AMGA
Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
O 703.838.0033
F 703.548.1890

Nov. 10, 2026

The Honorable Mike Johnson
Speaker
U.S. House of Representatives
Washington, DC 20515

The Honorable John Thune
Majority Leader
U.S. Senate
Washington, DC 20510

The Honorable Hakeem Jeffries
Minority Leader
U.S. House of Representatives
Washington, DC 20515

The Honorable Chuck Schumer
Minority Leader
U.S. Senate
Washington, DC 20510

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

On behalf of AMGA and our members, I urge Congress to act swiftly on critical healthcare policies during the lame-duck session of the 119th Congress. On Jan. 1, 2027, multispecialty medical groups and integrated systems of care will face not one Medicare cut but several at once: a reduction to the Physician Fee Schedule (PFS) conversion factor; cuts of up to 15% per test under the Clinical Laboratory Fee Schedule (CLFS); cuts to Medicare payment for 340B-acquired drugs, paired with an accelerated 340B remedy offset; the launch of a 340B drug rebate model; a 20% cut to many same-day evaluation and management (E/M) visits; and the expiration of the work Geographic Practice Cost Index (GPCI) floor and the Advanced Alternative Payment Model (APM) incentive. Policymakers usually debate each of these policies individually. Our members experience them together through the same budgets that pay for their clinicians, care teams, laboratories, pharmacies, and community clinics.

The recommendations below share a single goal: to stop these cuts from compounding on Jan. 1 and to give medical groups and integrated systems of care the predictable, stable payment they need to keep serving their communities. Each is a near-term step. AMGA remains committed to working with Congress on durable Medicare reform so that patient access no longer depends on year-end legislative action.

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing integrated systems of care and multispecialty medical groups, we advocate, educate, innovate, and empower our members to deliver the next level of high performance health. AMGA is the national voice promoting awareness of our members' recognized excellence in the delivery of coordinated, high-quality, high-value care. More than 186,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in high-value care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

To protect patient access, AMGA urges Congress to take the following actions before the end of the year:

- Stop Cuts to Medicare Part B Reimbursement
- Sustain the 340B Drug Pricing Program
    - Prevent Hospital Outpatient Prospective Payment System (OPPS) Cuts to 340B Entities
    - Stop the 340B Drug Rebate Model
- Prevent Drastic CLFS Cuts
- Extend the Advanced APM Incentives
- Continue the Medicare GPCI Floor of 1.0
- Extend the Current Telehealth Waivers Permanently
- Prevent Medicare Global Procedures Same-Day E/M Payment Reduction

Stop Cuts to Medicare Part B Reimbursement

The Centers for Medicare & Medicaid Services (CMS) estimates that the Medicare Economic Index (MEI), which measures inflation in the cost of operating a medical practice, will be 2.5% in 2027. That increase stands in stark contrast to the payment cuts the agency finalized in the calendar year (CY) 2027 Medicare PFS final rule.[i] Qualifying APM participants will see a 1.83% cut to the conversion factor, while nonqualifying clinicians will face a 2.31% cut.[ii] According to the Medicare Payment Advisory Commission (MedPAC), from 2000 to 2024, the MEI rose 56% while PFS payment updates rose 14%.[iii] AMGA members have deep concerns that the current gap between Medicare reimbursement and the cost of delivering care will continue to widen. Cutting reimbursement while costs continue to rise is not sustainable for clinicians or the Medicare patients they serve.

While we remain committed to long-term reform of Medicare Part B, in the coming weeks, Congress must once again intervene to, at a minimum, prevent the conversion factor cuts of 1.83% and 2.31% from taking effect on Jan. 1, 2027. Policymakers should also factor the MEI into any temporary legislative patch for Medicare Part B.

Sustain the 340B Drug Pricing Program

The 340B Drug Pricing Program provides savings to federal grantee organizations and several types of hospitals, including critical access hospitals, sole community hospitals, rural referral centers, and public and nonprofit disproportionate share hospitals that serve the low-income and indigent populations that need them most. Entities eligible for 340B serve a substantial share of low-income and uninsured patients and make that care more affordable by purchasing outpatient drugs below list price. These safety-net clinicians serve vulnerable populations across the U.S., and the 340B Program allows them to maximize limited federal resources by lowering the price of outpatient pharmaceuticals and enhancing health services for patients and communities.[iv]

Prevent OPPS Cuts to 340B Entities

In the CY 2027 OPPS and Ambulatory Surgical Center (ASC) Payment System final rule, CMS finalized a reduction in OPPS payment for 340B-acquired drugs from Average Sales Price (ASP) plus 6% to ASP minus 28%, effective Jan. 1, 2027. The agency grounded the policy in a hospital drug acquisition cost survey it conducted in early 2026, following the CY 2026 OPPS/ASC final rule.

AMGA has significant concerns about this policy. First, the fact that only 23.1% of 340B hospitals and 34.9% of all hospitals responded with data to the survey raises questions about whether the survey data

are representative of the broader 340B hospital population.[v] Creating a new national payment methodology from one year's worth of data from fewer than a quarter of the nation's 340B hospitals appears unnecessarily rushed, risking the implementation of an ill-informed payment policy that has a disproportionately large impact on clinicians serving the most vulnerable beneficiaries. Analyzing data from additional years (rather than from a single point in time) and incorporating data from more than 23.1% of the country's 340B hospitals would help inform policy with more robust information.

Second, the same rule increases the annual reduction to the OPPS conversion factor used to recoup 340B remedy payments from 0.5% to 2%, accelerating full repayment of $7.8 billion from 2041 to 2031. CMS declined to finalize the same acceleration last year. Layered together, these policies will impose significant, immediate financial harm on health systems serving low-income, rural, and underserved patients.[vi]

Congress should direct CMS to delay the 340B drug payment cut until it has representative, multiyear acquisition cost data and to maintain the current, more gradual 340B remedy recoupment schedule.

Stop the 340B Drug Rebate Model

Last year, the Health Resources and Services Administration (HRSA) announced the 340B Rebate Model Pilot Program, which proposed a shift from an upfront discount to a post-sale rebate model. The pilot poses serious financial, operational, and other mission-threatening challenges for safety-net clinicians and the vulnerable patients AMGA members serve.

AMGA believes this rebate model has several critical flaws. First, it would cause severe financial strain and cash flow disruptions, since forcing safety-net clinicians to purchase drugs at wholesale acquisition cost before receiving rebates would drain limited operating funds, delay care, and threaten the viability of hospitals and clinics. Second, it would increase complexity and administrative burden, as the proposed rebate model would impose new reporting, tracking, and claims processes under unrealistic timelines, diverting staff time and resources from direct patient care. Third, it risks giving manufacturers greater control over the 340B Program; allowing them to dictate payment terms and data requirements would erode statutory protections and shift program governance. Fourth, the model lacks sufficient safeguards for clinicians, with vague enforcement guidelines and rebate requirements that would only increase clinicians' financial and operational risks. Finally, it threatens the safety net itself, as delayed savings from rebates would undermine the 340B Program's stated intent and its ability to support uncompensated care, particularly in low-income, rural, and underserved communities.

In the interest of protecting patients' access to care, Congress should direct HRSA not to implement the 340B drug rebate model.

Prevent Drastic CLFS Cuts

On Sept. 21, 2026, CMS released preliminary CY 2027 CLFS rates based on the first full round of private payor data collected under the Protecting Access to Medicare Act of 2014 (PAMA) since 2017. CMS would reduce payment for 1,171 of the approximately 1,500 codes with private payor data, capping cuts at 15% per code each year and phasing them in from 2027 through 2029.[vii] Because many commercial and Medicare Advantage contracts tie their rates to the CLFS, the impact will reach well beyond Medicare. One AMGA member that performs more than 1 million laboratory tests a year projects that the preliminary rates would reduce its laboratory receipts by approximately $200,000 in the first year alone, more than the laboratory's entire operating margin, and expects that it would have to close its laboratory if the final rates mirror the preliminary rates. Without action this year, these cuts may force

medical groups and independent laboratories to reduce testing services or close, jeopardizing timely access to essential tests for patients with heart disease, diabetes, cancer, and other conditions.

Congress should delay or limit the CY 2027 reductions and enact durable reform so that CLFS rates reflect a representative sample of the laboratory market, including physician office and medical group laboratories.

Extend the Advanced APM Incentives

For performance year 2024, CMS announced that the Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) earned savings totaling $4.1 billion and saved Medicare $2.5 billion.[viii] The success of the MSSP demonstrates the importance of the Advanced APM incentive payment under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The statute created a 5% Advanced APM incentive, which motivated clinicians to move toward high-value payment. The original 5% incentive ended with the 2024 payment year. Congress has since extended smaller incentives several times, most recently through the Consolidated Appropriations Act, 2026, which provides a 3.1% incentive in 2028 based on 2026 participation. Without action, clinicians who participate in Advanced APMs after 2026 will not be eligible for an incentive.

We urge Congress to extend the Advanced APM incentive payment so AMGA members can continue to invest in the ACO model and patients will continue to reap the benefits of being in a high-value care model.

Continue the Medicare GPCI Floor of 1.0

The GPCI floor helps prevent Medicare physician payment cuts in rural and low-cost geographic areas by establishing a floor for the work component of the PFS. Under current law, the 1.0 work GPCI floor that CMS uses to calculate payments under the Medicare PFS expires Dec. 31, 2026.

We urge Congress to extend the current GPCI floor so that clinicians can continue to have payment stability in an increasingly unstable environment.

Extend the Current Telehealth Waivers Permanently

For more than six years, the telehealth waivers Congress passed during the COVID-19 pandemic have remained in place. The waivers, which set aside Medicare's telehealth originating site and geographic limitations, created a dramatic shift in how clinicians deliver care in this country. Congress also extended recognition of audio-only payments in that same period. Because of the waivers, patients in rural and urban areas who lack transportation can receive care from their clinicians in their homes. As a result, patients have come to expect their clinicians to offer telehealth services as a standard method of care. Currently, these waivers expire Dec. 31, 2027. Repeated short-term extensions and temporary lapses create uncertainty for medical groups and integrated systems of care and can disrupt patients' access to services. Although the waivers do not lapse until the end of next year, the lame-duck session is an opportunity to end the cycle of short-term extensions.

We ask Congress to extend these telehealth policies permanently so clinicians can confidently invest in this technology and patients can continue to receive care.

Prevent Medicare Global Procedures Same-Day E/M Payment Reduction

In the CY 2027 Medicare PFS final rule, CMS finalized a 20% payment reduction for the lower-paid, separately identifiable same-day office/outpatient E/M visit furnished by the same physician.[ix] AMGA

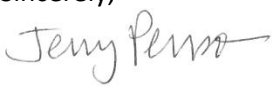
has urged CMS to maintain full payment for significant, separately identifiable E/M services that clinicians report with modifier -25. CMS's policy ignores the full value of the physician's clinical expertise and diagnostic work by using a blunt instrument to cut payments by 20% for clinical services that require a high degree of professional expertise and skill. The policy also disproportionately harms clinicians and patients in specialty services that often diagnose complex conditions and offer immediate intervention during the same encounter, including dermatology, otolaryngology, orthopedics, podiatry, and wound care. Beyond its clinical and administrative flaws, this policy raises significant concerns about patient access to care. Continued Medicare payment reductions may force practices to limit the number of Medicare beneficiaries they can serve, reduce services or staffing, and delay investments in equipment and technology. For patients, this translates into reduced access to community-based care and greater difficulty obtaining timely, coordinated care close to home.

For these reasons, we ask Congress to urge CMS to maintain full payment for significant, separately identifiable E/M services that clinicians report with modifier -25.

Taken together, these actions would keep a series of compounding cuts from taking effect on Jan. 1 and give medical groups and integrated systems of care the stability to continue caring for their patients. AMGA looks forward to working with you during the lame-duck session and in the 120th Congress on durable Medicare reform.

Thank you for considering our recommendations. If we can provide you with more information, please contact me or AMGA's Senior Director of Government Relations Jamie Miller at jmiller@amga.org.

Sincerely,



Jerry Penso, MD, MBA
President and Chief Executive Officer
AMGA

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[i] https://www.federalregister.gov/d/2026-22743
[ii] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2027-medicare-physician-fee-schedule-final-rule
[iii] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, ch. 4 (March 2026).
[iv] HRSA (2025), "340B Drug Pricing Program," https://www.hrsa.gov/opa
[v] 91 FR 41880
[vi] AMGA, Comments on the CY 2027 OPPS and ASC Payment System Proposed Rule (CMS-1850-P), Aug. 31, 2026.
[vii] AMGA, Comments on Preliminary CY 2027 Medicare Clinical Laboratory Fee Schedule Payment Rates, Oct. 21, 2026.
[viii] https://www.cms.gov/newsroom/fact-sheets/2026-medicare-accountable-care-organization-initiatives-participation-highlights
[ix] https://www.federalregister.gov/d/2026-22743