September 12, 2025

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 2026 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 [CMS-1832-P]

Dear Administrator Oz:

The Medical Group Management Association (MGMA) is pleased to submit the following comments in response to the calendar year (CY) 2026 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 16, 2025.

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 2026 PFS proposed rule. CMS should:

- **Work with Congress to provide a positive update to the Medicare conversion factor in CY 2026 and all future years while addressing outdated budget neutrality policies.** While MGMA appreciates the proposed increases to the two newly introduced conversion factors for 2026, mainly due to congressional intervention, we remain deeply concerned with the trajectory of Medicare physician payment. Reductions in Medicare

reimbursement over the years have compounded well-documented administrative and financial pressures facing medical groups, which have only grown more pronounced because of the 2.83% Medicare payment cut that has been in place all of 2025. Outdated budget neutrality policies, coupled with a lack of an inflationary update, undermine the ability of physician practices to remain financially viable.

- **Do not finalize the efficiency adjustment of -2.5% to work relative value units (RVUs) and the intraservice portion of physician time of non-timed-based services, as this arbitrary cut would significantly impact thousands of codes without considering the underlying factors and complexities of each code.** CMS should explore alternatives that embrace physician practice input to more effectively update non-time-based codes on a more targeted basis.

- **Do not finalize the proposed reduction to the indirect practice expense for services performed in the facility setting, as this would not accurately reflect the current practice landscape and potentially drive further consolidation by undermining private practices offering services in facilities.** Instead, CMS should collaborate with the healthcare community to incorporate the 2024 AMA Physician Practice Information (PPI) Survey while working to better supplement data to reflect the reality of both office-based and facility-based settings.

- **Work with Congress to extend telehealth flexibilities scheduled to expire at the end of September while utilizing its full statutory authority to cover telehealth services permanently**. Medical groups continue to utilize telehealth services to best serve their patients; access to care will be significantly impacted if the current policies in place, such as geographic and originating site flexibilities, are not extended.

- **Finalize many telehealth proposals, including permanently extending direct supervision requirements and removing frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.**

- **Make the current Medicare policy permanent by allowing practitioners to list their currently enrolled practice location on their Medicare enrollment form while billing telehealth services from their home.** Requiring practitioners to report their home address when providing telehealth services would lead to security concerns and excessive administrative burden.

- **Work to reduce the significant administrative burden medical groups face under the current construction of the Merit-based Incentive Payment System (MIPS)**. CMS should examine comprehensive changes to MIPS — through its regulatory authority and working with Congress — to ensure the program works as intended and promotes Medicare beneficiary access to care.

- **Finalize maintaining the MIPS performance threshold at 75 points**. CMS should ensure its methodology avoids unsustainable increases to an already high threshold.

- **Ensure that MIPS Value Pathways (MVPs) reporting remains voluntary and work with the physician specialties to design MVPs that are workable and appropriate.** Do not sunset the MIPS program in the future before MVPs and other value-based care models are mature enough to capture the full spectrum of medical groups.

- **Do not finalize mandatory subgroup reporting for multispecialty medical groups, as it would institute significant administrative complexity and costs.** CMS should move forward with its subgroup reporting attestation proposal and its exception for small multispecialty group practices from dividing into subgroups, while expanding this exception to larger multispecialty groups.

- **Finalize proposed changes to MIPS cost measures that allow for a two-year informational period for new cost measures and make changes to the candidate and attribution criteria for the Total Per Capita Cost (TPCC) measure.** We urge CMS to remove the TPCC measure due to its inherent flaws in measuring clinicians for costs outside of their control.

- **Finalize Medicare Shared Savings Program (MSSP) proposals that create more flexibility for participants and lower the barrier to entry.** We urge CMS to finalize rules that reduce required beneficiary levels, expand EUC policies, and improve beneficiary assignment. However, CMS should not counteract these initiatives by reducing pathways for inexperienced Accountable Care Organizations (ACOs) and continuing to require burdensome reporting.

- **Do not finalize the mandatory Ambulatory Specialty Model (ASM).** CMS should not finalize ASM as a mandatory model and should instead explore other value-based care alternatives for involving specialists treating heart failure and low-back pain.

Physician Fee Schedule

Conversion Factor

CMS proposal: CMS is instituting two conversion factors for 2026 as required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) – one for qualifying Alternative Payment Model (APM) participants (QPs), including a +0.75% adjustment, and one for non-QPs, consisting of a +0.25% adjustment. The agency is proposing a conversion factor of $33.59 for QPs and $33.42 for non-QPs – an increase of $1.241, or 3.83% for QPs, and $1.074, or 3.32% for non-QPs over the CY 2025 conversion factor of $32.3465.

The increase to the conversion factor includes a 0.55% positive adjustment necessary to account for changes in misvalued codes and a newly introduced efficiency adjustment, as well as the 2.5% increase to the 2026 Medicare PFS from the One Big Beautiful Bill Act (OBBBA).

MGMA comment: MGMA remains deeply concerned about the trajectory of Medicare physician payment. We appreciate that CMS is proposing to increase the two newly introduced conversion factors, by 3.83% for QPs and 3.32% for non-QPs for 2026, however, this does not remedy previous cuts that physician groups have a had to absorb due to flawed policy, nor does it address potential future cuts due to budget neutrality.

The 2.83% cut to the Medicare conversion factor that went into effect at the beginning of 2025 continues to put medical groups' ability to stay financially viable in peril. We appreciate Congress for stepping in and increasing the 2026 Medicare payment by 2.5%, but that does not remedy the current reduction that is further exacerbated by years of Medicare cuts that have only been partially mitigated by congressional intervention. CMS's inaccurate utilization projections related to the HCPCS G2211 complexity add-on code triggered Medicare payment cuts due to outdated budget neutrality constraints — an illustrative example of the flaws with the antiquated budget neutrality process. Amplifying this dire financial reality are continued inflationary and other financial pressures, such as staffing shortages, increased administrative burden, and more. Simply put, comprehensive payment reform is long overdue.

Medical groups have been ringing the alarm bells for years about reimbursement failing to keep up with costs and its impact on current and future Medicare patient access. In MGMA's most recent regulatory burden survey, 87% of medical group practices said that reimbursement not keeping up with inflation would impact current and future Medicare patient access.[1] As one MGMA member put it, "[b]etween the reimbursement cuts and increasing regulatory costs, keeping the doors open becomes more challenging daily." Practices have detailed 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 continue on this trajectory.[2]

According to MGMA data, physician practices saw total operating cost per FTE physician increase by over 63% from 2013 to 2022, while the Medicare conversion factor increased by only 1.7% over the same timeframe. Further, 90% of medical groups reported increased operating costs in 2025.[3] Increased consolidation has resulted from independent physician groups being unable to stay in operation due to these financial tensions and increasing regulatory burden.

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[1] MGMA, 2023 Annual Regulatory Burden Report, Nov. 2023, https://www.mgma.com/federal-policy-resources/mgma-annual-regulatory-burden-report-2023.
[2] MGMA, Impact of Payment Reductions to Medicare Rates in 2023, Sept. 8, 2022, https://www.mgma.com/federal-policy-resources/impact-of-payment-reductions-to-medicare-rates-in-2023.
[3] MGMA Stat, Medical practice operating costs are still rising in 2025 — here's how to control them, June 11, 2025, https://www.mgma.com/mgma-stat/medical-practice-operating-costs-are-still-rising-in-2025-heres-how-to-control-them.

The 2025 Medicare Board of Trustees' annual report outlines the inadequacy of Medicare payment and its potential impact on 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."[4] Moreover, the Medicare Payment Advisory Commission (MedPAC) recognized the gap between input cost and payment rate growth, and recommended that Congress provide a positive update to the PFS for 2026 tied to the Medicare Economic Index (MEI).[5]

The lack of an inflationary update coupled with outdated budget neutrality requirements work in tandem to undermine the financial viability of medical practices. MGMA asks CMS to work with Congress and advocate for a positive update to the Medicare conversion factor in CY 2026 and all future years. We support the passage of legislation that would provide an annual Medicare physician payment update tied to inflation as measured by the MEI and modernize antiquated statutory budget neutrality requirements.

Changes to Practice Expense (PE) Methodology – Site of Service Payment Differential

CMS proposal: CMS proposes not to incorporate the AMA's Physician Practice Information (PPI) and Clinician Practice Information (CPI) Survey data from 2024 for 2026 rate setting, due to concerns from the agency about the accuracy, utility, and suitability of the data. Instead, as a result of the changing healthcare landscape, decreasing number of private practices, and the increase in physicians being employed by hospitals and operating in facility settings, the old system of allocating indirect PE costs is outdated in CMS's eyes, and the agency is proposing a "significant refinement to our PE methodology to better reflect trends in physician practice settings."

CMS is concerned about duplicative payments for practice expenses for services in a facility setting and intends to recognize greater indirect costs for office-based settings compared to facility settings to reflect current clinical practice. The agency proposes reducing the proportion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs starting in 2026 for each service valued in the facility setting under the PFS. This would result in a total decrease in the facility setting of -7%, with many specialties receiving a larger cut, while non-facility-based payments would increase by 4%.

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[4] 2024 Medicare Board of Trustees, Annual Report, May 6, 2024, https://www.cms.gov/oact/tr/2024.
[5] MedPAC, Mar. 2025 Report to Congress: Medicare Payment Policy, https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_MedPAC_Report_To_Congress_SEC.pdf.

MGMA comment: MGMA believes that CMS's proposed changes to indirect practice expense would not accurately reflect the cost of providing services in a facility setting and would undermine private practices providing services in facility-based settings. We support many of CMS's goals of bolstering private practice and accurately reflecting the current landscape, but the proposed solution would undermine these goals by utilizing a flawed method to make drastic cuts to many practices. CMS should examine alternative policies to facilitate accurate payment rates.

CMS raises numerous concerns with the AMA's 2024 PPI survey and chose not to incorporate this data while moving forward with its proposal to reduce indirect practice expenses in facility settings. MGMA supports CMS's desire for accurate payment rates for all settings and empirically sound data. Input from medical groups and physicians is essential to accurately capture the full scope of the practice landscape. MGMA supported the 2024 AMA PPI Survey alongside more than 170 other organizations, as it was an effort to collect robust and accurate up-to-date information to be used in rate setting. The 2024 PPI Survey includes data from 831 departments (18,086 physicians), in addition to two separate but related surveys that collected data from thousands of over physicians and healthcare professionals. CMS should incorporate the survey results in a thoughtful manner and aim to supplement with additional data instead of resorting to drastic cuts that hurt the very private practices that CMS is purportedly trying to support. A top-down rate setting approach without a full understanding of the practice landscape gained through these surveys and additional data would have severe consequences.

CMS's proposal does not factor in the complexities of hospital cost reporting nor account for the multitude of real-life scenarios where reducing the indirect practices expense would not simply remove duplicative payments but fail to account for actual costs. For example, costs related to physician billing may be reclassified as non-allowable on hospital cost reports and charged back to the department overseeing the physician, and staff time for Medicare Part B billing may not be considered a hospital cost.

The proposed 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, destabilizing their financial viability. 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's proposal would have unintended consequences for many services such as cutting surgical global codes with bundled post-operative office visits. This policy would potentially increase consolidation by failing to account for real costs.

MGMA has championed private practices' ability to maintain financial viability in the face of increasing regulatory burden and decreasing reimbursements for years. We support efforts to strengthen private practice reimbursement in a thoughtful way that accurately reflects their value while not inadvertently cutting certain physician practices that provide services to facilities that are already subject to woeful reimbursement under the Medicare PFS.

Consolidation in the healthcare industry results from a confluence of policies, many of which emanate from CMS, that coalesce to make private practice untenable for many. Tackling the root causes of this reality by adequately reimbursing medical groups and cutting bureaucratic red tape would go a long way to supporting a thriving and diverse practice environment. The fact that Medicare does not have an annual inflationary update has played a significant role in the current situation.

We urge CMS to work with the healthcare community to address site of service issues to avoid duplicative payments and incorporate the 2024 AMA PPI Survey results that better account for differences in practice costs. The 2024 AMA 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. The agency should further collaborate with the healthcare community to fill gaps in data for certain specialties.

Efficiency Adjustment

CMS proposal: CMS proposes introducing an efficiency adjustment that would apply to work RVUs and the interservice portion of physician time of non-timed-based services. The agency's reasoning for this proposal is that the time-based assumptions in these services have likely been overvalued due to efficiencies accruing over time, resulting from technological advancements and clinicians gaining experience. The agency raises issues about inflation of physician time and concerns about the timeliness of review for services, while also desiring payment for primary care services. CMS is also reassessing its reliance on AMA Relative Value Scale Update Committee (RUC) survey data to estimate practitioner time, work intensity, and practice expense, often reflected in the valuation of codes under the PFS.

CMS plans to use the sum of the past five years of the MEI productivity adjustment to calculate the efficiency adjustment, resulting in a proposed -2.5% adjustment for 2026 to work RVUs and the corresponding intraservice portion of physician time for non-time-based codes. Time-based codes such as E/M services, services on the telehealth services list, behavioral health services, and more would be exempt from this efficiency adjustment. According to CMS's estimates, this

proposal would reduce overall payments to most specialties by up to 1%, with some specialties, such as clinical psychology and geriatric medicine, that bill more time-based codes receiving a positive update. This efficiency adjustment would start in 2026 and apply every three years.

MGMA comment: MGMA opposes the introduction of the efficiency adjustment as it is an unfounded cut to all non-time-based codes, over 7,000 total, based on a flawed notion that increases in clinical familiarity with services and technological changes have led to the overvaluation of these codes that is not reflective of current practice. By cutting these codes, regardless of considering the underlying factors and complexities of each code, CMS is not accurately accounting for the reality of these services to the detriment of physician practices.

MGMA supports CMS's intention to better account for the costs of offering primary care services, as we have historically agreed with CMS that reimbursement for E/M visits may not always adequately reflect the resources associated with primary care visits. There are numerous policy levers at CMS's disposal to more accurately pay for primary care services, chief among them is instituting comprehensive payment reform as described above. We appreciate CMS's attention to this issue and urge the agency to collaborate with primary care stakeholders on policies that are workable in practice, but caution against instituting a severe cut to thousands of codes to accomplish this goal.

Assuming over 7,000 codes have been subject to the same efficiency gains over the last five years does not reflect the myriad clinical circumstances underlying those codes; CMS acknowledges as much in the proposal by stating "there may be variation in the efficiencies accrued service-by-service." It is also not reflective of what specialty societies are saying. A recent study in the Journal of the American College of Surgeons found: "The sample included 1,704,311 operations across 249 CPT codes and 11 surgical specialties. Collectively, these codes accounted for $3.2B in fee-for-service Medicare spending in 2023. Overall, operative times increased by 3.1% (CI 3.0-3.3%, p<0.001) in 2023 compared to 2019, or 0.8%/year (CI 0.7-0.8%/year, p<0.001). At the procedure level, 90% of CPT codes had longer or similar operative times in 2023 compared to 2019."[6] This echoes similar findings from other specialties that demonstrate CMS's broadly applied efficiency adjustment is off base.

CMS proposes to apply the efficiency adjustment to recently reviewed and revalued codes, adding a second cut to these codes. Numerous codes would be subject to significant decreases of up to 29% from just a few years ago after combining their recent revaluation and the efficiency

[6] Childers, Christopher P MD, PhD; Foe, Lauren M MPH; Mujumdar, Vinita JD; Mabry, Charles D. MD, FACS; Selzer, Don J MD, MS, FACS; Senkowski, Christopher K MD, FACS; Ko, Clifford Y MD, MS, MSHS, FACS, FASCRS; Tsai, Thomas C MD, MPH, FACS, Journal of the American College of Surgeons, *Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023*, Aug. 13, 2025, https://journals.lww.com/journalacs/abstract/9900/longitudinal_trends_in_efficiency_and_complexity.1369.aspx.

adjustment. There are numerous examples of codes introduced for 2026, such as endoscopic sleeve gastroplasty, that would receive an initial reduction before utilization data exists. CMS includes numerous codes under the efficiency adjustment that are meant to be exempt, such as numerous time-based services, telehealth services, and more. Lastly, the efficiency adjustment would introduce untenable complications in maintaining relativity with RBRVS, such as impacting the links between clinical staff time and equipment time to physician intra-time.

This proposal would have substantial implications for medical group operations, how productivity is measured, and how physicians are compensated. Indiscriminately cutting this many work RVUs will create distortions in measuring efficiency while adding further administrative complexity and cost to practice management on top of the reimbursement reduction. For example, the Expense per wRVU ratio is an efficiency metric organization used to show how much an organization spends per unit of provider work generated. This proposal will introduce greater difficulty in measuring productivity through this ratio, ultimately impacting the sustainability of compensation plans.

Given that these reductions would occur every three years, the short- and long-term implications of the efficiency adjustment are considerable. Using the MEI productively adjustment to lower reimbursement is illustrative of a piecemeal process that neglects to account for the fact that practices do not receive yearly MEI updates to account for inflation, like other payments systems under CMS's purview. MGMA urges CMS not to move forward with this proposal and work to take a more balanced approach to revaluing codes that incorporates feedback from physician practices.

There are workable alternatives available to ensure the accurate valuation of codes, such as ensuring there is a more frequent review of higher volume codes that would take into account the specific clinical circumstances for each one. We urge CMS to work with the healthcare community to find a path forward that appropriately captures the reality of these non-time-based codes in a prudent manner.

Telehealth

Expiration of the Telehealth Extensions Implemented in the Full-year Continuing Appropriations and Extensions Act

CMS proposal: The Full-Year Continuing Appropriations and Extensions Act, 2025, extended many telehealth flexibilities until the end of the fiscal year (September 30, 2025). Absent future congressional action, telehealth flexibilities for geographic location, originating site, and practitioner type are scheduled to end at the close of the fiscal year. Medicare beneficiaries would then have to be in a rural area and at a medical facility to receive most services. However, CMS proposes extending Federal Qualified Health Centers' (FQHCs') and Rural Health Clinics'

(RHCs') ability to furnish medical services via telehealth through December 31, 2026, making this an important exception to the broader Medicare telehealth flexibilities that are set to expire at the end of the fiscal year. These services would continue to be billed using HCPCS code G2025 and reimbursed at a rate based on the current year's physician fee schedule.

MGMA comment: While MGMA appreciates CMS using its authority to propose extending FQHCs' and RHCs' ability to furnish medical services via telehealth through December 31, 2026, the expiration of telehealth flexibilities for geographic location, originating site, and practitioner type are scheduled to end at the close of the fiscal year and will make it exponentially more difficult for many patients to receive care.

The current flexibilities have allowed practices to continue providing necessary telehealth treatment to their communities through various modalities. MGMA urges CMS to work closely with Congress to craft a permanent solution that extends beyond September 30, 2025. CMS should further utilize its full statutory authority to permanently extend more policies that facilitate access to care wherever possible. An abrupt cut-off to these vital services could severely impact patients nationwide.

Changes in the Medicare Telehealth Services List

CMS proposal: CMS proposes to add codes related to mental health, including behavioral counseling for obesity (HCPCS G0473), behavioral counseling to prevent sexually transmitted infections (HCPCS G0545), and multiple-family group psychotherapy (CPT 90849). CMS also proposes adding codes relating to central auditory functions (CPT 92622 and 92623). CMS proposes to remove the social determinants of health risk assessment (HCPCS G0136) from the telehealth list.

Additionally, CMS proposes to streamline its process for evaluating new codes for the Medicare Telehealth Services List by eliminating two of the five current review steps. Specifically, CMS would remove steps that assess whether a requested telehealth service is similar to existing permanently covered services and whether it offers comparable clinical benefit. The agency believes this change will simplify and clarify the submission process for stakeholders.

MGMA comment: MGMA appreciates CMS's proposal to expand the Medicare Telehealth Services List to include additional mental and behavioral health services and services related to central auditory functions. These additions will support medical group practices in delivering comprehensive care and meeting the growing demand for behavioral health services among Medicare beneficiaries.

MGMA also supports CMS's proposal to streamline the code review process for the Medicare Telehealth Services List by eliminating unnecessary steps. Reducing administrative complexity will create a more transparent and predictable pathway for stakeholders to propose additional codes that meet evolving patient care needs. We encourage CMS to ensure that the revised

process continues to prioritize timely access and clear communication with the provider community.

Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations

CMS proposal: Certain services added to the Medicare Telehealth Services List in the past had restrictions regarding how frequently they may be furnished via telehealth, such as a limit of once every three days for subsequent inpatient visits. Starting in CY 2026, CMS proposes fully eliminating the telehealth frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.

MGMA comment: MGMA supports CMS's proposal to eliminate telehealth frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations starting in CY 2026. Removing these restrictions will allow providers to deliver care based on clinical need rather than arbitrary limits, improving patient access to timely services and supporting care coordination in complex or acute cases.

We encourage CMS to finalize this policy and continue monitoring its impact to ensure providers can fully leverage telehealth for medically necessary visits without unnecessary administrative constraints.

Direct Supervision Via Use of Two-Way Audio/Video Communications Technology

CMS proposal: In the CY 2026 proposed rule, CMS proposes to permanently revise the definition of direct supervision to allow the supervising practitioner to be "immediately available" via real-time audio and video communication technology (excluding audio-only) for most services provided incident to a physician's services, except those with a 010 or 090 global surgery indicator, which are considered higher-risk and may require in-person oversight. CMS's current policy of allowing teaching physicians to supervise residents virtually (via audio/video) when furnishing services in all teaching settings runs through the end of 2025. The agency proposes not to extend the policy allowing teaching physicians to supervise residents virtually in all settings and will transition back to the pre-PHE policy, except in rural training sites, where limited flexibility would remain.

MGMA comment: MGMA supports CMS's proposal to permanently allow direct supervision via real-time audio and video communication technology for most services provided incident to a physician's services. This policy provides important flexibility for practices, reduces administrative burden, and helps maintain patient access to care, particularly in rural and underserved areas.

MGMA urges CMS to extend virtual direct supervision flexibility for teaching physicians. Continuing to allow real-time audio and video supervision in all teaching settings would support

medical education, minimize disruptions to patient care, and preserve the benefits realized during the PHE.

Home Enrollment for Telehealth

CMS policy: CMS's policy of allowing providers to list their currently enrolled practice location on their Medicare enrollment form while billing telehealth services from their home expires on December 31, 2025. During the PHE, CMS allowed practitioners to render telehealth services from their homes without reporting their home addresses on their Medicare enrollment forms and allowed billing from their currently enrolled location. The proposed rule does not review extending this policy past the end of 2025.

MGMA comment: MGMA appreciates CMS's efforts during the PHE to allow providers to render telehealth services from their homes while using their currently enrolled practice location for Medicare billing. This policy has reduced administrative burden and supported continuity of care for patients.

MGMA urges CMS to permanently extend this flexibility beyond December 31, 2025, allowing providers to continue using their currently enrolled location rather than their home address when delivering telehealth services. This would appropriately balance protecting providers' need for privacy of their home address with program integrity concerns. Security for practitioners at home is paramount as this information may be publicly available should they be required to report. Allowing practitioners to provide these services without requiring them to report their home address and safeguarding their privacy outweighs the potential benefits of publicly listing practitioners' home addresses. Maintaining this policy is essential to minimizing administrative complexity, supporting provider workflow, and preserving patient access to care.

Clinical Lab Fee Schedule

CMS policy: The Full-Year Continuing Appropriations and Extensions Act, 2025, changed the data reporting and payment requirements for clinical diagnostic laboratory tests (CDLTs). For the data reporting period for January 1, 2026, through March 31, 2026, the corresponding data collection period will be January 1, 2019, through June 30, 2019. Data reporting will continue every three years thereafter. CMS is applying a 0% payment reduction for CY 2025 so that a CLDT that isn't an advanced diagnostic laboratory test (ADLT) won't be reduced compared to the payment amount for the test in 2024. CMS won't reduce payment by more than 15% below the preceding rate for calendar years 2026-2028. The CY 2026 proposed rule does not introduce any new CLFS policy changes.

MGMA comment: Laboratory testing furnished at the point of care, such as in a physician's office, is a cornerstone of patient-centered care, improving outcomes while reducing delays, care coordination costs, and administrative burden. MGMA recommends CMS use its authority to avert any significant reduction in payment for critical healthcare tests to maintain patient access to medically necessary diagnostic testing. MGMA has long expressed concerns about the flawed

data collection and reporting process used to reduce CDLT payment rates. We remain concerned that the underlying data collection and reporting framework continues to undervalue CDLTs performed in physician office laboratories (POL). Reliance on flawed and unrepresentative market data will perpetuate downward pressure on payment rates, forcing many POLs to scale back or eliminate in-office testing. Such reductions diminish timely access to diagnostic testing, particularly for patients with chronic conditions such as diabetes, heart disease, and cancer, who rely on routine laboratory services to prevent costly complications.

MGMA supports a long-term solution that would ensure accurate, representative data collection across the laboratory market and set a sustainable reimbursement pathway. Improving payment stability for diagnostic testing is essential to maintaining patient access, supporting value-based care, and reducing avoidable healthcare costs.

E/M Services

Add-on Code (HCPCS Code G2211)

CMS proposal: CMS proposes to extend the application of HCPCS code G2211 to home and residence E/M visits, and to be billed as an add-on code with the home or residence evaluation and management visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350). The HCPCS code G2211 descriptor would be, "*(Visit complexity inherent to evaluation and management* associated with *medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add* -on code*, list separately in addition to home or residence or* office */* outpatient *evaluation and management* service*, new* or *established))".*

MGMA comment: MGMA appreciates CMS's proposals and still believes it is necessary for CMS to provide more information and overall clarity on the billing of G2211 to ensure practices understand the parameters of the code. CMS should continue to issue guidance around documentation and differentiating when to use this code versus billing a higher-level visit, as well as the typical patient who is expected to receive these services. Lack of clarity may impede medical groups' readiness and/or willingness to use HCPCS code G2211.

CMS's erroneous utilization projection of HCPCS code G2211 previously led to a 2.18% cut to the 2024 Medicare conversion factor. The 2024 Medicare PFS projected that G2211 would be billed with 38% of all E/M visits; the 2026 PFS proposed rule includes 2024 utilization data that shows CMS overestimated its utilization projection by a substantial amount as the actual percentage was 11.2%. CMS should correct this error and use actual claims data to include a positive adjustment to the 2026 proposed conversion factor. This would help support all practices, but especially primary care, as it would reinstate $1 billion that was incorrectly removed from the Medicare PFS.

Advanced Primary Care Management (APCM) Services

CMS proposal: CMS proposes three new optional add-on codes for APCM services (HCPCS codes G0556, G0557, and G0558) that would facilitate providing complementary behavioral health integration (BHI) services by removing the time-based requirements of the existing BHI and CoCM codes. The proposed codes would be considered a designated care management service and could be provided by auxiliary personnel under the general supervision of the billing practitioner.

MGMA comment: MGMA supports CMS's efforts to alleviate the administrative burden on practitioners by reducing documentation requirements for billing. If implemented effectively, these add-on codes could strengthen holistic primary care while streamlining administrative requirements. CMS should work closely with primary care practices and the appropriate physician specialties to ensure the proposed coding changes are workable in practice and will not create undue confusion or burden.

Federal Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs)

CMS proposal: To align with the PFS and support advanced primary care, CMS proposes to adopt new add-on codes for behavioral health integration (BHI) and CoCM services. Additionally, FQHCs and RHCs would be required to report individual CPT/HCPCS codes in place of the bundled codes for psychiatric CoCM (G0512) and communication technology-based services (G0071).

CMS also proposes permanently allowing virtual direct supervision through real-time audio/video technology for all FQHC and RHC services. The agency proposes a temporary payment approach using code G2025 through December 31, 2026, to facilitate the continuation of payment for non-behavioral telehealth visits. The rates are similar to average PFS telehealth payment amounts to support non-behavioral telehealth care. These changes are intended to improve alignment with broader Medicare payment policy and promote care coordination without significantly impacting Medicare spending.

MGMA comment: MGMA applauds CMS' proposal to permanently allow direct supervision via telecommunication for FQHCs and RHCs. This policy remains critical to ensuring patient access, particularly in rural and underserved areas where workforce shortages and travel barriers persist.

MGMA appreciates CMS's proposal to establish a temporary payment approach through December 31, 2026, using code G2025 to reimburse non-behavioral telehealth services. We support efforts to provide payment stability for practices delivering telehealth services and recognize the importance of aligning payment policy with the broader Medicare payment policy. MGMA urges CMS to closely monitor utilization and practice costs during the temporary period and to consider developing a permanent payment methodology that ensures equitable reimbursement for non-behavioral telehealth services while promoting care coordination and maintaining patient access.

MGMA appreciates CMS proposals related to BHI and CoCM services and the agency should work with FHQCs and RHCs to ensure the proposed add-on codes for BHI and COCM services do not create undue confusion or burden, and that there is clear guidance regarding how these add-on codes should be billed.

Skin Substitutes

CMS proposal: CMS proposes paying separately for skin substitute products as incident-to supplies in both the non-facility and hospital outpatient settings. The proposal would create three groups to pay for skin substitutes based on their FDA regulatory categories and would calculate initial payment rates for each category using the volume-weighted Average Sales Price (ASP), when available. CMS proposes a payment rate of $125.38 per square centimeter for 2026 and would be updated annually. Beginning in 2027, skin substitute payment adjustments would impact PE RVUs for other services.

MGMA comment: MGMA appreciates CMS' concerns around wasteful spending on skin substitutes and commitment to determining an accurate reimbursement rate for these services. However, we are concerned about the methodology and impact on future payment. CMS outlines how future changes in payment rates to the skin substitution codes would be incorporated into PFS relativity once claims data from 2026 is available and that would impact the development of PE RVUs for other services. To prevent future reductions in payment through the PFS, MGMA urges CMS to explore alternative approaches to paying for skin substitutes outside the PFS.

MSSP

We appreciate CMS's commitment to expanding and improving MSSP and applaud the proposals to increase flexibility and lower barriers to entry for new ACOs. Updating the 5,000 beneficiary requirement, expanding EUC policies, and aligning the beneficiary assignment list will reduce burden for medical groups and encourage new participation in MSSP. However, we oppose proposed policies that would ultimately abbreviate glide paths for inexperienced ACOs and remain concerned about burdensome reporting requirements in APP Plus.

Participation Options Under the BASIC Track

CMS proposal: CMS proposes to limit participation in a one-sided model to an ACO's first agreement period and require ACOs to progress more rapidly to higher levels of risk. For agreement periods beginning on or after January 1, 2027, an ACO that is inexperienced with performance-based Medicare ACO initiatives entering the BASIC track's glide path at Level A may remain under a one-sided model the performance years of its first agreement period (5 years) but must enter a two-sided risk model in its second agreement period.

MGMA comment: While we appreciate the CMS's interest in seeing ACOs progress more rapidly through the BASIC track and take on risk, we are concerned about the impact on

prospective participants who would rely on the existing glide-path as they transition to value-based care. The current policy of allowing ACOs to participate in a one-sided model (BASIC track Levels A and B) for two agreement periods (up to 7 performance years) ensures they can invest the time and money needed to succeed in developing a value-based care program. Limiting inexperienced ACOs to take on higher levels of risk and only allowing them to participate in a one-sided model for one agreement (up to 5 performance years) will hinder the growth of MSSP by creating new barriers to entry.

As such, we recommend CMS maintain the current options for ACOs lacking experience with performance-based risk Medicare ACO initiatives to participate in BASIC track Levels A and B two agreement periods years. While we understand two-sided risk may result in a higher level of care and benefits the agency's financial priorities, this proposal could disincentivize prospective ACOs and hamper the trajectory of MSSP growth. CMS's own data shows a significant decline in BASIC track Levels A and B participation from 41% of participants in PY 2022 to 29% of participants in PY 2025. ACOs are already shifting willingly to take on more risk and the administration could consider bringing back other incentives such as the Advanced APM incentive payment to further encourage participants shift towards two-sided models.

MGMA has viewed consistency as a critical component of success for medical groups participating in MSSP. Providing consistent, reliable glide paths will allow prospective participants to feel confident in making the investments needed to succeed in MSSP. Rather than requiring faster adoption of downside risk, we recommend CMS explore other voluntary opportunities for ACOs to take on increased risk. This could include a full risk-option with increased shared savings along with appropriate caps on savings and losses. CMS should work closely with stakeholders to develop voluntary pathways to take on higher risk rather than create new requirements that push unprepared ACOs to take on risk too quickly.

Eligibility Requirements

CMS proposal: CMS proposes to modify eligibility requirements that ACOs have at least 5,000 assigned Medicare FFS beneficiaries to require ACOs applying to enter a new agreement period to have at least 5,000 assigned beneficiaries in BY3 while allowing the ACO to have under 5,000 assigned beneficiaries in BY1, BY2, or both. ACOs entering a new agreement period with less than 5,000 assigned beneficiaries would be required to enter the BASIC track and would have capped shared savings and losses at a lesser amount. They would also be excluded from being eligible to leverage existing policies that provide certain low volume ACOs participating in the BASIC track with increased opportunities to share in savings.

MGMA comment: MGMA supports CMS instituting additional flexibilities to allow ACOs to participate in MSSP with less than 5,000 beneficiaries in the first two base years. The modification of the 5,000-beneficiary requirement lessens the barrier to entry and will help smaller ACOs participate in value-based care. We urge CMS to finalize this proposal and continue to identify opportunities to attract new ACOs to MSSP.

Expanding EUC Policies

CMS proposal: CMS proposes expanding the application of the MSSP quality and finance extreme and uncontrollable circumstances (EUC) policies to an ACO that is affected by an EUC due to a cyberattack for performance year 2025 and subsequent performance years.

MGMA comment: MGMA appreciates CMS's proposal to extend EUC policies to ACOs that experience cyberattacks and urges the agency to finalize this proposal. Cyberattacks can create serious operational disruption and hinder practices' ability to accurately measure and report quality performance measures. Even with the best security practices, medical groups can still be subject to attacks and should not be punished for these types of events out of their control. We also appreciate CMS's proposal to retroactively implement this policy for performance year 2025.

Changes to ACO Participant List

CMS proposal: CMS proposes to require ACOs that experience certain ACO participant changes of ownership outside of the change request cycle to update their certified ACO participant list to reflect said change. This applies to instances in which an ACO participant has undergone a change of ownership resulting in a change to its Medicare enrolled tax identification number (TIN) whereby the surviving Medicare enrolled TIN has no Medicare billing claims history.

MGMA comment: MGMA supports CMS's efforts to ensure ACO participant lists are accurate and to allow mid-year participant list changes in change of ownership scenarios. We support an approach that will account for changes and restructuring without severely disrupting programmatic calculations during the performance year. CMS should make the process as streamlined as possible and maintain appropriate flexibility while avoiding penalizing ACOs during the reporting process.

Beneficiary Assignment

CMS proposal: CMS proposes updating the definition of a beneficiary eligible for Medicare CQMs for performance year 2025 and subsequent performance years so that the population identified for reporting within the Medicare CQM collection type would have greater overlap with the beneficiaries assignable to an ACO. The definition would be revised to require at least one primary care service from an ACO professional within the applicable performance year.

MGMA comment: MGMA supports this proposal to revise the definition and appreciates CMS's effort to more closely align the list of beneficiaries assignable to an ACO with those the ACO is required to report Medicare CQMs. If finalized, we agree this proposal could help reduce the burden of patient matching between the two lists and streamline processes for ACOs. Additionally, we support the retroactive implementation beginning in performance year 2025.

APP Plus Quality Measure Set

CMS proposal: CMS proposes updating the APP Plus quality measure set for ACOs including the removal of the screening for social drivers of health.

MGMA comment: MGMA strongly opposed the creation of the APP Plus Quality measures in the 2025 PFS due to the administrative burden and applicability concerns for certain specialties and medical groups. We remain troubled about these measures and urge CMS to reevaluate the proposal. We also urge CMS to consider the challenges of collecting and reporting these eCQMs even if they are clinically relevant to a practice. Not all EHR vendors support the eCQMs included in the APP Plus quality measure set if the measures were removed as individual options from MIPS. As CMS works to identify opportunities for deregulation, we urge the agency to reconsider the APP Plus reporting requirements.

Quality Payment Program (QPP)

Merit-based Incentive Payment System (MIPS)

MIPS Final Score and Payment Adjustments

Performance Threshold

CMS proposal: The agency proposes to maintain the MIPS performance threshold at 75 points for the 2026 performance year, and to maintain the 75-point threshold through the 2028 performance year/2030 payment year. CMS is proposing to continue using the mean final score of the 2017 performance period and will continue to use the mean to determine the performance threshold through the 2028 performance year. The agency's intention is to provide continuity and stability to the MIPS program by maintaining these policies for the next three years.

MGMA comment: MGMA appreciates CMS proposing to maintain the current performance threshold and supports the proposal to maintain it at 75 points through the 2028 performance year. However, we continue to believe the threshold is unnecessarily high as it is based on a methodology utilizing nonrepresentative years of the current healthcare landscape as 2017 was pre-COVID-19 and occurred in a vastly different MIPS program and care environment. Medical groups participating in MIPS must expend significant resources to comply with program requirements that would be better directed towards patient care. These clinicians provide critical care to Medicare beneficiaries and negative payment adjustments due to a high threshold do not necessarily reflect care quality, but rather administrative issues.

MIPS reporting requirements remain one of the most significant regulatory burdens faced by medical groups — according to our most recent regulatory burden report, 67.19% of practices surveyed found MIPS reporting requirements very or extremely burdensome.[7] A 2019 study

[7]MGMA Regulatory Burden Report, Oct. 2023, https://www.mgma.com/getkaiasset/423e0368-b834-467c-a6c3-53f4d759a490/2023%20MGMA%20Regulatory%20Burden%20Report%20FINAL.pdf.

found that physicians spent more than 53 hours per year on MIPS-related activities.[8] The researchers concluded that if physicians see an average of four patients per hour, then these 53 hours could be used to provide care for an additional 212 patients per year. The same study found that the MIPS program cost practices $12,811 per physician to participate in 2019.

We appreciate the Trump Administration's focus on deregulation and removing unnecessary regulatory burdens that hamper practices' ability to successfully treat Medicare beneficiaries. The MIPS program remains overly punitive and has a disproportionate impact on smaller practices who have less resources to divert for MIPS reporting and are more likely to receive a negative payment adjustment. We echo our comments in response to recent requests for information (RFIs) on deregulation earlier this year and urge CMS to incorporate the following policy recommendations that were developed in collaboration with physician organizations to the extent feasible under its statutory authority, while concurrently working with Congress to institute lasting reform that enhances the MIPS program.

- ***Improve the performance threshold.*** The current MIPS threshold of 75 points results in many providers being unnecessarily penalized. Congress should freeze the threshold at 60 points for three years. Further, the Government Accountability Office (GAO) should submit a report to Congress and HHS in consultation with physician organizations that details recommendations for a replacement performance threshold.
- ***Reduce reporting burden and better align performance measures with clinical care.*** Siloes should be removed between the different performance categories; providing multi-category credit for MIPS measures that fulfill multiple categorical functions would avoid the duplicative steps of documenting and reporting on the same activities. The MIPS cost performance category has numerous issues related to measuring costs outside of a provider's control and opaque scoring procedures — it is important to significantly revise this category. Additional changes are needed to improve reporting on quality measures and allow providers reporting through clinical data registries to automatically satisfy promoting interoperability and improvement activities requirements.
- ***Reform how payment adjustments are calculated.*** The current tournament-style model of MIPS needs to be eliminated to stop undermining the financial viability of practices participating in the program who receive a negative payment adjustment. A new model where payment adjustments would be tied to the annual payment update would be more equitable while also continuing to incentivize groups to improve their performance. Groups who score below the performance threshold would receive a reduced payment update compared to those at or above the threshold. The penalties would fund bonuses for the high performers and go towards an improvement fund.

[8]Dhruv Khullar, Amelia Bond, and Eloise May O'Donnell**,** *Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System,* JAMA Network**,** May 2021, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2779947.

- ***Ensure timely and actionable feedback from CMS.*** Providers do not receive the timely and accurate feedback from CMS needed to understand their performance and be able to make changes to reduce costs or improve scores. A redesigned MIPS program must include this vital feedback, and if quarterly reports are not provided, medical groups should be held harmless from any penalties.

These important reforms would help stabilize MIPS, avoid unintended consequences of disincentivizing participation, and move towards a more equitable framework for medical groups. We urge CMS to work with Congress to enact these recommendations.

Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey

CMS proposal: CMS proposes to add a web-based survey mode to the current CAHPS for MIPS Survey administration; this change is meant to increase participation in the survey and thus increase its usefulness to groups, subgroups, virtual groups, and APM Entities (including Shared Savings Program ACOs). Further, CMS is proposing to sunset the requirement that entity applying to become a CMS-approved survey vendor must send an interim survey data file to CMS that establishes the entity's ability to accurately report CAHPS data.

MGMA comment: MGMA appreciates CMS updating its CAHPS for MIPS survey requirements to include the ability offer a web-based survey mode. This gives physician practices needed flexibility to administer the survey in the best possible manner for their patients. CMS should ensure that vendors do not increase expenses for offering a web-based survey to avoid heaping additional financial pressures onto practices given the survey is already fraught with costs and administrative tasks. The agency should continue to work to address the flaws with the CAHPS for MIPS Survey and reduce the burden associated with it.

MIPS Quality Category

Quality Measure Inventory

CMS proposal: CMS proposes to remove 10 quality measures from the MIPS quality measure inventory, make substantive changes to 32 quality measures, and add 5 new measures (including 2 eCQMs). The agency is proposing a total of 190 quality measures for the 2026 performance period.

MGMA comment: CMS should ensure that it maintains stability in the quality performance category and 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 and MVPs 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: CMS proposes to apply its previously finalized methodology for topped out measures to 19 quality measures that belong to specialty sets and MVPs with limited measures choice in areas that lack measure development and impacts meaningful participation in MIPS.

MGMA comment: MGMA supports this proposal and urges CMS to expand this policy as CMS's topped out policies often negatively impact certain specialties more than others and lead to reduced MIPS scores all the while these medical groups provide high-quality care. We support this policy to mitigate these negative impacts but ask that CMS apply this proposed policy more broadly to additional topped out measures under MIPS.

Benchmarking Methodology for Scoring Administrative Claims-Based Quality Measures

CMS proposal: CMS proposes to update the benchmarking methodology for administrative claims quality measures to align with changes made in last year's PFS to benchmarking methodology for cost measures beginning in the 2025 performance period. The median performance rate for a measure would be set at a score derived from the performance threshold, and the cut-offs for benchmark point ranges would then be calculated based on standard deviations from the median.

MGMA comment: MGMA urges CMS to adopt its proposed benchmarking methodology for scoring administrative claims-based quality measures. To reduce complexity of the various scoring methodologies dependent on the source of data and type of MIPS measure, we urge CMS review expanding this benchmarking methodology to other quality measures. The current scoring system can result in penalties for MIPS participants that score better than the benchmark median. Improving the benchmarking methodology would promote reporting for specialty or condition-specific measures.

Further, we ask that CMS provide timely feedback for administrative claims-based quality measures. Medical groups cannot build these measures themselves to accurately reflect performance. It is critical that physician practices be able to understand how their performance is being measured in order to improve.

MIPS Cost Category

Total Per Capita Cost (TPCC) Measure

CMS proposal: CMS proposes to modify the TPCC measure candidate event and attribution criteria starting in the 2026 performance year/ 2028 payment year. The agency is proposing to:

- Exclude any candidate events initiated by an advanced care practitioner Taxpayer Identification Number-National Provider Identifier (TIN-NPI) if all other non-advanced care practitioner TIN-NPIs in their group are excluded based on the specialty exclusion criteria;
- Require the second service used to initiate a second candidate event to be an E/M service or other related primary care service provided within 90 days of the initial candidate event service by a TIN-NPI within the same TIN; and
- Require the second service used to initiate a candidate event be provided by a TIN-NPI that has not been excluded from the measure based on specialty exclusion criteria.

MGMA comment: While we appreciate CMS working to mitigate the negative impacts of the TPCC measure by adjusting candidate event and attribution criteria, these positive steps still do not address the fundamental flaws with the TPCC measure. We harbor serious concerns about the use of TPCC in the MIPS program and urge the agency to cease measuring clinicians on this measure due to longstanding structural issues that incorrectly penalize providers by holding them accountable for costs outside of their control. TPCC includes all of Medicare Part A and B spending, holds clinicians accountable for patient treatment costs long after the patient has left their care, includes changes in drug pricing, and more. The measure can have a negative impact on group practices' MIPS final scores, undermining their financial viability. The confluence of issues with the TPCC measure necessitates its removal.

The lack of robust feedback on TPCC makes it extremely difficult for clinicians and group practices to understand how cost measurement works and undertake efforts to improve efficiency. One of the most common concerns raised by MGMA members regarding the MIPS program is that they have no ability to influence cost measurement and that attribution methodologies are confounding and inappropriate. Members have informed us that despite reviewing the materials made available by CMS and endeavoring to understand evaluation and patient assignment, they struggle to link evaluation with actions they can take to improve cost efficiency.

The agency must provide timely and actionable specifications regarding TPCC and all cost measures. CMS makes the annual MIPS Feedback Report available six to 18 months after the clinician has provided services to the Medicare beneficiary. Given that the cost measure accounts for 30% of their MIPS score, a significant portion of a group's score occurs in a black box where clinicians have no idea on how they are performing. Practices do not know what cost measures they are being scored on, which patients have been attributed to them, and how they can improve.

We encourage CMS to provide comparative information, such as the number of procedures a clinician performs compared to peers. We have heard from MGMA members that this type of

comparative data is helpful in cost reduction, as clinicians can see where they fall on utilization compared to their peers. CMS should provide quarterly reports about performance on cost measures to allow medical groups to understand their performance and make necessary adjustments to save costs.

The candidate and attribution changes are positive steps to address issues with the measure, and we support these adjustments, while also recommending that CMS continue to make changes should they maintain using TPCC. CMS should work to address inappropriate attribution issues with Qualified Health Professionals (QHPs) in multi-specialty groups made up of included and excluded specialties. Due to the cross-cutting nature of these multi-specialty groups, QHPs working with excluded specialists may be attributed to the group. Additionally, preventive services, necessary to keep patients healthy and avoid more serious conditions, are included in TPCC calculations and end up harming MIPS scores. Preventive services — that save costs in the long run — should be removed from cost calculations to avoid incentivizing undertreatment.

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.

Informational-Only Feedback Period

CMS proposal: CMS proposes a 2-year informational-only feedback period for new cost measures starting with the 2026 performance period. This proposal would allow MIPS participants to receive informational-only scoring feedback on a new cost measure for two years before it contributes to their final score. CMS would calculate the cost measure score and provide it to the MIPS participant along with performance feedback

MGMA comment: We appreciate CMS's informational-only feedback proposal and support its implementation to alleviate the strain that new cost measures have medical groups reporting under MIPS. Although the agency does not propose any new cost measures for 2026, this new two year informational-only feedback offers a path for medical groups to understand how new cost measures operate and allows for CMS to provide much needed feedback that has been lacking up to this point.

CMS should utilize its authority to extend this two-year informational period in various circumstances that would impact the MIPS cost measures, such as when CMS revises cost measures substantially changing them. The informational-only period should be used to understand how these adjustments work without significant uncertainty.

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. 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.

MIPS Promoting Interoperability (PI) Category

Protect Patient Health Information Objective, Security Risk Analysis Measure

CMS proposal: CMS proposes to modify the Security Risk Analysis Measure to include a second attestation component that requires MIPS eligible clinicians to attest "Yes" or "No" to having conducted security risk management as required under the risk management component of the HIPAA Security Rule, in addition to the existing measure requirement to attest "Yes" or "No" to having conducted or reviewed a security risk analysis in accordance with the HIPAA Security Rule. The measure would remain required, and a "No" response for the measure would continue to result in a total score of zero points for the Promoting Interoperability (PI) category.

MGMA comment: MGMA recommends CMS not move forward with instituting additional administrative burden by including another attestation requirement to the Security Risk Analysis. Medical groups are already subject to robust HIPAA privacy and cybersecurity requirements; increasing MIPS reporting burden by adding this additional attestation does not meaningfully address security risk management. This reporting requirement is redundant and adds unnecessary complications for MIPS-reporting medical groups. CMS should work to reduce the burden of the PI category and not finalize this proposal.

High Priority Practices SAFER Guide Measure

CMS proposal: CMS proposes to modify the High Priority Practices SAFER Guide measure by requiring the use of the 2025 SAFER Guides. A MIPS eligible clinician would attest "Yes" or "No" to completing an annual self-assessment using the High Priority Practices Guide within the 2025 SAFER Guides. The measure would remain required, and a "No" response for the measure would result in a total score of zero points for the Promoting Interoperability performance category.

MGMA comment: MGMA does not support modifying the High Priority Practices Guide measure by requiring the use of the 2025 SAFER guides. While we are supportive of the updated SAFER guides that help explain best practices for health IT safety, this measure should be voluntary given the newness of the guides and the need for additional information on their efficacy. We urge CMS to reduce administrative burden by not requiring additional health-IT-related reporting requirements, as PI policies compound burden by adding bureaucratic requirements that divert valuable and finite resources from medical practices focusing on providing high-quality, cost-effective care.

Measure Suppression Policy

CMS proposal: CMS introduces a measure suppression policy that includes establish criteria for determining circumstances in which a measure could be suppressed and subsequently not scored

for MIPS eligible clinicians and eligible hospitals and critical access hospitals (CAHs) participating in the Medicare Promoting Interoperability Program, respectively. The suppression policy would provide CMS with the means to address future potential circumstances that would warrant the necessity to suppress a Promoting Interoperability measure from scoring and would be effective starting with the CY 2026 performance period/2028 MIPS payment year and the EHR reporting period in CY 2026.

MGMA comment: MGMA appreciates CMS introducing a measure suppression policy aimed to mitigate the impact of significant events outside of the control of MIPS participants that impact their ability to report the PI category. The last five years have included numerous circumstances, such as the Change Healthcare cyberattack, that demonstrate the need for an effective PI measure suppression policy. With that said, we have questions about how this policy would work in practice, how CMS would select PI measures, and how long the suppression would last. CMS should provide additional information and ensure that for circumstances that warrant measure suppression in the future are clearly communicated and that there is a clear process in place that does not unintentionally undermine MIPS participants.

Public Health Reporting Using the Trusted Exchange Framework and Common Agreement (TEFCA) Measure as an Optional Bonus Measure

CMS proposal: CMS proposes to adopt a new optional bonus measure: the Public Health Reporting Using the TEFCA measure. A MIPS eligible clinician would attest that they're in active engagement (validated data production) with a public health agency to transfer health information using TEFCA. The measure would be 1 of 4 available bonus measures under the Public Health and Clinical Data Exchange objective, in which a maximum of 5 points could be earned if reporting one, more than one, or all optional bonus measures.

MGMA comment: MGMA supports the addition of this optional bonus measure for providers to receive bonus points for voluntarily exchanging public health information through TEFCA. These kinds of voluntary policies are helpful to properly incentivize providers to join TEFCA and promote interoperability.

MIPS Improvement Activities Category

Number of Required Activities

CMS proposal: CMS proposes the following changes to the improvement activities inventory for the 2026 performance period: adding three new activities, modifying seven existing activities, and removing eight 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.

Requests for Information

Query of Prescription Drug Monitoring Program (PDMP) Measure

CMS request for comment: The agency is seeking comment on the Query of Prescription Drug Monitoring Program (PDMP) Measure and changing it from an attestation-based measure to a performance-based measure. CMS requests feedback on potentially expanding the types of drugs to which the PDMP measure could apply.

MGMA comment: MGMA does not support changing the Query of PDMP measure from an attestation-based measure to a performance-based measure, noting that while PDMPs may increase accountability in opioid prescribing practices by providing information directly to the clinician to facilitate safe prescribing practices, tying PDMP use to performance may disproportionately disadvantage physician practices—particularly those that have not been able to make financial investments to integrate PDMP functionality into their EHRs. A PDMP performance measure would increase the administrative burden on practices striving to satisfy the metric.

Transition Toward Digital Quality Measurement

CMS request for comment: CMS is soliciting comments on their anticipated approach to the use of Health Level Seven (HL7) Fast Healthcare Interoperability Resources (FHIR) in electronic clinical quality measure (eCQM) reporting. Currently, several CMS programs use, or are considering using, eCQMs for various clinicians, facilities, providers, and other organizations to report their respective quality performance data. CMS is collaborating with Federal agencies to support data standardization and alignment of requirements for the development and reporting of digital quality measures. They are seeking feedback on FHIR-based eCQM activities in CMS programs.

MGMA comment: CMS should work towards transitioning directly to FHIR-based dQMs to reduce reporting burdens and data collection. FHIR dQMs include added functionality for medical groups to utilize their EHR data while also facility organizations with broader capabilities to use other claims and health information data. This transition should be thoughtful and include objective criteria such as demonstrated technical capabilities, sufficient adoption rates, stakeholder consensus on feasibility, proper training and technical support, and more before moving through the phases of implementation.

MGMA urges CMS to institute a transparent timeline that embraces active engagement with the healthcare community. A glidepath to adoption should include incentives for medical groups that encourage adoption and account for the costs of building the necessary infrastructure to report FHIR dQMs.

MIPS Value Pathways (MVPs)

New MVPs

CMS proposal: The proposed rule would add the following six MVPs for reporting in CY 2026:

- Diagnostic Radiology,
- Interventional Radiology,
- Neuropsychology,
- Pathology,
- Podiatry, and
- Vascular Surgery.

The agency proposes to modify the 21 MVPs that have already been finalized. CMS is updating the format of the MVP tables to stratify quality measures by clinical conditions and/or episodes of care for each MVP. This format is not changing the measures and activities included in the MVP but intended to provide a more user-friendly format for MIPS eligible clinicians when choosing the measures and activities most applicable to their practice.

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. The most recent data reported by CMS indicated that a very small number of groups voluntarily reporting through an MVP chose to use their scores, exemplifying our concerns with MVPs. We urge CMS to be cognizant of the developing state of the MVP program.

We appreciate CMS being receptive to stakeholder feedback and delineating clinical groupings within MVPs, as it is a positive step towards making MVP reporting more meaningful for specialties and subspecialties, but we still hold significant reservations about MVPs amplifying the problems in MIPS as currently designed. CMS should not move forward with sunsetting MIPS in the near future and continue to allow MVPs to be a voluntary reporting option — we oppose making MVP participation mandatory. 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 under MVPs that are not clinically relevant.

There are numerous recommendations on MVPs that MGMA has 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 longstanding problems with cost measures, and more. 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 specialty societies to address specific concerns with quality measures and other issues with the proposed MVPs in this year's PFS.

MVP Subgroup Reporting

CMS proposal: CMS proposes an exception for small multispecialty groups from having to report by subgroup starting in 2026. The agency reviews the issues that may result from requiring smaller multispecialty groups to form subgroups, such as lack of appropriate resources and not being able to meet case minimums. Multispecialty groups that are small practices (15 or fewer clinicians) would still be able to register to report an MVP as a group, and multispecialty groups that are small practices wouldn't be required to register as subgroups if they didn't want to report as individuals.

The agency proposes to update the definition of an MVP Participant to include small practices. CMS proposes that beginning with the CY 2026 performance period, an MVP Participant would mean an individual MIPS eligible clinician, single-specialty group, multispecialty group that meets the requirements of a small practice, subgroup, or APM Entity.

MGMA comment: MGMA remains opposed to mandatory subgroup reporting that will be implemented in 2026, as partitioning practices into subgroups would undermine the advantages of the group practice model. The changes in this proposed rule, such as the exception for small multispecialty groups, illuminate the difficulty in segmenting multispecialty practices into subgroups. Multispecialty group practices will face increasing administrative burden, additional financial strain, and operational complexities trying to implement subgroup reporting.

MGMA members report having to contract with multiple vendors to report for every eligible clinician as there isn't a single vendor that supports all MVP measures. 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 two 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.

We support CMS in finalizing its proposal to allow small multispecialty groups the option to report MVPs as a group practice rather than dividing into subgroups or individuals. CMS should expand this policy to larger multispecialty groups as they experience many of the same issues CMS outlined for small multigroup practices, but oftentimes at a larger and more complex scale. CMS should explore additional opportunities for allowing multispecialty groups to report as group practices.

Lastly, CMS should work to reduce the confusion caused by its proposed definitional changes as these shifting requirements can lead to a chilling effect in physician practices understanding of the MVPs and how they should report.

Specialty Group Attestation for Subgroup Reporting

CMS proposal: CMS proposes that groups attest to their specialty composition during the MVP registration process. Groups would attest to whether they're a single specialty or multispecialty group that meets the requirements of a small practice; CMS wouldn't make this determination for them.

MGMA comment: MGMA appreciates CMS's proposed changes and agrees with allowing groups to attest to their specialty. This utilizes the expertise of the practice and avoids instituting a flawed process where CMS may erroneously assign a group to an MVP based on claims data. We urge CMS to make the attestation process as seamless as possible.

Core Elements and Use of Procedural Codes in an MVP Request for Information

CMS request for comment: CMS is soliciting feedback on the development of a subset of key quality measures within MVPs, referred to as "Core Elements," from which an MVP Participant would be required to report one Core Element that would highlight measures that represent the foundation and focus of an MVP. The agency believes this would provide for more accurate comparisons of similar clinicians and would give patients the best information available about clinicians so they can make the most informed decisions about their care. CMS is also seeking feedback on identifying Medicare Part B procedural billing codes that align with each MVP to encourage specialists to report the relevant MVP based on their use of the procedural billing codes.

MGMA comment: MGMA opposes CMS moving to mandatory Core Elements across all MVPs and urges the agency to instead focus on developing MVPs for certain episodes of care and procedures. Requiring these elements would constrain physician practice's ability to choose the most relevant measures for their patients while also potentially limiting reporting options depending on the measures chosen. Instead, CMS should make improvements to the MVP program discussed above to better facilitate medical group participation without facing significant hurdles.

CMS should not move forward with assigning a specialist to a specific MVP based on the use of procedural billing codes as MVP reporting should remain voluntary and groups should be able to join an MVP that works for their practice. A group self-attesting to one MVP would then potentially be assigned to a separate MVP, undermining the value of the attestation process and without a clear appeals process. Further, there are issues surrounding utilization data for certain codes that would hinder this process.

Advanced APMs

Qualified Participant (QP) Determinations

CMS proposal: CMS proposes to add a QP determination at the individual level for Advanced APM participants, beginning with the 2026 QP performance period. CMS would calculate at the APM entity level and the individual level for each eligible clinician at each of the snapshot dates

throughout the QP performance period and is making revisions to ensure that an eligible clinician is a QP for a year under the Medicare Option if beginning with the CY 2026 QP Performance Period, the clinician individually, or as part of an APM entity group, achieves a Threshold Score that meets or exceeds the corresponding QP payment amount threshold or QP patient count threshold.

MGMA comment: MGMA continues to be concerned about the introduction of individual-level QP determinations. We previously commented on the CY 2024 proposed rule and highlighted how specialists will likely be excluded from participating in advanced APMs if the QP determination is made at the individual level. Many specialists will not individually qualify as a QP or partial QP, while they are more likely to qualify at the APM entity-level. We appreciate the changes CMS made to this proposal in terms of keeping the APM entity level determination. This change helps ensure continuity and sustainability for advanced APM participants.

However, introducing the individual determination in addition to the entity determination will still increase the reporting burden as medical groups will have to adjust their administrative practices to report for each clinician. MGMA and our member group practices have been longtime champions of a team-based approach to care. We have heard concerns from members about making QP determinations at the individual clinician level, including that it would add confusion and administrative redundancy and require medical groups to adopt more rigid and less variant medical management protocols.

Patient Attribution

CMS proposal: The agency proposes to modify the sixth criterion under the definition of "attribution-eligible beneficiary." The proposal would include any beneficiary as attribution eligible who has received a covered professional service furnished by an eligible clinician for the purpose of making QP determinations.

MGMA comment: MGMA continues to support CMS reviewing changes to improve the APM attribution process and address attribution issues that may be dissuading specialties from participating in APMs. We supported this change when it was proposed in the 2025 PFS, but asked for CMS to provide more information and analysis about this change's potential impact on participation in APMs, as the proposal does not discuss how the number of participants is likely to be increased, and also states that there may situations where the proposal would limit QP determinations in certain situations. While we still support the intent of this proposal, without more information about the impact this would have across models, specialties, and populations, it is challenging to understand the full effect of the change. Additionally, the agency alludes to ongoing analysis since last year's proposal but does not provide any further details. We urge CMS to share its findings on the impact of this change before finalizing this proposal.

Ambulatory Specialty Model

CMS proposal: CMS proposes to create a new, mandatory 5-year model focusing on the care provided by select specialists to Medicare beneficiaries with chronic conditions of heart failure and low back pain. Clinicians would be required to report a select set of measures and activities clinically relevant to their specialty type and the chronic condition of interest. The model would leverage components of the existing MVP framework and aim to reduce low-value services such as unnecessary imaging, surgeries, and hospital admissions.

MGMA comment: MGMA applauds CMMI for creating new opportunities for specialists to participate in value-based care. We appreciate the effort to support physicians in independent practices by allowing physicians to participate without needing to be part of an ACO or larger group. While the ASM could provide a valuable new avenue for value-based care, there are many concerning aspects of the model that we urge CMMI to modify to improve the financial and operational sustainability for participants.

To ensure no undue burden is placed on practices, CMS should make ASM a voluntary model. Mandatory models create an unnecessary burden on medical practices and raise concerns, especially when they are new and untested. MGMA strongly supports the development of new, voluntary models that provide opportunities for practices to explore value-based care. However, when untested models are forced upon practices, it imposes new financial and operational uncertainties. We share the Administration's optimism around value-based care but strongly believe the best way to grow collaborative care is by creating voluntary models that provide the appropriate financial incentives to attract practices into the program. As outlined in our MSSP comments, glidepaths are essential to a practice's transition to value-based care. Allowing practices that are new to value-based care to transition in a more financially predictable manner creates a more stable and successful transition. CMS should modify ASM to be a voluntary model and allow practices to determine the appropriate amount of risk for them to take on.

The proposed payment methodology branches out from traditional CMMI models and benefits participants by not requiring them to repay CMS if the total cost of care exceeds the benchmark set by CMS. We appreciate the departure from mandatory downside risk payment arrangements. However, we are concerned about the "tournament" style model, which pits physicians against each other and could result in penalties for physicians even if they improve their quality of care and reduce spending.

Additionally, the proposed "redistribution percentage" further hinders physicians' opportunity to succeed in ASM. By only paying out 85% of the savings generated back to high-performing physicians, it will be even more challenging for physicians to achieve a sustainable payment. Unlike in MIPS, where payment reductions for low performers go towards payment increases for high performers, this redistribution percentage methodology will reduce payment for more physicians. CMS should not finalize the use of a redistribution percentage and should explore payment methodologies that adequately reimburse physicians for improving quality of care and reward physicians who generate savings.

MGMA is also concerned the proposed cost and quality measures will not accurately reflect the quality of care provided or be relevant for all physicians required to participate in ASM. There multiple issues with the proposed measures including applicability to heart failure and low back pain and lack of physician experience with new measures. We urge CMS to work closely with prospective ASM participants to determine relevant measures that appropriately reflect the quality of care and savings produced through the model.

Payment Policy for Software as a Service (SaaS) Request for Information

CMS request for comment: The agency seeks comment on factors it should consider when paying for SaaS and how to evaluate the quality and efficacy of SaaS and AI, including additional suggestions that would enhance its ability to provide accurate and consistent payment for procedures incorporating SaaS.

MGMA comment: MGMA commends CMS for its focus on evaluating the quality and efficacy of AI. Our August 2025 MGMA poll found that 71% of practice leaders report some use of AI for patient visits, while 29% say AI plays no role in their visits.[9] Among practices not currently using AI, we found views on future adoption were mixed. Several leaders expressed clear intent to adopt AI tools in the next year, particularly for scribing, scheduling, phone call management, and EHR-integrated solutions. Others remained cautious, citing barriers such as high costs, limited EHR integration capabilities, unclear return on investment (ROI), accuracy concerns, or lack of organizational readiness. High-quality, high-value emerging technologies using AI can support medical group practices in many ways, including improving clinician productivity, expanding patient access to continuous support, and enabling more efficient practice operations.

As part of the agency's focus on factors to evaluate regarding the quality and efficacy of AI, the initial costs to adopting and using these technologies, including the associated change management workflow implications, as well as any ongoing maintenance expenses are impactful factors for medical practices, and we encourage the agency's further analysis informed by medical group practice site use cases including marketplace surveillance. MGMA is encouraged that the agency is focused on the value of advanced health technologies enabled by AI, while recognizing that payment for these technologies can present challenges resulting from limitations on the physician fee schedule due to budget neutrality rules. MGMA supports CMS's well-intended efforts to explore potential, sustainable pathways in the future for use of these technologies particularly benefit medical groups and smaller practices operating outside of value- based arrangements. We look forward to collaborating with CMS in the future as part of this effort to ensure the most impactful factors for medical group practices are considered as part of any future payment reform.

Conclusion

[9] MGMA Stat, Most practices use some form of AI, but is it actually reducing staff workloads?, Aug. 6, 2025, https://www.mgma.com/mgma-stat/most-practices-use-ai-but-is-it-reducing-staff-workloads.

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, Associate Director of Government Affairs, at jhaynes@mgma.org or 202.293.3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs