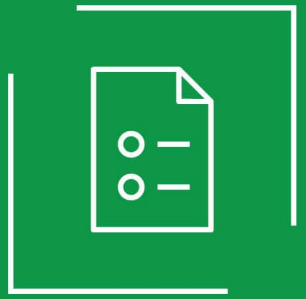
2026 Washington Update

October 2026

James Haynes

Associate Director, Government Affairs





AGENDA

Key Topics:

- Proposed 2027 Medicare Physician Fee Schedule
- Proposed 2027 OPPS & ASC Rule
- Legislative developments
- 2026 watchlist

MGMA

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HOW DO WE ADVOCATE FOR YOU IN D.C.?

Listen

Solicit feedback from MGMA members regarding challenges stemming from federal policies

Advocate

Inform policymakers of these challenges & work towards solutions

Educate

Educate MGMA members on policy changes that affect their practices









Policy Landscape & Proposed Payment Rules



2026 POLICY CHANGES TO DATE

- ACA subsidies expired
- Appropriations bill included key Medicare provisions:
  - Telehealth flexibilities extended through 2027
  - 1.0 work GPCI floor extended through 2026
  - APM incentive bonus reinstated and QP threshold lowered for 2026 performance year
  - Lab cuts delayed until 2027
- New prior authorization requirements went into effect (improved decision timeframes, denial documentation requirement)
- Electronic Claims Attachment final rule
- No Surprises Independent Dispute Resolution Operations final rule
- Section 504 accessible medical diagnostic equipment compliance date

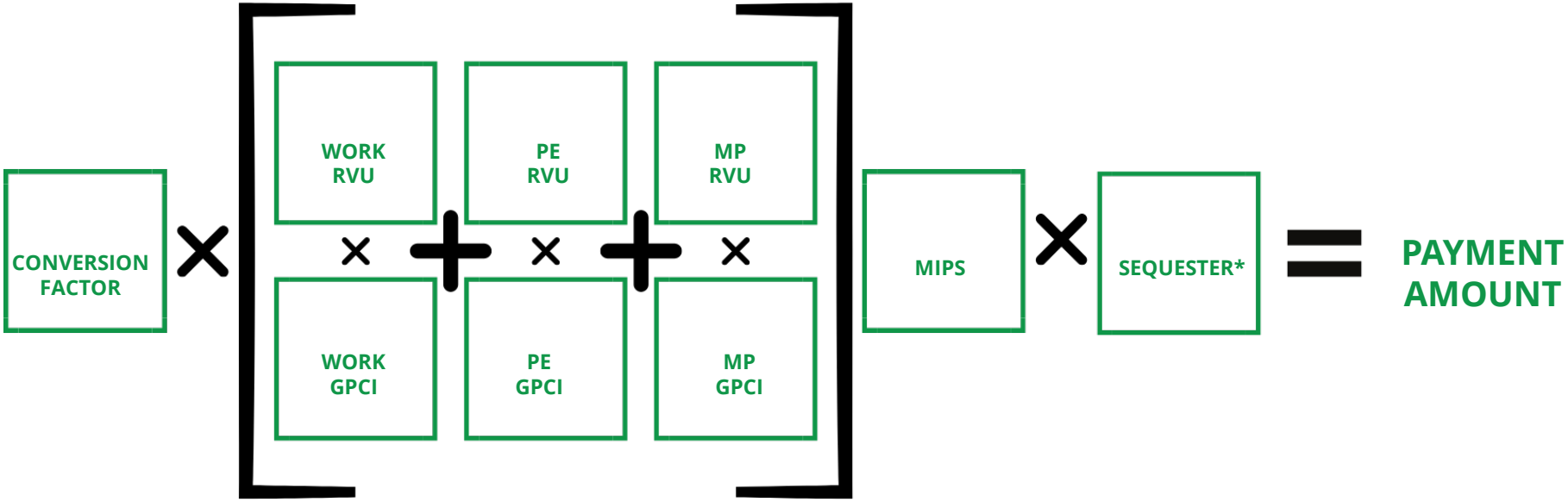
2027 PROPOSED PHYSICIAN FEE SCHEDULE

Key Themes

CMS continues to intervene in payment decisions	• Conversion factor cut, changes to practice expense RVUs, reduction for remote monitoring services
Push towards value-based care	• Increased savings, benchmark adjustments, incentives for new providers and beneficiaries
Quality reporting changes	• Plans to sunset MIPS after 2028, transition to MVPs is imminent

Comments closed September 14; final rule expected in November.

MEDICARE SERVICE PAYMENT CALCULATION



2027 PROPOSED PHYSICIAN FEE SCHEDULE

Cuts to Conversion Factors

$33.17
for qualifying APM participants (QPs)

$32.84
for non-QPs

A decrease of 1.19% for QPs and 1.68% for non-QPs over 2026 rates

- Includes statutory 0.75% increase for QPs and 0.25% for non-QPs
- 0.53% positive budget neutrality adjustment
- Expiration of temporary 2.50% increase from the OBBBA for 2026

2027 PROPOSED PHYSICIAN FEE SCHEDULE

Physician Payment Changes

Practice Expense (PE) RVU Methodology

- Revising indirect PE allocation
- Phasing out the Indirect Practice Expense Cost Index
- Introducing a PE stabilization adjustment

G2211

- Changing from add-on code to modifier
- MOD1 – increase payment of the E/M base code by 16%
- MOD2 – for E/M visits for practitioners in MSSP or ACO LEAD, increase of 32%

Global Procedures and Modifier -25

- Reducing payment when a separately identifiable E/M visit (billed with modifier -25) is furnished by the same physician, or a physician in the same practice, on the same day as a 0-, 10-, or 90-day global procedure; most expensive service is 100%, all other procedures 50%

2027 PROPOSED PHYSICIAN FEE SCHEDULE

Quality Payment Program

MIPS

- Sunsetting MIPS following the 2028 performance year
- 75-point performance threshold remains in place
- MIPS core measures – clinicians would be required to report 1 CMS-designated core measure instead of an outcome or high-priority measure
- Promoting Interoperability:
  - Electronic prior authorization measure
  - Removing security risk analysis attestation

MIPS Value Pathways (MVPs)

- Mandatory starting in the 2029 performance year for those not in an APM
- Three new proposed MVPs – Diabetic Disease, Hospitalist, Hypertension
- Large multispecialty groups would have to report as subgroups

Advanced Alternative Payment Models (APMs)

- Applying QP and Partial QP determinations at the TIN/NPI level instead of NPI level

2027 PROPOSED PHYSICIAN FEE SCHEDULE

Medicare Shared Savings Program (MSSP)

Beneficiary Assignment Methodology

- Adjusting to allow for more beneficiaries to be assigned to ACOs

Financial Methodology

- Increasing shared savings rate in Level E of the BASIC track from 50% to 60%
- Reducing maximum weight on regional adjustment to 35% in the ENHANCED track

Reporting Requirements

- Extending existing reporting options (MIPS & Medicare CQM) during the transition to digital quality measures

Benchmark Adjustments

- Modifying to reward:
  - Successfully lowering spending (prior savings adjustment)
  - Treating high-cost patients & reward (risk adjusted benchmark)
  - Recruiting clinicians inexperienced in value-based care (growth adjustment)
- Updating accountable care prospective trend (ACPT) methodology to establish annual growth rates and implement guardrails on ACPT fluctuations

2027 PROPOSED PHYSICIAN FEE SCHEDULE

Additional Proposals

Ambulatory Specialty Model

- Mandatory model starting in 2027 for select specialists treating heart failure or low back pain
- Proposing numerous technical changes such as adding participation exceptions, adjusting reporting requirements, and adding a rural scoring adjustment

Remote Monitoring

- Initiating visit required before using RPM/RTM services
- RPM/RTM services allowed only by clinical staff and not contractors
- Revaluation of numerous remote monitoring codes

Coding Changes

- Maternal Care
- Advanced Care Planning
- Behavioral Health

2027 PROPOSED OPPS & ASC

Key Themes

Expansion of site-neutral policies	• Proposal is limited to select imaging services, signals CMS's continued interest in site-neutral policies as a savings opportunity
Provider-based department reporting requirements	• Additional reporting related to provider-based departments, including off-campus HOPD NPI and attestation requirements
Continued phase out of the inpatient only (IPO) list	• Removing 637 additional procedures for 2027 as part of CMS's three-year plan to eliminate the IPO list

Key Issues & Policy Priorities



MEDICARE PAYMENT & QUALITY REFORM

Physician Payment

- **Strengthening Medicare for Patients and Providers Act of 2025** – Introduces an annual Medicare conversion factor update tied to MEI
- **Provider Reimbursement Stability Act** – Modernizes antiquated Medicare budget neutrality rules

Quality Reporting

- **Medicare Physician Data-driven Performance Payment System Act**

Patients First Act

- Annual inflationary update
- Modernizing budget neutrality changes
- **Quality reporting:** redesign MIPS by creating a new committee to oversee selection of quality measures
- **Value-based care:** new requirements for comments on mandatory model, freezing APM thresholds

SHIFTS IN VALUE-BASED CARE

> CMMI's focus is on cost savings and expanding savings beyond its physician-focused models. The center is being used as a vehicle to test new payment and technology initiatives involving artificial intelligence.

Impact

- New models targeted towards non-physician participants
- Reducing reimbursement or termination of existing models
- Mandatory specialty models requiring downside risk

MGMA Policy Priority

- Long-term extension of the Advanced APM incentive payment and QP threshold freeze
- Focus on developing physician-led, optional models that include partial-risk options for new APM participants

CMMI MODEL LAUNCHES

WISeR
Participants: Technology companies

Introduces prior authorization for certain Traditional Medicare services in six states

Status: Launched January 2026

ACCESS
Participants: Technology companies

New payment option for providing digital services to improve patients' metabolic, musculoskeletal, or behavioral health conditions

Status: Launched July 5

LEAD
Participants: Providers

- Builds on ACO REACH
- 10-year model offering both partial and full risk options

Status: Launches January 2027

ASM
Participants: Providers

- Mandatory model for specialists treating heart failure and low back pain
- Final participant list released September 2026

Status: Launches January 2027

PRIOR AUTHORIZATION CHANGES FOR 2026

Medicare Advantage & Medicaid

- Faster decisions required
  - Standard request: 7 days
  - Expedited request: 72 hours
- Approvals must last for the full course of treatment
- Denials must include specific clinical reasons
- Plans must publicly report metrics

Traditional Medicare

- WISeR launched in 6 states (AZ, NH, OH, OK, TX, WA)
- Select services impacted
- Technology companies utilizing AI in PA review process

Commercial Plans

- Over 50 health plans issued a pledge to reduce prior authorization across commercial markets

MGMA Policy Priority

- Improving Seniors' Timely Access to Care Act
- Reducing Medically Unnecessary Delays to Care Act
- Mitigate problematic WISeR implementation
- Ensure electronic prior authorization plan compliance and implementation

MEDICARE ADVANTAGE

Medicare Advantage (MA) has grown to the point where over 55% of Medicare beneficiaries are enrolled in an MA plan, introducing new administrative / financial burdens. Potential downstream impact on large systems with MA plans / delegated risk.

Impact

90% of MGMA members have seen an increase of MA in their practices

78% of those report the shift towards MA has a negative impact on their practice

MGMA Policy Priority

- Medicare Advantage Improvement Act
- Medicare Advantage Prompt and Fair Pay Act
- Legislation to address downcoding
- Mitigate downstream impacts on reimbursement

CMS FOCUSED ON FRAUD PREVENTION

Increased Scrutiny on Medicare and Medicaid Fraud

- Nationwide moratorium on Medicare enrollment for new DME suppliers, hospices, and home health agencies (HHAs)
- Request for states to revalidate Medicaid providers
- Focus on rising cost of skin substitutes
- CMS request for information on ways to combat fraud
- Proposed changes to Medicare enrollment to address fraud

Looking Forward



LEGISLATIVE OUTLOOK

Mid-term Elections

- Potential change in leadership and priorities across House and Senate
- Lame duck session uncertainty

Federal Funding Expires

- Extended until December 11
- Opportunities for end of year package to include healthcare initiatives

End-of-year package opportunities:

- GPCI floor extension
- APM incentive payment extension
- Seniors' Act
- Medicare payment

MEDICAID CHANGES

Work Requirements

- January 1, 2027 implementation deadline
- Flexibilities for how states implement medical frailty exemption documentation

Funding and Reimbursement Changes

- State-directed payments being capped at Medicare payment levels (phased in beginning 2028)
- Reduced federal matching funds via limits on provider taxes for Medicaid expansion states

Key takeaways for medical groups:

- Varied impact depending on state implementation
- Prepare for higher rates of uncompensated care, reduced Medicaid reimbursement
- Track state rollout of work requirements

FEDERAL POLICY OUTLOOK

November 2026
- Final 2027 Medicare physician fee schedule released
- United States elections (Nov. 3)

December 2026
- Government funding expires (Dec. 11)
- APM incentive payment expires
- GPCI floor expires
- PAMA lab cut extension expires

January 2027
- Medicaid work requirements take effect
- Prior authorization API compliance, CMS-0057

2027-2028
- State Medicaid financing changes phase in (provider taxes, SDPs)
- Medicare telehealth flexibilities expire (Dec. 31, 2027)

Also watching: HIPAA privacy & security rules | Fraud & abuse | Drug e-prior auth

STAY INVOLVED

Ways to engage with MGMA advocacy

Join a workgroup

Scan the QR code to sign up for our new ad-hoc workgroups:

- **Billing & Payment**
- **MIPS/MVPs**
- **Value-based Care**
- **Medicare Advantage**
- **Health IT**

Send us your questions

We would like to hear from you! Questions on the Medicare Physician Fee schedule? Stories to share about the impact of telehealth policies or mandatory models?

Please reach out at **202.293.3450** or **govaff@mgma.org**