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Advancing High Performance Health

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The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: 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 AMGA, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2027 Physician Fee Schedule (PFS) proposed rule [CMS 1848-P].

Founded in 1950, AMGA is a trade association leading the transformation of healthcare in America. Representing multispecialty medical groups and integrated systems of care, 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 177,000 physicians practice in our member organizations, delivering care to more than one in three Americans. Our members are also leaders in value-based care delivery, focusing on improving patient outcomes while driving down overall healthcare costs.

This year's proposed rule includes several significant payment and policy changes that will affect our members. As such, AMGA is pleased to offer comments on the CY 2027 PFS Proposed Rule for your consideration.

Specifically, we are providing comments on the following:

- **Conversion Factor:** The proposed CY 2027 conversion factors represent yet another reduction in Medicare physician reimbursement. AMGA urges CMS and Congress to pursue durable, structural reform rather than continued reliance on short-term legislative patches.
- **Practice Expense Methodology:** AMGA urges CMS to proceed cautiously, given the magnitude of the proposed changes to modernize the practice expense (PE) methodology and its potential to significantly redistribute payment across specialties and sites of service.

- **Replacement of G2211:** AMGA is concerned about CMS' proposal to convert G2211 from a standalone add-on code to a percentage-based modifier. Establishing two materially different payment increases for functionally identical visits, based solely on whether the billing practitioner participates in a specific value-based payment model, would devalue the intensity, quality, and continuity of care provided by clinicians outside of Qualifying Alternative Payment Model (APM) participation.
- **Global Procedures:** Reduced payment for separately identifiable same-day evaluation and management (E/M) visits furnished with a global procedure is detrimental to patient-focused, efficient care. AMGA urges CMS to maintain full payment for significant, separately identifiable E/M services reported with modifier -25.
- **Ambulatory Specialty Model (ASM):** AMGA remains deeply concerned about the mandatory nature of the Ambulatory Specialty Model (ASM), its low patient-attribution threshold, and its overlap with Merit-based Incentive Payment System (MIPS) and Medicare Shared Savings Program (MSSP). The proposed CY 2027 technical refinements do not resolve these structural concerns.
- **Quality Payment Program (QPP):** AMGA is concerned that the proposal to sunset traditional MIPS in favor of mandatory MIPS Value Pathways (MVPs) reporting will increase administrative burden and fragmentation for multispecialty groups. We encourage CMS to delay this transition.
- **Primary Care Exception:** AMGA urges CMS to finalize its expansion of the primary care exception to all levels of office/outpatient E/M services. Not only is this a needed update to allow teaching practices flexibility to help develop the next generation of clinicians, but it also ensures the proper level of physician supervision.
- **Telehealth:** If finalized, CMS' proposed expansion of virtual presence for teaching physicians would provide needed flexibility while maintaining appropriate supervision and oversight.
- **Remote Physiologic and Remote Therapeutic Monitoring:** While AMGA supports *targeted* RPM and RTM program-integrity safeguards that address Office of the Inspector General's (OIG's) concerns, these safeguards must be narrowly tailored and preserve access to clinically integrated, technology-enabled care without creating unnecessary barriers to care.
- **Advance Care Planning:** AMGA supports the finalization of separate payment for advance care planning (ACP) services furnished by clinical staff and encourages CMS to finalize HCPCS codes GACP1 and GACP2 with sufficient flexibility to reflect team-based care. AMGA also urges CMS to avoid imposing a same-day E/M or other unnecessary initiating-visit requirement that could create a new barrier to ACP services.
- **Screening, Brief Intervention, Referral to Treatment (SBIRT) Services:** AMGA recommends that CMS finalize the policy as proposed.
- **Medicare Shared Savings Program (MSSP):** AMGA appreciates and supports the policy proposals to strengthen financial incentives, increase beneficiary engagement, and reduce participation burden. AMGA encourages CMS to incorporate sufficient timelines, information, and stability to allow Accountable Care Organizations (ACOs) to effectively plan and implement these proposals.
- **Request for Information (RFI) on Primary Care Payment:** AMGA urges CMS to enhance primary care payment to strengthen Medicare's focus on prevention and address reimbursement challenges that threaten patient access.
- **RFI on CPT Code Set:** A new coding framework could create significant operational disruption and administrative burden across physician practices and the broader healthcare system. AMGA urges CMS to proceed thoughtfully, assessing CMS and industry capacity and needed resources to support such a transition.

Detailed comments on each policy proposal follow.

Conversion Factor

Comment: *AMGA calls on CMS and Congress to advance comprehensive reforms that stabilize conversion factors, better align reimbursement with costs, and strengthen support for value- and team-based care.*

AMGA is deeply concerned that the proposed CY 2027 conversion factors represent yet another reduction in Medicare reimbursement. This pattern, masked in certain years by a temporary Congressional fix, illustrates precisely why AMGA has continuously urged CMS and Congress to move beyond annual patchwork relief. Reimbursement for clinicians in Medicare Part B should be stable and transparent and not reliant upon an act of Congress each year to adequately reflect the value of the care provided to more than 70 million Medicare beneficiaries.

CMS proposes a CY 2027 conversion factor of $33.17 for Qualifying Alternative Payment Model (APM) Participants (QPs), a decrease of $0.40 (−1.19%) from CY 2026, and $32.84 for non-qualifying APM participants (non-QPs), a decrease of $0.56 (−1.68%). Although current law provides positive updates (+0.75% for QPs and +0.25% for non-QPs) and a budget neutrality adjustment (+0.53%) tied to proposed work relative value unit (RVU) changes, these gains are outweighed by the expiration of the temporary 2.5% conversion factor increase enacted for CY 2026, resulting in a real-dollar cut to physician reimbursement. The conversion factors also continue to lag behind the Medicare Economic Index (MEI), limiting providers' ability to plan investments in staffing, technology, and value-based care infrastructure amid ongoing reimbursement uncertainty.

AMGA continues to urge CMS to work with Congress to establish a predictable, stable, and transparent annual conversion factor update tied to practice cost inflation, such as the MEI, and to pursue comprehensive Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act of 2015 (MACRA) reform that provides stability without requiring repeated legislative intervention. Absent such action, AMGA is concerned that continued erosion of the conversion factor will further widen the gap between Medicare reimbursement and the true cost of care, jeopardizing beneficiary access, particularly in rural and underserved communities.

Practice Expense (PE) Methodology

Comment: *AMGA urges CMS to proceed cautiously when modernizing the practice expense (PE) methodology, given the magnitude of the proposed changes and their potential to significantly redistribute payment across specialties and sites of service.*

CMS proposes to substantially revise the indirect PE methodology, including (1) phasing out the Indirect Practice Cost Index (IPCI) over a two-year period, eliminating steps of the PE RVU calculation that rescale indirect PE RVUs using specialty-specific PE per-hour survey data from the American Medical Association (AMA), in favor of a new "PE stabilizer" intended to reduce volatility without permanently anchoring values to outdated data; (2) applying a more uniform indirect allocator formula across nearly all services, rather than varying the allocation based on billing characteristics such as whether a service has separately billable professional and technical components; and (3) revising the indirect PE allocation for evaluation and management (E/M) visits furnished to beneficiaries during a Medicare Part A skilled nursing facility stay, consistent with the facility/non-facility site-of-service differential finalized in the CY

2026 PFS final rule. To temper the impact of these combined changes, CMS also proposes capping year-over-year changes in a code's PE RVU at plus or minus 5%.

AMGA recognizes the need to modernize a methodology that continues to rely on nearly two-decade-old AMA survey data. However, CMS should not replace an outdated methodology with numerous untested changes. The impacts of such changes must be thoroughly evaluated prior to finalization and incorporation into the methodology. Implementing multiple revisions to the 18-step PE calculation simultaneously creates substantial risk of unpredictable and potentially significant payment shifts across specialties and services. The proposed 5% annual cap merely delays these effects but does not mitigate the magnitude of the phased-in payment changes.

Accordingly, AMGA urges CMS to provide a complete and transparent code- and specialty-level impact analysis before finalizing the proposed changes. CMS should also adopt a more measured implementation approach when it does incorporate changes such as these into the calculation methodology. At a minimum, CMS should extend the phase-in period in which projected PE RVU changes exceed the cap over multiple consecutive years and establish a process to monitor claims experience, assess unintended consequences, and revise the methodology as necessary.

AMGA also urges CMS to proceed cautiously in considering broader changes to the facility/non-facility payment differential, as these could have significant financial implications for integrated delivery systems and multispecialty group practices. AMGA strongly recommends that CMS undertake robust data analysis and stakeholder engagement before proposing specific policy changes in future rulemaking.

Replacement of G2211

Comment: *AMGA is concerned about CMS' proposal to convert G2211 from a standalone add-on code to a percentage-based modifier. Establishing two materially different payment increases for functionally identical visits, based solely on whether the billing practitioner participates in a specific value-based payment model, would devalue the intensity, quality, and continuity of care provided by clinicians outside of Qualifying Alternative Payment Models (APMs)*.

AMGA has consistently supported CMS' recognition of the resource costs associated with longitudinal, relationship-based care and appreciates CMS' rationale that a percentage-based modifier may more equitably distribute the value of longitudinal care across E/M levels than the current flat-dollar add-on. AMGA remains a strong supporter of the transition to value-based care and of policies that reward practices for participating in Alternative Payment Models (APMs). However, AMGA is concerned that operationalizing that incentive by establishing two materially different payment increases for functionally identical visits—based solely on whether the billing practitioner participates in a specific value-based payment model—risks penalizing, rather than incentivizing, physicians and specialties for whom no relevant APM is currently available, and could disadvantage primary care physicians and specialists who provide the same continuity of care outside of a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) or Long-term Enhanced ACO Design (LEAD) arrangement. This risk is compounded because CMS proposes to fund the differential through budget neutrality rather than new investment—meaning the incentive would be paid for by redistributing finite dollars away from other cognitive and specialty services, rather than by genuinely rewarding value-based participation. AMGA urges CMS to clarify how this differential will be operationalized, to model its effect on non-APM practices, and to ensure that budget neutrality adjustments associated with this change do

not erode the value of the modifier for the broad base of practitioners the policy is intended to support. CMS is proposing to value MOD1 and MOD2 as a percentage of the total RVUs for the associated E/M service, based on G2211's historical payment impact and adjusted for budget neutrality. AMGA urges CMS to further clarify how it would implement these methodological differences by providing additional information on issues such as whether the increase will be reflected in the code's published work RVU or applied only as an aggregate payment adjustment. The specific implementation mechanism CMS selects for MOD1 and MOD2 carries significant administrative implications for medical groups. Work RVUs are the common data element underlying most groups' internal compensation models, productivity tracking, budgeting, and financial planning systems. If the MOD1/MOD2 payment increase is applied solely as an aggregate payment adjustment rather than reflected in the code's published work RVU, medical groups will need to build and maintain separate tracking and reconciliation processes outside their existing RVU-based infrastructure simply to account for this new payment stream. This bifurcated approach would add operational complexity and administrative cost precisely where CMS intends the modifier to recognize valuable, longitudinal care efficiently. Therefore, AMGA urges CMS to clarify how the MOD1 and MOD2 changes will affect work RVUs and to adopt an implementation approach that minimizes administrative burden for medical groups.

Global Procedures — Same-Day E/M Payment Reduction

Comment: *CMS' proposal to reduce payment by 50% for the lower-paid, separately identifiable same-day office/outpatient E/M visit furnished by the same physician as a 0-, 10-, or 90-day global procedure is detrimental to the provision of patient-focused, efficient, and administratively streamlined care*. *AMGA urges CMS to maintain full payment for significant, separately identifiable E/M services reported with modifier -25.*

AMGA supports maintaining the current policy permitting use of modifier -25 to indicate that an E/M visit is significant, separately identifiable, and complementary to—rather than duplicative of—the pre- and post-operative care associated with a procedure furnished on the same day. CMS appropriately declined to finalize a similar payment reduction in 2019, recognizing that a blanket reduction could undermine value-based care, discourage same-day care, and create administrative burden.

CMS' CY 2027 proposal ignores the full value of the physician's clinical expertise and diagnostic work by using a blunt instrument to cut payments in half for clinical services that require a high degree of professional expertise and skill. The proposal is also disproportionately harmful to providers 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. While AMGA recognizes that some modest administrative efficiencies may occur when services are furnished on the same day, a 50% payment reduction substantially overstates the true impact of those efficiencies.

CMS has had ample opportunity since the previous proposal to collect and analyze cost and utilization data, yet instead, the agency proposed a seemingly arbitrary 50% payment reduction. AMGA believes it is critical that payment policy be grounded in data and realistic assumptions about real-world impact. If finalized, AMGA strongly urges CMS to demonstrate how they reached the reduction of 50%.

Beyond its clinical and administrative flaws, this proposal presents significant concern regarding patient access to care. Practices facing continued Medicare payment reductions may be forced to limit the

number of Medicare beneficiaries they can serve, reduce services or staffing, delay investments in equipment and technology, consolidate with larger health systems, or, in some cases, shut down altogether. For patients, these pressures could mean reduced access to community-based care, and greater difficulty obtaining timely, coordinated care close to home.

Accordingly, AMGA urges CMS to maintain full payment for significant, separately identifiable E/M services reported with modifier -25.

Ambulatory Specialty Model (ASM)

Comment: *AMGA values CMS' commitment to testing new approaches to improving care quality and lowering costs but remains deeply concerned about the mandatory nature of the Ambulatory Specialty Model (ASM), its low patient-attribution threshold, and its overlap with existing programs. CMS' technical and operational refinements proposed for CY 2027 do not resolve these fundamental concerns.*

In response to the CY 2026 PFS proposed rule, AMGA raised serious objections to several aspects of the proposed Ambulatory Specialty Model (ASM), including mandatory participation for specialists in selected regions, a minimum patient-attribution threshold of only twenty patients per year, and substantial overlap between ASM performance categories and those already used in MIPS Value Pathways (MVPs) and the Medicare Shared Savings Program (MSSP). For CY 2027, CMS proposes a series of technical corrections and streamlining changes to the ASM. While AMGA appreciates CMS' efforts to respond to stakeholder input, these refinements are operational in nature and do not address the model's core structural flaws which still remain a concern.

The mandatory nature of the model forces specialists, many of whom lack prior experience with value-based care, into a model without the preparation time, infrastructure, or resources needed to succeed. Additionally, CMS' own historical experience with mandatory models demonstrates their potential to disrupt care delivery and create financial instability. A 20-patient minimum attribution threshold remains too small a denominator to produce statistically reliable performance results, as a single adverse outcome could disproportionately skew a specialist's quality score, unfairly penalizing physicians who treat patients who are sicker, more complex, or less adherent. Finally, because many participating specialists are already accountable for cost and quality performance through MSSP ACOs, layering a mandatory specialty model on top of existing value-based arrangements risks creating conflicting incentives, benchmarks, and reconciliation methodologies.

AMGA again urges CMS not to move forward with mandatory ASM participation. Should CMS proceed with the model in any form, AMGA recommends excluding providers who participate in an accountable care organization, as the goals of the two models overlap. AMGA does appreciate CMS' proposals to align the promoting interoperability performance category in ASM more closely to MIPS and continues to encourage CMS to reduce any additional differences between these two programs. This would eliminate duplicative or conflicting obligations for specialists who participate in more than one model.

AMGA also urges CMS to provide participants with additional guidance, technical assistance, and educational resources as the model is set to begin January 1, 2027. Additional webinars and other resources will be essential to specialists' success as they work to understand the model's requirements and prepare for implementation. Participating specialists will have varying levels of experience in value-based care and resources available to support their participation in the model. CMS should ensure that

participants have adequate support and preparation time to successfully engage in the model.

Quality Payment Program (QPP)

Comment: *AMGA is concerned that CMS' proposal to sunset traditional MIPS reporting after the CY 2028 performance period and require Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) reporting beginning in CY 2029—paired with three new MVPs and modifications to all 27 existing MVPs—will increase administrative burden and fragmentation for multispecialty groups and integrated delivery systems.*

CMS proposes to sunset the traditional Merit-based Incentive Payment System (MIPS) reporting option after the CY 2028 performance period (2030 MIPS payment year), making MIPS Value Pathways (MVPs) the only reporting pathway for MIPS-eligible clinicians who do not participate in an Alternative Payment Model. CMS also proposes three new MVPs—covering diabetic disease, hypertension, and hospital-based care—bringing the total MVP inventory to thirty. Additionally, the final rule includes proposals to modify all 27 existing MVPs to incorporate new MIPS core measures. The cumulative impact of these changes would increase administrative burden and fragmentation for multispecialty groups and integrated delivery systems.

AMGA has consistently expressed concern that the MVP framework, particularly the expectation that multispecialty groups report through single-specialty subgroups is inconsistent with the collaborative, team-based model of care that defines multispecialty medical groups and integrated health systems. Requiring a mandatory transition away from traditional MIPS by a date would compel every group to select, build reporting infrastructure for, and validate an MVP—or, where no MVP appropriately aligns with a group's mix of specialties, to force a subgroup into an ill-fitting reporting structure. These requirements would be performed regardless of whether doing so improves care coordination or simply adds a new layer of compliance obligations and administrative and operational burdens. AMGA is similarly concerned that mandating a MIPS core measure set across both traditional MIPS and all MVPs, in addition to specialty-specific and population-specific MVP measures, could add layers of reporting complexity rather than the streamlining and simplification that CMS intends.

AMGA continues to believe that the greatest barriers to meaningful, low-burden quality reporting are structural. In particular, the continued use of the low-volume threshold excludes a substantial share of clinicians from the program and dampens the incentive to invest in the value-based infrastructure necessary for meaningful participation. Additionally, the absence of a true multispecialty group practice reporting option requires groups to navigate a framework built around individual specialties or conditions, rather than one that reflects coordinated, team-based care delivery. CMS previously implemented a mechanism to address this exact problem: the Group Practice Reporting Option (GPRO) under the Physician Quality Reporting System (PQRS) allowed multispecialty group practices to report quality measures collectively as a single unit, rather than fragmenting reporting across individual specialties or subgroups. AMGA urges CMS to develop a comparable group-level reporting option within the MVP framework, allowing multispecialty groups and integrated delivery systems to report as a unified group consistent with how care is actually organized and delivered, rather than forcing selection among ill-fitting single-specialty MVPs. AMGA further urges CMS to address these underlying structural issues before finalizing a mandatory transition date and provide ample time and transitional flexibility for groups needing to update their infrastructure. Furthermore, AMGA urges CMS to work with stakeholders and ensure that any new MVPs or core measures are developed with meaningful input from

multispecialty and integrated systems.

Primary Care Exception

Comment: *AMGA supports CMS' proposal to expand the primary care exception to all levels of office/outpatient E/M services, providing teaching practices with greater flexibility while preserving appropriate physician supervision.*

AMGA supports CMS' proposal to expand the primary care exception to permit residents to furnish all levels of office/outpatient E/M services, including level 4 and 5 visits, when the teaching physician determines doing so is clinically appropriate. This change would better reflect residents' capabilities while preserving appropriate teaching physician supervision. The current limitation to lower- and mid-level visits can unnecessarily restrict resident participation in the care of more complex patients. Expanding the exception would give teaching practices greater flexibility to structure care based on patient needs and resident competency, while also strengthening residents' experience managing the full range of primary care needs. AMGA urges CMS to finalize the proposal and implement it through clear, administratively simple program instructions.

Telehealth

Comment: *AMGA supports CMS' proposed telehealth policies, particularly the expanded use of virtual presence for teaching physicians, which would provide greater flexibility while maintaining appropriate supervision and oversight.*

AMGA supports CMS' proposals to continue and expand Medicare telehealth flexibilities for CY 2027, including implementation of the statutory extensions enacted through the Consolidated Appropriations Act, 2026; updates to the originating-site facility fee; additions to the Medicare Telehealth Services List; and related coding changes. These policies will help preserve access to care and provide medical groups with greater flexibility to integrate virtual care into established clinical workflows.

AMGA also supports CMS' proposal to continue payment to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for non-behavioral health visits furnished through telecommunications technology through December 31, 2027, as well as the continued waiver of in-person visit requirements for mental health services during this period. These extensions are particularly important for patients who rely on RHCs and FQHCs for access to primary and specialty care and will help preserve continuity of care in rural and underserved communities. AMGA urges CMS to implement these statutory flexibilities in a manner that minimizes administrative burden and supports continued integration of telehealth into RHC and FQHC care delivery.

AMGA urges CMS to finalize its proposal to permit Medicare telehealth services involving residents when either the teaching physician or the resident is physically present with the patient and the other participates through real-time audio-video technology. Requiring the teaching physician, resident, and patient to all be located separately does not reflect how telehealth is commonly incorporated into team-based teaching environments and can unnecessarily constrain otherwise appropriate supervision arrangements. CMS' proposal would provide teaching practices with greater operational flexibility while maintaining existing documentation, supervision, and teaching physician oversight requirements.

Allowing virtual teaching physician presence in these circumstances can also support graduate medical education and improve access to physician expertise, particularly across rural and underserved areas. AMGA therefore urges CMS to finalize this proposal, as well as the broader telehealth policies described above, and to continue pursuing permanent Medicare telehealth policies that allow medical groups to determine when virtual care is clinically appropriate for their patients.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)

Comment: *AMGA supports a targeted approach to Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) that implements narrowly tailored program-integrity safeguards that address the Office of the Inspector General's (OIG's) concerns while preserving access to clinically integrated, technology-enabled care and avoiding unnecessary barriers to care.*

AMGA supports CMS' goal of strengthening program integrity for RPM and RTM, particularly in light of concerns identified by the OIG. However, AMGA is concerned that several of the proposed policies could have the unintended effect of disrupting clinically integrated remote monitoring programs and reducing beneficiary access to care. As AMGA's MACRA and Value-Based Care Task Force emphasized, Medicare policy should support, rather than impede, the transition to high-value care by reducing unnecessary regulatory barriers and ensuring that rural and underserved practices have access to the resources and infrastructure needed to participate successfully.

AMGA is particularly concerned about CMS' proposal to limit RPM and RTM clinical services to staff directly employed by the billing practitioner or practice. High-quality remote monitoring often requires patient onboarding, device logistics, technical support, data review, alert management, documentation, and escalation protocols, capabilities that may be provided efficiently through clinically integrated arrangements with specialized partners. A categorical prohibition on contracted clinical staff could therefore disrupt responsible care models along with the arrangements CMS is seeking to address. This concern is especially significant for small, rural, and underserved practices, which AMGA's Task Force has recognized often lack the scale, staffing, and capital to independently build the infrastructure necessary to support high-value care.

AMGA has specifically recommended policies that allow such practices to pool resources and access shared care-coordination and technical capabilities rather than requiring them to recreate these functions independently. AMGA therefore urges CMS to develop targeted safeguards that ensure the billing practitioner maintains clinical oversight, accountability, and meaningful integration of remote monitoring into the patient's plan of care, without categorically prohibiting appropriately structured contracted arrangements.

AMGA also encourages CMS to reconsider requiring a new separately reportable initiating visit where the billing practitioner already has an established relationship with the patient and sufficient information to determine that remote monitoring is medically appropriate. Requiring an additional visit without regard to recent E/M care could result in duplicative services, create additional administrative burden, and exacerbate access constraints. This would run counter to the Task Force's broader recommendation that CMS remove regulatory and administrative barriers that do not meaningfully improve patient care. CMS should instead permit an appropriate recent practitioner encounter to satisfy the initiating-service requirement when the practitioner has assessed the patient's condition, established the treatment

relationship, and documented the clinical need for RPM or RTM.

Finally, AMGA agrees that CMS should examine whether the existing RPM and RTM coding structure provides sufficient transparency to support appropriate program oversight. In its 2024 report, OIG identified legitimate concerns, including beneficiaries receiving individual components of RPM without corresponding treatment management and CMS' limited ability to identify what data are being monitored, who ordered the service, and who furnished services incident to the billing practitioner. Rather than broadly restricting access to established remote monitoring models, AMGA encourages CMS to address these concerns through targeted improvements to coding, claims reporting, and program-integrity safeguards. This could include reexamining whether the current component-based code sets should be modified or supplemented to better demonstrate that remote monitoring services are clinically integrated and appropriately furnished, while also improving transparency regarding ordering and incident-to services. Any new bundled codes, however, should be carefully developed with stakeholder input and should not inadvertently underpay legitimate programs or eliminate necessary flexibility in how RPM and RTM are delivered.

Advance Care Planning (ACP) (HCPCS Codes GACP1 and GACP2)

Comment: *AMGA strongly supports CMS' proposal to establish separate payment for advance care planning (ACP) services furnished by clinical staff and encourages CMS to finalize HCPCS codes GACP1 and GACP2 with sufficient flexibility to reflect team-based care. AMGA also urges CMS to avoid imposing a same-day E/M or other unnecessary initiating-visit requirement that could create a new barrier to ACP services.*

AMGA appreciates CMS' continued attention to improving access to meaningful ACP. Under the proposal, CMS would establish GACP1 and GACP2 to separately recognize ACP services furnished by clinical staff, while CPT codes 99497 and 99498 would reflect time personally furnished by the billing practitioner. AMGA supports this team-based approach, which more accurately reflects how ACP is delivered within multispecialty medical groups and integrated health systems.

This proposal aligns with the work of AMGA's MACRA and Value-Based Care Task Force, which identified protecting patient dignity at the end of life as a foundational element of modernizing Medicare and advancing value-based care. The Task Force has called for policies that facilitate meaningful conversations among patients, families, and care teams and appropriately reimburse providers for ACP. AMGA believes Medicare payment policy should support the multidisciplinary infrastructure needed for these conversations and enable patients to make informed decisions consistent with their goals and preferences.

Accordingly, AMGA recommends that CMS finalize GACP1 and GACP2 as separate clinical-staff codes and permit them to be reported with CPT codes 99497 and 99498 when the respective time thresholds are independently met. AMGA also encourages CMS to continue considering a combined practitioner-and-clinical-staff code as an additional option, particularly for team-based encounters in which neither individual independently meets a time threshold, but such a code should supplement rather than replace GACP1 and GACP2. Any coding framework should remain straightforward and avoid unnecessary documentation or time-tracking burdens.

AMGA further urges CMS to preserve flexibility regarding initiating-service, incident-to, and supervision

requirements. CMS should not require a separately billable E/M visit or practitioner-performed ACP service on the same day as GACP1 or GACP2 when the practitioner has already established and continues to manage the patient's course of treatment. AMGA also supports permitting direct supervision through real-time audio/video technology. These flexibilities would better support longitudinal, team-based care and help ensure that ACP can occur when clinically appropriate, including before a patient reaches an acute crisis or advanced stage of illness.

Screening, Brief Intervention, Referral to Treatment (SBIRT) Services

Comment: *AMGA encourages CMS to finalize this proposal.*

AMGA supports CMS' proposal to apply the 19.1% work RVU adjustment to Screening, Brief Intervention, Referral to Treatment (SBIRT) services, including CPT codes 99406 and 99407 and HCPCS codes G2011 and G0397. These services play an important role in identifying and addressing modifiable risk factors for chronic disease, including tobacco use, poor nutrition, physical inactivity, and excessive alcohol use. Applying the same adjustment previously adopted for timed behavioral health services would better recognize the clinical work involved in delivering these interventions and support broader integration of preventive and behavioral health services into routine care.

Medicare Shared Savings Program (MSSP)

Comment: *AMGA supports CMS' proposals to strengthen the Medicare Shared Savings Program (MSSP) through enhanced financial incentives and beneficiary engagement while reducing burden. AMGA also encourages CMS to incorporate sufficient timelines, information, and stability to allow Accountable Care Organizations (ACOs) to effectively plan and implement strategies to improve patient outcomes while managing costs.*

For CY 2027, CMS outlines a series of reforms to the Medicare Shared Savings Program (MSSP) aimed at strengthening financial incentives, increasing beneficiary engagement, and reducing participation burden. AMGA generally supports these proposals, particularly to allow ACOs to enter into cost-sharing agreements, but offers several considerations for CMS on the modifications to the program's financial methodology.

Financial Methodology
CMS proposes several financial methodology changes to balance incentives and address selection concerns between Level E of the BASIC track and the ENHANCED track. Although AMGA supports these proposals, moving to value-based care—especially downside risk—requires providers to spend substantial time understanding program requirements, forecasting performance, and implementing necessary initiatives. Changes made during an agreement period are particularly disruptive because providers have already invested significant resources in evaluating performance; for example, ACOs with current agreements will likely have to update their forecasts.

We appreciate CMS' recognition of these financial methodology changes and its proposal to allow eligible ACOs applying for the January 1, 2027 agreement start date a limited opportunity, after publication of the final rule, to switch between the BASIC and ENHANCED tracks. However, we urge CMS to extend this transition period to give ACOs more time to determine which track best fits their needs, engage in change management activities to effectuate such changes, and implement initiatives

accordingly.

Beneficiary Engagement
CMS proposes two changes to expand ACOs' ability to support beneficiary engagement in their care, including allowing MSSP ACOs to enter into Part B cost-sharing support agreements beginning April 1, 2027. AMGA strongly supports this proposal as eligible ACOs could reduce or eliminate all or part of a beneficiary's Medicare fee-for-service (FFS) Part B deductible and/or coinsurance for specified categories of services and eligible beneficiaries identified by the ACO. AMGA supports eliminating cost-sharing as this will increase participation in MSSP and decrease costs for beneficiaries.

This proposal aligns with engagement structures seen in Medicare Advantage and private insurance markets, where patient engagement is promoted through financial incentives. AMGA providers have reported improvements in patient engagement when cost-sharing requirements no longer serve as barriers to care. Reducing financial barriers can increase uptake of preventive services, follow-up visits, and chronic disease management—key elements of effective care delivery. Further, costs to beneficiaries can be particularly burdensome for individuals with complex healthcare needs.

Request for Information (RFI): Primary Care Payment

Comment: *AMGA urges CMS to strengthen primary care payment to support prevention and to address reimbursement challenges that threaten patient access.*

AMGA appreciates the opportunity to respond to CMS' request for information (RFI) on reconsidering primary care service valuation to support a shift toward preventive care. As outlined in our Value-Based Care Task Force Recommendations report, AMGA supports payment policies that strengthen primary care, incentivize investment in high-value care models that improve health outcomes, enhance patient engagement, and reduce long-term health care costs by preventing avoidable utilization.

Primary care remains underfunded and undervalued, contributing to a reactive healthcare system rather than a preventive one. Absent supportive payment policies, primary care will remain strained and chronically underfunded, threatening patient access to care and perpetuating rising healthcare costs.

Accordingly, CMS should ensure any future payment policy recognizes the resources needed to deliver comprehensive primary care, including technology-enabled services, standardized data infrastructure, and flexible prospective payment arrangements. To do this, CMS must align financial incentives with prevention, chronic disease management, and patient-centered care to enable sustained physician and patient engagement, improved outcomes, and reduced avoidable high-cost utilization.

RFI: CPT Code Set

Comment: *AMGA urges CMS to carefully consider and plan for the transition to a new coding system from the current CPT-based system, given the significant operational disruption and administrative burden that a new coding framework could impose across physician practices and the broader health care system.*

AMGA appreciates CMS' RFI regarding the role of the CPT coding system in Medicare physician payment and potential alternatives. From an operational perspective, AMGA urges CMS to proceed cautiously

before considering any fundamental transition away from CPT as the principal coding framework for physician and other professional services. CPT is deeply embedded throughout the healthcare system, including in clinical documentation, electronic health records, claims submission, payer contracts, coding and compliance programs, quality measurement, prior authorization, and revenue-cycle operations. Replacing or substantially restructuring this framework would therefore entail significant implementation costs and operational disruption for physician practices, hospitals, health plans, vendors, and other stakeholders.

Any transition to a new coding system would also require extensive mapping between existing CPT codes and a replacement framework, substantial modifications to electronic health record and billing systems, payer testing, clinician and coder education, and potentially prolonged periods in which multiple coding systems would need to operate concurrently. AMGA is particularly concerned about the potential for inconsistent mappings or implementation timelines across Medicare, Medicaid, and commercial payers, which could increase administrative burden and create new risks of claim denials, payment delays, and coding errors.

These considerations would be especially important if CMS were to explore use of ICD-10-PCS as a basis for professional payment, given the substantial operational differences between a procedure classification system developed for inpatient hospital reporting and the coding infrastructure currently used for physician services. AMGA also encourages CMS to carefully evaluate whether it has the administrative capacity and infrastructure necessary to assume a substantially larger role in developing, maintaining, reviewing, and valuing the thousands of codes required to support physician payment. The current coding and valuation process distributes significant portions of this work outside CMS while preserving the agency's ultimate authority over Medicare payment policy. Moving these functions into a more CMS-directed coding system could require the agency to establish and continuously maintain a significantly expanded clinical, technical, and valuation apparatus.

Accordingly, AMGA recommends that CMS prioritize improvements to the efficiency, transparency, and timeliness of existing coding and valuation processes before pursuing wholesale replacement of the CPT framework. If CMS continues to evaluate alternative approaches, any changes should be thoughtfully planned, incremental, extensively tested, coordinated across payers and health information technology vendors, and accompanied by sufficient transition time and resources to avoid unnecessary disruption to physician practices and patient care.

Conclusion

We thank you for your consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director of regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

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