MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

September 14, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS-1848-P. Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the over 20,000 physician, resident, and medical student members of the Massachusetts Medical Society (MMS), we appreciate this opportunity to offer our comments to the Centers for Medicare & Medicaid Services (CMS) on the calendar year (CY) 2027 Notice of Proposed Rulemaking (Proposed Rule) on the revisions to Medicare payment policies under the Medicare Physician Payment Schedule (MPFS) and Quality Payment Program (QPP), published in the Federal Register on July 16, 2026.

EXECUTIVE SUMMARY

The MPFS is the only major Medicare payment system without an automatic, inflation-based annual update. Medicare physician reimbursement rose only 7 percent from 2001 to 2025 while practice costs rose 59 percent, resulting in a **33 percent decline relative to inflation**, even as Medicare hospital updates rose roughly 80 percent over the same period. Congress has provided only temporary relief in five of the last six years, and with the most recent 2.5 percent update expiring at the end of CY 2026, **physicians again face a net payment cut in CY 2027** absent Congressional action, even though CMS itself projects the Medicare Economic Index (MEI) will rise 2.5 percent over the same period.

Physician practices that have survived this erosion cannot weather additional cuts, yet this rule advances several redistributive changes at once, whose combined effect falls hardest on the small, independent, and rural practices least able to absorb it, with some being reimbursed less than it costs to deliver care to our most vulnerable patients. The MMS shares CMS' goal of sustaining independent practice, a goal that will be in serious jeopardy if several policies proposed in this rule are finalized.

Before finalizing these changes, we ask CMS to publish the specialty-level impact estimates stakeholders need to evaluate them, particularly since the four major practice expense proposals are interrelated and operate on the same RVUs, and since several diverge from CMS' own commissioned analyses or the updated Physician Practice Information (PPI) Survey data the American Medical Association (AMA) provided in January 2025. **Before proceeding with such redistributive policies, we urge CMS to pause, collect the necessary data, publish the underlying analyses, and continue to engage with the physician community.**

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We are particularly concerned about the following:

- **Annual inflation-based payment update.** We urge the Administration to bring Medicare physician payment updates in line with rising practice costs by supporting a permanent, inflation-based update tied to the Medicare Economic Index, including through H.R. 9693 the Patients First Act.

- **Payment reduction for services furnished with a separately identifiable E/M visit (Modifier -25).** CMS proposes to cut payment 50 percent when a separately identifiable office/outpatient E/M visit is furnished the same day as a procedure with a 0-, 10-, or 90-day global period. CMS proposed this change in 2019 but withdrew it after stakeholder concerns; this version reaches even more procedures, with no evidence of duplication or its magnitude, even though the RUC valuation process already excludes overlapping work from these codes. **CMS should not finalize this flawed policy and should instead address any genuine overlap on a code-specific basis.**

- **Changes to the practice expense (PE) methodology.** CMS proposes four distinct, interrelated changes: a revised indirect allocator, elimination of the indirect practice cost indices, a five percent stabilization cap (which does not appear to operate as described), and a new utilization modifier. These are layered atop the 50 percent facility-based work adjustment already cutting facility payment seven percent overall. Instead, we ask that **CMS repeal the 2026 adjustment and phase in any further change over multiple years, working closely with stakeholders and avoiding unintentionally harming independent practices.**

- **Cuts and new restrictions on remote monitoring services.** Citing a lack of device data and HHS OIG recommendations, CMS proposes to cut Remote Physiologic Monitoring (RPM)/Remote Therapeutic Monitoring (RTM) practice expense RVUs, often up to the 19 percent statutory limit, and to bundle 19 codes into four new G-codes, imposing an immediate 80 percent cut. **The MMS strongly urges CMS to pause these reductions while the RUC gathers the missing data (work that is already moved up to January 2027) and not finalize new requirements for a separately reportable initiating visit or restrict delivery to practice-employed staff.**

- **Mandatory transition to MIPS Value Pathways.** The MMS strongly opposes sunsetting traditional Merit-based Incentive Payment Systems (MIPS) and requiring MIPS Value Pathway (MVP) reporting beginning in 2029. MVPs remain built around specialties and broad problem categories rather than the conditions a clinician treats, yielding inaccurate comparisons and significant ongoing measure gaps. We, instead, ask **CMS to incentivize, not mandate, MVP reporting while working to close these gaps.**

- **Restriction of Alternative Payment Model (APM) incentives to APM-participating taxpayer identification numbers (TINs).** CMS proposes to limit APM Incentive Payments and the differing conversion factor to claims from Advanced APM-participating TINs. This limitation exceeds CMS' authority under MACRA, adds unnecessary complexity, and would diminish future incentives to join APMs, particularly for specialty, small, rural, and independent practices. **We urge CMS not to finalize this proposal.**

We thank CMS for their attention to these critical issues and offer more detailed comments on these and other proposals in the comments that follow.

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I. UPDATES TO PAYMENT PROVISIONS

A. Determination of Practice Expense Relative Value Units

Conversion Factors

The MMS appreciates that CMS proposes implementing the statutory updates together with a positive 0.53 percent budget neutrality adjustment reflecting proposed changes in work RVUs. We are concerned, however, that these positive updates are more than offset by the expiration of the one-year 2.5 percent update that Congress provided for CY 2026. As a result, **under current law, physicians would face a net Medicare payment cut in CY 2027**. CMS proposes a qualifying APM conversion factor of $33.17, a decrease of 1.19 percent from CY 2026, and a nonqualifying APM conversion factor of $32.84, a decrease of 1.68 percent from CY 2026. In short, **physicians are facing yet another year in which Medicare payment goes down while practice costs and inflation continue to climb.**

The MMS, and physicians nationwide, continue to advocate to Congress for **permanent updates to the conversion factor that account for the growth in physician practice costs**. The recurring pattern of temporary, expiring patches underscores why a one-year fix is no substitute for a durable, inflation-based update. Despite temporary updates in five of the last six years, Medicare physician payment has continued to erode as economic pressures on physician practices, including rising costs of rent, wages, supplies, and administrative burdens, have intensified. **CMS projects that the Medicare Economic Index (MEI) will increase by 2.5 percent for CY 2027, yet statutory updates for physician payment fall far short of that benchmark, widening the gap between payment and the cost of delivering care.**

Inadequate physician payment has real-world consequences, accelerating the trend toward consolidation of independent physician practices and **compromising seniors' access to care**. These pressures are not borne equally. Small, independent, and rural practices, which operate on the thinnest margins and lack the scale to absorb administrative and input-cost increases, are least able to withstand another year of declining payment, and specialties with higher practice expenses are disproportionately exposed, as fixed statutory updates fail to track their rising costs. The bifurcated conversion factor further magnifies these disparities: physicians unable to participate in qualifying alternative payment models (APMs), often because no suitable model exists for their specialty or practice setting, absorb a steeper reduction than their qualifying participant (QP) counterparts, compounding the payment differential over time.

To protect Medicare for the next generation, **we urge the Administration to support congressional action to enact permanent, inflation-based updates for physician payments tied to the MEI. We specifically support the Patients First Act (H.R. 9693)**, which would establish an annual MEI-based update, reform budget neutrality, replace the Merit-based Incentive Payment System, improve APM incentives, and create a new primary care payment pilot outside of budget neutrality. The need for this reform is reinforced by independent expert bodies. In its 2026 report, the Medicare Payment Advisory Commission (MedPAC) recommended increasing payment rates for physician services to bring fee-for-service (FFS) Medicare payment levels closer in line with providers' costs. The 2026 Medicare Trustees Report likewise warned that the current MACRA structure raises long-range concerns that will almost certainly need to be addressed through future legislation. The Trustees cautioned that physician payment updates do not account for or vary with underlying economic conditions and are not expected to keep pace with increases in physician practice costs. Absent changes to the delivery system or payment updates through subsequent legislation, the Trustees expect beneficiary access to Medicare-participating physicians to become a significant issue in the long term.

Practice Expense (PE) RVU Methodology

The MMS supports a Resource-Based Relative Value Scale (RBRVS) grounded in accurate, current data that reflect the resources actually incurred to furnish services, including differences across settings and practice arrangements. Resource-based relativity has been a foundational principle of the Medicare Physician Fee Schedule since its inception. Consistent with that principle, the MMS has welcomed and supported CMS' recent efforts to update key practice expense inputs including clinical labor, supply, and equipment pricing.

We are concerned, however, that several practice expense and related proposals over the past two rulemaking cycles have moved in the opposite direction of a resource based, data driven approach. These proposals replaced specific data inputs with broad, round-number methodological adjustments whose empirical basis is not established in the rulemaking. In several instances, these adjustments also diverge from the analyses CMS itself commissioned. For example, the multi-phase RAND practice expense studies recommended developing improved and recurring data sources rather than eliminating data-driven components of the methodology. Similarly, the RAND analysis underlying the proposed indirect allocator proposal modeled a policy that did not include the 010- and 090-day global exclusion that CMS now proposes.

Moreover, updated Physician Practice Information (PPI) Survey data, collected by the AMA through a multi-year effort and provided to CMS in January 2025, offer current, specialty-level practice-cost information of the type that several of these proposals assert is lacking.

Changes of this significance should be grounded in robust empirical evidence. We therefore urge CMS to rely on the best available data before making fundamental changes to the PE methodology, and we support the RUC's willingness to work with CMS to that end.

Proposed Modifications to the PE Formula

Recommendations:

- Postpone implementation of these practice expense proposals until a future rulemaking cycle in which a granular specialty impact analysis may be published for each distinct proposed change in the practice expense methodology.

- Work with the AMA to consider how the 2024 PPI data could be used in the future to reflect changes in physician practice cost and physician hours worked.

- Implement the proposal to continue to use the 2006-based MEI cost shares for CY 2027 until the 2024 PPI data can be considered.

The MMS appreciates that CMS published the Practice Expense (PE) Relative Value Unit (RVU) Algorithm on the CMS website. The PE formula is complex, and changes can have significant redistributive effects across services and specialties. Therefore, full transparency is required to ensure that stakeholders have all relevant information available to meaningfully comment on proposed methodological changes. We encourage CMS to consider providing additional supporting materials, including utilization crosswalk files between the current and previous years, restoration of key utilization file fields (such as undiscounted allowed services and PE, PLI, and work discounted allowed services, complete modifier column), documentation of any scalar adjustments applied to indirect scaling adjustments or other steps throughout the rate-setting process, identification of codes with professional and technical components that do not use

TC or PC/26 modifiers, and identification of any codes whose RVUs are assigned outside the standard rate-setting process.

For CY 2027, CMS is proposing four major changes that impact the indirect PE methodology as follows:

(1) Utilization: Utilization is a significant driver in the PE methodology, both in developing the pools of available PE RVUs and in determining the specialty mix of a particular CPT code. Utilization has historically been adjusted to account for modifiers, payment rules (such as the multiple procedure payment reduction), and geographic mix. For 2027, CMS proposes a new approach to account for these items by calculating the ratio of allowed charges to the national PFS payment amount for each claim line. CMS would also use this approach to adjust time within the PE methodology.

CMS states that these proposed changes have "a very minimal impact on the resulting PE RVUs." However, CMS does not publish a separate impact analysis demonstrating how this proposal impacts individual codes or specialties. CMS does publish a utilization file online that shares the newly discounted utilization. Within this file, and within the allowed charges included in the published specialty impact table, these data indicate significant utilization changes for pathology, independent laboratories, and physical/occupational therapy. However, it is not evident how these dramatic changes in utilization impact these specialties and others within the PE methodology.

(2) Indirect PE Allocation: Expand the allocation of indirect PE to utilize the sum of both work RVUs and clinical labor (rather than the greater of the two) for all services except 010- and 090-day global period codes.

A report related to this modification is available from RAND. However, RAND does not exclude the 010- and 090-day global period codes from the proposal. CMS does not provide a rationale in the Proposed Rule for adding the exclusion of the 010- and 090-day global period codes.

Additionally, the RAND analysis does not reflect the current state of the methodology or other changes proposed for CY 2027. RAND modeled this change against a CY 2025 baseline. It therefore does not account for the CY 2026 policy reducing the facility-based indirect allocation to 50 percent of the work RVU, nor for the other proposals in this rule that interact with indirect PE allocation, most significantly, the proposed removal of the indirect practice cost index (IPCI). Because these policies operate on the same indirect PE RVUs, their effects cannot be assessed in isolation, and the specialty-level impacts shown in the RAND report do not represent what would result under the combined set of policies CMS now proposes. The MMS therefore cannot evaluate the full impact of this proposal on code-level accuracy or specialty-level payment. The MMS urges CMS to publish an impact analysis that reflects the proposal as actually proposed, including the global period exclusion and the CY 2026 facility-based indirect allocation change, and that accounts for its interaction with the other practice expense changes proposed for CY 2027.

(3) Indirect Practice Cost Index (IPCI): Remove the IPCI from the calculation of the PE RVUs over a 2-year transition period.

The IPCI was implemented to ensure that all indirect costs measured at the specialty level in the PPI Survey are appropriately reflected in the PE methodology. CMS argues that improvement in code level direct expense data and allocation methodologies allow for the elimination of the IPCIs over two years. CMS also expresses concern about the use of the dated PPI Survey information; however, the PPI PE/Hour data and proportion of direct to indirect costs remain a component of the PE methodology.

Code and specialty level impacts are not available for this specific proposed change to the PE methodology.

(4) Stabilization Factor: Initiate a PE stabilization factor for PE RVUs for CPT codes that are not new, revised or revalued to ensure that the PE RVU does not change by more than five percent relative to the previous year. Concerned that removal of the IPCI may cause disruption year-to-year for codes that should otherwise be stable, CMS introduces the stabilization factor to counterbalance the proposed removal of the IPCI. CMS explains that the existing limit on how much a stable code may be decreased in total RVUs will remain at 19 percent and will be employed after this stabilization factor.

Unlike the codes subject to the transition in total RVU reduction, the codes that are subject to the five percent stabilization factor in 2027 were not specifically published. It is not apparent which codes will be subject to reductions in future years due to the employment of the five percent stabilization factor in 2027.

In general, the MMS is supportive of transitions and methods to stabilize RVUs from year-to-year to protect physicians and other clinicians from large reductions that may destabilize their practices. To the extent practicable, this stability should apply to all services.

The MMS is concerned, however, about the specific proposals discussed in this rulemaking process as CMS has not provided sufficient information for stakeholders to evaluate the effects of these four complex and interrelated proposals. CMS has historically published impact analysis for each significant proposed modification to the practice expense methodology. As these proposals are all intertwined, it is not possible for most individuals to understand how each individual proposal impacts their specific codes or specialty based on aggregate tables alone. Further, important elements of CMS' rationale are also missing, such as the decision to exclude 010- and 090-day global period codes from the expansion of the sum of work plus clinical labor as an indirect allocator. **MMS asks CMS to postpone implementation of these practice expense proposals until a future rulemaking cycle in which granular specialty impact analysis may be published for each distinct proposed change in the practice expense methodology.**

The MMS also encourages CMS to re-examine the results of the recent Physician Practice Information (PPI) Survey. The AMA's PPI survey was a multi-year effort to collect updated physician practice data for potential use in the RBRVS. These data were collected at the specialty level and shared with CMS in January 2025. The PPI data represent the most recent data on physician practice costs and hours. In the CY 2026 Proposed Rule, CMS stated that "we intend to work with interested parties, including the AMA to understand whether and how such data should be used in PFS rate setting in future rulemaking." At that time, the AMA recommended that CMS should delay implementation of any modifications to the indirect practice expense methodology until the 2024 PPI data are implemented. While the MMS supports CMS' efforts to simplify the complex PE formula, we continue to believe that **CMS should work with the AMA to consider how the 2024 PPI data could be used in the future to reflect changes in physician practice cost and physician hours worked. The MMS also supports the CMS proposal to continue to use the 2006-based MEI cost shares for CY 2027 and until 2024 PPI data may be considered.**

Updates to Practice Expense Methodology – Site of Service Payment Differential

Recommendations:

- Repeal its 2026 implementation of the 50 percent work adjustment to the indirect practice expense methodology effective January 1, 2027.

- Implement the proposal to modify the PE RVUs for nursing facility visits, CPT codes 99304-99316, to restore equalized payment between skilled and non-skilled nursing facility PE RVUs effective January 1, 2027.
- Work with the AMA to better understand the 2024 PPI data and how these data could be used within the PE methodology.
- Utilize data-driven approaches to address CMS' concern regarding potential duplication of indirect expense payment between the Medicare Physician Payment Schedule and hospital payment systems. CMS should work closely with stakeholders to ensure that independently practicing physicians are not unintentionally harmed.

Effective January 1, 2026, CMS implemented a significant refinement to the PE methodology, allocating half the amount of indirect PE RVUs per work RVU for services furnished in the facility setting (e.g., hospital, ambulatory surgical center) compared to those allocated to services furnished in the non-facility setting. This policy resulted in a seven percent cut to facility-based payment, while non-facility-based payment increased by four percent; some specialties fared worse, with facility-based ophthalmology cut 13 percent, otolaryngology 12 percent, and gastroenterology 10 percent. CMS states it remains open to additional data and refinements, and we support that position; until a more data-driven approach is developed, however, we urge CMS to repeal the 2026 change.

Unintended Consequences of CMS Indirect Practice Expense Methodology 2026 Change

The AMA previously shared with CMS examples of impacts to individual services and patient care that may have been unintended by this broad-based adjustment. We again share three such examples, which illustrate the need for a more targeted approach.

- **All Surgical Global Codes with Bundled Post-operative Office Visits:** Over 4,220 CPT codes bundle post-operative office visits into their surgical global period, even though those visits are typically furnished in the non-facility setting regardless of where the surgery itself occurred. Cataract surgery with intraocular lens implantation (CPT 66984), for example, is performed in the ASC setting 81 percent of the time, yet ophthalmologists still maintain and staff an office to perform the required follow-up visits. The CY 2026 PE methodology change reduces the entire surgical global facility PE RVU without accounting for this.

- **Direct Costs in Facility RVUs:** CMS states that indirect costs allocated to the facility setting are meant to reflect the typical practice expenses of that setting, but this does not fully reflect how the RBRVS is structured. CMS includes direct PE inputs (clinical staff, supplies, equipment) in the facility RVUs for 5,410 CPT codes, and these direct costs correlate with indirect costs incurred by the physician practice. A broad reduction in indirect PE therefore may not accurately reflect the resource costs physicians incur in the facility setting.

- **Nursing Facility E/M Visits:** CPT codes 99304-99316 describe services to patients who may be classified as skilled or non-skilled overnight in the same bed, with no meaningful change in the physician's work or costs. 2025 payment for these codes was appropriately identical regardless of classification; in 2026, the practice expense payment for skilled nursing facility visits (e.g., CPT 99309) is 35 percent lower than for non-skilled, even though most physicians who see these patients maintain offices whose indirect costs do not vary by how the facility classifies the patient.

The MMS supports CMS' proposal to correct this RUC-identified anomaly for CY 2027 by equalizing the non-facility and facility PE RVUs for nursing facility visits effective January 1, 2027, and agrees that "[t]his

particular situation illuminates ongoing concerns regarding the site of service differential." (Vol. 91, No. 135 FR 43860)

The AMA Physician Practice Information (PPI) Survey

The broader site-of-service payment differential creates inherent unfairness to office-based physicians competing with higher-paid sites of service. **The main driver of this differential, however, has been the lack of an inflationary update to physician payment**—in contrast to facility payment schedules, which receive annual inflation updates—compounded by inconsistent and unreliable hospital cost reporting.

The AMA's 2024 PPI Survey offers current, specialty-level practice-cost information that the current methodology does not reflect. Under the current methodology, each specialty is assigned a single blended PE per hour (PE/HR) across facility and non-facility settings, obscuring the same site-of-service issue CMS' policy attempts to address. The 2024 PPI data show direct PE/HR increased 40 percent since the legacy 2007 data while indirect PE/HR increased only 5 percent, and the indirect share of total practice expense per hour fell from 74 percent to 68 percent, meaning a data-driven update would allocate more expense to the non-facility setting.

The 2024 PPI Survey found $57 in indirect expenses per hour of direct patient care for hospital-based medicine and $62 for hospital-based surgery — costs incurred by the physician practice for coding, billing, scheduling, administrative and clinical staff, and office space, not by the facility. **MMS urges CMS to work with the AMA to better understand these data and how they could be used within the PE methodology.**

Example Impact of Indirect PE Methodology Change – Physician vs. Hospital

To ensure accurate payment, indirect costs should continue to be paid under both the professional and facility claims without overlap. When private-practice physicians provide services in the facility setting, their practice still incurs administrative costs paid only via the professional claim; shifting all indirect payment to the facility fee would leave these practices uncompensated. As illustrated by the colonoscopy example below (CPT 45385), a 2025 baseline payment of $243 to a private practice, $1,179 to a hospital working with a private-practice physician, and $1,422 to a hospital working with an employed physician, private practices incurred an eight percent payment reduction in 2026, while hospital systems gained whether the performing physician was in private practice (+3.7 percent) or hospital-employed (+1.7 percent).

			2026 Non-APM Medicare Physician Payment Schedule Total Payment	2026 Hospital Outpatient Payment	2026 Total Payment	Percentage Change
Payment for CPT Code 45385 Colonoscopy w/ Lesion Removal (AFTER PE Methodology Change)*	**Scenario 1: Private Practice Physician Performs Service in Facility**	**Private Practice Receives:**	$223		$223	**-8.0%**
		Hospital working with private practice receives:		$1,223	$1,223	**3.7%**
	Scenario 2: Hospital-Employed Physician Performs Service in Facility	**Hospital working with employed physicians receives:**	$223	$1,223	$1,446	**1.7%**

*Using 2026 Non-APM Medicare Conversion Factor

CMS cites a large reduction in private practice physicians as a rationale for this proposal, noting a drop to 35.4 percent by 2024. But CMS conflates employment status with practice ownership structure: according to the 2024 AMA Benchmark Survey, 42.2 percent of physicians are in private practice, 6.5 percent work for a private-equity-owned practice, and 4.6 percent for another ownership structure, while 46.7 percent work for or are employed/contracted by a hospital. No single arrangement holds a plurality, and these data do not support a simple dichotomy between independent and hospital-employed practice.

CMS needs to more fully understand the consequences to independent physician practices. Many physicians in independent practice (41 percent) routinely provide patient care in both the facility and non-facility settings, including well over half of general surgeons (81 percent), orthopedic surgeons (77 percent), surgical subspecialists (77 percent), obstetrician/gynecologists (75 percent), ophthalmologists (68 percent), and cardiologists (63 percent). (AMA 2024 Physician Practice Benchmark Survey.)

Potential Alternatives to the CMS Indirect Practice Expense Methodology Change

CMS has called for comment on other approaches to address potential overlap in practice expense payment. Site of service is not, by itself, a reliable proxy for the practice expenses actually incurred, and we applaud CMS' decision to keep considering the best way forward. CMS should work closely with stakeholders to ensure independently practicing physicians are not unintentionally harmed, and should consider the following data-driven alternatives in lieu of the existing broad-based policy:

- **Modify the current adjustment.** The current 50 percent reduction of the work component substantially overestimates any potential overlap; CMS should recognize at a minimum 75 percent of physician work in the indirect cost allocation.

- **Develop a modifier to identify hospital-employed physicians.** A modifier identifying hospital-employed physicians — who lack separate administrative or clinical offices — would let CMS target the indirect PE reduction more precisely, provided CMS first shares specialty-level impact analysis in proposed rulemaking.
- **Consider a claims-based methodology.** MedPAC's June 2025 report to Congress presents a claims-based alternative identifying physicians most likely to be facility-employed by analyzing both clinicians and services with more than 90 percent facility utilization, while cautioning that any threshold-based approach remains subject to judgment calls and payment cliffs.

Consistent with other CMS phase-in implementation, MMS asks that all changes to the practice expense methodology be phased in over a four-year period to be consistent with long-standing policy to phase in new practice cost data (PPI; clinical staff wages; medical supplies and equipment policies).

Valuation of Specific Codes – Shared Medical Appointments

The MMS strongly supports CMS' recognition of SMAs as an effective and valuable model of care delivery, particularly for patients with chronic conditions. By combining individualized clinical assessment with education, counseling, peer support, and opportunities for meaningful patient engagement, SMAs can improve access to care and support patients in managing complex and chronic health needs.

We agree that individual patient assessments and clinical care can appropriately occur within a group setting, provided that the practitioner documents the specific services furnished to each patient; however, we respectfully urge CMS not to establish a new, separate HCPCS code for SMAs. The existing Evaluation and Management (E/M) coding framework is sufficiently flexible to support appropriate billing for the individualized medical care furnished during an SMA. Physicians and other qualified health care professionals can document the medically necessary services provided to each patient and select the appropriate standard billing code based on either the time spent on the delivery of care, when applicable, or the complexity of medical decision-making, consistent with existing coding requirements.

Importantly, the current E/M codes allow payment to reflect meaningful differences among patients participating in the same group visit. The individualized clinical needs of participants may vary substantially, and a single new SMA code based on a "typical" visit could fail to appropriately recognize the time and complexity associated with the care of individual patients. The existing coding structure is better suited to account for these differences while preserving flexibility for physicians to furnish care in the manner most appropriate for their patients.

We are also concerned that creation of a new billing code could create unintended barriers to broader adoption of SMAs. New codes may not be promptly recognized by insurers, and even when recognized, they may not be reimbursed appropriately, which could result in inconsistent coverage and payment policies that discourage physicians and other clinicians from offering a model of care that has demonstrated important benefits for patient engagement and chronic disease management.

Accordingly, we encourage CMS to explicitly recognize and support SMAs as a legitimate and effective care delivery model while continuing to permit physicians to bill for individualized, medically necessary services using existing standard E/M codes. CMS should provide clear guidance confirming that individualized assessments may occur within the group setting and that appropriate documentation can support billing based on the applicable level of medical decision-making or time, consistent with existing coding rules.

This approach would promote flexibility, reduce unnecessary administrative complexity, and help ensure that payment appropriately reflects the individualized care provided to each patient without creating new coding and reimbursement barriers. We oppose the requirement for an existing patient-physician relationship, which would effectively prohibit referral of patients directly to established SMA programs run by other physicians or practitioners, implementing an unnecessary barrier to entry for many patients. We also oppose the imposition of proposed limits on the maximum time and patient capacity of SMAs. Such restrictions are too limiting for a typical SMA, which can easily run in excess of 90 minutes. In cases where language interpretation is required, the presentation of material and discussion may take twice as long, which would cause an inequity in access to SMAs. Similarly, a restrictive 10-person limit for an SMA is too inflexible, especially as no-show rates often require clinicians to enroll more patients than they expect to attend an SMA just to ensure economic feasibility. Trying to establish a single, one-size-fits-all time limit and capacity limit serves only as barriers to the promise of SMAs both from a patient standpoint and from a clinician perspective in terms of health benefits and financial impact sustainability, respectively. We strongly support the use of telehealth for SMAs, as this care modality is one of the most commonly used, valuable, and legitimate health care models. It would decrease no-show rates and increase contact hours, improving patient outcomes.

Importantly, compliance programs are already in place to guard against fraud, waste, and abuse. Physician documentation serves as evidence that care was provided to patients and justifies the appropriate level of billing. With regard to documentation, SMAs are the same as other clinical visits with patients and are subject to the same level of billing scrutiny.

SMAs are beneficial when a patient's chronic medical condition would improve with frequent, repeated contact with a physician or other health care provider for education, counseling, and motivational interviewing or encouragement. Patients additionally benefit from social interaction and conversational exchanges with others who have the same condition. For pediatrics in particular, SMAs are ideal to address risk factors for disease development to prevent disease. It is important to note that many health conditions improve with frequent contact, counseling, monitoring, and encouragement. Additionally, given the current physician shortages, SMAs fill a gap in care experienced by many patients. Allowing physicians to be paid for SMAs using the codes with which they are already familiar reduces complexity and encourages the SMA model to be used, enabling additional outcome research.

We urge CMS to support the continued use and expansion of shared medical appointments while relying on the existing, well-established billing framework that physicians already understand and use.

B. Remote Physiologic Monitoring (RPM) or Remote Therapeutic Monitoring (RTM)

Recommendations:

- CMS should refrain from implementing any changes to the direct practice expenses or creating G codes for Remote Physiologic Monitoring (RPM) or Remote Therapeutic Monitoring (RTM) until specialty societies and the RUC review these services in January 2027. CMS should not impose any new regulatory burdens on physicians associated with the proposed requirement for an initiating visit to precede RPM or RTM services. The proposal to restrict delivery of remote monitoring to staff employed by the medical practice should not be finalized.

Codes and Relative Values for Remote Monitoring

CMS began paying for CPT codes for RPM in 2019. Codes for RTM followed, as well as expansion of coding for RPM. Citing a lack of data regarding the typical device used in the provision of RPM and RTM

services, CMS notes that this may have led to overpayments for the services. Therefore, CMS proposes to decrease the PE RVUs for several of these services using crosswalks to other services and eliminating all direct practice costs for the treatment management codes. If finalized, these changes will result in significant 2027 payment reductions for RPM and RTM services, often as much as the 19 percent statutory limit, with further reductions then transitioned into 2028 and beyond. CMS also proposes bundling the 19 RPM and RTM CPT codes and creating four new HCPCS G-codes in 2027 to describe remote monitoring services, which would lead to immediate implementation of the full cut, an 80 percent decrease.

As CMS cites that it lacks current data on the typical devices and other resources used to provide RPM and RTM services, the MMS agrees with the RUC that it would be far better to collect the needed data than to reduce payments without any data to serve as a foundation for revised RVUs. The RUC was scheduled to begin re-examining the RPM and RTM services in January 2028. Given CMS' concern regarding the direct practice expense inputs on the typical devices used and typical clinical staff workflow/time for these services, the RUC is moving up its review of all 19 RPM and RTM codes to January 2027 to review practice expense only. The MMS urges CMS to maintain the current direct practice expenses and refrain from creating G-codes for RPM or RTM to allow time for the RUC to review the practice expenses for these services.

Proposals Responding to HHS Office of Inspector General (OIG) Reports

The HHS OIG has issued two reports on remote monitoring that raised concerns about whether RPM and RTM services are being delivered appropriately. Its 2024 report, "Additional Oversight of Remote Patient Monitoring in Medicare Is Needed," said that, although use of remote monitoring rose "dramatically" from 2019 to 2022, nearly half the patients who received these services did not get all three components and "Medicare lacks key information for oversight, including who ordered the monitoring for the enrollee." The report included recommendations that CMS: implement additional safeguards to ensure appropriate use and billing; require that information about the ordering provider be included on claims; and identify and monitor companies that bill for remote monitoring. One year later, its report, "Billing for Remote Patient Monitoring in Medicare," noted that use of these services had continued to grow and suggested further scrutiny in instances of billing for a high proportion of patients who have no prior history with the medical practice and for those receiving multiple monitoring devices a month.

In an OIG meeting following the 2024 report, AMA participants noted that the claims the OIG reviewed were from the COVID public health emergency and that the observed growth in remote monitoring was part of a larger digital health transformation. Responding to the report's concern that many patients for whom RPM claims were submitted had not received all three elements of the service and may not have received education and set-up or treatment management, participants explained that education and set-up is only provided once for each patient, not monthly, and some devices may not require patient education and set-up. Also, if the patient did not collect 16 days of data or the physician did not spend at least 20 minutes on treatment management, then treatment management would not be reported that month, which is an example of correct coding, not a program integrity issue.

In response to the OIG reports, CMS is making several proposed changes to its RPM and RTM policies for 2027. Although CMS has required that RPM services be furnished only to established patients since 2021, CMS proposes to extend this policy to RTM services. It also proposes that physicians reporting remote monitoring furnish a separately reportable initiating visit in association with the onset of RPM or RTM. In addition, CMS proposes to only allow payment for RPM or RTM services when performed by clinical staff employed by the practice and not when those services are delivered by contractors.

The MMS agrees that it would be good practice for the notes from the visit at which the physician determines that a patient should receive remote monitoring to include that information but does not support new regulatory burdens being imposed on medical practices to allow CMS to document these occurrences. Many Medicare administrative requirements increase compliance burdens and disrupt practice workflows without benefiting patients' care. The Administration has made important strides in removing unnecessary regulations, and it should not impose new ones such as these.

We are also concerned about the use of the phrase "separately reportable." We believe the intent is to distinguish the visit at which RPM or RTM is discussed with the patient from the delivery of the first RPM or RTM service. It is confusing, however, because it is unclear what would need to be separate. For example, the need for remote monitoring following a hospital stay could be discussed with the patient during a hospital or discharge visit that is part of a global surgical service and not separately reported even though this visit is separate from the remote monitoring services. It would be helpful for CMS to clarify the meaning of "separately reportable."

CMS should withdraw its proposal to only allow staff who are employees of the medical practice to deliver RPM and RTM services. A variety of clinical and financial arrangements are used to deliver remote monitoring; limiting it to employed practice staff would be highly disruptive and impair patients' access. For example, nursing staff employed by a medical center or hospital may provide remote monitoring that is ordered and billed by a faculty practice plan or medical group that is a separate employer. Under the proposed policy, the faculty practice physicians would be unable to use the services of the nursing staff who perform the remote monitoring even though they are all part of the same system. There are also arrangements that have been developed to comply with state laws. In Texas, medical schools cannot own hospitals, so RPM is provided post-discharge through a partnership between the school and the hospital. Academic health systems may also serve as remote monitoring vendors for rural hospitals as part of the Rural Health Transformation Program (RHTP). Independent practices and small, rural, or safety net practices and hospitals are unlikely to have the resources to train or hire their own staff for this purpose instead of contracting with organizations that serve a larger patient population. **At a time when initiatives such as RHTP aim to improve rural patients' access to innovative technologies, this proposal would have the opposite effect.** The OIG recommended that CMS "identify and monitor companies that bill for remote patient monitoring," and CMS concurred, but the OIG did not say that CMS should no longer allow them to provide the services. If finalized, this proposal would harm patients' access to care and reverse progress in digital health transformation.

The MMS urges CMS not to replace the existing RPM and RTM CPT code families with the four proposed HCPCS G-codes. Although the MMS supports efforts to reduce unnecessary administrative burden and strengthen program integrity, collapsing 17 distinct CPT codes into four Medicare-specific codes would eliminate clinically and operationally meaningful distinctions while creating another parallel coding structure.

The MMS recommends that CMS:

1. Retain the existing RPM and RTM CPT code families rather than adopting GRPM1, GRPM2, GRTM1, and GRTM2.
2. Allow sufficient time to evaluate utilization of the recently revised CPT structure before considering a replacement taxonomy.
3. Use the existing component-level claims data to develop targeted program-integrity safeguards.
4. Avoid requiring every monitoring component during every calendar month when the component is not clinically necessary.
5. Base valuation changes on representative evidence concerning devices, software, licensing, data transmission, staffing, and clinical workflows.

6. Address supervision and third-party arrangements according to accountability for the service, rather than assuming that employment status determines whether the service was appropriately furnished.

C. Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS Code G2211)

Recommendations:

- The MMS is concerned that transitioning to a percentage-based modifier without assigned RVUs would remove physicians' ability to receive RVU credit for this work under RVU-based productivity models, and that CMS has not provided sufficient data, analysis, or methodology to demonstrate that ACO participation status warrants valuing MOD2 at twice the rate of MOD1.
- The MMS recommends that CMS commit to timely and transparent public reporting of MOD1 and MOD2 utilization disaggregated by specialty, care setting, and E/M visit level so that stakeholders can assess whether the modifiers are functioning as intended.

CMS proposes to delete HCPCS code G2211 and replace it with a modifier (MOD1), valued at 16 percent of the associated E/M service, together with a second modifier (MOD2), valued at 32 percent and available only to ACO participants. This is a mechanical change to the billing mechanism for recognizing visit complexity; it does not resolve the concerns the AMA has raised about G2211 since its inception.

The central concern with G2211 has never been about recognizing the resource costs of longitudinal care, but about the accuracy of CMS' utilization assumptions. CMS originally assumed G2211 would be reported with 38 percent of office/outpatient E/M visits, an estimate the MMS warned in its CY 2024 comment letter was unsupported, citing CMS' similar overestimation of the transitional care management codes (99495/99496) in 2013, which cost the PFS more than $5.2 billion through 2021. Those concerns proved well founded: 2024 claims data show G2211 was reported with only about 10.5 percent of visits, roughly one-quarter of CMS' estimate, producing a budget-neutrality cut to the conversion factor nearly three times larger than warranted and removing an estimated $1 billion from the PFS, ultimately reducing payment to the primary care physicians the code was meant to support by more than it helped them.

Because those funds cannot be restored retroactively, the MMS strongly supports the reconciliation mechanism in the Patients First Act of 2026 (H.R. 9693), which would require CMS to compare estimated against actual utilization for new separately payable services and prospectively correct material gaps, exempt from budget neutrality. We urge CMS to support this reform and, in the interim, use its existing authority to correct material utilization misestimates prospectively, as the AMA requested in its May 2025 letter.

Impact on Physicians Compensated Under RVU-based Models

Physicians compensated under RVU-based productivity models face a real-world consequence from this transition: G2211 currently carries assigned RVUs that count toward productivity and compensation, but CMS proposes to value MOD1 and MOD2 as flat percentages of the base E/M code with no RVUs attributable to the reporting physician. A physician performing identical work would receive no comparable RVU credit under the modifier approach, even though CMS continues to recognize the underlying work for payment purposes. While compensation-arrangement design is a business decision outside CMS' authority, we raise this so CMS has a complete picture of the proposal's practical effect on physicians.

Operational Questions

CMS proposes to pay MOD2 at 32 percent, twice MOD1's 16 percent, when reported by ACO participants, reimbursing what can be identical longitudinal E/M work at different rates based on ACO-participation status rather than the complexity of the visit, which is the standard the modifier is supposed to measure. CMS has not provided data or methodology supporting the size of this differential, and to the extent ACO participation involves added infrastructure or coordination costs, the Shared Savings Program and LEAD

Model already compensate ACOs for those investments through shared savings payments. The MMS urges CMS to commit to timely, transparent public reporting of MOD1 and MOD2 utilization, disaggregated by specialty, care setting, and E/M visit level, and to make the underlying methodology and data available for review.

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

- Do not finalize the proposed 50 percent payment reduction for services furnished on the same date as a separately identifiable Office/Outpatient Evaluation and Management (E/M) visit reported with modifier -25.
- Do not extend the policy to procedures furnished on the same date as inpatient or other E/M services.
- Address any genuine overlap through the established misvalued code and RUC valuation processes on a code-specific basis, rather than through a uniform, payment-level reduction. Where CMS believes specific codes do not fully account for such overlap, the RUC welcomes the opportunity to work with CMS to strengthen the resource-based process.

CMS proposes to reduce payment when a separately identifiable Office/Outpatient (O/O) E/M visit is furnished by the same physician (or group) on the same day as a 000-, 010-, or 090-day global procedure: the higher-paid service would be paid at 100 percent and all other same-day services at 50 percent. CMS states this mirrors its 2019 proposal and the longstanding surgical multiple-procedure payment reduction, and is meant to address the "likely" duplication of payment between the global surgical package and a separately identifiable E/M visit billed with modifier -25 (91 FR 43908).

The MMS opposes this proposal and urges CMS not to finalize it. CMS offers no evidence of duplication or its magnitude, only a hypothesis that payment is "likely" duplicated. In fact, this overlap has already been identified and removed through the misvalued code initiative and the RUC's survey and valuation methodology, which are expressly designed to exclude work associated with a separately identifiable E/M service. CMS now proposes a second, across-the-board 50 percent cut to the entire value of the lower-valued service, whether physician work, practice expense, or professional liability alike, to address, at most, a small overlap confined to portions of pre- and post-service time. The burden would fall hardest on the office-based, independent practices CMS says it wants to sustain. We do not dispute that payment should reflect only the resources actually required when services are furnished together, but that principle is served by code-specific analysis through the established misvalued code and RUC processes, not a blanket payment-level reduction, and we welcome the opportunity to work with CMS on strengthening those processes.

<u>CMS has not addressed the concerns that led the Agency to decline to finalize a substantially similar proposal in 2019.</u>
This is not a new proposal. CMS proposed a substantially similar, narrower policy in the CY 2019 MFS Proposed Rule and declined to finalize it after considering public comments. The current proposal is broader, extending to 010- and 090-day globals and reducing payment for all same-day services other than the highest-valued one, yet CMS has not developed the evidentiary basis whose absence contributed to its earlier decision not to proceed.

<u>The RUC valuation process already removes the overlap CMS seeks to address.</u>
The RUC has long recognized potential overlap and recommends only physician work and direct practice expense inputs that are not duplicative when a procedure is typically furnished with a same-day E/M visit; because indirect practice expense is allocated based on work and direct PE, those reductions flow through to indirect PE as well. CMS itself frames the overlap only as "likely" but a payment reduction of this scope should rest on demonstrated overlap in identified services, not an unsubstantiated assumption. That the

RUC's adjustments are, in CMS' own words, "minor" is not a gap in the process; it reflects that the actual overlap, which is limited to a share of pre-service evaluation and post-service time, not intra-service work, procedure-specific supplies, or the physician's technical skill, is itself small.

CMS' own methodology confirms this. In the Methodology for Establishing Work RVUs section of every MFS rule, CMS explains that it assumes roughly one-third of pre- and post-service time overlaps with a same-day E/M visit and adjusts work RVUs and/or times accordingly when the RUC has not already done so. CMS has also repeatedly identified specific codes for review through the misvalued code initiative. For example, reviewing 83 services with a 000-day global period in CY 2017 rulemaking and removing overlap from the 21 that warranted it. **Implementing this proposal on top of that prior work would reduce payment a second time for resources already adjusted to eliminate duplication.**

RUC processes include specific safeguards against this double-counting: the physician work survey instructions direct respondents to exclude work for a "distinct evaluation and management service...reported with modifier -25," and established pre-, intra-, and post-service time standards are designed to prevent duplication. Where CMS identifies "pre-operative visits" as a concern, that time is captured only as minimal pre-evaluation time for activities above and beyond an E/M service. The RUC also reviews claims data and removes overlapping clinical labor, such as greeting the patient, confirming records, obtaining vital signs, preparing the room, and cleaning up afterward, which accounts for approximately 13 minutes when these activities are shared between a same-day E/M visit and procedure.

Practice expense supplies and equipment for an office visit account for only $6 in direct costs, resources that are similarly not duplicated within procedure codes carrying substantial, unrelated supply and equipment costs of their own. We urge CMS to continue working with the RUC and other stakeholders to ensure codes typically reported with a same-day E/M visit are valued to include only resources distinct from that visit, and welcome the opportunity to strengthen that process further where warranted.

<u>The proposed 50 percent reduction bears no reasonable relationship to the overlap it targets.</u>
CMS analogizes to its surgical multiple-procedure payment reduction (MPPR), but that policy addresses overlap between procedural services sharing substantial resource costs, a rationale that does not extend to a minor procedure and a separately identifiable E/M visit. When CMS calibrates reductions for genuine overlap elsewhere in the fee schedule, such as for diagnostic imaging or cardiovascular and ophthalmology services, it identifies the specific component involved and sizes the reduction to the overlap actually present. The proposed policy reflects neither form of precision: it applies a uniform 50 percent cut to the entire value of the lower-valued service, including components in which CMS has identified no overlap at all. For these reasons, the MMS strongly opposes the proposed reduction, which far exceeds any reasonable estimate of overlapping resource costs.

<u>The proposal would disproportionally harm the independent, office-based practices CMS seeks to support.</u>
These services are frequently furnished in independent settings that bear the full cost of clinical staff, supplies, and equipment reflected in the non-facility payment, with no facility revenue to offset a reduction. Many procedures would be paid below their direct cost of delivery, falling most heavily on the practices CMS has said it wants to sustain and risking the very consolidation CMS has identified as a concern.

<u>Extension of the policy to other E/M services</u>
CMS also seeks comment on extending this reduction to procedures performed on the same date as inpatient or other facility-based E/M visits. The MMS opposes any such expansion: inpatient and other facility-based E/M services carry no direct practice expense payment, and the physician work for a same-day procedure generally occurs at a different time and reflects distinct clinical activities, so there is no meaningful duplication to address.

We appreciate CMS' responsibility to ensure that Medicare payments accurately reflect the resources required to furnish care. Consistent with that goal, we urge CMS to address the following in the final rule:

- The specific evidence demonstrating that separately identifiable, same-day E/M services systematically contain duplicative resources warranting a reduction, and the basis for setting that reduction at 50 percent;
- The analysis CMS conducted regarding the policy's impact on independent physician practices and on beneficiary access, particularly in rural and underserved communities; and,
- What evidence or circumstances have changed since CMS declined to finalize a similar policy in 2019.

D. Medicare Telehealth Services

Recommendations:

- Finalize its proposal to allow teaching physicians to bill for telehealth services when either they or the resident is in the same location as the patient and extend this policy to include scenarios in which the teaching physician and the resident are in the same location while the patient is receiving the telehealth service in a different location. MMS urges CMS to allow public comments on the subregulatory guidance it plans to issue for the new modifiers BB and BC.

The Consolidated Appropriations Act (CAA), 2026, extended flexibilities that allow Medicare telehealth services to be delivered nationwide and patients to receive services in their homes through 2027. Audio-only services are also extended, and in-person visit requirements for telehealth for mental health services are delayed through 2027.

The CAA 2026 also requires CMS to create modifiers for telehealth furnished through a virtual telehealth platform by a physician who contracts with or has a payment arrangement with an entity that owns the platform. In the proposed rule, CMS states that it is establishing modifiers BB and BC for this purpose, but they are for reporting only and will not affect payment rates. It also says that it will issue sub-regulatory guidance on the use of the modifiers. It is not clear what the purpose of these modifiers is. Physicians have many different types of arrangements for providing telehealth services, and they do not know which ones would be subject to these modifiers. For example, they may use a virtual platform because it is used by the health system in which they practice. The MMS recommends that CMS provide its subregulatory guidance in draft form and allow an opportunity for public comments to make sure that people understand this new policy and that it is not unnecessarily burdensome.

The MMS supports the proposal to provide more flexibility for teaching physicians providing virtual supervision of residents. The current policy requires that the teaching physician, resident, and patient be in three different locations. CMS should finalize the proposed policy to allow teaching physicians to bill for services on the Medicare Telehealth List involving residents when either the teaching physician or the resident is in the same physical location as the patient. The MMS also recommends that CMS allow for the teaching physician and the resident to be in the same location and the beneficiary to receive telehealth services in a different location.

E. Limiting Medicare Coverage of Certain Individuals

Recommendation:

- Maintain the original definition of "eligible noncitizen" to ensure that a greater percentage of legally present individuals can continue to qualify for Medicare.

The proposed rule would add a new Medicare specific definition of 'eligible noncitizen.' Specifically, an "eligible noncitizen" would be an individual who is (1) an alien lawfully admitted for permanent residence under the Immigration and Nationality Act; (2) an alien who has been granted the status of a Cuban or Haitian Entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980 (Pub. L. 96-422); or (3) an individual who lawfully resides in the United States in accordance with a Compact of Free Association (COFA) referred to in 8 U.S.C. 1612(b)(2)(G). The rule expressly states that noncitizen U.S. nationals who are eligible for Medicare under section 1899C(a)(1) of the Act would no longer be considered "eligible noncitizens." However, legal permanent residents who meet the five-year continuous residency requirement and other applicable Medicare requirements would maintain their Medicare benefit. On January 1, 2027, individuals who do not meet the proposed revised definition of an "eligible noncitizen" would no longer be able to obtain benefits under Medicare. CMS also included a proposed termination, enrollment, and notification framework to implement these changes within the proposed rule.

Prior to the passage of the One Big Beautiful Bill Act (OBBBA), all lawfully present immigrant workers who had paid Medicare payroll taxes for at least 40 quarters and were 65 or older or disabled were eligible for premium-free Medicare Part A. Those who did not qualify for premium-free Part A coverage could still be eligible for the coverage by paying premiums, if they met the five-year continuous residency requirement, and accordingly these individuals were then also eligible for Medicare Part B, C, and D. However, with the passage of the OBBBA, the categories of lawfully present immigrants who can now qualify for Medicare have been reduced, and the proposed rule would implement some of these changes. For example, the proposed rule would remove most refugees, self-petitioners, individuals with deferred action, asylum seekers, and those with temporary protected status from the definition of eligible noncitizens. With these changes, it is estimated that at least 100,000 people will lose access to Medicare coverage as soon as this proposed rule is implemented.

The MMS advocates for the best possible health care for every patient regardless of immigration status. Accordingly, we urge CMS to maintain a broad definition of 'eligible noncitizen' to ensure that those who patients can continue to maintain and gain access to this health care coverage.

II. UPDATES TO QUALITY PAYMENT PROGRAM PROVISIONS

A. Merit-based Incentive Payment System (MIPS)

Performance Threshold

Recommendation:

- The MMS supports CMS maintaining the performance threshold at 75 points for the next two performance periods, as previously finalized.

The MMS appreciates CMS' decision to maintain stability and continuity with the MIPS program by maintaining the performance threshold at 75 points for the next two performance periods (through the CY 2028 performance period/2030 payment year), as previously finalized. Maintaining the current performance

threshold provides physician practices a greater opportunity to avoid a penalty and earn an incentive, and it aligns with President Trump's Executive Order 14192, Unleashing Prosperity Through Deregulation. We urge CMS to be cognizant of the impact the transition to MVP and digital quality measure (dQM) reporting will have on practices as it reviews CY 2026 performance period/ 2028 payment year data. We are concerned that if CMS raises the performance threshold prematurely, and in combination with requiring mandatory MVP reporting, practices will be challenged with meeting a higher threshold, especially given the limited number of measures within an MVP.

B. MIPS Value Pathways (MVPs)

Proposal to Mandate MVPS and Sunset Traditional MIPS

Recommendation:

- The MMS opposes CMS' proposal to sunset traditional MIPS after the 2028 performance period/2030 MIPS payment year and require MVP reporting for all eligible clinicians participating in MIPS starting in 2029.

Since CMS has introduced MIPS Value Pathways (MVPs) for MIPS reporting, the MMS, together with the house of medicine, has repeatedly emphasized the need to maintain traditional MIPS reporting and has not supported mandatory MVP reporting. MVPs must be redesigned to focus on specific health conditions that an individual physician would treat, rather than physician specialties or broad groups of different health conditions. The current set of MVPs cannot fairly or accurately assess physician performance because CMS has created MVPs primarily based on certain physician specialties and broad categories of health problems, rather than focusing each MVP on a specific type of health condition, procedure or episode of care that would reasonably be treated by the same clinician. Therefore, the MMS is disappointed that, despite these longstanding concerns, CMS proposes to sunset traditional MIPS after the 2028 performance period/2030 MIPS payment year and require MVP reporting for all eligible clinicians who are participating in MIPS who are not reporting the Medicare Shared Savings Program (MSSP) APP Plus measure set.

We recognize that CMS claims that 98 percent of specialties will be covered by an MVP if CMS finalizes the three new proposed MVPs. However, CMS must ensure that 100 percent of all specialties have a relevant MVP because MACRA mandates that all eligible clinicians are subject to MIPS. Therefore, it is imperative that CMS design a program that meets the needs of all specialties and subspecialties. For example, clinicians who specialize in allergy and immunology or radiation oncology do not have a relevant MVP, despite these specialties making several recommendations to CMS over the years.

We are also concerned that the 98 percent figure is an overestimation, as it does not take into consideration whether an existing MVP has enough measures to cover a condition, procedure, or episode of care. CMS should perform a more thorough analysis before sunsetting traditional MIPS. The current minimum number of quality measures that must be reported for each MVP is four, plus the population health measure, yet most MVPs do not include that number of relevant measures for a specific condition, procedure, or a connected episode-based cost measure.

An MVP that nominally applies to orthopedic surgery, gastroenterology, cardiology, or any specialty but does not offer a viable reporting pathway to most physicians within the specialty should not be used as the exclusive reporting mechanism for the specialty. Therefore, the lack of a comprehensive set of measures for each procedure and/or condition within each MVP will force physicians to select measures that do not reflect their scope of practice and will continue to exacerbate the ongoing challenge of this program: quality reporting is completed to satisfy reporting requirements rather than drive quality improvement efforts and

provide useful information on the quality of care provided to patients. It also contributes directly to scoring discrepancies between different subspecialists within the same MVP. Essentially, CMS is just rearranging the deck chairs and giving a new name to MIPS reporting. We urge CMS to work with the impacted specialties to create meaningful MVPs.

We reiterate the following key recommendations to improve MVPs:

- *MVP By Patient Health Conditions:* While there is no one-size-fits-all approach to MVPs that will work for every medical specialty, in order to support patient-focused care, MVPs must focus on patient health conditions rather than medical specialties and MUST prioritize alignment of quality and cost measures. Many MVPs have quality measures for specific health conditions without corresponding cost measures for those conditions, and some have cost measures without matching quality measures. As a result, some physicians in an MVP can be scored vastly differently on both quality and cost, some can be scored on quality for some patients and costs for other patients, and others can be scored only on quality, all due to the availability of measures, which is beyond their control. This means that neither the individual performance category scores for cost and quality nor the final MIPS scores based on both categories will be comparable for different physicians in the same MVP, which is the purported goal of MVPs.
- *MVP Clinical Groupings:* If CMS continues to maintain specialty-specific MVPs, MVP clinical groupings must also prioritize alignment of quality and cost measures and be clinically relevant. We continue to have concerns that even with the clinical groupings, MVPs still ignore the variation in care provided by subspecialists, differences among patient populations, and the relevancy of the cost measures. For example, the proposed Hospitalist MVP is based around a specialty rather than a specific health condition or group of similar conditions. It also ignores that the majority of hospitalists participate in MIPS through the Facility-based option.
- *Newly Proposed Condition Specific MVPs:* We appreciate CMS considering the AMA's feedback by proposing two condition specific MVPs for the 2027 program (Diabetic Disease and Hypertension), but refinements are needed. The 2027 proposals are overly broad, and the groupings within the MVP are by specialty. For detailed feedback, please see our comments on the proposed new MVPs for the 2027 performance period/2029 payment year.
- *Facility-based Option:* MMS asks CMS to provide the option to apply facility-based scoring to MVP participants that otherwise qualify for this scoring option in traditional MIPS to encourage alignment of quality improvement efforts between physicians and the facilities where they provide care.
- *Group Reporting:* We are concerned that requiring group practices to form multiple subgroups to report MVPs will add significantly to the burden of compliance and reduce the reliability of their scores. At a minimum, to reduce the burden on multispecialty practices of forming subgroups and reporting multiple MVPs, we recommend that CMS establish a maximum number of MVPs for multi-specialty groups and develop guidelines for choosing MVPs for multi-specialty groups, such as MVPs that correspond with the highest volume of services and/or largest number of clinicians.
- *Benchmark Methodology:* Update the quality measure benchmark methodology to align with the administrative claims quality measures and cost measures methodology.
- *Data Completeness:* We continue to urge CMS to reduce the data completeness requirement for satisfactorily reporting on a measure in MIPS, MVP, MSSP, and ASM. Alternatively, consider a proposal like the modified data completeness proposal CMS proposes for MSSP. Please see FHIR RFI for more specific information.
- *Total Per Capita Cost (TPCC) Measure:* We urge CMS to remove the TPCC Measure from MVPs, particularly for MVPs that have other available episode-based cost measures. Should CMS continue to use the TPCC measure in MVPs, it should be substantially revised to exclude costs for preventive services and services outside the control or influence of the physician being evaluated.

Therefore, **we urge CMS to incentivize the reporting of MVPs, rather than mandate it, and refrain from sunsetting traditional MIPS.** In 2024, which is the most recent data CMS has published, only about 11,000 clinicians received a MIPS score through an MVP. Those scores were based on the performance of only 634 separate entities – 216 groups, 16 subgroups, and 402 individuals. In many cases, MVP participants received a default score of 75, rather than a score based on their actual performance on the measures in the MVP, because they were exempt from submitting one or more of the required measures. For many participants who did receive a score other than 75, it was often based solely on quality measures and improvement activities, not on cost or promoting interoperability. It is likely that many of our recommended changes to MVP would encourage and lead to voluntary participation in MIPS, and, as a result, increased MVP participation, which should be CMS' focus before mandating.

C. Proposals Specific to MIPS Quality Performance Category

For the 2027 performance period/2029 MIPS payment year, CMS proposes a measure set inventory of 180 MIPS quality measures (177 of which are available in traditional MIPS and 3 of which are available only for MVPs), including 20 measure removals, 10 new measures for 2027 and one new measure for 2028, and 43 substantive changes to existing measures. The AMA offers the following measure-specific comments:

New Measures
There is an urgent need for CMS to consider and accept more measures into MIPS to better ensure alignment with the growing number of episode-based cost measures, APMs, and other quality and certification programs. In addition, new measures would further equip patients with usable quality information and provide physicians with the opportunity to be successful in CMS' quality programs and APMs. If these gaps are not filled, we believe that the future of the program, specifically the transition to and adoption of meaningful MVPs, is in further jeopardy.

The MMS is concerned that there is an assumption among the Administration, CMS, and its contractors that decreasing the number of measures and MVPs will minimize burden, and there appears to be a desire to reduce the work for CMS and its contractors. **However, it is not the number of measures or MVPs that causes physician burden, but rather the overly complex reporting requirements and poorly designed programs.** The program should allow physicians to track and measure individual health conditions, episodes of care, or major procedures that can be directly linked to and drive quality improvement activities. Therefore, **CMS must maintain a robust portfolio of quality measures that enable quality improvement in addition to promoting accountability.**

D. Advanced APMs

Recommendation:

- Finalize its policy to apply APM-related financial incentives only to NPI/TIN combinations for TINs participating in an APM Entity, particularly for the differential conversion factor for APM participants, due to statutory limitations and logistical feasibility concerns and the negative impacts it would have on future APM adoption.
- If CMS moves forward with this policy, MMS requests the Agency to redirect funding towards initiatives to advance APM adoption, particularly by small, rural, independent, safety net, and specialty practices.

CMS proposes to apply APM-related financial incentives — including APM Incentive Payments and the QP conversion factor differential — only to claims from Advanced APM-participating TINs, rather than

all TINs associated with a qualifying NPI. We understand the goal of directing incentives to APM-participating practices and physicians, but have several practical concerns about unintended consequences for APM participation and physician reimbursement.

Because the 0.5 conversion factor differential is designed to be cumulative each year under MACRA, applying the policy at each unique TIN/NPI combination could quickly become logistically complex, particularly given its interaction with simultaneous MIPS adjustments at the same combinations, an interaction the proposed rule does not address. CMS should also clarify how it would treat a physician who qualifies for APM incentives under one ACO's TIN and then moves to a different ACO's TIN before the payment year; at minimum, that physician should retain the incentive, having demonstrated APM commitment twice.

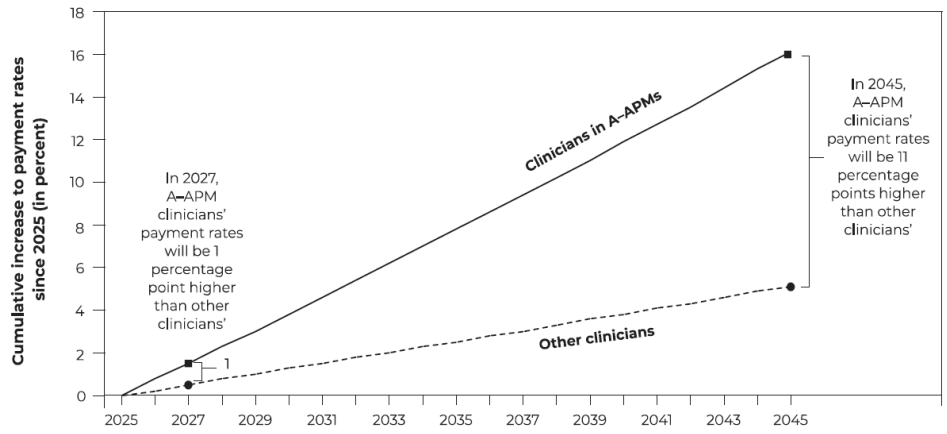
Because of the lag between qualifying for an Advanced APM and receiving the incentive, physicians who earned it in the performance year could lose access to it in the payment year simply by changing or opening practices, discouraging exactly the mobility and practice growth CMS says it wants to support.

This approach also runs counter to Congress' intent. MACRA defines a qualifying APM participant based on APM participation in a prior performance period, not the payment year, and directs the differential conversion factor to apply to all of a clinician's payments in the applicable payment year based on that participation, a benefit already earned and not negated by a subsequent move between TINs. This is also inconsistent with CMS' own MIPS adjustments, which follow a clinician's past performance, good or bad, to a new practice at the TIN/NPI level.

Because APM incentive payments and the conversion factor differential are not budget neutral, CMS stands to generate savings by finalizing this change, savings CMS estimates at $2.38 billion, a figure that will compound in future years. Physicians already lack an inflation-based payment update and have seen real reimbursement fall 33 percent since 2001; withdrawing this differential removes funds practices would otherwise reinvest in the infrastructure needed for future APM participation. The figure below, from MedPAC's March 2026 report, illustrates the growing value of this differential over time.

FIGURE 4–11

Under current law, the difference between payment rates for clinicians in A–APMs and other clinicians will be small in the 2020s but large by the 2040s



Note: A–APM (advanced alternative payment model). Graph does not show adjustments to payment rates prompted by budget-neutrality requirements, which take into account additions, deletions, or modifications of fee schedule billing codes and can result in payment updates that are larger or smaller than specified in statute. Graph also does not show (1) annual Merit-based Incentive Payment System adjustments, which can increase or decrease payments to individual clinicians based on performance measures, or (2) annual A–APM participation bonuses available from 2019 through 2026 because these adjustments are one time only and not built into subsequent years' payment rates. Graph also does not show the effects of the expiration of the 2 percent sequester that applies to payment rates through February 2033.

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This burden would fall hardest on physicians and practices that remain locked out of APM participation today for lack of relevant models and pathways, particularly as CMS develops more targeted pathways for rural, specialty, independent, and small practices. For these reasons, the MMS urges CMS not to finalize this policy. If CMS moves forward regardless, it should reappropriate any resulting savings toward APM adoption and growth. For example, through advance funding or infrastructure support for practices preparing to join new or existing APMs.

III. REQUESTS FOR INFORMATION (RFIs)

The MMS appreciates CMS' inclusion of numerous requests for information (RFIs) throughout the proposed rule and its willingness to seek stakeholder input on a broad range of important policy and operational issues. We commend the Agency for seeking input at an early stage, particularly on topics that would benefit from careful evaluation before future policy changes are considered. The MMS responds to the RFIs below.

A. Request for Information: Current Procedural Terminology (CPT)

The MMS refers the Agency to the comment submitted by the AMA, which responds to this RFI in a detailed manner that the MMS fully supports.

B. Request for Information: Redesigning Primary Care to Make America Healthy Again

The MMS appreciates CMS' focus on strengthening primary care as a foundation for improving health, preventing disease, and reducing avoidable health care spending over time. We agree that Medicare payment policy should support investment in high-value primary care and recognize that the current payment structure does not fully align with how longitudinal, team-based primary care is delivered. We therefore welcome CMS' examination of new payment approaches and offer the following comments on how Medicare can better align payment with the delivery of comprehensive, longitudinal, coordinated primary care.

C. Request for Information: Applying Electronic Prior Authorization Measures to Shared Savings Program ACOs

The MMS appreciates CMS' interest in using electronic prior authorization (ePA) to improve patient access, strengthen care coordination, and reduce reliance on payer portals, fax, telephone calls, and other manual processes. The MMS has supported ePA when it reduces actual administrative work, is integrated into physician workflows, and expedites approvals. **However, digitization alone does not reduce burden, and ACOs should not be held accountable for payer requirements, technology, or determinations they do not control.**

The RFI does not propose requiring ACOs to administer prior authorization programs or make coverage decisions. Rather, CMS is considering whether completion of an ePA transaction could be required or recognized as a measure of CEHRT use. While this distinction is important, several questions warrant further consideration. **CMS should more clearly explain how a mandatory ACO ePA measure would assess the quality of care furnished by an ACO, reduce administrative burden, and ensure that ACOs have a fair and consistent opportunity to comply.**

Electronic Prior Authorization for Medical Items and Services

The MMS supports further consideration of a voluntary CEHRT use option under which an ACO could attest that a participating physician or practice successfully submitted at least one ePA request for a medical item or service**. Accordingly, MMS urges CMS not to require the ACO to receive a payer determination to satisfy the option.** ACOs and participating physicians control whether they submit a request, but the payer controls whether and when it processes the request, returns a determination, or provides a technically valid response. Conditioning ACO compliance on the receipt of a payer response would improperly make the ACO responsible for payer performance.

CMS should also permit the voluntary option to be satisfied through a qualifying ePA request involving any patient and payer. Limiting qualifying transactions to assigned Medicare beneficiaries would create uneven opportunities among ACOs because traditional Medicare applies prior authorization only to certain items and services. Specialty composition, patient populations, payer mix, and local coverage policies would further affect whether an ACO has a qualifying transaction. **MMS requests that voluntary CEHRT use options demonstrate that the ACO or its participating practices used electronic functionality rather than test whether an ACO happened to encounter a payer requirement.**

A successful electronic submission should be sufficient. MMS requests that CMS withhold from requiring every component of the Coverage Requirements Discovery (CRD), Documentation Templates and Rules (DTR), and Prior Authorization Support (PAS) workflow to be used in a single transaction when a particular authorization does not require every function. MMS asks CMS to recognize the portions of the workflow that are applicable to the transaction and within the physician's control.

Readiness and Implementation Safeguards

MMS urges CMS not to implement even a voluntary option beginning in performance year 2028 unless it first demonstrates that the necessary payer and provider technology is operational, broadly available, conformant, and reliable. Before implementation, CMS should conduct a pilot involving diverse ACOs, including small, rural, independent, safety net, and specialty organizations. The pilot should include testing among payers, EHR developers, intermediaries, ACOs, and participating practices under real-world workflows. MMS recommends that CMS delay the option if testing shows that payer APIs, certified health IT, or ePA workflows are not sufficiently reliable or widely available. Certification of individual health IT modules does not establish that the complete transaction will work across multiple systems. CMS should evaluate endpoint availability, conformance with applicable standards and implementation guides, data quality, authentication, documentation exchange, acknowledgments, error handling, response delivery, and the availability of effective support when transactions fail.

The MMS also urges CMS to ensure that physicians and ACOs can access the necessary functionality without additional fees. **A voluntary option will not provide meaningful flexibility if selecting it requires an ACO or its practices to purchase costly software.** MMS recommends coordination with ONC to require transparent disclosure of the capabilities included in certified products, associated costs, dependencies on third-party modules, and known limitations.

Most importantly, MMS urges CMS to determine whether the electronic workflow replaces manual work. A successful electronic request should not be treated as evidence of burden reduction if physicians and staff must continue using payer portals, fax, telephone calls, duplicative data entry, or manual status checks. **CMS should not incentivize an electronic transaction that merely adds another channel to an already fragmented process.**

CONCLUSION

As always, the Massachusetts Medical Society appreciates the opportunity to provide comment and work with CMS on our shared goal of providing the highest quality health care to patients. Should you have any questions, please contact Casey Rojas, JD, MBE, Federal Relations Director, at crojas@mms.org or (781) 434-7082.

Sincerely,

Rebecca Brendel, MD, JD

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