Advancing High Performance Health

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September 12, 2025

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

**RE: [CMS-1832-P] Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program**

Dear Administrator Oz:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule (PFS) proposed rule for Calendar Year (CY) 2026.

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. Over 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.

AMGA is pleased to offer comments on the CY 2026 PFS proposed rule for your consideration. Specifically, we provide comments on the following:

- **Conversion Factor:** Short-term fixes to the Medicare PFS do little to counter years of payment erosion. AMGA strongly calls on CMS and Congress to implement lasting reforms that stabilize the conversion factor, better align reimbursement with actual practice costs, and sustain high-value, team-driven care models.
- **Efficiency Adjustment and Site of Service Payment Differential:** CMS' proposed efficiency adjustment and site of service payment differential focus on marginal redistributions while ignoring the core issue: Medicare Part B payments are insufficient and do not cover the full cost of care delivery Without broader reforms to stabilize and modernize physician payment, these changes risk adding financial strain and reducing access to care.

- **Medicare Telehealth Services List:** AMGA commends CMS for proposed changes to the Medicare Telehealth Services List review process, removal of frequency limitations to support telehealth subsequent care services, and allowing virtual presence for services that require direct supervision of a physician. We also urge CMS to collaborate with Congress to extend crucial flexibilities slated to expire on September 30, 2025.
- **Virtual Supervision of Resident Physicians:** AMGA recommends CMS not finalize its proposal to end the virtual presence of teaching physicians during telehealth visits.
- **Remote Patient Monitoring:** AMGA strongly supports the agency's recommendation to expand remote patient monitoring through the addition of several new codes with lower data collection thresholds.
- **G2211:** AMGA supports CMS' proposal to allow G2211 to be billed as an add-on to home or residence Evaluation and Management (E/M) visits, as it promotes continuity of care.
- **Work Geographic Practice Cost Indices (GPCI) 1.0 Floor:** AMGA asks CMS to advocate for an extension of the GPCI 1.0 floor.
- **Advanced Primary Care Management Add-On Codes:** We support CMS' efforts to expand and modernize care management through Advanced Primary Care Management (APCM) codes and the removal of outdated time-based requirements for Behavioral Health Integration and Collaborative Care Model services.
- **Request for Information on Prevention and Management of Chronic Disease:** AMGA recommends CMS modernize chronic care models by expanding coverage for digital therapeutics and strengthening partnerships with community-based organizations.
- **Mandatory Ambulatory Specialty Model:** AMGA values CMS' commitment to exploring new ways to enhance care quality and lower costs. However, we are deeply concerned about several aspects of the proposed Ambulatory Specialty Model (ASM), especially its required participation, the very low patient attribution threshold, and the significant overlap with current initiatives like the Merit-based Incentive Payment System (MIPS) and the Medicare Shared Savings Program (MSSP).
- **Medicare Shared Savings Program:** While AMGA supports many of the proposed changes to the MSSP, we are concerned that tightened beneficiary thresholds will limit high-value care participation opportunities for smaller MSSP participants.
- **Quality Payment Program:** AMGA is concerned that the proposed updates to the Quality Payment Program (QPP) MIPS Value Pathways (MVPs) and Qualifying Alternative Payment Model (APM) Participant (QP) determinations could lead to increased fragmentation and administrative burden. While intended to streamline reporting, these changes may disrupt care coordination and shift the program toward a compliance-focused approach.

## Conversion Factor

**Comment:** Legislative patches to the Medicare Physician Fee Schedule offer only temporary relief and fail to address long-standing payment erosion. AMGA urges CMS and Congress to pursue comprehensive reforms that stabilize the conversion factor (CF), align payments with costs, and support value- and team-based care.

AMGA is deeply concerned that recent short-term measures to soften payment cuts fail to address the underlying need for fundamental reform of the Medicare PFS. While congressional action has temporarily prevented an additional decrease to the CF for CY 2026, this action is

only a temporary reprieve. Without such interventions, the CF would have continued its downward trend, further eroding payment levels. This ongoing instability threatens the financial health of medical groups and integrated delivery systems, while weakening efforts to advance high-value care.

The proposed CY 2026 CFs—$33.59 for Qualifying Alternative Payment Model (APM) (QP) Participants and $33.42 for non-QPs—reflect a modest rebound from the current $32.35 rate, including a one-time, congressionally required 2.5% increase and technical adjustments. However, these modest gains do not resolve the core issue: Medicare physician reimbursement has not kept pace with inflation or the rising costs of running a practice, leaving providers under increasing strain.

Medical groups and health systems are being asked to deliver modern, team-based care within an outdated payment structure which does not provide sufficient reimbursement. Relying on short-term fixes only postpones more significant challenges. AMGA urges CMS and Congress to work together to create a more durable and predictable payment model that:

- Provides annual CF updates that reflect inflation and practice costs;
- Establishes stronger incentives for participation in high-value and alternative payment models;
- Streamlines administrative and reporting requirements; and
- Supports coordinated, preventive, and chronic care delivery.

Long-term stability for Medicare providers and patients will require structural change, not piecemeal solutions. AMGA strongly recommends CMS collaborate with Congress to update the PFS framework to ensure sustainable, reliable payments for the future.

## Efficiency Adjustment and Site of Service Differential

> **Comment:** Redistributing inadequate dollars among services or across settings only adds pressure to an already unstable system and risks undermining access. CMS should prioritize stabilizing and modernizing physician payments before layering on targeted redistributions.

CMS' proposed changes, including the application of a -2.5% efficiency adjustment to most non-time-based services and a recalculation of indirect practice expense (PE) RVUs, adds another level of complexity on top of a payment system that is already under strain. While the idea of capturing efficiency gains is understandable, it is misguided to focus on marginal redistributions from one side of the Physician Fee Schedule ledger to another. The larger problem is that Medicare Part B payments simply do not keep pace with inflation, workforce costs, and technological demands.

The conversion factor also continues to decline in real terms, with the proposed CY 2026 updates providing little relief against rising practice expenses. Moving small pieces of an already inadequate pie, whether by site of service or efficiency adjustments, does not solve the structural underfunding that threatens access to care. Providers in both facility and non-facility settings are making significant investments to comply with regulatory requirements, adopt new technologies, and manage increasingly complex patients. These realities drive indirect costs

upward, not downward.

Layering site-of-service differentials and efficiency cuts onto an already unstable payment foundation risks amplifying financial pressures on practices, especially those serving rural and underserved populations.

While many specialties will be adversely affected, the proposals would have a disproportionately large effect on cardiology. CMS estimates a 7.0% decrease in facility-based cardiology services, which total approximately $2.2 billion in allowed charges nationwide based on CY 2024 utilization and CY 2025 rates. As a result, essential life-saving services—such as percutaneous coronary interventions (PCI), transcatheter aortic valve replacements (TAVR), pacemaker implantations, and atrial fibrillation (AF) ablations—will see significant and arbitrary reimbursement reductions at a time when the demand for these services is only growing with the increasing prevalence of coronary artery disease (CAD), congestive heart failure (CHF), and AF and other arrhythmias.

Medicare beneficiaries with these and other cardiac-related diagnoses are often older and frailer, and have multiple chronic comorbidities. To preserve patient access and advance President Trump‘s overall agenda to Make America Healthy Again, CMS should not finalize the efficiency adjustment proposal.

## Telehealth

> **Comment:** AMGA commends CMS for proposed changes to the Medicare Telehealth Services List review process, removal of frequency limitations to support telehealth subsequent care services, and allowing virtual presence for services that require direct supervision of a physician. We also urge CMS to collaborate with Congress to extend crucial flexibilities that face a regression to pre-pandemic rules at the end of September.

AMGA appreciates CMS' recognition of telehealth’s vital role in expanding access to care, particularly during the COVID-19 Public Health Emergency (PHE). While we acknowledge that CMS' authority to extend certain critical telehealth flexibilities is limited, we commend the agency for maintaining many of the flexibilities that have helped transform care delivery. We urge CMS to work with Congress to establish permanent payment parity between telehealth services and an in-person office visit and make permanent the ability for patients to receive telehealth services from any location, including their homes. Without changing the statute to remove geographic and originating site restrictions, telehealth utilization risks regressing to pre-pandemic levels, which would disproportionately impact rural and chronic disease populations who face barriers to receiving in-person care.

AMGA also supports CMS’ proposed changes to streamline the Medicare Telehealth Services List review process, permanent expansion of new flexibilities to providers furnishing subsequent care services via telehealth, and the proposal to allow the use of audio/video real-time communication to deliver services that require a physician’s direct supervision. Together, these changes show CMS’ commitment to protecting valuable flexibilities and represent iterative changes that will help doctors tackle the chronic disease crisis while reducing provider burden.

Whether by streamlining procedural processes through removal of the "provisional" designation on the Medicare Telehealth Service List or expanding telehealth care options to broaden care access possibilities, these changes are important steps forward in continuing to improve patient outcomes while driving down costs.

## Virtual Supervision of Resident Physicians

> **Comment:** AMGA recommends CMS not finalize its proposal to end the virtual presence of teaching physicians during telehealth visits. These changes have helped enhance medical education and delivery of high-quality patient care, while better representing the varied needs of the care delivery landscape across our nation.

AMGA disagrees with CMS' proposal to terminate the flexibilities that currently allow teaching physicians to maintain a virtual presence while providing real-time observation of residents during telehealth visits through 2025. This flexibility, introduced during the PHE and expanded through CY 2025, has proven invaluable in ensuring continuity of medical education while adapting to the challenges of a rapidly changing healthcare environment. AMGA supported extension of these flexibilities in last year's rule. This change does not align with administration priorities to tackle the chronic disease crisis and deliver care effectively across the nation. The removal of this flexibility would limit the availability of appropriate telehealth-delivered care, while leaving our future physicians with reduced access to telehealth instruction in an increasingly digital world.

Additionally, AMGA would request CMS advocate to Congress for the permanent extension of PHE-era telehealth waivers related to geographic restrictions and originating site requirements. These vital flexibilities are scheduled to expire absent Congressional action. These flexibilities have guaranteed patient access to care for millions and transformed the delivery of patient care across the country in the more than five years since their implementation. By allowing the delivery of telehealth services in a patient's home, regardless of whether they reside in rural or urban areas, CMS has enabled timely, convenient, and cost-effective care for countless individuals and families who otherwise may have foregone care altogether—particularly those with mobility challenges, multiple chronic conditions, or limited transportation options.

## Remote Patient Monitoring

> **Comment:** AMGA strongly supports the agency's recommendation to expand remote patient monitoring through the addition of several new codes with lower data collection thresholds. The new codes would provide additional options that expand patient access to important technologies.

AMGA strongly supports the agency's proposal to expand the remote patient monitoring code set. Medicare's current reimbursement for remote patient monitoring, both therapeutic (RTM) and physiologic (RPM), is constrained by strict compliance requirements, which has limited the availability of these services. By adding new care coordination codes and establishing a lower data collection threshold— from 16 to 2 days per month—for these codes, CMS will make it

easier for providers to capture meaningful information about patients' health status. This change has dual benefits: It empowers patients to engage more actively in their care, and it gives providers actionable data to shape care plans. This change also helps advance high-value care by enabling early intervention and effective prevention, particularly for rural or underserved populations who face greater barriers to in-office visits.

In our rapidly changing digital landscape, these updates will allow providers to expand access to remote monitoring devices, capture more information about their patients' conditions, facilitate important discussions between patients and providers, and guide more effective courses of treatment.

At the same time, we urge CMS to recognize the potential for misuse and overutilization of these codes. Lowering the data collection threshold may inadvertently fuel inappropriate billing practices, especially by entities not directly involved in patients' longitudinal care. To preserve the integrity of these important services, any expansion must be paired with safeguards that ensure remote monitoring is delivered by providers meaningfully engaged in patients' care, includes appropriate discharge criteria, and truly supports care coordination.

## G2211

> **Comment:** AMGA supports CMS' proposal to allow G2211 to be billed as an add-on to home or residence Evaluation and Management (E/M) visits, as it promotes continuity of care.

AMGA commends CMS for recognizing the additional time and resources necessary to build and sustain a long-term, trusting relationship with patients. AMGA supported CMS' proposal in the CY 2024 PFS to allow G2211 to be separately billable to help foster continuous, comprehensive care. In this same vein, we support the agency's efforts to allow G2211 to be billed as an add-on to home or residence E/M visits, allowing clinicians greater flexibility to provide optimal care even when it is delivered in home or residential settings.

In addition, we echo our concerns from our CY 2024 and 2025 PFS proposed rule comments urging CMS to better educate patients on the fact that, while there is no cost-sharing associated with the annual wellness visit (AWV), other services provided during that visit, such as G2211, will result in a co-pay.

## Work Geographic Practice Cost Indices (GPCI) 1.0 Floor

> **Comment:** AMGA asks CMS to advocate for an extension of the GPCI 1.0 floor.

Maintaining the work GPCI 1.0 floor is essential to protecting access to care for patients and ensuring appropriate compensation for clinicians practicing in rural and underserved areas. If the floor is allowed to expire, many clinicians would face reimbursement reductions for the same work relative to their peers in higher-cost urban regions. For patients, the result could mean fewer accessible clinicians in their region, longer travel distances to receive essential services, and delays in receiving needed care. AMGA asks that CMS strongly advocate Congress to extend the work GPCI 1.0 floor beyond the current expiration date of September 30, 2025.

## Expansion of Advanced Primary Care Management Codes

**Comment:** AMGA supports CMS' proposals to modernize care management through the addition of new APCM add-on codes, which will strengthen team-based, coordinated primary care. However, CMS should ensure payment for APCM services is not limited to practices reporting through the Value in Primary Care MIPS Value Pathway (MVP) to avoid restricting access and innovation across diverse care models.

AMGA appreciates CMS' efforts to expand and modernize care management through the introduction of new Advanced Primary Care Management (APCM) add-on codes and the removal of outdated, time-based requirements for Behavioral Health Integration (BHI) and Collaborative Care Management (CoCM) services. These proposals recognize the importance of proactive, team-based care, allowing care teams to focus on patient needs rather than rigid billing structures. However, payment for APCM services should not be restricted solely to practices reporting through the Value in Primary Care MVP, as doing so would limit access and stifle innovation for practices participating through other reporting mechanisms.

The APCM framework has the potential to be especially impactful in rural and underserved communities, where shortages of physicians and specialists make it difficult to deliver comprehensive, coordinated care. By recognizing and reimbursing the value of integrated care teams, these policies will help sustain primary care practices that are essential to rural health infrastructure and reduce disparities between urban and rural populations.

To maximize the reach and effectiveness of APCM, we urge CMS to waive beneficiary cost-sharing for preventive services delivered under these codes. Removing financial barriers will encourage greater patient participation, promote early intervention, and support the broader shift toward value-based, preventive primary care.

Additionally, AMGA strongly supports CMS' proposals to expand and clarify policies for Community Health Integration (CHI) and Principal Illness Navigation (PIN) services, particularly in the context of behavioral health. Allowing Clinical Social Workers (CSWs), Marriage and Family Therapists (MFTs), and Mental Health Counselors (MHCs) to perform these services under the supervision of a billing practitioner reflects the vital role these professionals play in improving care coordination, helping patients navigate complex health needs, and addressing barriers to timely treatment. We also support the expansion of initiating visit types to include psychiatric diagnostic evaluations (CPT 90791) and Health Behavior Assessment and Intervention (HBAI) services, as these flexibilities will create more practical entry points for patients with behavioral health conditions.

## Request for Information: Prevention and Management of Chronic Disease

**Comment:** Building on AMGA's MACRA and Value-Based Care Task Force recommendations, CMS should integrate upstream drivers and community-based supports into chronic care models.[1] Standardized metrics, workforce investments, and reimbursement for services like patient navigation, digital tools, and partnerships with local organizations are essential to reduce disparities and improve population health.

[1] AMGA's MACRA and Value-Based Care Task Force Report

AMGA appreciates the opportunity to provide input on how CMS can strengthen chronic disease prevention and management. As outlined in our Medicaid Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) and Value-Based Care Task Force Recommendations report (January 2025), providers must be empowered with flexible, evidence-based tools and payment structures to manage the growing burden of chronic illness. In response to CMS' Request For Information (RFI), we recommend the following targeted actions:

1. **Create dedicated payment mechanisms for whole-person, behavior-focused interventions.**
   CMS should establish new Healthcare Common Procedure Coding System (HCPCS) codes or refine existing care management codes to pay for services such as motivational interviewing, health coaching, and medically tailored meals. These interventions are effective at supporting behavioral change and addressing risk factors that fuel chronic disease. Payment should reflect the multidisciplinary nature of these services and allow care teams to include dietitians, health educators, and community health workers. Integration with APCM will ensure alignment and avoid duplication.

2. **Integrate upstream drivers into chronic care models.**
   As our Task Force emphasized, up to 80% of health outcomes are determined by factors outside the clinic.[2] CMS should test or expand payment models that support assessment and mitigation of social needs, including transportation, food insecurity, housing instability, and social isolation. For example, CMS could pilot payment adjustments tied to socioeconomic risk factors or allow reimbursement for referrals and partnerships with community-based organizations. Building upon lessons learned from the Accountable Health Communities Model, investments like these would improve outcomes and reduce downstream costs.

3. **Expand coverage for digital therapeutics and community-based supports.**
   Many evidence-based interventions—such as remote monitoring, app-based behavioral change programs, and virtual group visits—are not well captured under the current PFS. CMS should create clear coverage and coding pathways for these services, including digital therapeutics for conditions like diabetes and cardiovascular disease. Regulations should include guardrails for evidence of effectiveness and integration with electronic health records to support data sharing and care coordination.

4. **Standardize metrics and strengthen data infrastructure to evaluate impact.**
   To ensure accountability, CMS should invest in standardized, interoperable data collection and reporting systems that capture health outcomes across populations. As emphasized in our Task Force report, the absence of common metrics prevents more rigorous evaluation of innovative care models. CMS should promote Fast Healthcare Interoperable Resource (FHIR)-based data exchange to facilitate timely feedback and benchmarking.

5. **Support workforce and resource alignment to scale interventions.**
   CMS should allow payment for patient navigators, behavioral health specialists, and community health workers, recognizing their role as integral members of the care team.

[2] Magnan, S. 2017. Social Determinants of Health 101 for Health Care: Five Plus Five. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC.

Financial incentives should support recruitment, training, and retention, especially in underserved and rural areas where access is most constrained.

6. **Reform chronic care management (CCM) coding.** Chronic care management is a critical part of coordinated care. As a result, Medicare began reimbursing physicians for CCM under a separate billing code in the Medicare Physician Fee Schedule in 2015. This code is designed to reimburse providers for non-face-to-face care management. Providers and care managers have discovered several positive outcomes for CCM beneficiaries, including improved patient satisfaction and adherence to recommended therapies, improved clinician efficiency, and decreased hospitalizations and emergency department visits.

   However, the current guidelines from the U.S. Preventive Services Task Force do not classify CCM as a preventive service, leading to CMS requiring beneficiaries to pay a 20% coinsurance for this care. This is a significant barrier because these services are primarily non-patient-facing, and patients do not understand why they are billed for them. The latest data reveals that only 4% of Medicare beneficiaries potentially eligible for CCM received these services, amounting to 882,000 out of a potential pool of 22.5 million eligible CCM beneficiaries.

   By reclassifying CCM as a preventive service and eliminating the coinsurance requirement, providers will increase the utilization of this important service, benefiting a larger proportion of eligible CCM beneficiaries. AMGA recommends CMS work with Congress to waive the current CCM code coinsurance for Medicare beneficiaries to ensure appropriate use of CCM services, maximum access for patients, and improved health outcomes.

## Mandatory Ambulatory Specialty Model

> **Comment:** AMGA appreciates CMS' continued efforts to test innovative approaches to improving quality and reducing costs. However, we have serious concerns with the proposed Ambulatory Specialty Model (ASM), particularly its mandatory nature, low patient attribution threshold, and overlap with existing programs such as MIPS and MSSP.

**Concerns with Mandatory Participation**

CMS proposes making ASM participation mandatory for specialists in selected geographic regions. While we recognize the goal of driving innovation and accountability, mandatory participation forces providers into a model without adequate preparation or resources to succeed. CMS' historical experience with mandatory models has demonstrated that they can disrupt care delivery, create financial instability, and erode trust between providers and the agency.

Rather than compelling participation, CMS should focus on voluntary models that reward willing participants and allow lessons learned to inform broader reforms. Providers already face multiple, overlapping reporting and payment programs. Adding a new, mandatory specialty model will only compound administrative complexity and shift resources away from direct patient care.

**Unreliable Results Due to Low Attribution Threshold**
The proposed minimum attribution threshold of twenty patients per year raises significant concerns about statistical reliability. With such a small denominator, even a single adverse event could disproportionately skew performance results. For example, if one of twenty patients has a serious complication, the provider's quality score would appear far worse than peers managing higher volumes. Without adjustment, the ASM would unfairly penalize providers who treat sicker, more complex, or less adherent patients, effectively discouraging them from caring for the populations most in need of specialty expertise. This is also particularly problematic for specialists serving rural and underserved communities, who often have smaller caseloads.

**Overlap with MIPS and MSSP Requirements**
The ASM's structure closely mirrors the MIPS Value Pathways (MVPs), incorporating similar performance categories (Quality, Cost, Improvement Activities, and Promoting Interoperability). Although clinicians participating in ASM would be exempt from MIPS requirements, the measures, scoring policies, and payment adjustment application largely mirror those of MIPS, rendering the "exemption" effectively moot.

Further, many participating specialists are already engaged in MSSP Accountable Care Organizations (ACOs), where they are responsible for cost and quality performance under two-sided risk arrangements. Introducing ASM in these settings risks creating conflicting incentives, as providers could face contradictory benchmarks and reconciliation methodologies. CMS must align new specialty models with MSSP to avoid redundant or conflicting obligations. Should CMS opt to move forward with the model, AMGA recommends clinicians be permitted to participate voluntarily.

## Medicare Shared Savings Program

> **Comment:** While AMGA supports many of the proposed changes to the Medicare Shared Savings Program (MSSP), we are concerned that tightened beneficiary thresholds will limit high-value care participation opportunities for smaller MSSP participants.

**SNF Changes of Ownership Flexibilities for ACOs**
AMGA supports the proposed change that would allow ACOs to integrate Skilled Nursing Facilities (SNFs) that undergo a mid-year Change of Ownership (CHOW) into their certified participant list and SNF affiliate list, extending the ability to utilize 3-day SNF waivers without waiting for the annual change request cycle. Importantly, AMGA firmly believes the 3-day SNF policy is no longer aligned with contemporary clinical practice. We reiterate the recommendation included in our 2025 CMS Deregulatory RFI comment to remove this arbitrary requirement. To further strengthen the intent of this proposal, we suggest CMS clarify that even if a mid-year CHOW occurs without a change in the taxpayer identification number (TIN), this material change should merit the same flexibility.

**Expansion of the Extreme and Uncontrollable Circumstances Exception**
AMGA supports CMS' proposal to broaden agency discretion under the Extreme and Uncontrollable Circumstances exception, recognizing the increasing frequency and disruptive power of cyberattacks on our nation's providers.

**ACO Beneficiary Thresholds**
AMGA strongly recommends the agency not finalize its proposals to bar or limit ACO participation based on a minimum attributed beneficiary count of 5,000. As our healthcare system continues the transition to high-value care, these arbitrary requirements would prevent smaller ACOs from participating in the ENHANCED track if they fall below 5,000 beneficiaries during benchmark years 1 or 2. Those falling below in benchmark in year 3 would be unable to renew their agreement.

These new restrictions would disproportionately harm rural and underserved communities, where attributed populations are smaller and more prone to year-over-year fluctuations. These changes would discourage the formation of new ACOs and penalize existing ACOs for changes outside their control, undermining the MSSP's goal of expanding access to coordinated, high-quality care. These limitations would reduce opportunities for collaboration and shared savings, ultimately harming both providers and the Medicare program.

## Quality Payment Program

> **Comment:** AMGA is concerned that the proposed updates to the Quality Payment Program (QPP), including new MIPS Value Pathways (MVPs) and changes to Qualifying Alternative Payment Model (APM) Participant (QP) determinations could lead to increased care delivery fragmentation and administrative burden. While CMS aims to streamline reporting, these proposals risk shifting the program toward a compliance-focused approach that undermines integrated, patient-centered care. AMGA urges CMS to enact updates that and reduce complexity and support care coordination.

**New MIPS Value Pathways**
CMS proposes six new MIPS Value Pathways (MVPs) for diagnostic and interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery. While aligning measures with specialties, this approach may inadvertently reinforce specialty silos—discouraging collaboration among clinicians managing complex patients. AMGA advocates for MVPs designed to promote cross-specialty coordination, ensuring quality and continuity of care are not compromised.

**Advanced APMs**
Currently, QP determinations are made at the APM Entity level, ensuring that all participants in an Advanced APM are evaluated collectively. CMS now proposes a hybrid approach that would allow clinicians to qualify individually or through their entity beginning with the 2026 QP performance period.

This proposed dual-level system is likely to create unintended consequences, including administrative burdens, misaligned incentives, and care fragmentation. With Advanced APMs built on collective accountability, allowing individuals clinicians to qualify outside of their entity diminishes the collaborative nature of these models. This proposal functionally erodes the very incentives designed to drive coordinated care delivery, cost efficiency, and patient outcomes. Providers who previously had been working towards a common goal may be incentivized to prioritize their own performance thresholds, rather than advancing the broader goals of the

APM model.

This proposed dual-level methodology would also create significant administrative burden for both CMS and APM entities. With new requirements to track and reconcile determinations at both the group and individual levels, the program would increase barriers to participation and complicate administration, counter to this administration's stated goals of reducing provider burden. By contrast, maintaining entity-level determinations provides clarity and consistency, ensuring all participants in an APM are evaluated under the same framework.

While CMS notes challenges for clinicians in condition-specific models, these concerns should be addressed through adjustments to entity-level methodologies rather than creating a bifurcated system. Maintaining a uniform standard at the entity level ensures that all APM participants are measured against the same collective benchmarks and a shared framework for performance measurement.

For these reasons, we strongly urge CMS to preserve the current policy of QP determinations at the APM Entity level, a policy that best advances the objectives of the Quality Payment Program and the broader shift toward high-value care.

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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,

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