September 12, 2025

The Honorable Mehmet Oz, MD
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Re: Calendar Year 2026 Medicare Physician Fee Schedule Proposal; CMS 1832-P

Submitted via Federal eRulemaking Portal at www.regulations.gov

Dear Dr. Oz,

On behalf of the Texas Medical Association (TMA) and our more than 59,000 physician and medical student members, we thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the 2026 Medicare Physician Fee Schedule proposed rule.

TMA is a private, voluntary, non-profit association and the largest state medical society in the nation. It was founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and improvement of public health. Today, its vision is "improving the health of all Texans."

The 2026 Medicare Physician Fee Schedule (PFS) reflects the administration's new Make America Healthy Again[1] strategy emphasizing prevention, early intervention, and fiscal responsibility. Proposals such as the ambulatory specialty model (ASM), new chronic disease management initiatives, and adjustments to efficiency and practice expense methodologies align with this vision.

TMA is concerned that several proposals in the 2026 PFS, though well-intentioned, may have unintended consequences for Texas physicians and the patients they serve:

Temporary Relief, But No Lasting Solution. TMA appreciates the temporary one-year Medicare payment increase of 2.5% and the additional 0.75% increase for qualifying alternative payment model (APM) participants and 0.25% increase for non-qualifying APM participants. However, Congress must act to permanently reform physician Medicare payments. When

[1] U.S. Department of Health and Human Services, Make America Healthy Again

adjusted for inflation, Medicare physician payment rates have declined 33% from 2001 to 2025[2]. Many practices already operate on extremely thin margins as operational costs continue to rise. This directly threatens patient access to timely, high-quality care, particularly in underserved areas.

Federal spending must not be balanced on the backs of patients, physicians, and other health care professionals. TMA encourages CMS to work with health care organizations and Congress to enact an annual, permanent inflationary payment update that is tied to the Medicare Economic Index (MEI). Without significant updates to Medicare physician payment rates, the foundation of health care – the physician practice – will remain under immense financial strain that could ultimately lead to more physician practices closing.

Unsustainable Cuts on Top of Eroding Medicare Payments. Despite not keeping up with inflation, CMS proposes new cuts that further weaken physician practices. TMA strongly urges CMS not to implement the 2.5% practice efficiency cut, which would reduce payment for 8,961 non-time-based physician services. TMA strongly supports American Medical Association (AMA) development of a Medicare resource-based relative value scale (RBRVS) that is free of the distortions imposed by federal policy decisions, and TMA is disappointed that CMS has proposed to not use the AMA's Physician Practice Information Survey (PPIS) data for the 2026 practice expense (PE) update. While CMS cites concerns, the agency itself acknowledges that the PPIS remains the most comprehensive source of PE information available. TMA urges CMS to reconsider its position and incorporate AMA's 2024 PPIS data into the update.

CMS also should not implement the 50% indirect expense cut that will affect physicians providing services in facilities. Practice location does not equal practice ownership or practice management. TMA recognizes that physicians may experience the proposed site-of-service differential differently depending on practice size, setting, and ownership. While hospital-employed physicians may not directly bear these expenses, independent practices continue to absorb significant overhead for billing, coding, scheduling, and prior authorization regardless of where the service is delivered. Policies that weaken the viability of independent practices ultimately reduce patient choice, accelerate consolidation, and threaten access to care. TMA urges CMS to work with physicians across all practice settings to design policies that fairly recognize shared costs and strengthen the profession as a whole, with a common goal of preserving patient choice and access.

ASM: Promise Undermined by Flawed Foundation. In May 2025, the Centers for Medicare & Medicaid Innovation (CMMI) unveiled its 2025 Strategic Direction[3], with the ambulatory specialty model (ASM) as one of the first initiatives to realign specialist incentives toward proactive, longitudinal care for high-cost chronic conditions such as heart failure and low back pain. TMA supports CMS' recognition of specialists' critical role in prevention, chronic care

[2] https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf
[3] CMS Innovation Center Strategy to Make America Health Again, Accessed version updated 5/13/25

management, and care coordination but is concerned that ASM relies on the flawed Merit-Based Incentive Payment System (MIPS)/MIPS Value Pathways (MVP) framework, which is complex, administratively burdensome, and has shown little evidence of improving quality or reducing costs. Given the very limited uptake of MVP reporting, which was introduced only in 2023, building the ASM on such a narrow and untested foundation risks undermining physician confidence and discouraging participation. Because ASM could set a precedent for future specialty-based models, TMA urges CMS to delay implementation until MVP experience is better able to inform well-designed programs that inspire, rather than mandate, specialist engagement while delivering real value to Medicare beneficiaries.

Ultimately, TMA calls on CMS to refine its proposals so Medicare payment policy supports equitable Medicare participation across all practice settings and protects patient access to high-quality care.

Attached to this cover letter, TMA offers detailed comments, recommendations, and suggestions to improve the Medicare program. For ease of reference, a summary of the attached follows:

Regarding Updates to Relative Values (RVUs) and Geographic Practice Cost Indices (GPCI), TMA:

- Calls for CMS to reconsider its position and incorporate the AMA's 2024 Physician Practice Information Survey (PPIS) data into the 2026 update. In addition, TMA requests that CMS provide a clear timeline and plan for addressing the gaps it identified in the PPIS dataset.
- Urges CMS to reverse its proposal to reduce indirect costs for facility-based services by 50% as practice location does not equal practice ownership or practice management. TMA further calls on CMS to model the impact of its proposal by specialty and practice size, and to consider caps or exemptions to ensure small, solo, and independent practices are not disproportionately harmed.
- Implores CMS to demonstrate real, measurable productivity gains at the code level before applying across-the-board cuts in the form of an efficiency adjustment. If the agency proceeds despite these concerns, TMA strongly recommends beginning with a pilot program, requiring public reporting, and including a sunset clause unless the policy is re-justified with clear evidence.
- Strongly supports CMS working in close collaboration with the AMA and its RVS Update Committee (RUC) to ensure code valuations through the fee schedule eliminate distortions within the RBRVS framework.
- Appreciates the agency's efforts to ensure that malpractice relative value units reflect the most accurate and recent malpractice cost data while keeping overall Medicare spending stable.
- Calls on Congress to extend the 1.0 work GPCI floor beyond 2025 to prevent disproportionate harm to rural and underserved communities.

- Agrees that CMS should explore more direct methods of incorporating actual physician wage data when updating work RVUs, rather than relying solely on professional proxies to better align payment adjustments with practice realities.

Regarding Medicare Physician Payment, TMA:

- Encourages CMS to rely on coding and valuation processes that reflect the clinical expertise of physicians and other qualified health care professionals, as established through the CPT® and RUC processes. A bifurcated code set imposes unnecessary administrative burdens on practices, particularly since G-codes are often recognized only by Medicare and not by other payers.
- Applauds CMS for recognizing that, in certain circumstances, payment of the office/outpatient evaluation and management (E/M) visit complexity add-on code is appropriate when billed with the home and residence E/M code set.
- Expresses concern about unintended consequences of CMS' proposal regarding payment for skin substitutes and urges the agency to adopt a phased approach to implementation to ensure patient care is not compromised, particularly for underserved patients.
- Recognizes CMS' interest in reviewing the valuation of global surgical packages but strongly opposes all three proposed methodologies as they shift the financial burden onto physicians and reduce the critical revenue needed to sustain surgical practices.
- Recommends that CMS adopt the RUC's recommendations for bundled post-operative visits to ensure valuations accurately reflect their worth compared to stand-alone E/M visits.
- Urges CMS to incorporate the full increase in work and physician time for inpatient and office visits into valuations of 10- and 90-day global surgical periods.

Regarding Telehealth Services, TMA:

- Appreciates CMS' addition of new services and add-on codes for telehealth.
- Commends the agency for permanently removing the frequency limitations for certain Medicare telehealth services.
- Urges CMS to make permanent the inclusion of teaching physicians, when clinically appropriate, under the definition of virtual direct supervision.
- Agrees that entities facilitating telehealth visits should be paid appropriately, aligned with the Medicare Economic Index (MEI) to reflect inflationary changes.
- Calls on Congress to remove existing geographic-site restrictions for telehealth so that beneficiaries may continue receiving care in their homes after the current waiver expires on Sept. 30, 2025.

- Urges CMS to extend the waiver allowing distant-site practitioners to use their enrolled practice location rather than their home address when providing telehealth services from their home.

Regarding the Ambulatory Specialty Model (ASM), TMA:

- Appreciates CMS efforts to develop a specialist-focused value-based payment model centered on the ambulatory care setting, where individual physicians – rather than health care facilities or physician aggregators – can take the lead.
- Voices concern that the proposed ASM model relies on the flawed Merit-Based Incentive Payment System (MIPS) and the MIPS Value Pathways (MVP) framework.
- Recommends CMS delay implementation of the new ASM model until the agency gains a clearer understanding of MVP participation trends and outcomes.
- Stresses the importance of phasing in voluntary financial risk, consistent with the gradual opportunities historically afforded to primary care physicians in population health models.
- Urges CMS to adopt a more measured glide path to risk by lowering payment adjustments rates from the proposed ±9% to levels consistent with the 2017 MIPS rollout.
- Applauds CMS for recognizing the importance of risk adjustment to protect physicians caring for vulnerable patients and appreciates the proposal to incorporate a complex patient adjustment based on Hierarchical Condition Category risk scores and the proportion of dual-eligible beneficiaries.
- Expresses deep concern that building ASM on narrow and untested quality metrics may create a model that is not evidence-based and could undermine, rather than encourage specialists' appetite for value-based care.
- Cautions CMS against requiring clinicians to report on *all* five quality measures within the ASM data set and encourages CMS to continue collaborating with national specialty societies to ensure that selected measures are clinically appropriate and meaningful.
- Urges CMS to proceed cautiously with cost measures in ASM. While episode-based measures may be more targeted than broad per capita cost measures, they still hold physicians accountable for costs largely outside of their control, such as hospital services, post-acute care, or drug pricing.
- Appreciates CMS' intent to recognize solo and small practices with scoring adjustments, but stresses that these concessions will not adequately offset the significant costs and compliance burdens. TMA is particularly disappointed that CMS has chosen not to include a rural adjustment.
- Urges CMS to clarify how ASM participation and attribution would affect or interact with other CMS value-based programs to prevent conflicting requirements, duplicative reporting, and inconsistent payment adjustments.

Regarding the Medicare Diabetes Prevention Program (MDPP), TMA:

- Supports the CMS MDPP as a vital initiative to prevent type 2 diabetes among Medicare beneficiaries.
- Advocates for expanded program delivery through existing remote models and urges CMS to consider including individuals already diagnosed with type 2 diabetes who could still benefit from lifestyle interventions.
- Recommends allowing a more flexible documentation window, such as a rolling weekly timeline, to promote operational efficiency, reduce the risk of unintentional noncompliance, and enhance supplier participation across diverse settings.
- Urges CMS to streamline the supplier enrollment process and provide more technical assistance to smaller practices.
- Asks CMS to consider integration of the MDPP with advanced primary care services, consistent with the proposed behavioral health model that allows G-codes to be billed as add-on codes for same day services for same-day advanced primary care management of patients with chronic conditions.

Regarding the Medicare Shared Savings Program (MSSP), TMA:

- Appreciates CMS' efforts to strengthen and expand participation in the MSSP, including adoption of conservative glide paths to risk-bearing arrangements; implementation of advance investment payments; adjustments to quality performance thresholds that benefit low-revenue accountable care organizations (ACOs); and efforts to ensure fair, accurate, and sustainable benchmarking and risk adjustment policies. Despite the improvements, TMA remains concerned that independent, solo, and small group practices often lack the capital, staff, and infrastructure necessary to succeed in such programs.
- Recognizes the need for CMS to address change-of-ownership (CHOW) policies in today's dynamic health care environment and urges CMS to develop clear, transparent standards to guide these decisions and ensure a fair and consistent process for all ACOs.
- Emphasizes that CHOW events, whether or not there is an existing billing history, can significantly affect performance measurement, outcomes, and program stability, and recommends CMS adopt policies that reflect the operational realities of ACO restructuring.
- Appreciates CMS' efforts to ensure that small, low-revenue, and often physician-led ACOs that do not meet the 5,000-beneficiary minimum can continue to participate in the MSSP.
- Urges CMS to reconsider its proposal to eliminate the health equity adjustment (HEA) as it could weaken ACOs' ability to finance and prioritize care for underserved populations and may disadvantage ACOs caring for dual-eligible or low-income beneficiaries.

- Supports CMS' efforts to align APM quality measures across multiple quality programs and urges CMS to work with physician leaders representing all medical specialties and practice settings to ensure measure sets remain clinically relevant and meaningful.
- Urges CMS to carefully weigh the financial and administrative burdens faced by low-revenue ACOs before finalizing the transition to electronic clinical quality measures (eCQMs).

Regarding the Quality Payment Program (QPP), TMA:

- Remains concerned the complexities of MIPS and MVP mirror those of the voluntary MSSP – yet without offering the meaningful financial incentives needed to offset the significant administrative burdens of participation.
- Remains deeply concerned that physicians participating in MIPS/MVPs continue to face steep penalties – up to 9% of their Medicare payments – without evidence the program delivers meaningful improvements in patient care.
- Commends CMS for incorporating organized medicine's feedback in updating MVP tables that stratify quality measures by clinical groupings and for recognizing the important role of qualified clinical data registries (QCDRs) in collecting, tracking, and comparing data across various practice settings.
- Applauds the agency's efforts to maintain flexibility in reporting methods and strongly urges the agency to keep subgroup reporting voluntary.
- Emphasizes the importance of close collaboration with AMA and national specialty societies in developing relevant, clinically meaningful measures and reporting methods that are appropriate for all practice settings.
- Appreciates CMS' effort to provide informational feedback reports allowing physicians more time to understand and adapt to new cost measures before they affect payment adjustments. However, there is concern this policy applies only to *newly introduced* cost measures and not to modifications of existing measures.
- Agrees protecting patient health information is of the utmost importance and encourages CMS and the Assistant Secretary for Technology Policy (ASTP)/Office of the National Coordinator of Health IT (ONC) to provide fact sheets, guidance, and educational materials specific to the management of the security risk analysis.
- Appreciates that ONC has updated the Safety Assurance Factors for EHR Resilience (SAFER) Guides and agrees CMS should encourage use of the updated version. If finalized, TMA encourages CMS to widely promote this change to ensure clinicians are aware of the update.
- Favors new options for obtaining bonus points for MIPS and agrees participation in the Trusted Exchange Framework and Common Agreement (TEFCA) could help reduce barriers to health information exchange over time.

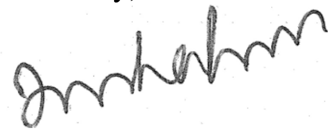
- Urges CMS to work with the Centers for Disease Control and Prevention (CDC) to not only streamline its infrastructure, but to also support state and county public health departments so information is promptly received and authorities can promptly react to any communicable disease threats.
- Urges CMS not to change the query of the Prescription Drug Monitoring Program (PDMP) measure from attestation-based to performance-based reporting.
- Opposes shifting public health measures reporting to performance-based requirements, noting that public health agencies' inconsistent adoption of interfaces and reporting capabilities already makes compliance burdensome for eligible clinicians.
- Appreciates that CMS is not making changes to the scoring policies for cost, improvement activities, and promoting interoperability MIPS categories. However, TMA opposes dynamic scoring of quality measures based on measure type, reporting method, or topped-out status.

Regarding Advanced Alternative Payment Models, TMA:

- Appreciates CMS' proposal to expand qualifying APM participant (QP) determinations to the individual clinician level but is concerned this could also create complexity and administrative challenges, particularly for group practices where some clinicians qualify as QPs and others do not.
- Urges CMS to pair the QP policy change with robust technical assistance and clear, timely QP status reporting so practices can anticipate and manage these outcomes effectively.

Thank you for the opportunity to comment. TMA stands ready to provide you and others within the agency with our policy insight and any additional assistance you may find useful. If you have any questions, please do not hesitate to contact Shannon Vogel, associate vice president of health information technology, by emailing shannon.vogel@texmed.org or calling (512) 370-1411.

Sincerely,



Jayesh "Jay" Shah, MD
President
Texas Medical Association

Comments of the Texas Medical Association

<u>Determination of Practice Expense Relative Value Units (RVUs) (section II.B.)</u>

Summary

Each service paid under the Medicare physician fee schedule comprises work, practice expense (PE), and malpractice (MP) expense components. PE relative value units (RVUs) are developed by considering the direct and indirect practice resources involved in furnishing each service. Direct expenses include costs tied specifically to patient care, such as clinical staff salaries, medical supplies, and equipment. In contrast, indirect expenses are broader overhead costs, such as administrative staff, rent, and utilities, and other practice-wide expenses which support the entire practice and are not linked to a single service.

CMS' current methodology for determining PE RVUs relies on several data sources including the American Medical Association's (AMA's) Physician Practice Information Survey (PPIS); legislatively mandated supplemental sources such as survey data for oncology and hematology specialties; and crosswalks that allocate indirect PE per hour values for certain specialties and provider types.

While CMS acknowledges that AMA's PPIS is the "most comprehensive source of PE survey information available," the agency voiced concerns regarding the "accuracy, utility, and suitability" of the data. CMS specifically cites low response rates, limited specialty representation, small sample sizes, and sampling variations. As a result, the agency states it will maintain the current PE data and cost shares for 2026 rate setting. CMS further indicates it will continue to work with stakeholders and partner agencies to determine how the AMA PPIS data should inform future updates to the Physician Fee Schedule.

Response

TMA is disappointed that CMS proposes not to use the AMA's PPIS data. While CMS cites concerns, the agency itself acknowledges the PPIS remains the most comprehensive source of PE information available. TMA urges CMS to reconsider its position and incorporate AMA's 2024 PPIS data into the update. TMA further requests that CMS provide a clear timeline and plan for addressing the gaps identified in the PPIS data.

Summary – Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

For procedures that can be furnished either in a physician's office (non-facility) or in a facility setting (e.g., hospital outpatient department), CMS establishes two sets of PE RVUs. When services are provided in a facility, CMS excludes practice resources that are typically supplied by the facility rather than the physician. As such, facility PE RVUs are generally lower than non-facility PE RVUs.

In the 2026 proposed rule, CMS introduces a significant refinement of its PE methodology. To address concerns over potential duplicate payments, RVUs related to indirect costs such as billing, coding, and scheduling, would be reduced by 50% for facility-based services.

Response
TMA urges CMS to reconsider its proposed methodology for applying indirect practice expense reductions. Practice location does not equal practice ownership or practice management. In Texas, where corporate ownership bans require even fully integrated physician practices to remain legally separate from hospital management, physicians continue to bear significant indirect costs when furnishing services in a facility. Administrative and clinical staff employed by the physician handle billing, coding, scheduling, prior authorization, and medical record functions that are not performed by the facility. These costs are real and ongoing regardless of where the service is delivered.

TMA further calls on CMS to model the impact of its proposal by specialty and practice size and to consider caps or exemptions to ensure small, solo, and independent practices are not disproportionately harmed. These practices do not benefit from hospital system support, and their fixed expenses – such as rent and staffing – do not decrease simply because CMS reduces payment.

To ensure accurate and equitable payment, indirect costs should continue to be recognized under both the professional and facility claims, while at the same time ensuring there is no overlap. Shifting all indirect payments to the facility fee would leave these practices uncompensated for legitimate expenses and create a financially discriminatory model for non-hospital-employed physicians.

Potentially Misvalued Services Under the PFS (section II.C.)
Summary
CMS has the authority to examine potentially misvalued services in several categories. In addition, through an annual public nomination process, the agency receives public nominations for review of potentially misvalued codes by Feb. 10 of each year.

In the 2026 proposed regulation, CMS proposes to accept 89% of the AMA/Specialty Society RVS Update Committee's (RUC's) recommendations for new and revised Current Procedural Terminology® (CPT®). However, the agency also discussed the public's nomination of the following CPT codes as potentially misvalued:

- 21076, 21077, 21079, 21080, 21081, 21082, 21083, 21084, 21085, 21086, 21087 (maxillofacial prosthetic services)
- 95145, 95146, 95147, 95148, 95149 (allergen immunotherapy supervision)
- 95970, 95976, 95977 (electronic neurostimulator analysis)
- 93296 (remote interrogation device evaluation)

- 10021, 10004, 10005, 10006 (fine needle aspiration)
- 31000 and 31002 (nasal sinus irrigation)
- Cryoablation therapy to treat postoperative pain

Response
It is TMA's longstanding policy to strongly support the AMA's development of a Medicare resource-based relative value scale (RBRVS) that is free of the distortions imposed by the federal policy decisions. Rather than modifying code values through the physician fee schedule, TMA urges CMS to work collaboratively with the AMA's RUC to value these and other services in a manner that is consistent and applicable across all payers.

<u>Payment for Medicare Telehealth Services (section II.D.)</u>

Summary – Additions to the Medicare Telehealth Services List
CMS is proposing to add to the telehealth services list multi-family group psychotherapy, group behavioral counseling for obesity, an infectious disease add-on code, and auditory osseointegrated sound processor codes.

Response
TMA appreciates the addition of new services and add-on codes for telehealth**.** Behavioral health is an important use of telemedicine, especially with populations in underserved and rural areas. Telemedicine continues to be a viable care option for numerous services, and especially for vulnerable populations facing transportation and mobility challenges.

Summary – Frequency Limitations on Medicare Telehealth Subsequent Care Services in Inpatient and Nursing Facility Settings, and Critical Care Consultations
CMS is proposing to permanently remove frequency limitations when furnishing telehealth services for subsequent inpatient nursing-facility visits and critical-care consultation visits for the following codes: 99231, 99232, 99233, 99307, 99308, 99309, 99310 and G-codes G0508, G0509.

Response
TMA commends CMS for permanently removing the frequency limitations for certain services. Physicians are required to meet the same standard of care for virtual care as required for in-person care and are best able to determine when continued virtual care is appropriate for a patient.

Summary – Direct Supervision via Use of Two-Way Audio/Video Communications Technology
CMS proposes to permanently adopt a definition of direct supervision that allows the supervising physician to provide supervision through real-time audio and visual real-time communications. This proposal excludes services with a global surgery indicator of 010 or 090. CMS is not proposing to extend its current policy for teaching physicians to have a virtual presence for

purposes of billing for services furnished involving residents. In fact, CMS is proposing to transition back to the pre-public health emergency (PHE) policy requiring teaching physicians to maintain a physical presence during critical portions of resident-furnished services to qualify for Medicare payment. CMS is maintaining an exception for rural areas.

Response
TMA agrees that CMS should adopt a permanent definition of virtual direct supervision. TMA supports the inclusion, as qualifying for payment, the virtual presence of physicians supervising, when clinically appropriate, residents, fellows, and nonphysician practitioners. This supervision should be conducted using real-time audio/video communications and all state and federal regulatory and scope of practice requirements must be met as though the supervision were provided in person. Therefore, CMS should not transition back to the pre-PHE policy requiring teaching physicians to maintain a physical presence. Rather, CMS should permanently include teaching physicians as part of the virtual direct supervision definition.

Summary – Telehealth Originating Site Facility Fee Payment Amount Update.
CMS proposes increasing the originating site facility fee from $31.01 to $31.85 for telehealth services furnished in 2026. This increase aligns with the Medicare Economic Index (MEI) as directed by the act that established the Medicare telehealth facility fee.

Response
TMA agrees that entities facilitating telehealth visits should be paid appropriately and in line with MEI, thus reflecting inflationary changes. However, Medicare facilities (inpatient and outpatient hospitals, hospice, and ambulatory surgical centers) automatically receive annual and positive inflationary updates, but not Medicare physicians[4]. TMA continues to press Congress to make necessary changes, so physicians receive positive inflationary updates like Medicare facilities.

Other Considerations Not Mentioned

Geographic Site Restrictions. TMA continues to press Congress to remove the existing geographic-site restrictions so beneficiaries may continue to receive care in their own home upon expiration of the existing waiver on Sept. 30, 2025. This is especially important for patients who face transportation and mobility challenges. If Congress does not permanently remove the geographic-site restriction, TMA urges CMS to extend the waiver.

Home Address for Telemedicine. TMA urges CMS to extend the waiver allowing distant-site practitioners to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. Unless CMS acts, this waiver expires Dec. 31, 2025. Physicians are very concerned about safety and privacy, and CMS should consider a permanent fix.

[4] Medicare 2025 updates; https://www.ama-assn.org/system/files/medicare-provider-updates-chart-2025.pdf

Valuation of Specific Codes (section II.E.)

Summary

CMS routinely establishes values for newly created and revised CPT® codes to make sure payment rates reflect changes in medical practice and the current prices of inputs used in the practice expense calculations. In the 2026 proposed rule, CMS introduces a significant new policy, a negative 2.5% efficiency adjustment, intended to recalibrate how certain services are clinically valued, rather than administratively adjusted, to reflect efficiency gains over time. The adjustment would apply to both the work RVUs and intra-service time for 8,961 non-time-based physician services.

The agency contends that efficiency gains achieved through physician experience and technological advancements are not adequately reflected under the current system, which relies on infrequent surveys. This adjustment would primarily affect procedural, surgical, and diagnostic specialties such as radiology and pathology, while excluding time-based services such as E/M visits.

The 2.5% adjustment is derived from a five-year review of the Medicare Economic Index (MEI) productivity adjustment and, if finalized, would be reapplied every three years. Additionally, CMS seeks input on whether to extend this adjustment to direct PE inputs, such as clinical labor and equipment related to physician time.

Response

TMA is alarmed that CMS is proposing yet another way to cut physician payment**.** While the proposed rule also includes a modest positive update to the conversion factor, the efficiency adjustment is expected to largely offset this increase for affected specialties, with an overall projected 1% reduction in overall payments for those specialties. CMS should demonstrate real, measurable productivity gains at the code level before applying across-the-board cuts. If the agency proceeds despite these concerns, TMA strongly recommends beginning with a pilot program, requiring public reporting and including a sunset clause unless the policy is re-justified with clear evidence.

Physicians are already suffering under Medicare payment rates that fail to keep pace with inflation, compromising the practice viability and patient access to physician practices. TMA implores CMS to reject the 2.5% efficiency adjustment.

As stated in the potentially misvalued services section, it is TMA's policy to strongly support AMA development of a Medicare resource-based relative value scale (RBRVS) that is free of the distortions imposed by the federal government. We ask CMS to work with the AMA/Specialty Society RVS Update Committee's (RUC) to value these and other services.

<u>Evaluation and Management (E/M) Visits (section II.F.)</u>

Summary

In 2024, CMS finalized separate payment for the office/outpatient (O/O) E/M visit complexity add-on code, which the TMA fully appreciated and supported.

In the 2026 proposed regulation, CMS recognizes that valuation of O/O E/M codes currently do not reflect resource costs "in building trust in a long-term practitioner-patient relationship." CMS then agrees to allow the O/O E/M visit complexity code to be billed with the home and residence code set. The O/O E/M visit complexity code does recognize the resources involved in building long-term relationships, and it is appropriate to extend it to home and residence E/M visits (CPT® codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350).

Response

TMA fully agrees and applauds CMS for recognizing that, in certain circumstances, it is appropriate for the payment of the O/O E/M visit complexity add-on code when the home and residence E/M code set is billed.

<u>Enhanced Care Management (section II.G.)</u>

Summary

In 2018, CMS began making separate payment to practitioners who provide behavioral health integration (BHI) services to patients. Clinicians using the psychiatric collaborative care model (CoCM) may bill for BHI services using codes 99492, 99493, and 99494. Practitioners who provide general BHI services to patients may use CPT® code 99484. Each of these codes has a time-based component ranging from 20 to 70 minutes. In 2025, CMS finalized separate coding and payment for advanced primary care management (APCM) services for beneficiaries with chronic conditions. In the final rule, however, the agency agreed with many commenters that BHI services complement APCM services in the context of overall health.

Consequently, for 2026, CMS proposes creation of three behavioral integration G-codes for APCM services (GPCM1, GPCM2, and GPCM3) that would be billed as add-on services when the APCM base code is reported by the same practitioner in the same month. Time-based requirements for existing BHI and CoCM codes would be removed. CMS asserts this will ultimately help reduce documentation burdens for physicians and increase access to BHI and CoCM services for primary care patients. Notably, CMS does not propose to create an add-on code for initial or subsequent psychiatric collaborative care management, each additional 30 minutes (CPT® 99494).

CMS proposes to directly crosswalk the current work relative value unit (RVU) and practice expense RVU values to the Healthcare Common Procedure Coding System (HCPCS) codes GPCM1, GPCM2, GPCM3.

Response
TMA encourages CMS to rely on coding and valuation processes that incorporate the clinical expertise of physicians and other qualified health care professionals, as reflected in the CPT® and RUC processes. TMA is concerned that creating a bifurcated code set could impose additional administrative burdens on practices, particularly since G-codes are often recognized only by Medicare and not by other payers.

CMS' proposals for 2026 build on its 2025 Strategy to Make America Healthy Again[1] which emphasizes a multi-faceted, preventive approach to improving public health outcomes and reducing chronic disease rates by addressing root causes rather than just treating symptoms. TMA supports this direction and urges CMS to embed preventive care into new payment models and while incentivizing physicians to promote healthier lifestyles and long-term wellness.

Summary - Payment for Skin Substitutes
Medicare spending on skin substitutes ballooned from $256 million in 2019 to over $10 billion in 2024. CMS attributes this dramatic spending increase largely to abusive pricing practices in the sector, including the use of products with limited evidence of clinical value. In an effort to combat wasteful practices, CMS proposes to pay for skin-substitute products as incident-to supplies in both the non-facility and hospital outpatient settings.[5] This does not apply to biological products licensed under section 351 of the Public Health Service Act. CMS further proposes the creation of three groups to pay for skin substitutes based on FDA regulator categories (pre-market approval, 510(k) clearance, and Section 361 HCT/P (human cells, tissues, and cellular and tissue-based products). For all three categories, CMS would pay a single rate using the same HCPCS at a rate of $125.38 per square centimeter (prior to geographic price adjustments).

Response
TMA supports CMS' stated goals of reducing waste, fraud, and low-value utilization that has resulted in skyrocketing care costs. However, TMA has concerns about unintended consequences with CMS' proposal related to payment for skin substitutes. Rather than applying this new policy globally, CMS should take a phased approach to implementation so care to underserved patients is not compromised. CMS should support price transparency through timely and regularly updated published average sales price data. Additionally, there should be risk adjustments and exceptions, particularly for complex wounds or for those needing large-volume and high-evidence products.

Other Considerations Not Mentioned

CMS Wasteful and Inappropriate Service Reduction (WISeR) Model. On July 1, CMS'

[5] Centers for Medicare & Medicaid Services. CMS Proposes Physician Payment Rule to Significantly Cut Spending Waste, Enhance Quality Measures, and Improve Chronic Disease Management for People with Medicare (Jul. 14, 2025)

Center for Medicare & Medicaid Innovation announced a six-year pilot program, the WISeR Model. Texas is one of the states required to participate in the pilot which focuses on testing the implementation of prior authorization and pre-payment review for specific services. CMS touted the program as "voluntary" because its "participants" are technology vendors that voluntarily apply to operationalize the prior authorization process using artificial intelligence (AI).

TMA strongly opposes the WISeR program and requests that CMS pause implementation until additional stakeholder input is provided, the model is fully analyzed, and clear guidance can be provided to impacted physicians and patients. This model has potential to add unanticipated and substantial administrative burden to physician practices. Physicians are already overwhelmed with prior authorization burdens from Medicare Advantage plans as well as private payers. TMA is also concerned with the incentives that allow vendors to be paid according to the savings accrued, which is a perverse incentive in health care since it will likely result in increased denials. Recognizing the issue with using AI to deny health care services, Texas recently enacted SB 815[6] which prohibits health plans from utilizing an automated decision system for adverse determinations. TMA urges CMS to withdraw the Jan. 1, 2026 implementation date for the WISeR pilot program.

Global Surgery Payment Accuracy

Summary

CMS proposes changes to how payments are allocated for global surgical packages, which bundle the surgical procedure with pre- and post-operative care. This proposal stems from a 2015 Medicare and CHIP Reauthorization Act mandate directing CMS to collect data to improve the accuracy of global package valuation. An internal 2023 analysis found that only 28% of post-operative visits were provided, suggesting current payments do not accurately reflect the work involved. In its 2026 proposed rule, CMS shared three potential strategies for more accurate payment splits and indicated a preference for the second approach:

- **Work RVU Subtraction:** Subtract the value of each post-operative visit from the total global payment.
- **Claims-Based Data:** Use data from the no-pay CPT® code 99024 to create a more accurate, data-driven system for payment division.
- **Time-Based Ratio:** Apply a ratio of post-operative visit time to total global package time and multiply it by the total procedural time.

Response

TMA recognizes CMS' interest in reviewing the valuation of global surgical packages but strongly opposes all three proposed methodologies. Each option inappropriately shifts the financial burden onto physicians and would reduce critical revenue needed to sustain surgical

[6] Texas Senate Bill 815; https://capitol.texas.gov/BillLookup/History.aspx?LegSess=89R&Bill=SB815

practice. TMA is particularly concerned that requiring the use of a no-pay CPT® code, such as 99024, adds administrative strain without financial benefit.

Instead of these new approaches, TMA recommends CMS adopt the AMA/Specialty Society RVS Update Committee's recommendations for bundled post-operative visits to ensure their value is accurately reflected compared to stand-alone E/M visits. The TMA also urges CMS to incorporate the full increase in work and physician time for inpatient and office visits into the valuations of 10- and 90-day global surgical periods. Physician time alone is not an appropriate measure as it does not account, in most cases, for the intensity of a surgical procedure as compared to post-operative care.

Determination of Malpractice Relative Value Units (MP RVUs) (section II.M.)

Summary

Each service paid under the Medicare physician fee schedule comprises work, practice expense (PE), and malpractice (MP) expense components. Traditionally, CMS updates all three components on a five-year cycle but has more recently adopted a three-year review cycle to align with the statutory review of geographic practice cost indices (GPCIs). MP relative value units (RVUs) were last updated in 2023.

For 2026, CMS proposes use of the core methodology applied in the 2023 update, with minor changes to reduce reliance on estimations for specialties with low-volume procedures and/or lack of sufficient professional liability premium data. The proposed process includes: 1) calculating national average premiums for each specialty based on $1M/$3M mature claims-made policies at the county level; 2) assigning specialties to one or more of the 17 premium service risk groups (e.g., surgery/no surgery, includes OB services, and a newly added technical component-only category); 3) calculating malpractice RVUs for each CPT®/ Healthcare Common Procedure Coding System code using a specialty-weighted risk index that reflects MP costs across all specialties furnishing the procedure; and 4) rescaling values to maintain budget neutrality.

Response

While these refinements represent minimal impact to most medical specialties, TMA appreciates the agency's efforts to ensure MP RVUs reflect the most accurate and recent malpractice cost data while keeping overall Medicare spending stable.

Geographic Practice Cost Indices (GPCIs) (section II.N)

Summary

CMS is required by statute to develop GPCIs to measure cost differences among localities for each of the three relative value unit (RVU) components: work, practice expense (PE), and malpractice (MP). The agency must review and update GPCI values at least every three years. When more than one year has passed since the last GPCI update, CMS phases in new adjustments over two years to help avoid sudden spikes or drops in payments that could disrupt practices.

Currently there are 109 payment localities: 24 cover entire states and 72 apply to specific regions within 16 states. Among these, 10 states have two localities, two states have three, one state has four, and three states have five or more. Texas, for example, has eight payment localities.

Work GPCIs. Work GPCIs reflect the relative cost of physician labor by Medicare locality and are measured from salary information of individuals with higher education as a proxy for physician salaries. Congress established a permanent work floor of 1.5 for services furnished in Alaska. Notably, the 2023-2024 updates included a statutory floor, which ensured no locality's work GPCI could drop below 1.0. The Continuing Appropriations and Extensions Act of 2025[7] extended the floor through Sept. 30, 2025, but it will not apply to calendar year 2026 unless new legislation is enacted.

Practice Expense (PE) GPCIs. PE GPCIs measure the relative cost difference in the prices of inputs to medical practice such as employee wages, purchased services, office rent, and equipment, supplies and other miscellaneous expenses. Congress established Montana, Wyoming, North Dakota, South Dakota, and Nevada as "frontier states" and requires a GPCI floor of 1.0.

Malpractice (MP) GPCIs. MP GPCIs measure the relative cost differences among Medicare localities for the purchase of professional liability insurance. They are based on insurer rate filings of premium data for $1 million to $3 million mature claims-made policies.

Geographic Adjustment Factors (GAFs). In addition to the GPCI values, CMS provides summarized GAFs, which represent a single, weighted composite number that combines the three GPCI's for a locality. While not used to set payment for a specific service, they give a quick snapshot of how expensive a locality is overall compared to the national average which is set at 1.000.

CMS proposes the following updates for the 2026-2027 GPCI revisions:

- Data sources for GPCI updates will be based on 2020-2023 data from the U.S. Bureau of Labor Statistics' Occupational Employment and Wage Statistics program (work); 2018-2022 data from the U.S. Census Bureau's American Community Survey (practice expense), and 2023 professional liability premium data based on state insurer rate filings (malpractice expense).

- Since the previous GPCI update was implemented in 2023 and 2024, CMS' current proposal phases in half of the latest GPCI adjustment in 2026 with the remaining half in 2027.

[7] Continuing Appropriations and Extensions Act, 2025; https://www.congress.gov/118/plaws/publ83/PLAW-118publ83.pdf

- CMS offers a technical contractor report from Actuarial Research Corporation, which found that the proposed transition GPCIs for 2026 produce fairly modest changes to the 2026 geographic adjustment factors. Compared to 2025, the 2026 GAF changes by less than half of a percent in 61 localities that collectively account for about 54% of total RVUs, and no locality had a GAF change of more than 4%.

Response
TMA supports geographic adjustments for Medicare payments based on the most current valid and reliable data and its use in calculating accurate geographic practice cost indices and in determining geographic payment areas. Further, TMA asserts that variation among geographic payment areas should be minimized and equitable access to medical care services should not be diminished by geographic practice cost indices that are unreasonably low in rural areas. The association also concurs with phasing in the revised GPCI values over two years as doing so helps mitigate disruptive impacts. While TMA understands this requires congressional action, TMA is concerned about the expiration of the national 1.0 work GPCI floor in 2025 which may disproportionately harm rural and underserved communities. Finally, TMA agrees CMS should explore methods to more directly reflect actual physician wage data rather than proxy occupational data to better align payment adjustments with practice realities.

Ambulatory Specialty Model (ASM) (section III.C.)
Summary
CMS proposes a new Ambulatory Specialty Model (ASM) under the CMS Innovation Center (CMMI). By aligning financial incentives with early intervention, evidence-based care, and care coordination, the ASM aims to improve quality and reduce costs by shifting specialist practice toward longitudinal, high-value management of two prevalent and costly chronic conditions in the Medicare program: heart failure and low back pain.

The model would run for five performance years (Jan. 1, 2027-Dec. 31, 2031). Participation would be mandatory for clinicians in geographically selected regions who manage at least 20 attributed episodes of heart failure or low back pain over a 12-month period, based on CMS claims data from two years prior. Clinicians will be notified of selection by the end of 2025, giving them more than a year to prepare for the January 2027 start.

Specialties most likely impacted include cardiology, orthopedic surgery, neurosurgery, pain management, anesthesiology, physical medicine and rehabilitation, and interventional pain management. Clinicians practicing in federally qualified health centers (FQHCs), rural health clinics (RHCs), and critical access hospitals (CAHs) that bill under Method II would be excluded.

Participants will be exempt from Merit-based Incentive Payment System (MIPS) during ASM

participation and may still take part in other CMMI episode-based models and accountable care organizations, including the Medicare Shared Savings Program (MSSP).

The model builds upon the MIPS and the MIPS Value Pathways (MVP) framework. Performance will be scored on a 0-100 scale with participants receiving a composite score based on two weighted performance categories: quality (50%) and cost (50%). Two additional categories, improvement activities and promoting interoperability, could result in deductions of up to 15 points each for those who fail to report or meet minimum requirements.

To maintain CMS budget neutrality requirements, clinicians would receive positive, neutral, or negative payment adjustments based on their performance relative to peers. In the first two payment years, adjustments would range from -9% to +9%. By the final year of the demonstration (performance year 2031, payment year 2033), the maximum adjustment would rise to ±12%. Like MIPS and MVPs, standard Medicare payments continue during the performance year, with adjustments applied two years later.

Finally, CMS proposes several adjustments to participants' final scores to more fairly assess physicians with similar clinical profiles who may face differences in patient caseloads and their capacity to manage the administrative and financial burdens of CMS value-based payment programs. A complex patient adjustment would account for a participant's caseload using Hierarchical Condition Category (HCC) risk scores and the proportion of patients with dual eligible status. Additional scoring adjustments are proposed for small practices (15 or fewer clinicians) and solo practices (one clinician). CMS elected not to include a rural adjustment, citing historical MIPS performance data and the view that such an adjustment would be duplicative, since a high proportion of likely ASM participants in small practices are already located in rural areas.

Response
TMA appreciates CMS' efforts to develop a specialist value-based payment model centered on the ambulatory care setting, where individual physicians – rather than health care facilities or physician aggregators – can take the lead. TMA also supports a model that rewards proactive, upstream care including prevention, longitudinal management of chronic conditions, and care coordination, rather than waiting for patients to become critically ill and require hospitalization.

TMA is concerned, however, that the proposed model relies on the flawed MIPS and MVP framework. According to CMS' most recent Quality Payment Program data, physician practices nationwide – particularly small, solo, and rural practices – continue to struggle with MIPS' complexity, administrative burden, and constantly shifting requirements. In the 2023 performance year results, CMS reports that even clinicians who achieved a perfect score of 100 points received only a +2.15% Medicare payment adjustment in 2025, an increase that falls far

short of rising medical practice expenses at a time of growing patient demand.[8] Understandably, physicians remain skeptical, as CMS has yet to demonstrate the MIPS or MPV programs have meaningfully improved patient outcomes or reduced Medicare program costs.

Program Timing. The 2023 performance year marked the launch of the MVP program. As CMS anticipated, initial uptake was limited with just 7.7% of MIPS clinicians (41,765) registered to participate. Importantly, clinicians submitting MVP data were still permitted to report through traditional MIPS, and nearly all (98%) did so. As a result, just 16% of MVP registrants (6,790) ultimately received a final MIPS score based on MVP participation.[8] TMA recommends delaying implementation of the new ASM model until CMS gains a clearer understanding of MVP participation trends and outcomes. Before adopting this framework for a new APM model – particularly one with a revised set of quality measures – CMS should carefully evaluate early experience with MVPs to ensure lessons learned inform future program design.

Voluntary Participation. Contrary to CMS' assertion that mandatory participation, "improves generalizability of model findings and reduces the self-selection bias and attrition seen in voluntary models," TMA continues to oppose mandatory participation in value-based care models. Solo, small, and independent practices already face significant challenges, including stagnant payment rates that do not keep pace with inflation, rising administrative burdens, workforce shortages, and ongoing consolidation and vertical integration across the health care marketplace. TMA urges CMS to consider these realities and recommends that CMS offer voluntary participation to rural, solo, and small practices while the agency evaluates program outcomes. The agency has previously taken a similar approach in the MSSP through its glide path to risk. A comparable strategy for the ASM would help preserve practice stability while still generating valuable program insights.

Gradual Glide Path to Risk. In July 2023, CMS issued a request for information[9] on the design of a future episode-based payment model intended to improve care transitions and strengthen specialist engagement in accountable care. Feedback from numerous national specialty societies confirmed that many specialists are eager to participate in value-based care models. To build on this interest, TMA stresses the importance of phasing in voluntary financial risk, consistent with the opportunities historically afforded to primary care physicians in population health models. Moreover, TMA notes that unlike MIPS and MVP participants who are benchmarked against all clinicians and specialties nationwide, ASM performance would be measured within a much smaller peer group. This narrower cohort raises the risk that clinicians who performed strongly under MIPS and MVPs could find it more difficult to quality for incentives, or even avoid penalties, under ASM. Accordingly, if CMS determines a voluntary approach is not feasible, TMA strongly urges adoption of a more gradual glide path to risk by lowering payment adjustments rates from the proposed ±9% to levels consistent with the 2017 MIPS

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[8] Primary Care Spending in the United States, 2002-2016, *JAMA Internal Medicine*, Vol. 180, No.7
[9] Request for Information; Episode-Based Payment Model, Centers for Medicare & Medicaid Services on 7/18/23

implementation. Like MIPS, this could be coupled with a bonus opportunity for exceptional performance.

Risk Adjustment. Clinicians participating in Medicare Advantage plans have long recognized the importance of HCC coding and risk adjustment to ensure that higher costs associated with patients who are more complex, require additional services, or face greater risk of complications are accounted for. TMA applauds CMS for recognizing that risk adjustment is essential to avoid penalizing physicians who care for these vulnerable patients and appreciates the agency's proposal to incorporate a complex patient adjustment model.

Quality Measures. TMA applauds CMS' decision to align ASM quality measures with a targeted set drawn from existing MVPs. Carrying over familiar measures should help reduce administrative burden and give clinicians greater confidence when transitioning into new models. However, TMA is deeply concerned that, according to CMS' 2023 Quality Payment Program Experience Report[10], only 6,790 clinicians received a MIPS score through an MVP. More than half of those entities reported under just two options — the Cancer Care and Anesthesia MVPs. The Advancing Care for Heart Disease MVP, which CMS proposes as one of the datasets for ASM quality scoring, underscores this problem clearly: Although 731 clinicians registered, only 534 submitted MVP data, and a mere 49 ultimately received a final score through the heart disease MVP. Additionally, the Rehabilitative Support for Musculoskeletal Care MVP – the other model informing ASM quality measures – was not introduced until 2024, leaving CMS with no track record to evaluate its performance. Building ASM on such a narrow and untested foundation risks creating a model that is not evidence-based and could undermine, rather than encourage, specialist's appetite for value-based care.

Finally, TMA cautions against requiring clinicians to report on *all* five quality measures within the ASM data set. Given the diversity of physician practices, even within a single specialty, some measures may not be clinically relevant or appropriate for every practice. Allowing a degree of flexibility, similar to MVPs, would help ensure fairness and encourage broader participation. TMA encourages CMS to continue collaborating with national specialty societies to ensure selected measures are clinically appropriate and meaningful. TMA also appeals to CMS to work to address the burden created by overlapping quality and payment programs among different payers, including other programs administered by CMS.

Cost Performance. Under the ASM, cost performance is measured using condition-specific episode-based cost measures tied to the chronic conditions being targeted: heart failure and low back pain. These measures closely mirror those already used in the MIPS and MVP programs. TMA urges CMS to proceed cautiously in applying cost measures within the ASM. While episode-based measures may offer a more targeted approach than broad per-capita cost measures, they still hold physicians accountable for costs largely outside of their control, such as

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[10] CMS 2023 QPP Experience Report; https://qpp-cm-prod-content.s3.amazonaws.com/uploads/3269/2023-QPP-Experience-Report.pdf; pgs. 23-25

hospital services, post-acute care, or drug pricing. To ensure fairness and clinician engagement, TMA urges CMS to gradually phase in cost accountability and to provide timely and actionable feedback reports. These safeguards are essential to prevent unintended penalties and to align ASM with CMS' stated goal of expanding specialist participation in value-based care.

Rural, Solo, and Small Practices. The ASM emphasizes individual clinician participation, which CMS describes as a way to "level the playing field" for small and independent practices that often face disadvantages under group reporting structures. TMA appreciates this intent and acknowledges CMS' proposal to implement scoring adjustments for solo and small practices. However, TMA is concerned these concessions will not adequately offset the significant cost and time burdens associated with compliance. Further, TMA is particularly disappointed CMS has chosen not to include a rural adjustment. While this might appear duplicative, rural practices face unique challenges beyond those of solo or small practices such as limited access to capital for technology upgrades, fewer options for hiring staff to manage reporting requirements, and additional barriers to adopting interoperable systems for care coordination with their primary care colleagues. These challenges are compounded by CMS' decision to require individual rather than group reporting. Some rural physicians have relied on ACO or hospital partners to manage participation in CMS value-based payment programs, and this support may not be available under the ASM.

Model Overlap. TMA appreciates that ASM participants will be exempt from MIPS during ASM participation and may still take part in other CMMI episode-based models and accountable care organizations. TMA remains concerned, however, that this could lead to confusion and duplication with existing CMS value-based payment programs TMA urges CMS to clarify how participation and attribution under the ASM would affect or interact with these programs to ensure alignment and avoid conflicting requirements, reporting, and payment adjustments.

A *JAMA* article, "Primary Care Spending in the United States, 2002-2016"[8], cites that specialty care represents more than 18% of the professional medical spend in the U.S. compared to just 4% for primary care. Clearly, physicians in all specialties will be required if CMS is to achieve its goal of moving all Medicare beneficiaries in a value-based care model by 2030. TMA urges CMS to take the time to implement a program that will inspire specialists to participate rather than mandate and punish those who do not.

<u>Medicare Diabetes Prevention Program - MDPP (section III.E.)</u>

Summary

CMS has proposed updates to the Medicare Diabetes Prevention Program (MDPP), which began offering services and began billing Medicare on April 1, 2018, to improve access and effectiveness in preventing type 2 diabetes among Medicare beneficiaries. These changes recognize the chronic nature of prediabetes and the need for ongoing interventions.

A central proposal is to remove the current once-per-lifetime limit on MDPP services. This restriction has been a barrier for many individuals who may require additional support over time. By eliminating this limit, CMS aims to offer more flexible access to the program. Instead, CMS proposes a five-year re-enrollment interval, allowing eligible Medicare beneficiaries to re-engage with MDPP every five years, as long as they meet clinical criteria, such as having prediabetes. This change seeks to balance improved access with necessary oversight.

These revisions also address stakeholder concerns that current limitations hinder the program's potential to reduce diabetes rates. By broadening eligibility and re-enrollment options, CMS hopes to enhance the long-term impact of MDPP and support sustained lifestyle changes.

Response
TMA supports MDPP as a vital initiative to prevent type 2 diabetes among Medicare beneficiaries. By offering structured lifestyle programs based on the Centers for Disease Control and Prevention's National DPP, MDPP aligns with TMA's mission to improve population health. TMA commends CMS for providing this no-cost, Part B-covered service and urges further investment, especially in underserved areas. To improve access, particularly for rural Texans and those with mobility or transportation barriers, TMA advocates for CMS to expand program delivery flexibility through existing remote models and to consider including individuals already diagnosed with type 2 diabetes for lifestyle interventions.

CMS' proposal to revise the statute to address operational questions and barriers related to weight collection requirements is a welcome step toward reducing administrative burdens while maintaining program integrity. However, requiring MDPP suppliers to submit documentation within two calendar days of each session places undue strain on providers, especially smaller or resource-constrained organizations in rural areas. TMA recommends allowing a more flexible documentation window, such as a rolling weekly timeline, to promote operational efficiency, reduce the risk of unintentional noncompliance, and enhance supplier participation across diverse settings. These adjustments would help strengthen the program's infrastructure while preserving accountability and oversight.

CMS should follow the behavioral health model proposed in this regulation, which allows G-codes that are billed as add-on codes for same-day services as part of advanced primary care management for patients with chronic conditions. TMA stands ready to collaborate with CMS on meaningful reforms that strengthen the program and ensure it fulfills its mission to reduce the burden of diabetes for all Medicare beneficiaries.

Finally, to improve MDPP, TMA further urges CMS to streamline the supplier enrollment process and provide more technical assistance to smaller practices. Expanding collaborations with primary care providers can also help reach high-risk communities. While synchronous and asynchronous program options increase flexibility, larger organizations are still better positioned to absorb program costs, given the for enough participants with prediabetes to sustain coaching programs. Live interaction between asynchronous sessions is important to maintain engagement,

and the benefits of virtual visits demonstrated during the COVID-19 pandemic highlight the potential for remote support. At the same time, scaling these programs remains challenging, as remote patients may require Bluetooth-enabled scales or other monitoring tools, adding complexity and cost. Despite these hurdles, TMA believes these developments are moving in the right direction by supporting preventive care, expanding access, and ensuring the program remains financially viable for physicians and suppliers.

Medicare Shared Savings Program – MSSP (section III.F)

Summary

Established under the Affordable Care Act in 2010 and launched in 2012, the Medicare Shared Savings Program (MSSP) has grown into one of the nation's largest value-based payment models and remains the only such program authorized by statute for traditional Medicare. The program encourages groups of physicians, hospitals, and other health care providers to form accountable care organizations (ACOs) that take responsibility for both the cost and quality of care for their assigned Medicare beneficiaries. When an ACO meets established quality and cost benchmarks, CMS shares savings with the organization; conversely ACOs may also share in losses if spending exceeds expectations.

In performance year 2025, the MSSP included 477 ACOs representing more than 650,000 health care providers and organizations, collectively serving nearly 11.2 million traditional Medicare beneficiaries. Looking ahead, CMS' proposals for 2026 build on its 2025 Strategy to Make America Healthy Again[1]. Key elements include: 1) embedding preventive care in all model designs; 2) expanding independent provider participation in value-based programs; 3) standardizing model features to reduce administrative burden; 4) requiring all alternative payment models to include downside financial risk; and 5) reducing overall costs for taxpayers. Based on these proposed policies, CMS projects a net reduction of $20 million in total MSSP spending over the 10-year period from 2026 through 2035. Major proposed changes to the MSSP include:

Summary - Considerations for Timing of ACO's Progression to Performance-Based Risk.

The MSSP has included one-sided (shared savings only) and two-sided (savings and losses) models since its inception. Under the BASIC track, qualifying ACOs begin the program in a one-sided risk arrangement but progressively move to higher levels of financial risk. Currently, new ACOs without prior experience in CMS' performance-based risk models may participate in a BASIC track model for up to seven performance years before being required to transition to risk. Beginning Jan. 1, 2027, however, CMS proposes to limit their participation in a one-sided track to the ACO's first five-year agreement period. Further, these ACOs without prior experience in CMS' performance-based risk models would be required to transition more quickly to higher risk levels under Level E of the BASIC track or the ENHANCED track.

Response

TMA appreciates CMS' past efforts to strengthen and expand MSSP participation, including

adoption of more conservative glide paths to risk-bearing arrangements; implementation of advance investment payments; adjustments to quality performance thresholds that benefit low-revenue ACOs; and efforts to ensure fair, accurate, and sustainable benchmarking and risk adjustment policies. Despite the efforts**,** TMA remains concerned that independent, solo, and small group practices often lack the capital, staff, and infrastructure necessary to succeed in such programs. TMA will closely monitor how the proposed changes affect MSSP participation and outcomes, particularly given competition from Medicare Advantage plans, which typically provide monthly care coordination fees for the duration of their contracts acknowledging the additional work and resources required to care for the senior population, many with multiple chronic conditions.

Summary - ACO Participant Change of Ownership (CHOW)
To participate in the MSSP, an ACO must maintain, update, and submit to CMS an accurate and complete participant list that identifies each ACO participant by its Medicare-enrolled Taxpayer Identification Number (TIN) and legal business name. ACO participant agreements must also require each ACO participant to report changes in enrollment information to the ACO within 30 days of such changes. Currently, CMS accepts change requests only during the designated change request cycle with updates taking effect on Jan. 1 of the following performance year. Beginning Jan. 1, 2026, CMS proposes to require ACOs to update their participant lists outside of the normal cycle if a participating entity undergoes a change of ownership (CHOW) that results in a new Medicare-enrolled TIN with no prior billing history. CMS clarifies that when a new TIN lacks a Medicare billing history, it can't link past performance or claims data to the participant. Without immediate updates, this gap could disrupt the ACO's benchmarks, quality scoring, or cost calculations.

CMS proposes to limit out-of-cycle CHOW requests to only those participant TINs newly enrolled in Medicare's Provider Enrollment, Chain, and Ownership System (PECOS) with no prior Medicare billing claims history. The agency clarifies this limitation would not apply to CHOW situations in which a TIN is absorbed into an existing TIN that has a prior Medicare billing claims history.

Response
TMA recognizes the need for CMS to address a CHOW policy in today's dynamic health care environment and understands the potential negative impact that mid-year changes to an ACO participant list can have on performance outcomes. However, the proposed requirement – while intended to preserve program integrity and avoid disruptions in quality and cost measurement – grants CMS sole discretion over whether to approve such change requests. TMA urges CMS instead to develop clear, transparent standards to guide these decisions and ensure a fair and consistent process for all ACOs. In addition, TMA emphasizes that, with or without a billing history, CHOW events can significantly impact performance measurement, outcomes, and program stability. For this reason, TMA recommends that CMS should avoid using billing

history as the dividing line and instead develop a policy that accounts for the operational realities of ACO restructuring.

Summary - ACO Eligibility and Related Financial Reconciliation Requirements
ACOs must have at least 5,000 assigned Medicare fee-for-service beneficiaries to participate in the MSSP. CMS explains that smaller ACOs risk performance distortion due to random variation. For example, a single high-cost patient could make overall spending appear disproportionately high. However, CMS notes that experience with the MSSP shows ACOs can successfully participate with fewer than 5,000 assigned beneficiaries.

To address this, CMS proposes modifying eligibility and financial reconciliation requirements to allow ACOs that do not meet the 5,000-beneficiary minimum in one or more benchmark years to continue participating. Beginning with agreement periods on or after Jan. 1, 2027, ACOs applying for a new agreement period would be required to meet the 5,000 threshold in benchmark year (BY) 3, but could fall below that level in BY1, BY2, or both. CMS also proposes applying the following guardrails: 1) ACOs that drop below 5,000 in any benchmark year would be limited to the BASIC track; 2) they would be subject to caps on savings and losses; and 3) such ACOs would not be eligible for policies that provide certain low-revenue ACOs in the BASIC track with enhanced opportunities to share in savings.

Response
TMA is cautiously optimistic and appreciates CMS efforts to ensure that small, low-revenue, and often physician-led ACOs can continue to participate in the MSSP. Many of these groups face increasing pressure from consolidation. In addition, patient attribution remains a significant challenge in communities within markets with a disproportion number of Medicare Advantage penetration such as parts of Texas where enrollment exceeds 70%.

Summary – Proposal to Remove the Health Equity Adjustment (HEA)
In the 2023 PFS final rule, CMS finalized the HEA for ACOs that meet data completeness requirements for reporting the alternative payment model performance pathway (APP) quality measure set and the required Consumer Assessment of Healthcare Providers and Systems (CAHPs) patient experience survey. The level of the HEA adjustment is based on the ACO's performance on quality measures and the proportion of its assigned beneficiaries who live in underserved neighborhoods, qualify for Medicare Part D low-income subsidy (LIS), or are dually eligible for Medicare and Medicaid. Eligible ACOs may earn up to 10 additional points toward their MIPS quality performance category score. CMS asserts that since the HEA was adopted, the agency has implemented other scoring adjustments that support these ACO's in similar ways, including the electronic clinical quality measure (eCQM)/Merit-Based Incentive Payment System (MIPS) reporting incentive, and the complex organization adjustment. As a result, CMS proposes to retroactively eliminate the HEA beginning with performance year 2025.

Response
TMA urges CMS to reconsider its proposal to eliminate the HEA. ACO capabilities to collect, normalize, and report data from disparate systems vary widely. Well-funded organizations sponsored by integrated health systems, payers, private equity-backed organizations, and for-profit aggregators are more easily able to comply with all-payer/all-patient reporting mechanisms than others. The HEA adjustment addresses the separate and unique challenges of caring for dually eligible and low-income beneficiaries. Eliminating it could weaken ACOs' ability to finance and prioritize care delivery for these patients and may disadvantage ACOs caring for underserved populations. Physicians in these settings already carry a heavy burden in addressing non-medical drivers of health that impact patient access, prevention efforts, and adherence to care plans designed to manage chronic conditions.

Summary – Proposal to Update the APP Plus Quality Measures Set
To promote alignment with the adult Universal Foundation [11]measures and other CMS quality programs, the 2025 PFS final rule finalized the APP Plus quality measure set that would phase-in required measures beginning performance year 2025. CMS proposes substantive changes to the following measures beginning with the 2026 performance year (PY):

Table 51 - APP Plus Quality Measure Set for MSSP ACOs		
Year	**Measure**	**Collection Type**
2025 and subsequent PYs	CAHPS for MIPS (patient experience) 1. Hospital-Wide, 30-day, All-Cause Unplanned readmissions 2. Screening for Depression and Follow-Up Plan 3. Controlling High Blood Pressure 4. Breast Cancer Screening 5. Diabetes: Hemoglobin A1c Poor Control	Survey Administrative Claims All others eCQM or Medicare CQM (and MIPS CQM for PY 2025 and 2026)
2026 and subsequent PYs	All the above in addition to: 6. Hospital Admissions for Patients with Multiple Chronic Conditions (**delayed from 2025**) 7. Colorectal Cancer Screening (**delayed from 2025**)	Administrative Claims eCQM or Medicare CQM (and MIPS CQM for PY 2026)
2027 and subsequent PYs	8. Initiation and Engagement of Substance Use Disorder Treatment (**delayed from 2026**)	eCQM/Medicare CQM

[11] The Universal Foundation, Centers for Medicare & Medicaid Services; page last modified 6/26/25

Table 51 - APP Plus Quality Measure Set for MSSP ACOs		
Year	**Measure**	**Collection Type**
2028 and subsequent PYs (or the PY one year after the eCQM specification becomes available.)	All the above in addition to 9. Adult Immunization Status ~~10. Screening for Social Drivers of Health~~ **(deletion)**	eCQM/Medicare CQM

As outlined in the 2025 PFS final rule, CMS intends to fully transition to digital quality measurement (dQM) across its quality reporting and value-based purchasing programs. This ultimately includes electronic clinical quality measures (eCQMs) reporting which will eventually be mandated in future rulemaking as the required reporting option for the MSSP. The agency is actively gathering public input on the transition, including adoption of Fast Healthcare Interoperability Resources (FHIR) standards that enable health care systems and apps to share data in a standardized, digital way. FHIR-based application programming interfaces must be fully implemented by impacted payers by Jan. 1, 2027.

Response
TMA supports CMS efforts to align APM quality measures across its multiple quality programs, from MIPS, MSSP, and Medicare Advantage Star ratings to Medicaid Core Sets and the Health Insurance Marketplace Quality Rating System. While the myriad changes required for alignment is a complicated and painful process for many ACOs, TMA hopes commercial payers will ultimately follow CMS' lead with a small foundation of key, uniform measures across all payers that make the greatest impact on population health. TMA urges CMS to work with physician leaders representing all medical specialties and practice settings to develop and maintain relevant quality measure sets for MSSP and all Medicare value-based payment models.

Beyond technology and operational issues, the ultimate transition to eCQM all-payer reporting requirements may create unintended consequences. Currently, an ACO's quality performance is based on the quality of care furnished to Medicare beneficiaries affiliated with the ACO. The transition to eCQM requires reporting on the ACO's entire payer mix. This fact may put ACOs with higher proportions of underserved non-Medicare patients at a disadvantage, as they may now see lower performance on certain metrics for reasons outside the control of the ACO. Further, this requirement measures ACOs on their payer mix rather than the quality of care provided. Before finalizing plans for transition to eCQMs, TMA urges CMS to consider the financial and administrative burdens that many low-revenue ACOs must face to sustain MSSP participation.

Updates to the Quality Payment Program (QPP) (section IV)

Summary

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the Sustainable Growth Rate (SGR) formula for updates to the Physician Fee Schedule (PFS), replacing it with the Quality Payment Program (QPP). Under QPP, clinicians may receive payment adjustments through either the Merit-Based Incentive Payment System (MIPS), or, if eligible, as a qualifying participant (QP) in the advanced alternative payment model (APM) track, which requires participation in models that involve more than a nominal amount of financial risk.

Under MIPS – whether through traditional reporting or via the newer MIPS Value Pathways (MVPs) – fee-for-service payments are adjusted based on their performance across four weighted categories: quality (30%), cost (30%), improvement activities (15%), and promoting interoperability (25%). Introduced in 2023, MVPs proport to offer a more focused, clinically relevant, and specialty-specific reporting framework. While participation is currently voluntary, CMS indicates MVPs may fully replace traditional MIPS reporting as early as 2029.

CMS is proposing to leave the MIPS performance threshold at 75 points for performance year 2026/payment year 2028. CMS requests information regarding future proposals to increase the performance threshold based on data for a prior period, surmising that it would provide larger payment adjustments for MIPS eligible clinicians with higher scores.

Clinicians achieve qualifying APM participant (QP) status in an APM track if at least 75% of their Medicare Part B payments or 50% of their attributed Medicare patients are through the model, which exempts them from MIPS and provides a higher fee schedule conversion factor. CMS also recognizes partial QPs (50% payments or 35% patients), who do not receive QP fee schedule benefits, but may choose whether the report under MIPS.

Response

TMA supports the overall goals of QPP and appreciates CMS' decision to limit the number of proposed policy changes for 2026 to "focus on stability in the program." Frequent changes to reporting, participation, and other requirements add unnecessary complexity and confusion for physicians. TMA has consistently raised concerns about the agency's ongoing modifications to a program it intends to phase out in the near future. We thank CMS for listening.

Despite these efforts, TMA remains deeply concerned that physicians participating in MIPS/MVPs continue to face steep penalties – up to 9% of their Medicare payments – without evidence the program delivers meaningful improvements in patient care. The recently released 2023 QPP participation and performance results[10] highlight that MIPS disproportionately penalizes small, rural, and independent practices, along with the vulnerable patients they serve. Also troubling, clinicians who achieved a perfect score of 100 points received only a +2.15% adjustment in 2025, an increase that does not come close to covering the cost of compliance

(estimated at average $12,800 per physician[12]) or the rising costs of medical practice at a time of growing patient demand.

TMA appreciates the proposal to retain the MIPS performance threshold at 75 points for performance year 2026/payment year 2028. TMA believes raising the threshold would unfairly penalize smaller practices that are resource challenged in trying to stay abreast of the many and complex changes to the MIPS program annually. TMA urges CMS to maintain the 75-point threshold indefinitely.

Summary – Transforming MIPS: MVP Strategy
To advance its goal of phasing out traditional MIPS and transitioning to MVP reporting, CMS' 2026 proposals aim to encourage greater specialist participation:

Measures. CMS proposes addition of six new MVPs covering diagnostic radiology, interventional radiology, neuropsychology, pathology, podiatry, and vascular surgery. The agency also updated the MVP tables to stratify quality measures by clinical conditions and episodes of care, referred to as "clinical groupings". TMA appreciates this modification, which reflects the Jan. 24, 2025 feedback from the American Medical Association (AMA) and 31 specialty organizations[13]. TMA concurs that these refinements will help clinicians more easily identify and select the most relevant measures for their practice setting and patient populations.

Registries. In response to further feedback from AMA and its specialty coalition, CMS proposes additional flexibilities for qualified clinical data registries (QCDRs) and qualified registries. Specifically, the registries would be given one year after a new MVP is finalized to fully support it. This policy would take effect beginning with the 2026 performance year. TMA commends CMS for incorporating organized medicine's feedback and recognizes the important role QCDRs play in collecting, tracking, and comparing data across various practice settings.

Group/Subgroup Reporting. Since the 2023 performance year, both multi- and single-specialty groups have had the option to report as a group or form subgroups for MVP reporting. Beginning with the 2026 performance year, however, multispecialty groups will no longer be permitted to report as a single group; but must instead form subgroups. CMS proposes one exception: multispecialty groups with 15 or fewer eligible clinicians could still be allowed to report an MVP as a group without forming subgroups. TMA strongly opposes making subgroup reporting mandatory. Such a requirement directly conflicts with CMS' stated goals of reducing burden and promoting stability within QPP. For many small and midsize practices, especially those in rural or resource-limited settings, mandatory subgroup reporting would create unnecessary complexity, increase administrative costs, and jeopardize MVP scores due to an inability to meet

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[12] Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System, JAMA Health Forum, Vol. 2, No.5
[13] AMA Coalition letter to Acting Administrator, Center for Medicare & Medicaid Services, 2026 Proposed Candidate MVPs and Existing MVP Maintenance Feedback Period, Jan. 24. 2025

case minimums. Rather than fostering meaningful participation, these requirements risk driving practices out of the program entirely. TMA applauds the agency's efforts to maintain flexibility in reporting methods and strongly urges the agency to keep subgroup reporting voluntary.

Response
TMA supports CMS' stated goal of reducing administrative burdens on physicians as the agency transitions toward wider adoption of MVPs and greater alignment between MIPS and APM tracks. TMA remains concerned, however, that complexities of the program mirror those of the voluntary Medicare Shared Savings Program but without the opportunity to earn meaningful financial incentives that compensate for the additional administrative hassles of participation. TMA urges CMS to provide robust technical assistance and strong transition support, as well as to maintain optional MIPS/MPV reporting to facilitate adoption as MVPs continue to evolve. Further, TMA emphasizes the importance of close collaboration with AMA and national specialty societies in the development of relevant, clinically meaningful measures, and reporting methods that are appropriate for all practice settings. Finally, TMA strongly believes CMS must not phase out traditional MIPS in favor of MVPs, nor base new payment models on MVPs until the program is proven equitable, sustainable, and workable for practices of all sizes.

Summary – MIPS Quality Performance Category.
CMS continues to promote its vision for QPP, highlighting important updates to the quality performance category within MIPS. Central to this is the Universal Foundation, which aims to reduce burden, prioritize the development of interoperable digital quality measures, and enable comparisons across programs to help identify measurement gaps. For the 2026 performance year, CMS proposes an inventory of 190 MIPS quality measures, with 187 available under traditional MIPS and three applicable only to MVPs.

Response
TMA recognizes CMS' commitment to improving the quality performance category and advancing value-based care. However, without meaningful efforts to reduce reporting burden, stabilize measure requirements, and ensure fair scoring, many physicians may struggle to fully engage in the program.

The reporting process under QPP remains overly complex and time-consuming, creating significant challenges for physicians. TMA urges CMS to simplify reporting requirements and provide stronger technical support to make compliance more manageable. Because MIPS scores directly affect Medicare payments, the combination of complicated reporting rules and frequent measure changes can lead to unfair penalties, disproportionately impacting small and rural practices and those who care for high-risk or underserved patients.

Summary – MIPS Cost Performance Category
CMS does not propose adding or removing any cost measures for the 2026 performance year, leaving an inventory of 35 measures: two population-based measures and 33 episode-based

measures. However, the agency proposes a new two-year, informational-only feedback report for any newly implemented cost measures. Beginning in 2026, clinicians would receive a confidential performance feedback report enabling them to identify opportunities for improvement before a new measure affects their MIPS or MPV final score. Importantly, CMS would not publicly report data from this feedback phase.

Response
TMA appreciates CMS' effort to provide physicians with additional time to understand and adapt to new cost measures before they impact payment adjustments. However, there is concern this policy applies only to *newly introduced* cost measures and not to modifications of existing measures. Changes to established measures can be just as disruptive to practice operations and scoring outcomes, and physicians deserve the same opportunity to assess their performance before being held accountable under revised methodologies.

Summary – MIPS Improvement Activities
CMS is proposing the removal of eight improvement activities and the addition of three new improvement activities, including one related to patient safety in the use of artificial intelligence. CMS is proposing the removal of one subcategory, Achieving Health Equity, and the addition of a subcategory, Advancing Health and Wellness.

Response
TMA urges CMS to cease continuous changes to the improvement activities section of MIPS. The changes are burdensome to physicians as the care team must annually adjust measures and metrics tracked to meet program requirements that have shown little impact to patient care.

MIPS Promoting Interoperability

Summary – Proposal to Modify the Security Risk Analysis Measure
The security risk analysis measure currently requires an eligible clinician to positively attest to completing a security risk analysis during the performance year. CMS is proposing to add a second attestation to this measure indicating the eligible clinician has met the security risk management component, which includes addressing the security of data created or maintained by certified electronic health record technology (CEHRT) to include encryption.

Response
TMA agrees protecting patient health information is of utmost importance. Knowing health data breaches and cyberattacks are on the rise heightens the importance of conducting and managing the security risk analysis, including data encryption. If this proposal is finalized, TMA encourages CMS and the assistant secretary for technology policy (ASTP) to provide fact sheets, guidance, and educational materials specific to the management of the security risk analysis. Any guidance developed should be provided early enough in 2026 so physician practices have access during the performance year.

Summary – Proposal to Modify the High Priority Practices of the SAFER Guide Measure
In January 2025, ASTP published a revised set of SAFER Guides that contain new recommendations as an update to the version posted in 2016. CMS is proposing that as part of promoting interoperability, eligible clinicians attest yes to completing an annual self-assessment of the 2025 version of the High Priority Practices of the SAFER Guides rather than the 2016 version.

Response
TMA appreciates that ASTP has updated the SAFER Guides to reflect the current practice environment. TMA agrees CMS should encourage the use of the updated version and, if finalized, encourages CMS to widely promote this change to eligible clinicians so participants are aware of the change.

Summary – Proposal to Adopt the Public Health Reporting Using TEFCA measure
CMS proposes to add an optional bonus measure under the public health and clinical data exchange objective for health information exchange with a public health agency that occurs using the Trust Exchange Framework and Common Agreement (TEFCA). To be eligible for the bonus, the eligible clinician must attest "yes" for the bonus measure and transmit electronic health information for at least one measure under the public health and clinical data exchange objective using TEFCA.

Response
TMA favors new options to obtain optional bonus points for MIPS and agrees with CMS that participation in TEFCA could help reduce the difficulty of health information exchange over time. Additionally, TMA urges CMS to resolve all interoperability and data integrity issues with all CEHRT vendors and adhere to rules set by the public health agencies (regional, state, and federal jurisdictions) before adding measures and increasing the burden on clinicians. As a condition of certification, electronic health record (EHR) vendors must have a mechanism that allows users to review data before authorizing submission. As the systems evolve, there may be a need to ensure correct data is appropriately submitted. It's easier to verify data pre-submission than to try to pull back erroneous submissions.

Summary – Proposal to Suppress the Electronic Case Reporting Measure for Performance Year 2025
The Centers for Disease Control and Prevention (CDC) recently informed CMS that it has temporarily paused electronic case reporting registration and onboarding of new health care organizations so it can establish a more efficient and automated process. CMS proposes to suppress the electronic case reporting measure by excluding it from the calculations for score purposes. Eligible clinicians should still report the measure or claim the exclusion if applicable.

Response

TMA agrees CMS should have the authority to suppress the electronic case reporting measure if a heath care entity is unable to connect to the appropriate public health agency while CDC updates its infrastructure and process in an effort to automate and streamline future reporting. Many local health departments are suffering funding cuts, which further delay advancements in technology allowing bidirectional electronic exchange to support the reporting of notifiable health conditions. TMA urges CMS to work with CDC to not only streamline its infrastructure, but to also support state and county public health departments so information is promptly received and authorities can promptly react to any communicable disease threats.

Summary – Request for Information (RFI) Regarding the Query of Prescription Drug Monitoring Program Measure (PDMP)
CMS seeks feedback on changing the query of the PDMP measure from an attestation-based measure to a performance-based measure. The denominator would be the number of Schedule II opioids electronically prescribed, and the numerator would be the number of those prescriptions that included a check of the PDMP. CMS additionally seeks information about reporting requirements, exclusions, data validation, timeframes, and other measures.

Response
TMA strongly urges CMS not to change the query of the PDMP measure from attestation- to performance-based. PDMPs are state-run programs with various requirements by state. For example, Texas generally requires prescribers to check the PDMP before prescribing opioids, barbiturates, benzodiazepines, and carisoprodol. Not all of these medications are Schedule II even though the PDMP check is required. It would be challenging for PDMP and EHR vendors to prepare these reports considering the inconsistent state requirements for PDMP checks. If CMS decides to move forward by making the PDMP measure performance-based, please verify that EHR and PDMP vendors can work together to simplify the reporting process for MIPS eligible clinicians. Physicians do not need additional burdensome MIPS reporting requirements.

Summary – RFI regarding Performance-Based measures
CMS seeks information about requiring eligible clinicians to report performance-based rather than attestation-based responses for public-health reporting measures.

Response
TMA strongly believes CMS should not move to performance-based reporting for the public health measures. Public health measure reporting requirements have been difficult due to public health agencies' inconsistent adoption of interfaces and reporting capabilities for eligible clinicians. Agencies continue to be challenged with budget cuts and low staffing levels, which may further exacerbate the capabilities. In fact, CMS is asking for authority to suppress the electronic case reporting measure while CDC updates and streamlines its own capabilities for reporting. For this reason, and due to the extra unnecessary burden CMS is placing on eligible clinicians, please do not adopt performance-based reporting requirements.

Summary – RFI Regarding Data Quality
CMS seeks information about gaps and discrepancies in data accuracy, completeness, reliability, and consistency that undermine the integrity of health information exchange.

Response
For many years, TMA has advocated for universal use of extensible markup language (XML) or a similar standard (e.g., Fast Healthcare Interoperability Resources, or FHIR) as a way of exchanging meaningful health data, similar to what is used in accounting and other industries. Universal common encoding of all data elements could permit disparate systems to share and consume information much more easily. Information consumed by a receiving EHR could be placed correctly within the system to give it meaning and make it useful. Requiring this kind of data-element tagging as part of the United States Core Data for Interoperability (USCDI) has the potential to rapidly advance ASTP's interoperability goals while decreasing user burden. Standardized encoding of all data elements supports physicians who need to change EHRs by making it possible to seamlessly move from one EHR to another at little to no cost.

USCDI is an adopted ASTP standard that sets the foundation for sharing electronic health information to support patient care. USCDI version 1 is currently required, and USCDI version 3 will be required effective Jan. 1, 2026. USCDI version 6 was just released and almost 50% of the data elements do not have a correlating vocabulary standard. Without vocabulary standards, EHR vendors can choose their preferred vocabulary standard, which inhibits interoperability. TMA encourages CMS and ASTP to work with EHR vendors to reach consensus on vocabulary standards for each USCDI data element. Before advancing additional vendor requirements, testing should be conducted among certified EHR vendors to ensure the data is interoperable between disparate systems. Additionally, data should be collected from qualified health information networks (QHINs) and health information exchanges (HIEs) to understand if the required USCDI data elements can all be exchanged seamlessly and without additional user effort. The burden should not fall to physicians to solve this challenge with their health IT vendors and with HIEs.

Although standardized data elements have been defined in the Consolidated Clinical Document Architecture (C-CDA), there is lack of consistency in what elements are shared. Additionally, the data are not prioritized in a way that a physician would logically review the document after a patient's discharge from the hospital. TMA recommends CMS, ASTP, EHR vendors, and HIEs adopt the following list as the content and priority of items displayed on a C-CDA when a patient is discharged from the hospital. The following is the minimum suggested data set of elements and the order in which they should be listed. This recommendation is now published by the Sequoia Project in the Data Usability Workgroup Implementation Guide Version 1.

Discharge C-CDA Minimum Data-Set Content and Display Order:

1. Discharge summary narrative (aka, hospital course)

2. Discharge medications
3. Allergies
4. Admission diagnosis
5. Discharge diagnosis
6. Procedures: Includes interventional radiology, cardiac catheterization, operative procedures
7. Diagnostic imaging: Advanced imaging (e.g., MRI, CT, PET), nuclear imaging, ultrasound, echo, and venous doppler
8. Laboratory: Recommend first and last laboratory result for every test. Rare tests are only done once, so they would be included (e.g., anti-nuclear antibodies for rheumatoid arthritis)
9. Consultations
10. Assessment and plan: Includes future orders for follow-up with a primary care physicians and diagnostic tests)
11. Problem list

Additionally, if a QHIN fails, TMA recommends ASTP require each QHIN to have a contingency plan in place that allows for another designated QHIN to quickly take over a failed QHIN's data-exchange capabilities, including migration support for clinicians and organizations.

Summary – MIPS Final Score Methodology
CMS is not proposing any changes to scoring policies for cost, improvement activities, and promoting interoperability MIPS categories. CMS is proposing changes to the quality category scoring as related to benchmarks and removal of topped-out measures. Topped-out measures are measures for which performance is considered so high and unvarying that meaningful distinctions and improvements in performance can no longer be made.

Response
TMA appreciates that CMS is not making changes to the scoring policies for cost, improvement activities, and promoting interoperability MIPS categories. However, TMA is opposed to dynamic scoring of quality measures based on measure type, reporting method, or if the measure is topped out. In fact, CMS should not remove topped-out measures from the list of available quality measures. Not only does this limit achievable measures for physicians, but it also reduces their scoring opportunities and increases potential for MIPS penalties. Physicians should not be punished for performing well with certain measures and providing high-quality care to their patients. Additionally, seven of the measures proposed for removal are collected via Medicare Part B claims:

Measure	Measure Title
141	Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure by 20% or Documentation of a Plan of Care

249	Barrett's Esophagus
250	Radical Prostatectomy Pathology Reporting
320	Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients
395	Lung Cancer Reporting
397	Melanoma Reporting
406	Appropriate Follow-up Imaging for Incidental Thyroid Nodules in Patients

Currently there are 25 quality measures that can be reported via claims, and claims reporting is the only reporting method that can be accomplished without a data submission fee. TMA urges CMS to not reduce the number of quality measures that can be reported via Medicare Part B claims. Removing measures and changing the scoring methodology adds unnecessary complexity to the Quality Payment Program while increasing physician burden, frustration, and burnout.

Advanced Alternative Payment Models (APMs) (section IV.D.5)

Summary

CMS has a formal process for deciding whether a clinician meets the statutory thresholds to be considered a qualifying APM participant (QP) in an advanced APM. QPs are exempt from MIPS reporting and benefit from a higher physician fee schedule conversion factor. To qualify, a clinician (or their APM entity/group) must meet either: 1) a payment threshold whereby a set percentage of Medicare Part B payments must flow through the advanced APM (currently 75%); or 2) a patient-count threshold whereby a set percentage of Medicare patients must be attributed through the advanced APM (currently 50%). In addition, CMS recognizes a partial QP status for clinicians who meet lower thresholds (50% payments or 35% patients). Partial QPs do not receive QP benefits but may choose whether to participate in MIPS.

Currently, CMS makes QP determinations primarily at the APM entity level such as an ACO, medical group, hospital, etc. The services that CMS counts toward QP determination have traditionally been limited to professional services tied to evaluation and management services. Beginning with the 2026 performance year, CMS proposes to expand QP determination status to the individual level in addition to APM entity determinations. Further, as part of the effort to simplify this process, the agency proposes to use all covered professional services under the physician fee schedule rather than the existing subset of services.

Response

TMA appreciates CMS' proposal to expand QP determinations to the individual clinician level. Allowing clinicians to qualify for QP status based on their own work recognizes the range of practice types participating within large entities. This may provide new opportunities for specialists and independent physicians to benefit from advanced APM participation. TMA also supports CMS' proposal to use all covered professional services in QP determinations, as this provides a more consistent and transparent approach than relying on the narrower set of codes.

At the same time, TMA is concerned that introducing clinician-level QP determinations could also create complexity and administrative challenges, particularly for group practices where some clinicians qualify as QPs and others do not. This fragmentation risks confusion for both clinicians and patients, while adding yet another layer of reporting and compliance burden to practices already struggling with the complexity of QPP. TMA urges CMS to pair this policy change with robust technical assistance and clear, timely QP status reporting so practices can anticipate and manage these outcomes effectively.