians on G2211 educational efforts; replacing the code with two modifiers would require additional training and force practices to revise billing workflows, creating new administrative burdens that would necessitate updated CMS guidance. Because benchmarks are only beginning to reflect G2211 reporting, converting the code to a modifier would make those benchmarks less useful for another year or two.

Transitioning G2211 to two modifiers would also remove the work RVU value associated with the add-on code. This would impact RVU-based productivity models and physician contracts by creating distortions between the actual work performed without the corresponding work RVU credit. The same work would be performed, but clinicians would not receive the credit. This adds complexity to medical groups' productivity models as they would have to account for this shift.

CMS intends for the increase reimbursement rate for MOD2 compared to MOD1 to reflect "the cognitive work of providing longitudinal care, follow-up discussions through an assigned care coordinator with the beneficiary or other providers, and expanded access to educational resources, care options, and provider communication methods." While we support medical group ability to succeed in ACOs, the work related to managing a patient's longitudinal needs does not diminish for practices not participating in an ACO. Smaller physician practices and those not in position to join an ACO would be disproportionately impacted by this discrepancy even when providing important care. We urge CMS to explain its rationale for this differential, and to provide insight into its methodology and utilization of these modifiers so the public can better understand this proposal.

Ultimately, CMS should not move forward with these changes as written and provide additional guidance and education to allow medical groups to better understand G2211 as there remains uncertainty around the utilization of this add-on code.

Telehealth

Telehealth Flexibilities and Modifiers

CMS proposal: CMS recounts that Congress most recently extended telehealth flexibilities involving removal of geographic and site of service originating site restrictions as well as the types of practitioners furnishing telehealth services via the *Consolidated Appropriations Act, 2026* (CAA, 2026), through December 31, 2027. This Act further delayed the in-person visit requirements for mental health services furnished through telehealth and extended audio-only flexibilities until January 1, 2028. It also required CMS to establish modifiers for telehealth services in certain instances effective January 1, 2027. CMS proposes new modifiers involving virtual telehealth platforms and services furnished

incident to a physician's or practitioner's professional service (BB and BC) to distinguish certain Medicare telehealth services beginning January 1, 2027, as required by statute.

MGMA comment: MGMA appreciates that Congress extended central telehealth flexibilities through the end of CY 2027. We support these extensions and urge CMS to work with Congress to permanently institute these policies into statute to foster stability and ensure Medicare beneficiaries continue to receive important telehealth services.

CMS' proposal to establish modifiers for certain telehealth services is ambiguous as their rationale for utilizing them is unclear. These modifiers would introduce confusion for medical groups as BB and BC are only for reporting and not used for payment. The CAA, 2026, required the use of modifiers for situations where a clinician uses a telehealth platform it has a payment or contract arrangement with. CMS discusses issuing sub-regulatory guidance in the proposal; due to the breadth of different contractual arrangements that exist, we recommend the agency release this guidance with an opportunity for public comment so medical groups can understand and provide input on when these modifiers are required.

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with a Virtual Presence

CMS proposal: CMS proposes changes to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary.

MGMA comment: MGMA supports this proposal from CMS and urges the agency to extend this policy to other similar scenarios, such as when the resident and teaching physician are in the same location while the beneficiary is receiving telehealth services in a separate location.

Maternal Health

CMS proposal: CMS is adopting the American Medical Association (AMA)/Specialty Society Relative Value Scale (RVS) Update Committee's (RUC) recommendations to update the Maternity Care Services code set. Starting in 2027, the CPT code set will be updated in an effort to reflect current obstetric practice. CMS asks for comments on establishing 15 G-codes to maintain the current coding structure due to concerns about disruption.

MGMA comment: The creation of 15 G-codes in addition to adopting the new CPT code set would create substantial administrative burden in addition to creating confusion for

physician practices offering maternal health services. MGMA members have expressed significant concerns about CMS establishing two disparate coding structures, with some payers following the updated Maternity Care Series code set and others potentially utilizing the G-code structure. Managing different billing methodologies requires additional auditing, creates eligibility and claims adjudication challenges, and can increase the rate of denied claims. CMS should not establish a G-code system as it is essential to reduce administrative complexity and ensure consistency in this space.

Clinical Laboratory Fee Schedule

CMS proposal: CMS proposes conforming regulations to apply a Medicare Clinical Laboratory Fee Schedule payment reduction of up to 15% per year through CY 2029 based on private payer rate data; this reflects the *Continuing Appropriations Act of 2026* that changed the data reporting and payment requirements for clinical diagnostic laboratory tests (CDLTs).

MGMA comment: We believe the potential reductions delineate why congressional reform to the underlying PAMA methodology is still critical to address structural issues. We will continue to urge Congress to enact permanent PAMA reform for a representative picture of the laboratory market that adequately represents physician practice laboratories.

Medicare Shared Savings Program (MSSP)

Increase in BASIC Track Level E Shared Savings Rate

CMS proposal: CMS proposes increasing the maximum shared savings rate for BASIC Track Level E ACOs from 50% to 60%.

MGMA comment: MGMA supports increasing the shared savings rate for BASIC Track Level E participants. This proposal would incentivize MSSP participation for physician-led, low-revenue, and rural ACOs that may not be prepared to enter the ENHANCED track but are willing to accept two-sided risk.

Medical groups have consistently emphasized the importance of creating gradual and sustainable pathways into risk-bearing arrangements. Increasing the shared savings rate in Level E appropriately rewards organizations that have made substantial investments in care coordination, population health infrastructure, and data analytics while remaining in a lower-risk participation option than the ENHANCED track.

We agree with CMS that strengthening incentives within Level E could encourage greater participation among physician-led ACOs and improve long-term program sustainability. We urge CMS to finalize this proposal.

Reduction in Positive Regional Adjustment Weight for ENHANCED Track ACOs

CMS proposal: CMS proposes reducing the maximum weight used in calculating the positive regional adjustment for ENHANCED track ACOs from 50% to 35%.

MGMA comment: MGMA appreciates CMS' efforts to address concerns regarding benchmark advantages that may influence track selection independent of an ACO's actual ability to generate savings. However, we disagree with removing financial incentives that help ACOs succeed in the ENHANCED track.

We urge CMS to closely evaluate the impact this proposal may have on experienced, high-performing ACOs that have demonstrated sustained success in the ENHANCED track. Highly efficient ACOs rely on the regional adjustment to ensure they aren't competing against themselves. Reducing the weight of the positive regional adjustment could disincentivize mature and efficient ACOs from participating in the ENHANCED track.

If finalized, CMS should closely monitor participation trends and provide transparent analysis regarding the proposal's impact on benchmark accuracy, participation decisions, and overall Medicare savings.

Prior Savings Adjustment

CMS proposal: CMS proposes increasing the prior savings adjustment scaling factor from 50% to 75%.

MGMA comment: MGMA strongly supports this proposal as a meaningful step toward addressing the benchmark "ratchet effect" that has long been a concern among MSSP participants. Medical groups have consistently expressed concerns that successful efforts to reduce spending can lower future benchmarks, making it increasingly difficult to generate shared savings over time. This dynamic can undermine incentives for long-term participation and discourage organizations from making sustained investments in value-based care infrastructure.

Increasing the prior savings adjustment would better recognize prior performance, help preserve incentives for continued participation, and improve benchmark stability. We urge CMS to finalize this proposal.

Beneficiary Assignment Changes

CMS proposal: CMS proposes several modifications to beneficiary assignment, including excluding certain non-ACO TIN billing patterns from assignment calculations and updating Medicare enrollment criteria. CMS also proposes adding several additional services,

including advance care planning and certain preventive interventions, to the primary care services used for assignment.

MGMA comment: MGMA supports efforts to simplify and improve beneficiary assignment methodologies and understands CMS' desire to include more Medicare beneficiaries in MSSP ACOs. However, we are concerned about the specific impact these changes will have on ACOs in certain geographic regions. CMS predicts the newly assignable beneficiaries will be more medically complex and therefore have higher costs. These proposals would increase the beneficiaries assigned to most ACOs across the country but could have a particularly large impact on specific ACOs depending on their region and the makeup of the new beneficiaries. Given the compounding financial challenges ACOs face, we urge CMS to delay this policy until specific details on the impact across ACOs, geographic regions, and patient populations are identified and shared with stakeholders.

Beneficiary Notification Requirements

CMS proposal: CMS proposes simplifying beneficiary notification requirements by requiring notice once during an agreement period rather than tying notification to a beneficiary's first primary care visit. CMS also proposes eliminating the beneficiary follow-up communication requirement.

MGMA comment: MGMA supports this proposal to streamline and simplify beneficiary notifications. The current requirements can be administratively burdensome and may create confusion for beneficiaries. Simplifying notification requirements would reduce operational burden while preserving transparency regarding beneficiary participation in accountable care arrangements. MGMA appreciates the proposed increased flexibility around follow-up communication requirements and urges the agency to continue sharing best practices around beneficiary engagement. CMS should finalize this proposal.

Beneficiary Cost-Sharing Support

CMS proposal: CMS proposes allowing approved ACOs to reduce or eliminate beneficiary Part B cost sharing beginning in 2027.

MGMA comment: MGMA supports providing ACOs with greater flexibility to address financial barriers to care. Cost sharing can discourage beneficiaries from seeking preventive services and managing chronic conditions. Medical groups often discuss how patients want to participate in certain preventive care management but are confused when they receive copays for services where they didn't see a provider. Allowing participating ACOs to develop targeted cost-sharing support programs could improve patient engagement and better facilitate health outcomes. CMS should ensure implementation

requirements remain streamlined and provide clear guidance to participating organizations.

Risk Adjustment of the 5% Benchmark Cap

CMS proposal: CMS proposes risk-adjusting the current 5% cap on upward benchmark adjustments.

MGMA comment: MGMA supports this proposal and appreciates CMS' recognition that organizations caring for medically complex populations often face unique challenges under current benchmarking methodologies. Current benchmark policies do not always adequately account for patient severity and associated costs, especially for practices serving high-risk and underserved populations. Allowing benchmark adjustments to better reflect population risk could encourage greater participation among organizations serving vulnerable populations. While we support finalizing this proposal to risk-adjust the benchmark cap, we also encourage CMS to increase all benchmark adjustment caps to allow ACOs to benefit from other financial policy changes, such as the new growth adjustment factor. CMS should finalize this proposal and build on it by raising the benchmark cap for all ACOs.

Growth Adjustment to Historical Benchmarks

CMS proposal: CMS proposes establishing a growth adjustment to the historical benchmark to reward ACOs for recruiting providers inexperienced with value-based care and serving beneficiaries new to accountable care relationships.

MGMA comment: MGMA supports the creation of a growth adjustment that recognizes organizations expanding access to accountable care. Recruiting new physicians, integrating practices, and expanding accountable care relationships requires substantial operational and financial investments. This proposal would acknowledge those efforts while encouraging broader participation in value-based care arrangements. In addition to finalizing this proposal, CMS should continue to build out financial support and operational resources to ensure practices engaging in value-based care for the first time are set up for success.

Accountable Care Prospective Trend (ACPT) Reforms

CMS proposal: CMS proposes implementing guardrails that limit the degree to which ACPT projections can diverge from actual national expenditure growth.

MGMA comment: MGMA appreciates CMS' efforts to improve benchmark predictability and reduce the impact of forecasting inaccuracies. Medical groups rely on benchmark

projections when making investments in care management and population health programs. Medical groups participating in ACOs have been continuously impacted by ratcheting, and significant variation between projected and actual expenditure growth can create uncertainty regarding financial performance and shared savings opportunities. However, without details on whether the ACPT adjustment will be made to all ACOs at once or just as ACOs renew their benchmarks, it is difficult to understand the actual financial impact of the proposal. We urge CMS to delay implementation until more analysis on the financial impact of ACOs across geographic regions can be provided for stakeholder review and engagement.

Extension of MIPS CQM Reporting

CMS proposal: CMS proposes extending the availability of MIPS CQMs and associated incentives beyond 2026.

MGMA comment: MGMA strongly supports this proposal. Medical groups continue to face significant operational challenges associated with digital quality reporting. Extending existing reporting pathways while organizations prepare for future digital quality measurement initiatives will reduce disruption and administrative burden. CMS should continue maintaining flexible reporting options until digital quality reporting infrastructures and EHR capabilities are sufficiently mature and broadly accepted across medical groups of all sizes.

Medicare eCQMs

CMS proposal: CMS proposes establishing Medicare eCQMs as a new MSSP reporting option.

MGMA comment: MGMA supports creating additional reporting flexibility through Medicare eCQMs. Many medical groups have expressed concerns regarding the difficulty of collecting all-payer quality data. The proposed Medicare eCQM option focuses on assigned beneficiaries and may reduce reporting challenges while supporting the transition toward digital quality measurement. Increasing reporting options helps to ensure medical groups can decide which options work best for their practice and reduce strain on already limited technical support resources within the practice.

MSSP and CEHRT

CMS proposal: CMS proposes to simplify MSSP Certified Electronic Health Record Technology (CEHRT) requirements allowing ACOs to demonstrate CEHRT use through several alternative pathways and reducing reporting burden through exclusions and other relevant provisions.

MGMA comment: MGMA supports CMS' proposal to simplify the Shared Savings Program CEHRT-use requirements beginning in performance year (PY) 2027. In particular, MGMA supports sunsetting the requirement that ACOs report all applicable MIPS Promoting Interoperability measures and activities, which has created unnecessary complexity for ACOs that include practices with differing health IT systems and capabilities.

MGMA also supports CMS' proposal to allow ACOs to demonstrate CEHRT use through three alternative pathways: reporting at least one applicable APP Plus measure using the eCQM or Medicare eCQM collection type; using CEHRT and a FHIR-based API to support quality reporting; or attesting to one of the proposed ACO-specific CEHRT-use metrics for electronic prescribing, health information exchange, or provider-to-patient exchange. CMS should finalize all three options and preserve flexibility among them in future years.

MGMA appreciates CMS' recognition of eCQM and Medicare eCQM reporting as sufficient evidence of CEHRT use without requiring duplicative Promoting Interoperability reporting. CMS' related proposals to retain MIPS CQMs and establish Medicare eCQMs also appropriately recognize ongoing data aggregation challenges and varying levels of digital quality measurement readiness.

MGMA supports the proposed FHIR-based pathway as an important step toward more interoperable quality reporting. However, certified FHIR functionality does not necessarily mean ACOs can reliably obtain complete, standardized, usable data across multiple EHR vendors and practice environments. Any future expansion of FHIR-based requirements should therefore depend on demonstrated real-world readiness and reasonable implementation costs.

MGMA further supports reasonable exclusions for ACOs that cannot meet particular CEHRT or quality-reporting requirements because of circumstances such as technology limitations, specialty-specific systems, or other factors outside their control. Exclusion processes should be clear, objective, and administratively simple.

Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)

Sunsetting MIPS following the 2028 Performance Year and Transitioning to MIPS Value Pathways (MVPs)

CMS proposal: CMS proposes to sunset the traditional MIPS reporting option after the CY 2028 performance period; MVPs would be the only MIPS reporting option for MIPS eligible clinicians that don't participate in a MIPS APM beginning in the CY 2029 performance

period. Clinicians in a MIPS APM would continue to be able to report the APM Performance Pathway (APP).

MGMA comment: MGMA urges CMS to withdraw its proposal to sunset MIPS following the 2028 performance period and calls on CMS to maintain MIPS as a reporting option alongside a voluntary MVP reporting program. We oppose making MVP participation mandatory as we continue to hold significant reservations about MVPs amplifying the problems in MIPS as currently designed.

MIPS reporting requirements remain one of the most significant regulatory burdens faced by medical groups — 86% of MGMA members cited MIPS quality reporting as greatly impacting physician administrative burden in our 2026 Annual Regulatory Burden Report.[4] As one MGMA put it, "MIPS has created an environment of fear and excess workflows that add little to no value for staff and patients. Licensed providers are under the foot of regulatory burden, preventing patients from accessing appropriate treatments in a timely fashion." Failing to address structural issues in MIPS while amplifying them by requiring MVP participation would undermine physician practices' ability to succeed in the QPP.

While CMS believes that 98% of specialties will be covered by an MVP, this is likely an overestimate as numerous specialties, such as allergists, do not currently have an MVP applicable to them. Further, subspecialities that would be required to report in certain MVPs do not have adequate selection of measures. Underlining these concerns is the fact that current MVP participation is minimal given the program has only been in operation for a few years. CMS should continue to analyze MVPs, collect data on the program, and make updates to reduce reporting burden and avoid mandating a flawed program.

In order to improve the program, CMS should work closely with medical groups and physician specialties to make sure the design of each MVP accurately reflects the reality of clinical care and is not forcing physician practices to report measures that are not clinically relevant. There are numerous recommendations on MVPs that have been raised to CMS which, if implemented, would help to bolster the program: align cost and quality measures, develop MVPs for particular episodes of care/procedures that promote care coordination, address problems with cost measures, and more. We urge CMS to maintain MIPS, keep MVPs voluntary, and work in collaboration with healthcare stakeholders on improvements that best allow medical groups to focus on high-quality patient care.

Reweighting

CMS proposal: For automatic extreme and uncontrollable circumstances reweighting, CMS proposes that starting in the 2027 performance year, they will remove the

[4] MGMA, 2026 Annual Regulatory Burden Report, April 2026, https://www.mgma.com/getkaiasset/8c7263b8-882d-4f6a-8d6c-48180fba72c9/MGMA%202026%20Reg%20Burden%20Report%20.pdf.

specification of a data source (PECOS) to have more flexibility to use the most up-to-date data source available to determine eligibility. Beginning with the 2025 performance year, the agency also proposes to extend the deadline for clinicians to notify CMS if their data wasn't submitted by their third-party intermediary due to circumstances outside their control from November 1 to December 31 of the data submission year.

MGMA comment: MGMA supports these proposals and thanks CMS for proposing to extend the deadline for clinicians to notify CMS if their data wasn't submitted by their third-party intermediary. We appreciate CMS recognizing the scenarios where MIPS eligible clinicians may be unable to submit data outside of their control. The agency should continue to develop policies that avoid penalizing medical groups for outside factors and ensure that technical problems with entering performance data do not penalize practices.

MIPS Quality Category

MIPS Core Measures

CMS proposal: CMS intends to establish a MIPS core measure designation for traditional MIPS and MVPs; this designation would apply to 78 measures in the MIPS inventory. In conjunction with establishing a MIPS core measure set, CMS plans to remove the high-priority designation for quality measures and would no longer include the use of this designation as one of the considerations for retaining a quality measure. Further, CMS proposes to remove the requirement that MIPS eligible clinicians report at least one outcome measure or high-priority measure if an applicable outcome measure isn't available. Instead of reporting an outcome measure, or high-priority measure if an outcome measure isn't available, MIPS participants would report a MIPS core measure, with small practices exempt from this requirement. One of the six quality measures must be a MIPS core measure in traditional MIPS, while in MVPs clinicians would be required to report a MIPS core measure as one of their four quality measures.

If there is no applicable MIPS core measure available to report, CMS would require clinicians to attest that there was no applicable MIPS core measure, and the clinician would then choose another measure in its place. Small practices would be exempt from both the MIPS core measure requirement and the self-attestation process. Clinicians would receive 0 out of 10 points for one of their required measures if they do not report a MIPS core measure and are not a small practice, unless they submit an attestation and submit another measure in its place.

MGMA comment: CMS should not move forward with implementing its MIPS Core Measure proposal and instead work with stakeholders to test this approach to accurately understand its effect on medical groups. It is imperative that the set of core measures are reflective of each specialty or medical condition; the agency should work with specialty

societies and stakeholders to ensure that all relevant measures would be considered as core measures. CMS needs to allow for meaningful measure choice and avoid forcing practices to report measures that are not clinically relevant to their practice.

Additionally, CMS should ensure that each required core measure relies as much as possible on standardized, United States Core Data Set for Interoperability (USCDI) and USCDI+ data elements and avoids requiring practices to manually abstract or create data just for reporting. This is important for implementation, especially as CMS separately seeks comment on the transition to DQM FHIR.

MGMA supports CMS' proposed attestation process for small groups and clinicians without a relevant core measure. These commonsense exceptions are needed to ensure that medical groups are not required to report measures that are not relevant to their practice, thereby opening them up to potential penalties and undue reporting expenses.

Due to vendor readiness concerns and the quick turnaround from the final rule to implementation, we reiterate that CMS should work with stakeholders to refine and test this approach. This would give vendors a runway to ensure their systems support medical groups' ability to report these measures and allow for CMS to include the full breadth of measures through consultation with stakeholders should it move forward in the future.

Quality Measure Inventory

CMS proposal: CMS proposes to add 2 quality measures focused on prevention and chronic disease management, remove 20 measures, replacing 7 functional improvement MIPS measures with 5 functional outcome measures for orthopedic patients, adopt 4 Qualified Clinical Data Registry (QCDR) measures as MIPS CQMs, and make substantive changes to 43 existing measures.

MGMA comment: MGMA continues to believe that stability is critical in the quality performance category as it allows MIPS participants to report measures that are meaningful to their practices. The agency should work with specialty associations and the healthcare community to ensure it is not removing/changing important quality measures that undermine their ability to successfully participate in MIPS.

The agency needs to ensure that there are sufficient measures and reporting options available to practices to address long-standing concerns with the design of the program and avoid forcing medical groups to report quality measures that are not applicable to their practice. A smaller number of measures does not lessen the complications of reporting under the QPP, but rather exacerbates it given the significant administrative resources devoted to reporting requirements. CMS should work to tackle the administrative burden

permeating the program by incorporating our MIPS reform recommendations above without stifling medical groups' ability to report quality measures that are meaningful to them.

Topped Out Measures

CMS proposal: Starting in the CY 2027 performance period, topped out MIPS core measures subject to the 7-point scoring cap (i.e., are topped out for 2 or more consecutive performance periods) would no longer be subject to that cap and would instead be scored according to the defined topped out measure benchmark (with a 10-point maximum).

MGMA comment: CMS' topped out measure policies have historically had a disproportionate negative impact on certain specialties more than others and led to reduced MIPS scores all the while these medical groups are providing high-quality care. We support this proposed policy but ask that CMS apply it more broadly to additional topped out measures under MIPS.

MIPS Cost Category

CMS proposal: CMS is not proposing any cost measure inventory updates for 2027. CMS proposes to update its operational list of care episode and patient condition groups and codes to reflect non-substantive measure maintenance updates.

MGMA comment: MGMA reiterates our longstanding concerns related to the cost category and the need for reform. We continue to see issues given the various benchmarking, reliability, and technical problems. CMS does not provide timely actionable feedback to clinicians on this performance category, and it can have an outsized negative impact on practices. There needs to be improved transparency throughout the pre-rulemaking cost measure development. We urge CMS to continue revising flawed attribution and insufficient risk-adjustment methodologies for many measures as we remain concerned with penalizing providers by holding them accountable for costs outside their practices.

As raised in previous comments, MGMA generally supports the transition to episode-based measures and believes that cost measures should be centered around specific conditions or periods of care. These cost measures should reflect the group practice model of care where multiple practitioners utilize a team-based approach to treating patients. We urge the agency to ensure that episode-based cost measures are sufficiently reliable and do not double count costs when physicians report the Total Per Capita Cost (TPCC) or Medicare Spending Per Beneficiary measures. We recommend the agency incorporate feedback from physician specialty societies for specific episodes proposed here to prevent the establishment of impractical episode-based measures.

MIPS Improvement Activities Category

CMS proposal: The agency intends to add 6 new improvement activities including leveraging technology to improve coordinated, person -centered care for "clinician use of AI to improve patient care" and "use of data to improve practice workflows". The agency is also proposing to modify 5 existing activities and remove 11 activities.

MGMA comment: MGMA generally supports policies to maintain stable and consistent policies for the improvement activities category. CMS should not remove improvement activities that are applicable to medical group practices reporting under MIPS and ensure changes to improvement activities reflect the real-world practice environment while avoiding adding hurdles to reporting.

MGMA agrees with CMS that ongoing physician involvement in broader efforts to develop and refine AI-technologies is essential and supports the proposed AI improvement measure where clinicians would establish policies for evaluating and monitoring AI tools or participate in developing and refining AI enabled tools. As we've stated earlier, we agree with an outcomes-first approach to integrating AI to modernize care delivery and are committed to ensuring medical groups are empowered and enabled through clear and proportionate guardrails, sustainable reimbursement pathways, and standards that support responsible AI adoption.[5]

The use of data to improve practice workflows supports the integration of evidence-based guidelines into care and is important for real time, effective care delivery and usability. As with all new improvement activities, we believe the activity should not create any unintentional, new documentation burden and should remain flexible without necessitating new reporting infrastructure while recognizing the varying resources and levels of technological maturity across medical groups.

MIPS Promoting Interoperability Category

ONC Direct Review Attestation

CMS proposal: CMS proposes to remove the required ONC Direct Review attestation and the optional ONC ACB Surveillance attestation for 2026.

MGMA comment: MGMA supports the removal of these attestations to reduce unnecessary administrative work and avoid penalizing medical groups who may have inadvertently missed the ONC Direct Review attestation.

Removal of Automated Numerator Recording and Automated Measure Calculation Certification Criteria

[5] MGMA Response to HHS RFI, Accelerating the Adoption and Use of Artificial Intelligence as Part of Clinical Care, Feb. 26, 2026, https://www.mgma.com/getkaiasset/8df30454-ab19-4e03-a5ca-579f59c9eed0/MGMA%20HHS%20AI%20RFI%20Response%20.pdf.

CMS proposal: CMS is proposing removal of automated numerator recording and automated measure calculation certification criteria as currently specified in the CMS Certified Electronic Health Record Technology (CEHRT) definition for the MIPS Promoting Interoperability Performance Category noting that ONC proposed to remove these criteria from the Health IT Certification Program.

MGMA comment: MGMA opposes the removal of the automated numerator recording and automated measure calculation criteria given that CMS continues to require measures that depend on these capabilities and data. We believe CMS should retain the criteria as part of the Promoting Interoperability (PI) program until it has eliminated every measure across its programs that requires numerator and denominator data supported by these capabilities; retaining these capabilities is important for practice and vendor stability. Further, predictability and minimizing potential workflow disruptions remain critical for medical groups, especially for small and independent practices with limited capacity to compensate for gaps in health IT functionality and to reconstruct measure calculations.

As CMS explains, this proposal is related to one part of broader changes in the ONC HTI-5 proposed regulation that would affect ONC health IT certification criteria included in the CMS definition of CEHRT which applies to the MIPS PI performance category in several ways. Several ONC proposals either revise or remove certain ONC Health IT Certification Program certification criteria included within the Base EHR definition, which is incorporated into the CMS definition of CEHRT. Removal of these criteria from the ONC Health IT Certification Program and the Base EHR definition would therefore remove the requirement that a MIPS eligible clinician must use CEHRT that includes health IT certified to the removed criteria. While MGMA supports reducing unnecessary regulatory burden on health IT developers, we believe that in many instances the ONC's proposed removal of certification criteria risks shifting technical, operational, direct and indirect costs, and compliance responsibilities downstream to medical groups. This could lead to increased product variability, especially with new market entrants, and the potential loss of expected "out-of-the-box" functionality such as, in this example, having capabilities in place to calculate measures.[6]

Security Risk Analysis

CMS proposal: CMS proposes removing the Security Risk Analysis measure beginning with the CY 2027 performance period.

[6] *Id.*

MGMA comment: We support the removal of this measure as it is an unnecessary, duplicative attestation burden to practices already focused on HIPAA Security Rule requirements and cybersecurity priorities. As pertains to the security certification requirements currently in the Certification Program, we repeat our earlier input to ONC that these can help medical groups rely on a baseline set of security capabilities that are relevant to, and supportive of, HIPAA Security Rule implementation, without implying or guaranteeing HIPAA compliance. We believe that these certification criteria have played a critical role in enabling medical group practices to rely on consistent, tested technical security functionality within certified health IT, and that eliminating these criteria (as proposed in separate rulemaking) risks shifting additional implementation responsibilities to practices even where underlying legal requirements remain unchanged. These concerns are heightened as future HIPAA Security Rule regulatory actions are currently unclear.

Electronic Prior Authorization

CMS proposal: For the existing MIPS Promoting Interoperability electronic prior authorization measure for medical items and services excluding drugs, CMS is proposing to change it from a required attestation measure to an optional ten-point bonus measure for CY 2027 (a "no" response or not reporting does not impact score) and proposing it as a required but unscored measure beginning with the CY 2028 performance period. CMS is also proposing to require a new ePA attestation measure for prescription drugs under the pharmacy benefit that would require requesting prior authorization for at least one prescription drug electronically using CEHRT required for MIPS PI beginning CY 2028. Failure to attest "yes" or claim an exclusion would result in a zero for the entire MIPS Promoting Interoperability performance category.

MGMA comment: We support CMS' proposal to make ePA for medical items a bonus measure for CY 2027. We oppose the proposal for a mandatory ePA for prescription drugs measure beginning in CY 2028 given insufficient demonstrated readiness across payers, vendors, and medical groups. If CMS does proceed to finalize a mandatory ePA for prescription drugs measure in 2028, then MGMA seeks safeguards that prevent eligible clinicians from receiving a zero Promoting Interoperability (PI) score because of factors outside their control, including payer, vendor, API, interoperability, testing, or workflow integration limitations.

MGMA supports CMS' proposal to convert ePA for medical items measure from a required attestation to a bonus measure for CY 2027. CMS proposes to expand the measure's scope by requiring use of all three Health IT Modules certified under 45 CFR 170.315(g)(31), (32), and (33). Given our understanding of the current state of implementation, we do not believe widespread, integrated use of the Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR), and Prior Authorization Support (PAS)

capabilities will be achievable across medical groups by 2028. Further, we seek transparent, accurate national data on the status of CRD, DTR, and PAS adoption and implementation.

Successful implementation depends on many factors including payer participation, EHR vendor readiness, interoperability, workflow integration, testing, and operational support. Today, implementation efforts are largely concentrated on CRD capabilities. Integrated use of CRD, DTR, and PAS across payers, vendors, and provider workflows remains uncommon. For example, recent industry announcements involving major EHR vendors and health systems have focused on initial CRD implementation rather than full deployment of all three components. As such, we believe CMS should use the CY 2027 transition year to evaluate real-world readiness and make educational resources and technical assistance available to support practice implementation of these standard capabilities. MGMA supports allowing eligible clinicians to satisfy the measure using the combination of certified health IT modules necessary for the ePA workflow, rather than requiring use of all three certified modules. CMS should revise the measure requirement for the ePA for medical items to recognize successful use of CRD when it determines that prior authorization is not required. Under the proposal, a clinician could complete a CRD transaction yet fail the measure because no subsequent DTR or PAS transaction occurs. Clinicians should not be penalized when the electronic process successfully determines that prior authorization is unnecessary. Completion of a CRD transaction that confirms no prior authorization is required should satisfy the measure.

Regarding the proposed mandatory prescription drug ePA measure in 2028, if CMS does proceed to finalize this measure, then we believe clinicians should not be subject to a zero score in the Promoting Interoperability performance category due to barriers outside their control. CMS proposes exclusions to this measure, including instances where the payer does not support the specified ePA standard during the applicable performance period, but these proposed exclusions are too narrow. A payer's assertion that it supports a standard API does not necessarily mean the functionality is operational, tested, integrated into clinical workflows, or usable by a medical group. CMS should therefore expand the exclusions to include circumstances where capabilities have not been successfully implemented, tested, integrated, or made operationally available for a practice. Similar protections should be established for situations involving vendor readiness limitations.

MIPS Value Pathways (MVPs)

New MVPs

CMS proposal: CMS proposes to modify all 27 existing MVPS and rename the Rehabilitative Support for Musculoskeletal Care MVP to the Rehabilitative Support MVP. The agency intends to add three new MVPs to be available for reporting in the 2027 performance year:

- Diabetic Disease
- Hospitalist
- Hypertension

MGMA comment: MGMA continues to believe that CMS should design voluntary MVPs that are clinically relevant and alleviate reporting burden while allowing groups to transition to value-based care. We urge CMS to remain cognizant of the infancy of the MVP program and relatively low participation by MIPS-eligible groups.

CMS should work with physician specialty societies in the development of MVPs to better understand opportunities for quality and efficiency improvements and to avoid repackaging issues with MIPS. The agency should incorporate input from stakeholders to address specific concerns with appropriate quality measures and other issues with the proposed MVPs in this year's PFS. As addressed earlier in our comments, MGMA strongly urges CMS to not move forward with sunsetting MIPS and mandating MVPs.

MVP Scoring

Virtual Group and Subgroup Reporting

CMS policy: CMS proposes that virtual groups would be able to report an MVP starting with the 2029 performance period. Currently, virtual groups cannot report an MVP. The agency previously finalized a policy to require large multispecialty medical groups to report via subgroups.

MGMA comment: While MGMA supports allowing virtual groups to report an MVP, we maintain our opposition to mandatory subgroup reporting that was implemented in 2026, as partitioning practices into subgroups undermines the advantages of the group practice model. Multispecialty group practices will face increasing administrative burden, additional financial strain, and operational complexities trying to implement subgroup reporting.

Data validation, data and performance monitoring, and more for subgroup reporting would increase costs and staff time that one large medical group reports would result in having to add multiple FTE employees to manage this burden. Given it is currently burdensome to track and ensure reporting at the group level, this only grows in difficulty at the subgroup level for large multispecialty practices. CMS should explore additional opportunities for allowing multispecialty groups to report as group practices similar to the exception for small group practices it finalized in last year's PFS.

Advanced Alternative Payment Models (APMs)

Applying QP Determinations at the TIN/NPI Level

CMS proposal: CMS proposes tying QP status to a physician's APM-participating TIN and applying APM benefits (including the incentive payment and QP conversion factor) only to claims associated with the participating NPI/TIN combination.

MGMA comment: While we acknowledge CMS' desire to better align incentives with actual APM participation, we believe this could create administrative burden and complexity for group practices and does not align with Congress' original intent of providing qualified APM participants with financial incentives such as incentive payments and a 0.5% conversion factor differential.

Limiting QP status to a specific TIN/NPI will introduce new administrative burdens for practices and could ultimately discourage participation and limit growth in Advanced APMs. From a reporting perspective, if a provider achieves QP status and is exempt from MIPS under one TIN but required to participate under another, this introduces a new and very confusing scenario for practices and administrative staff. Practices would be required to track QP eligibility at a TIN/NPI level, determine which services qualify for the higher QP conversion factor, and monitor whether physicians are required to participate in MIPS under certain billing arrangements. For practices with multiple providers practicing under multiple TINs, this could be an enormous burden and ultimately force practices to reassess the costs versus benefits of Advanced APM participation. Applying QP status at the TIN/NPI level could also create unintended incentives regarding where clinicians furnish care which may result in unintended patient access consequences.

MGMA is concerned the burden of this policy could undermine CMS' efforts to encourage participation in Advanced APMs. QP financial incentives were established by Congress to reward providers and organizations that assume greater accountability for cost and quality outcomes. Limiting these benefits to individual TIN/NPI combinations reduces the overall value of Advanced APM participation, especially for integrated practices with providers who practice across multiple TINs. The reduction of QP-related incentives could discourage organizations from pursuing more advanced risk arrangements.

MGMA urges CMS not to finalize this proposal. CMS should conduct additional stakeholder outreach to better understand how medical groups structure their operations and how the proposal would affect Advanced APM participation across practice settings.

Ambulatory Specialty Model

CMS proposal: CMS proposes exemptions from participation in the Ambulatory Specialty Model (ASM) for cardiologists who redesignate their specialty type and physicians who redesignate their primary specialty or reassign billing rights from the TIN identified in the

ASM participant list. In both instances, CMS requires the physician to notify CMS by a given date for CMS to formally accept the exemption.

MGMA comment: MGMA remains steadfast in the belief that ASM should not be a mandatory model and should be optional for physicians and practices who believe they are prepared for success in a value-based care arrangement. However, as CMS proceeds with the mandatory aspect of the model, we appreciate the addition of these two commonsense exemption scenarios for physicians who do not fit the requirements for participating in ASM. That being said, we believe requiring physicians to notify CMS of these circumstances is an unnecessary administrative burden. In the case of cardiologists who redesignate their specialty type through the CMS-855 form or PECOS, CMS will already be aware of the redesignation and it is unnecessary for physicians to provide additional written notice to CMS to explicitly receive an ASM exemption. In the case of TIN reassignment, CMS will know what TIN physicians were assigned to on the ASM participant list and can determine whether those physicians switch to billing under another TIN. In both of these exemption scenarios, CMS should have the information needed to identify which participants should be exempt.

Requiring a written request for exemption and CMS' role in approving exemptions for given performance years raises new questions about the subjectivity of approval and what happens if an exemption is denied. We urge CMS to finalize these exemptions and utilize existing data and information to automatically exempt physicians.

MGMA remains concerned about CMS' plans to launch ASM on January 1, 2027. While the CY 2027 PFS proposed rule includes primarily technical and definitional updates to the model, the more pressing issue is whether practices will have sufficient time and information to prepare for implementation.

Since ASM was finalized in the CY 2026 PFS, CMS has provided limited communication regarding participant selection, operational requirements, and implementation timelines. When CMS released the preliminary participant list in February 2026, MGMA alerted affected medical groups with physicians on the list. Several practices reported that they were unaware their physicians had been identified as potential ASM participants, and it was unclear whether the listed physicians themselves had received direct communication from CMS. Although individual physicians are the designated model participants, successful implementation will depend heavily on practice administrators and other operational personnel who will ultimately be responsible for supporting compliance with model requirements, including quality reporting. CMS must ensure that both participating physicians and their practices receive timely and comprehensive outreach.

As of September 14, 2026, CMS has not released a final list of ASM participants despite the model's schedule implementation occurring in less than four months. Based on limited information currently available, CMS also intends to launch an ASM participant portal that physicians must access before authorizing additional practice contacts. However, CMS has not provided sufficient details regarding the portal's functionality, required user actions, or the extent to which key model activities will be conducted through the platform. Absent this information, practices are unable to evaluate staffing needs, establish workflows, or prepare training resources. MGMA is concerned that introducing another CMS reporting portal without adequate lead time or clear guidance will create additional administrative burden for practices already managing multiple federal reporting participation systems.

Therefore, MGMA urges CMS to delay implementation of ASM until the agency has finalized and communicated the participant list to both physicians and practices, completed development and testing of the participant portal, provided detailed operational guidance, and given practices adequate time to establish the workflows, staffing, and training necessary to support participation. Launching ASM before these foundational elements are in place risks creating unnecessary administrative burden, undermining practice readiness, and jeopardizing the model's successful implementation.

Requests for Information

Fast Healthcare Interoperability Resources-Based Digital Quality Measurement in the Quality Payment Program and other CMS Quality Programs

CMS request for information: CMS seeks input on the anticipated transition timeline, key milestones, and implementation considerations for FHIR-based quality reporting in the QPP and other CMS quality reporting programs.

MGMA comment: MGMA supports CMS' goal of advancing digital quality measurement and agrees that FHIR-based approaches have the potential to reduce manual reporting, improve interoperability, and provide clinicians with more timely and actionable information to support patient care. However, a transition to FHIR-based digital quality measurement must be grounded in the operational realities of medical groups. Practices operate across diverse health IT environments, have varying levels of FHIR readiness, and remain highly dependent on EHR vendors and other technology partners for implementation. CMS should therefore avoid equating the availability of FHIR functionality within certified technology with a medical group's readiness to successfully use that functionality for quality reporting. Before establishing mandatory reporting requirements, CMS should assess real-world adoption and readiness, conduct testing with medical

groups of different sizes and specialties, and ensure that FHIR-based capabilities can be integrated into existing clinical workflows without requiring costly workarounds or creating new administrative burdens.

CMS should establish a flexible, non-punitive glidepath to FHIR-based digital quality measurement that provides medical groups with sufficient time, resources, technical assistance, and implementation support to prepare for any future requirements. This transition should include greater standardization and alignment of measures' specifications, data definitions, and underlying data elements (including with the USCDI). It should rely, wherever possible, on standardized and reusable data rather than information created solely for reporting and account for differences in vendor capability and practice resources, particularly among smaller and less-resourced groups. CMS should disseminate best practices and evaluate real-world performance throughout the transition before establishing mandatory timelines. CMS should also ensure that medical groups are not held accountable for vendor capabilities or implementation- involved dependencies outside their control, and that FHIR-based reporting produces reliable and clinically meaningful and usable data. Ultimately, the success of digital quality measurement should be measured not by adoption of FHIR itself, but by whether it reduces duplicative reporting and manual work, produces trusted and complete quality information, and delivers actionable information within clinicians' workflows that helps medical groups improve care, practice operations, and positions them to succeed in value-based payment arrangements.

Current Procedural Terminology (CPT)

CMS request for information: CMS reviews numerous concerns it has with the CPT coding system and AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC). The agency is seeking comment on several areas regarding the influence of CPT and the AMA process on physician payment policy as part of Secretary Kennedy's effort to Make America Healthy Again, including examining potential alternatives to the current system.

MGMA comment: MGMA cautions CMS that replacing the CPT and RUC system that is incorporated in both federal statute and regulation would create widespread disruption throughout the nation's healthcare system. Disbanding these decades-old processes and establishing a new coding regime would add significant costs, untold administrative burden, and ultimately impact patient access to care.

Replacing the current system would require extensive and far-reaching changes to almost every facet of healthcare operations. Simply focusing on medical groups, any proposed changes to coding and valuation (beyond impacting payment rates) would likely require

medical groups to expend significant funds to update billing systems, coding workflows, staff training, and related administrative processes. This transition would likely increase claims delays, coding errors, and compliance risks, among many other consequences. EHRs, practice management systems, health IT products, and more would have to be updated. Adding further burden is the fact that private payers could maintain CPT instead of adopting this new system, further destabilizing medical groups.

The request for information incorrectly states that the RUC assigns a payment value when a new code is defined. Congress established through statute the Medicare physician payment system that is governed by CMS. The RUC makes recommendations on relative resources for furnishing a service and CMS can choose to accept or reject these recommendations. The value of this process is underscored by the RUC's clinical expertise, thorough deliberation, and evidence-based recommendations that result in CMS often choosing to adopt their recommendations. But CMS possesses the final authority.

The federal government using outside organizations to advise or assist in various capacities is not unique to healthcare. A review of other Departments shows that numerous non-governmental bodies assist in sharing expertise and valuable information with the ultimate goal of improving government functions. The case is no different here.

Improvements to the CPT coding system and RUC process can no doubt be made, but upending the current system is ill-advised, especially considering the alternatives. It could lead to unintentional and perverse incentives while at the same disrupting workflows and practice operations in an unprecedented manner. We urge CMS to collaborate with the healthcare community to improve the current system while maintaining stability.

Conclusion

We appreciate the opportunity to share our comments regarding the proposed changes to the Medicare PFS and QPP, and to offer recommendations to improve these policies to support group practices as they provide high-quality care for their communities. Should 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