CALIFORNIA MEDICAL ASSOCIATION

September 14, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services Attn: CMS-1848-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1848-P: Medicare Program: CY 2027 Payment Policies Under the Physician Payment Rule and Other Changes to Part B Payment and Coverage Policies (July 16, 2026)

Dear Administrator Oz:

On behalf of the more than 50,000 physician and medical student members of the California Medical Association (CMA), we appreciate the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the 2027 proposed revisions to the Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) published in the Federal Register on July 16, 2026. We support the detailed comments submitted by the American Medical Association (AMA) and provide the following comments that reflect some of the top priorities of California physicians.

I. Medicare Physician Payment Updates and Conversion Factor Increases

The MPFS is the only major Medicare payment system not subject to an automatic, inflation-based annual update. The impact of this policy is substantial. Between 2001 and 2025, Medicare physician payment increased only 7 percent, or 0.3 percent per year on average, even though the cost of operating a medical practice increased 59 percent, or 2.0 percent per year on average. Adjusted for inflation in practice costs, Medicare physician pay declined 33 percent from 2001 to 2025, or 1.7 percent per year on average. In comparison, Medicare hospital updates totaled approximately 80 percent, or a 2.5 percent per year on average increase, with inpatient services increasing by 83 percent and outpatient services by 80 percent. Congress has

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provided temporary relief in five of the last six years, but each of those adjustments has expired on its own terms.

With the expiration of the most recent 2.5 percent update at the end of CY 2026, physicians will once again see a net reduction to their Medicare payments for CY 2027, unless Congress acts to intervene. CMA is very concerned that the CY 2027 conversion factor updates represent a 1.68% reduction for physicians billing the MPFS and 1.19% reduction for physicians participating in Alternative Payment Models (APMs), while CMS projects the Medicare Economic Index will increase 2.5 percent over the same period.

We ask CMS to actively urge Congress to provide an annual inflation update to address the outdated Medicare payment rates that threaten further erosion of seniors' access to care across California. CMA and AMA have been urging Congress to enact an annual inflation update for physician payments tied to the Medicare Economic Index (MEI) just as all other providers (i.e., hospitals, nursing homes) are paid by Medicare. Such inflation updates must account for the growth in physician practice costs, including dramatically rising office rent, clinical and office staff wages, supplies, and administrative overhead. Without permanent, inflation-adjusted reforms, the growing gap between Medicare payments and the cost of providing care could make it increasingly difficult for physician practices to sustain their participation in Medicare ultimately jeopardizing patient access to care. At the same time, Medicaid reimbursement rates are generally set as a percentage of Medicare rates, so the Medicare rates that are negatively impacting access to care have a ripple effect for those enrolled in the Medicaid program. We urge the Administration to support congressional action to enact a permanent annual inflation update.

Against this backdrop of sustained payment erosion and rising practice costs, CMA is particularly concerned about layering several significant redistributive changes on physician practices at the same time. The cumulative impact of these policies could further strain practices already facing significant pressures, particularly small, independent, and rural practices with fewer resources to absorb payment reductions. Moreover, significant payment reductions could undermine the financial viability of independent practices and contribute to further consolidation, an outcome that would be directly at odds with CMS' stated goal of sustaining independent practice. We urge CMS to carefully evaluate the cumulative impact of these proposals before finalizing policies that could further destabilize physician practices and adversely affect patient access to care.

CMS should not finalize these substantial payment changes without first publishing the specialty impact estimates that stakeholders need to appropriately evaluate them. The four major practice expense proposals are presented without disaggregated, specialty-level estimates, even

though the proposals are interrelated and operate on the same practice expense relative value units (RVUs), making their combined effect impossible to assess from the aggregate tables alone. **Before proceeding with several policies that will have such redistributive effects, we urge CMS to pause, collect the necessary data, publish the underlying analyses including specialty-level impact estimates, and continue to engage with the physician community.**

CMA has significant concerns with the following proposals:

- **Payment reduction for services furnished with a separately identifiable E/M visit (modifier -25).** CMS proposes to reduce payment by 50 percent when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) service reported with modifier -25 is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period. CMS proposed a similar policy in 2019 and appropriately withdrew it after stakeholders raised serious concerns. This version would apply to even more procedures. CMS offers no evidence that duplication exists or of its magnitude, and its request for comment on alternative percentages suggests the 50 percent figure is not supported by data. Such overlaps in value have already been removed for the services typically furnished together through the misvalued code initiative and the AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) valuation process, which expressly excludes work associated with a separately identifiable E/M service. Any residual overlap sits largely in pre-service time, yet CMS proposed to cut the entire lower-valued service, including work, practice expense, and professional liability. The proposal also fails to account for the value to Medicare beneficiaries of receiving medically necessary, separately identifiable services in a single encounter, which can reduce the need for additional visits and associated patient burdens. CMA is also concerned about the magnifying effects of CMS finalizing such a policy. Once it is established, it could then be applied to other services and adopted by private payers. **CMS should not finalize this flawed policy and should instead address any genuine overlaps in valuation on a code-specific basis.**

- **Changes to the practice expense (PE) methodology.** CMS proposes four distinct changes: a revised indirect allocator that excludes 010- and 090-day globals, elimination of the indirect practice cost indices over two years, a five percent stabilization cap, and a modifier based on allowed charges. The stabilization cap does not operate as described, because pooling later in the methodology produces cuts exceeding five percent for codes that are otherwise unchanged. These cuts would be on top of the 50 percent work adjustment implemented for CY 2026, which cut facility-based payment by seven percent overall and considerably more for some specialties and physicians. **CMS should**

not move forward with the proposed adjustment and instead pursue a more targeted alternative with stakeholders and defer the remaining PE proposals until specialty-level impact analyses are published for each, and phase in any resulting change over multiple years.

- **Ambulatory Specialty Model.** CMA supports the concept of a specialty model that focuses accountability on the services participating physicians deliver, and we appreciate that several proposed refinements were made. However, CMS did not adopt several necessary fundamental changes including raising the redistribution percentage from 85 to 100 percent, setting performance thresholds prospectively so physicians know what success requires, and reducing the maximum risk level in the first two years from nine percent to two percent. As proposed, ASM would still exclude most physicians who manage these patients while mandating participation by specialists who may see such a patient once, rely on untested measures that penalize physicians for services they did not order or deliver, and reduce payments for small practices that are unable to submit patient-reported outcome data. **CMA and AMA are concerned that ASM implementation in 2027 under the current or proposed rules would have serious negative consequences for Medicare patients and physicians. CMA recommends that CMS delay ASM implementation by one year.**

- **Mandatory transition to MIPS Value Pathways.** CMA and AMA strongly oppose sunsetting traditional Merit-based Incentive Payment System (MIPS) and requiring MIPS Value Pathways (MVPs) reporting beginning in 2030. MVPs have been built around physician specialties and broad categories of health problems rather than the specific conditions a given clinician treats, so they yield inaccurate comparisons across subspecialties. Also, significant measure gaps remain, some specialties have no applicable MVP, and CMS has not explained what becomes of existing MIPS measures that do not appear in any MVP. **CMS should incentivize MVP reporting rather than mandate it, and close these critical gaps, before it considers proceeding with mandatory MVPs.**

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

CMA offers more detailed comments on these and other proposals in the comments that follow.

II. UPDATES TO PAYMENT PROVISIONS

A. Determination of Practice Expense Relative Value Units

Conversion Factors

CMA appreciates that CMS proposes implementing the statutory updates required under section 1848(d) of the Social Security Act, as amended by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), together with a positive 0.53 percent budget neutrality adjustment reflecting proposed changes in work RVUs. However, 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 non-qualifying APM conversion factor of $32.84, a decrease of 1.68 percent from CY 2026. Physicians are facing yet another year in which Medicare payment goes down while practice costs continue to climb.

Inadequate physician payment has real-world consequences, accelerating the consolidation of independent physician practices and worsening 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) colleagues, compounding the payment differential over time.

To protect Medicare, we urge the Administration to support congressional action to enact permanent, inflation-based updates for physician payments tied to the MEI. CMA supports 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. Independent expert bodies support these reforms. 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. In addition, the 2026 Medicare Trustees Report warned that the current MACRA structure raises long-range concerns that will 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 long-term issue.

Practice Expense (PE) RVU Methodology

CMA 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 is a foundational principle of the Medicare Physician Fee Schedule. Consistent with that principle, CMA has welcomed and supported CMS' recent efforts to update key practice expense inputs including clinical labor, supply, and equipment pricing.

Unfortunately, several practice expense and related proposals over the past two rulemaking cycles move in the opposite direction of a resource-based, data driven approach. These proposals replace specific data inputs with broad, round-number methodological adjustments whose empirical basis is not established in the rulemaking.

Significant changes should be grounded in robust empirical evidence. As such, we 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 on this important issue.

Proposed Modifications to the PE Formula

Recommendations:

CMS should postpone implementation of these practice expense proposals until a future rulemaking cycle in which a detailed specialty impact analysis may be published for each distinct proposed change in the practice expense methodology.

CMA 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 provide additional supporting materials, including utilization crosswalk files between the current and previous years,

restoration of key utilization files, documentation of any scalar adjustments applied to indirect scaling adjustments or other steps throughout the rate-setting process. In addition, it would be helpful to provide 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.

CMA 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. CMS introduces the stabilization factor to counterbalance the proposed removal of the IPCI due to concerns that removal of the IPCI may cause disruption year-to-year for codes that should otherwise be stable. 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.

CMA is supportive of transitions and methods to stabilize the 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.

CMA is concerned that 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 difficult to understand how each individual proposal impacts specific codes or specialty based on aggregate tables alone. 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. **CMS should postpone implementation of these practice expense proposals until a future rulemaking cycle in which detailed specialty impact analysis may be published**

for each individual proposed change in the practice expense methodology.

Updates to Practice Expense Methodology – Site of Service Payment Differential
Recommendations:

- CMS should repeal its 2026 implementation of the 50% work adjustment to the indirect practice expense methodology effective January 1, 2027.
- CMS should 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.
- CMS should 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 to physicians increased by four percent. Many specialties were subject to even more substantial cuts in the facility setting. In this CY 2027 Proposed Rule, CMS states that it remains open to additional data and feedback, including consideration of additional refinements to the methodology. We support the CMS decision to consider additional information and potentially reconsider its current approach. However, until a more data-driven approach is developed, we urge CMS to repeal the current change **to the indirect practice cost methodology. Specifically, CMS should repeal its 2026 implementation of the 50 percent work adjustment to the indirect practice expense methodology effective January 1, 2027.**

<u>Potential Alternatives to the CMS Indirect Practice Expense Methodology Change</u>
CMS has asked for comment on other approaches that may be employed to address the concern regarding potential overlap in practice expense payment. **Data-driven approaches should be utilized to address CMS' concern regarding 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.** A number of alternatives have been recommended by stakeholders, and we urge CMS to consider each of the alternatives in lieu of the existing broad-

based policy, while working with stakeholders to determine a solution that is data-driven and resource-based, including:

- Modify the current adjustment. The current 50 percent reduction of the work component within the methodology substantially overestimates any potential practice expense payment overlap. CMA would encourage CMS to recognize at a minimum 75 percent of the physician work in the indirect cost allocation method.

- Develop a modifier to identify hospital-employed physicians. CMS seeks comment on the development of a modifier that more precisely identifies hospital-employed physicians. This would enable CMS to apply the reduction in indirect PE only to these physicians, who do not have separate administrative or clinical offices. Billing staff for facility-employed physicians could append this new modifier to claims, allowing CMS to continue applying the relevant indirect PE adjustment. If CMS proposes to adopt a modifier in lieu of the current allocation method, CMS should first share specific specialty-level impact analysis in proposed rulemaking and allow for comment.

- Consider a claims-based methodology. MedPAC's June 2025 report to Congress presents a claims-based alternative that identifies physicians most likely to be facility-employed by analyzing both clinicians who provide more than 90 percent of their services in a facility setting and services that are provided more than 90 percent of the time in the facility setting. This approach is detailed throughout the chapter, particularly on pages 44-46, where MedPAC notes: "A hybrid approach (based on information about both clinicians and services) may be more accurate than either approach on its own, but it would still be subject to judgment calls about what thresholds should be used and payment cliffs between clinicians who are subject to the payment reduction and all other clinicians."

All changes to the practice expense methodology should 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). This would be consistent with other CMS phase-in implementation, such as in this Proposed Rule where CMS continues a phase-in to address the correction to a mathematical error in medical supply packages.

Global Surgical Packages
Recommendation:

CMS should implement the prior recommendation that the full increase of work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239), and office visits (99202-99215) be incorporated into the surgical global periods for each CPT code with a global of 010-day and 090-day. CMA and AMA also recommend that the practice expense inputs be modified for the inpatient hospital visits, observation care visits, and office visits within the global periods.

CMA and AMA urge CMS to implement the RUC's prior recommendation that the full increase of work and physician time for the inpatient hospital and observation care visits (99231-99233, 99238 and 99239), and office visits (99202-99215) be incorporated into the surgical global periods for each CPT code with a global of 010-day and 090-day. The RUC also recommends that the practice expense inputs be modified for the inpatient hospital and observation care visits and office visits within the global periods.

Valuation of Specific Codes

CMA appreciates that CMS proposes to adopt 88 percent of the RUC recommendations, including the RUC-recommended work RVUs for maternity care services. **CMA encourages CMS to finalize publication of the relative values for these services.**

Maternity Care Services

CMA is pleased CMS proposes to update the Maternity Care Services coding structure. Beginning January 1, 2027, the CPT codes will be updated to comprehensively revise the maternity codes, reflecting modern obstetric practice and providing greater specificity regarding antepartum care, labor management, delivery, and postpartum services. The new code structure will provide much-needed transparency for patients, and the increased granularity will improve the ability of physicians and researchers to better understand the drivers of maternal mortality. The CPT 2027 maternity-care restructuring represents nearly two years of sustained, multidisciplinary work led by the CPT Editorial Panel and its Maternity Care Services Workgroup of obstetricians, family physicians, certified nurse midwives, payers, and other interested parties. **CMA agrees with the CMS proposal to implement the new maternity care coding and payment structure.**

<u>Budget Neutrality</u>

After a thorough analysis, **the RUC recommended work RVUs and the expected utilization for the new and revised maternity care codes do not exceed the current utilization and work RVUs associated with the current code structure when typical patterns of care are considered. The RUC recommendations are, therefore, budget neutral.**

Creation of HCPCS G-codes to Maintain Current Coding

CMS is considering and seeks comments on an alternative to create 15 HCPCS G-codes that would maintain the historical global structure and payment for maternity care services in the PFS. CMS states that this is to ameliorate concern while it continues to consider the potential impact that changes in the maternity care code family have on clinical outcomes for maternal care. In the CY 2027 OPPS Proposed Rule, published prior to MFS rulemaking, CMS proposed to adopt the new maternity care CPT codes. CMA is concerned that creating 15 new Medicare-specific G-codes may not alleviate the potential disruption identified by CMS and could instead create significant administrative complexity and a potentially chaotic coding environment by establishing different coding structures across payer types and settings, with physicians using Medicare-specific G-codes under the PFS while the new CPT codes are used by commercial payors and hospitals. **CMA strongly opposes CMS' alternative proposal to maintain current coding through the creation of HCPCS G-codes in the MFS as it will create unnecessary chaos and confusion. CMA urges CMS to finalize the Maternity Care Services CPT code set without maintaining the historical global structure via HCPCS G-codes.**

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

Recommendations:

- CMA 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. CMS has not provided sufficient data, analysis, or methodology to demonstrate that ACO participation status warrants valuing MOD2 at twice the rate of MOD1.
- CMA 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.

Impact on Physicians Compensated Under RVU-based Models

CMA is concerned that replacing G2211 with percentage-based modifiers could adversely affect physicians compensated under RVU-based productivity models. G2211 currently carries assigned RVUs that can be credited toward physician productivity and compensation, while the proposed MOD1 and MOD2 would have no assigned RVUs. As a result, physicians performing the same work could lose RVU credit even though CMS continues to recognize and pay for that work. While physician compensation arrangements are outside CMS' authority, CMA urges CMS to consider this real-world consequence of the proposed change.

Operations Questions

CMS proposes to replace HCPCS G2211 with modifier (MOD1), valued at 16 percent of the associated E/M service, and create a second modifier (MOD2), valued at 32 percent and available only to ACO participants. While this changes the billing mechanism for recognizing visit complexity, it does not resolve longstanding concerns regarding CMS' utilization assumptions and the resulting budget neutrality adjustments.

The significant disparity between CMS' projected and actual utilization of G2211 underscores this concern. CMS initially assumed that G2211 would be reported with 38 percent of office/outpatient E/M visits. However, an AMA analysis of 2024 Medicare claims data found utilization of only approximately 10.5 percent through the first three quarters of the year. As a result, CMS applied a 2.18 percent budget neutrality reduction to the conversion factor when actual utilization supported a reduction of approximately 0.79 percent. The AMA estimates this discrepancy resulted in approximately $1 billion being removed from the PFS.

The experience with G2211 demonstrates the importance of using realistic utilization assumptions for MOD1 and MOD 2 and of having a mechanism to address material differences between projected and actual utilization. CMA supports the reforms in the Patients First Act of 2026 (H.R. 9693), which would establish a prospective reconciliation process for certain utilization misestimates. In the interim, CMA urges CMS to improve the accuracy of its utilization assumptions and use its existing administrative authority to prospectively correct material misestimates.

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

Recommendations:

- CMS should 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.
- CMS should not extend the policy to procedures furnished on the same date as inpatient or other E/M services.
- CMS should 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) Evaluation and Management (E/M) visit is furnished by the same physician (or a physician in the

same group practice) on the same day as a 000-, 010-, or 090-day global procedure. Under this proposal, the service with the highest payment rate (either surgical or E/M visit) would be paid at 100 percent, and all other surgical procedure(s) or E/M visit(s) would be paid at 50 percent. CMS states that "the 50 percent value aligns with our previous proposal from CY 2019 PFS Proposed Rule (83 FR 35840 through 35841) and matches the longstanding surgical multiple procedure payment reduction (MPPR)." According to CMS, "this proposal is meant to address the likely overlap and duplication of payment between the E/M services already paid for during the global surgical package, and any additional E/M services billed for through the use of modifier -25 as significant and separately identifiable." (91 FR 43908)

CMA strongly opposes this proposal and urges CMS not to finalize it. CMS proposes this payment reduction on the basis of a hypothesis that payment is "likely" duplicated when an E/M visit and a procedure are furnished on the same day. But CMS does not provide evidence demonstrating that duplication exists or the magnitude of that duplication. Through the potentially misvalued code initiative, CMS has identified, reviewed, and revalued codes typically furnished with a same-day E/M visit, and the RUC survey and valuation methodology are expressly designed to exclude the work and practice expense associated with a separately identifiable E/M service reported with modifier -25. Having already accounted for this overlap on a code-specific basis, CMS now proposes a second, across-the-board reduction that is untethered from the resources actually at issue, applying a 50 percent cut to the entire lower-valued service, including physician work, practice expense, and professional liability, to address, at most, a small overlap confined to portions of the pre-service evaluation, post-service time and practice expense components.

Moreover, the burden of this policy would fall on office-based, independent physician practices, which bear the full costs of the clinical staff, supplies, equipment, and infrastructure, and are the very practices CMS says it wants to sustain and strengthen. The proposed reduction is inconsistent with that goal. To the extent CMS believes specific codes warrant further review, the appropriate path is to identify those codes and address them through the established misvalued code and RUC processes.

In addition, CMS has not addressed the concerns that led the Agency to decline to finalize a substantially similar proposal in 2019. The RUC valuation process already removes the overlap CMS seeks to address. The resources that overlap between a same-day visit and a minor procedure are a small share of the pre-service evaluation and post-service time, not the intra-service work, the procedure-specific supplies and equipment, or the physician's technical skill and effort. Direct practice expense overlap is also limited and it flows through to the indirect practice expense once those inputs are adjusted, leaving no resource category unaddressed.

That the adjustments are "minor" is therefore not a deficiency in the process; it is an accurate measure of a genuinely small overlap and reinforces that a 50 percent reduction to the entire service bears no relationship to the limited resources actually shared. **CMA strongly opposes the proposed 50 percent reduction, which far exceeds any reasonable estimate of potentially overlapping resource costs.**

The proposed 50 percent reduction bears no reasonable relationship with the overlap it targets. The proposal would disproportionally harm the independent, office-based practices CMS seeks to support.

The CMS proposal would result in payment levels for many procedures that do not cover the direct costs of furnishing the service, let alone compensate physicians for the work involved. Physicians are already facing significant financial pressures in maintaining independent practices. These services are frequently furnished in independent, office-based settings, where the practice bears the full cost of the clinical staff, supplies, and equipment reflected in the non-facility payment and cannot offset a reduction in facility revenue. The proposal would therefore fall most heavily on precisely the practices that CMS has stated it seeks to sustain and strengthen. A policy that leaves payment below the direct cost of furnishing care sends the opposite signal, and risks accelerating the consolidation that CMS has identified as a concern.

The proposed policy would also penalize physician practices that structure their schedules to accommodate efficient, same-day care. Many physicians reserve additional time in their schedules to accommodate patients who, following an evaluation, are determined to need a procedure that can appropriately be performed during the same encounter. A 50 percent payment reduction for one of the two or more distinct services could make it increasingly difficult for practices to maintain this flexibility.

Where CMS believes Modifier –25 is being misapplied, the appropriate remedy is targeted — education, prepayment edits, and audit — not a blanket reduction that falls hardest on the physicians using the modifier correctly.

CMS also requests comments on whether this policy should be extended to procedures performed on the same date of service as other E/M services, such as inpatient visits. CMA strongly opposes any such expansion. Inpatient and other facility-based E/M services do not include direct practice expense payments, and the physician work associated with a procedure performed on the same date generally occurs at a different time and reflects distinct clinical activities. Accordingly, there is no meaningful duplication between these services. CMA urges CMS not to pursue payment reductions for procedures performed on the same date as inpatient or other facility-based E/M services.

Shared Medical Appointments (SMAs)

CMS proposes to create coding and valuation specifically for SMAs. The proposed HCPCS G code (temporarily designated as GSMAS) would be described as a "Voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff, or auxiliary personnel under the direction of the supervising physician or other practitioner. Session integrates group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per session."

CMA supports SMAs (or group visits), and we appreciate CMS' proposal to further recognize the value of this service by creating a dedicated code for it. The proposed descriptor represents a reasonable starting place for such a code. In general, CMA supports the proposed required components for each SMA session and accompanying limitations (e.g., number of patients, length of session, patient consent.) We believe these required components and limitations are sufficient guardrails to prevent fraud, waste, and abuse with one exception.

CMA recommends CMS modify the requirement that limits SMAs to beneficiaries who have received a professional service from the billing physician or other qualified health professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice "within the previous 12 months." CMA believes SMAs should be available to all established patients within a practice, not just those who have received a professional service within the previous 12 months. Thus, CMA recommends that this proposed requirement be removed.

C. Proposed Changes to the Ambulatory Specialty Model (ASM)

We appreciate the efforts CMS is making to create a payment model specifically focused on ambulatory care delivered by specialists that would not hold physicians accountable for total cost of care. Instead, ASM appropriately limits accountability to the kinds of services the participating physicians deliver and the patients they treat for heart failure or low back pain.

CMS issued proposed and final rules defining the key elements of ASM during the 2026 rulemaking cycle, but detailed recommendations on ways to improve ASM were not adopted in the final rule. Below are three important changes to ASM that were suggested for inclusion in the 2027 proposed rule that CMA requests be considered:

- Increase the redistribution percentage from 85 to 100 percent so that any reductions in payment rates for participating physicians are used to increase rates for other participants.
- Set ASM measure performance thresholds in advance so that physicians know what is required for success and are rewarded for achieving it, instead of penalizing them for good performance simply because other physicians had higher scores.
- Reduce the maximum risk level in the initial two years from nine percent to two percent to allow physicians to gain experience with the new model before being subject to higher levels of risk and significant penalties.

Several changes CMS has proposed for 2027 would improve ASM participation requirements, but the model would continue to exclude most physicians who manage care for patients with heart failure and low back pain while inappropriately mandating participation by specialists who may only see such patients for one visit, test, or procedure. CMA is also concerned that a problematic, untested measure would be added to the low back pain component of ASM that will inappropriately penalize physicians for services they did not order or deliver. In addition, proposed scoring changes would inappropriately reduce payments for small practices that are unable to submit patient-reported outcome data and those located in urban areas. CMA is concerned that ASM implementation in 2027 under the current or proposed rules would have serious negative consequences for Medicare patients and physicians.

Participation (Section III.D.2.b, 91 FR 43965-43971)

Recommendations:

- Physicians should be excluded from participation in ASM if they officially redesignate their primary specialty from cardiology to a different specialty, but they should not be required to have board certification in the new primary specialty. When a physician's specialty redesignation is approved by CMS, the physician should automatically be excluded from ASM and not also be required to notify CMS within 30 days of the change in specialty.
- Physicians in all specialties should be excluded from participation in ASM if they indicate that they do not direct the care of patients with heart failure or low back pain or if only a small proportion of the patients they treat have heart failure or low back pain.
- Any physician who manages the care of patients with heart failure or low back pain should be given the opportunity to voluntarily participate in ASM if they believe that it will be beneficial for their patients.

- Physicians should be automatically exempt from ASM participation if they are no longer part of the TIN in which they practiced when their ASM eligibility was determined and should not be required to notify CMS within 30 or 60 days of TIN changes based on when they occur relative to the performance year.
- Exemptions based on specialty redesignations or TIN changes should be retroactive to the beginning of the performance year in which the change occurred and automatically apply to all subsequent performance years.
- Physicians should only be terminated from ASM for reasons that are clearly described and justified in regulations.
- CMS should delay ASM implementation by one year and should expand education, outreach, and technical assistance efforts for affected physicians and practices before implementation begins.

Scoring and Benchmarks for Quality Measures (Section III.D.2.d.(4), 91 FR 43978-43979)

Recommendations:

- CMA strongly recommends that ASM benchmarks be based solely on performance data from previous years, not from the current performance year.
- We urge CMS to score physicians in small practices on administrative quality measures at the TIN level if they report other ASM quality measures at the TIN level.

Payment Approach (Section III.D.2.g, 91 FR 43990-43991)

Recommendations:

- Increase the redistribution percentage from 85 to 100 percent.
- Reduce the maximum risk level in the initial two years from nine percent to two percent.

The model should allow every physician to avoid a payment reduction by meeting a level of performance that is known to be feasible and established in advance. Downside risk should be phased in over several years as it has been in every other CMS APM.

<u>Redistribution Percentage</u>

We urge CMS to change the "redistribution percentage" in ASM from 85 percent to 100 percent. In contrast to the budget neutral redistribution in MIPS, the current ASM redistribution percentage guarantees that, no matter how well physicians perform, most participants will face payment cuts. These cuts could make it more difficult for all Medicare patients to access

services from specialists required to participate in ASM because ASM would cut payments to most of these specialists for all services they deliver, not just those that are relevant to ASM.

A true value-based payment model achieves Medicare savings by enabling and encouraging improvements in the delivery of patient care that lower avoidable Medicare spending, not by cutting physician payments. No such redistribution percentage is used in MIPS or the Hospital Value-Based Purchasing program. Instead, any penalties for lower-performing physicians and hospitals are used to fund increases for high performers, and all participants can avoid a penalty by performing at high levels. We strongly oppose implementing ASM unless it is modified so that it will no longer result in payment cuts for most participating physicians no matter how much they improve quality or reduce spending.

Maximum Risk Level

Payment models designed to reduce spending, particularly those involving significant financial risk, have the potential to harm patients as well as physicians. It is inappropriate for CMS to require physicians and their patients to participate in a new payment model that could significantly reduce physician payments before any testing or evaluation has been completed.

CMA has serious concerns that imposing cuts of up to nine percent immediately, beginning in the first year of ASM implementation, could have detrimental impacts on the physicians required to participate and negatively affect their patients' access to care. Although the maximum payment penalty under MIPS is also nine percent, ASM is very different from MIPS, and it is inappropriate to impose high penalties on physicians in the first year of a completely new payment model. For other payment models, including the voluntary Medicare Shared Savings Program that involves organizations managing care for thousands of Medicare patients and the mandatory Transforming Episode Accountability Model that involves large hospitals, CMS has provided a phase-in period or glide path before requiring any downside financial risk.

A key reason physicians leave private practice is that hospitals and other large organizations are better able to manage the financial risks of participating in APMs. Experience with other CMS models also shows that unanticipated problems arise during implementation. Phasing in risk under the model allows time for adjustments to be made so that physicians do not receive payment cuts solely due to problems with the model itself.

We strongly urge CMS to reduce the maximum risk level in ASM to no more than two percent for at least the first two model years. A transition will allow physicians to gain experience with the new model before subjecting them to higher risk levels and more significant penalties, and it will also allow time for CMS to identify and resolve any problems with the methodology and measures.

D. 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). 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.

Prior to the passage of H.R. 1, 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 H.R. 1, 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.

CMA supports public health policies and programs that aim to improve access to health care and minimize systemic health barriers for immigrant communities including ensuring medically appropriate care for refugees and asylees. Accordingly, **CMA urges CMS to maintain a broad definition of "eligible noncitizen" to ensure that those who are legally in the United States, and have paid into our Medicare system, can continue to maintain and gain access to this health care coverage**.

III. UPDATES TO QUALITY PAYMENT PROGRAM PROVISIONS

A. Merit-based Incentive Payment System (MIPS)

Performance Threshold

Recommendation:

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

CMA 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. 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:

- CMA strongly 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, CMA, AMA and 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, CMA 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 deeply concerned that the 98% 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.

We urge CMS to work with the impacted specialties to create meaningful MVPs and 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.
- *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.
- *Newly Proposed Condition Specific MVPs:* We appreciate CMS considering feedback by proposing two condition specific MVPs for the 2027 program (Diabetic Disease and

Hypertension), but refinements are needed. They are overly broad, and the groupings within the MVP are by specialty.

- *Facility-based Option:* CMS must 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 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 strongly urge CMS to reduce the data completeness requirement for satisfactorily reporting on a measure in MIPS, MVP, MSSP, and ASM.
- *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.

CMS should incentivize the reporting of MVPs, rather than mandate it, and CMA does not support 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.

Summary and Conclusion

CMA appreciates the opportunity to provide comments on CMS' 2027 Medicare physician fee schedule and the Quality Payment Program. For several initiatives in the proposed rule including the four modifications to the Practice Expense formula, we request that CMS not move forward at this time and instead provide data that can be independently reviewed and analyzed. We also urge CMS to consider the impact proposals in the 2027 Medicare physician fee schedule and QPP will have on small, independent and rural practices. In particular, the Modifer-25 proposal would reimburse physicians at a rate that would not cover the cost of providing care and could lead physicians to leave Medicare altogether, stop seeing new Medicare patients, or restrict care to only their current Medicare patients. The proposed 50% reduction far exceeds any reasonable estimate of potentially overlapping resource costs and would substantially underpay physicians for medically necessary care. In addition, all changes to the practice expense methodology should be phased in over a four-year period to be consistent with long-standing policy to phase in new practice cost data.

Thank you for your consideration of our comments. For questions or more information, please contact Amy Blumberg, Vice President of Federal Government Relations at ablumberg@cmadocs.org.

Sincerely,

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