MASSACHUSETTS MEDICAL SOCIETY
Every physician matters, each patient counts.

September 12, 2025

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code CMS–1832–P. Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz:

On behalf of the nearly 23,000 physician, resident, and medical student members of the Massachusetts Medical Society (MMS), I appreciate this opportunity to submit comments to the Centers for Medicare & Medicaid Services (CMS) on the Calendar Year (CY) 202 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) proposed rule, published in the *Federal Register* on July 16, 2025 (90 Fed. Reg. 32352). The MMS supports the comprehensive and detailed comments submitted by the American Medical Association (AMA). Our comments, which are guided by thoughtfully developed MMS policy priorities and advocacy initiatives, highlight specific areas of support, concern, and recommendation regarding the proposed rule.

MEDICARE PHYSICIAN FEE SCHEDULE PAYMENT

Conversion Factors

The MMS is grateful to Congress for providing a one-year 2.5% increase to 2026 Medicare physician payments and appreciates that CMS proposes positive 2026 conversation factors updates of 3.6% for physicians billing the MPFS and 3.83% for physicians participating in Alternative Payment Models (APMs).

While these adjustments are welcome, we continue to urge the adoption of permanent payment reforms to ensure long-term financial stability. The operational costs of running a medical practice increased 59% from 2001 and 2025 while physician payment remained stagnant, resulting in a 33% decline in physician pay when adjusting for inflation. Adequate physician payment is essential to medical practices to enable hiring sufficient clinical and support staff to be able to offer comprehensive, high-quality care. This is especially true for primary care practices.

Massachusetts is in the midst of a primary care crisis, with low primary care appointment openings, high levels of burnout for physicians, and thus access barriers for patients. In 2023, 41% of Massachusetts residents reported difficulty accessing care, with the most-cited reason being inability to get an appointment at a physician's office or clinic when needed.[1] Declining access is a result of financially unstable and unsustainable primary care practices. Our Health Policy Commission has asserted that one of the root causes

[1] Massachusetts Center for Health Information and Analysis, Primary Care Dashboard (2025), *available here* https://www.chiamass.gov/assets/docs/r/pubs/2025/MA-PC-Dashboard-2025.pdf.

of which is low-reimbursement.[2] Investing in primary care is both necessary and proven to be key to better health outcomes, lower costs, and more equitable access to care. **As such, we welcome increased payment to primary care physicians. However, while we appreciate CMS's efforts to stabilize primary care in the 2026 MPFS, Congress continues to fail to address the decades of underpayment that threaten all physician practices and patient access.** Without permanent, structural reforms, including inflation-adjustments, physicians will continue to face financial instability, which will in turn create access barriers for patients seeking physicians who increasingly cannot remain in the Medicare program. The MMS, the American Medical Association (AMA), and other state and national medical societies and specialty societies have long supported and continue to advocate for permanent updates to the conversation factor to account for inflationary and other growth in physician practice costs. **We urge CMS to call on Congress to enact a permanent, annual inflation-based update to Medicare physician payments tied to the MEI.**

Proposed Efficiency Adjustment

CMS proposes a 2.5 percent "efficiency adjustment" that would increase payments to some primary care physicians, but will otherwise reduce physician work relative value units (RVUs) and physician intra-service time for most services in 2026, with additional cuts every three years. The MMS appreciates CMS' aim to more accurately and appropriately reflect the work value of time-based services in primary care, which has been historically detrimentally undervalued. While we concur with the overarching goal of ensuring that the time data used in work RVUs is accurate, we recommend alternative approaches to achieve this end.

We are concerned about the impact of this invariable adjustment on more than 7,000 physician services. A flat 2.5% reduction is a blunt instrument that is overly broad and overinclusive and may have unintended consequences. An efficiency adjustment assumes gains from advanced technologies, deeper expertise, and improved workflows over time. This proposed adjustment inappropriately applies across the board, including to new and recently revised codes, assuming all services have achieved the same predetermined efficiencies. This is not supported by data, as laid out more comprehensively in the AMA's comments. In fact, some of the new CPT codes will not even be in use until January 1, 2026, meaning no real-world utilization data could possibly exist to justify a claim of increased efficiency. Furthermore, the proposal to re-apply the cut every three years has raised alarms across specialties, creating the prospect of a perpetual, cascading reduction in reimbursement that could incentivize speed over quality and threaten patient safety. Lastly, the RUC has already accounted for efficiencies in some high-volume codes, such as cataract surgery and gastrointestinal procedures and it would be duplicative and unfair to reduce those services again. For example, the 2025 work RVU for cataract surgery is nearly 30% lower than the 1992 work RVU.

Therefore, we urge CMS to not finalize the efficiency adjustment in 2026 and develop a more precise and balanced adjustment over a longer period of time. A one-size fits all approach to a diverse set of services is inapt. Instead, we urge CMS to work with independent physician practices to implement more refined, accurate efficiency adjustments that will achieve the objective of increasing primary care payment, while also ensuring a more frequent review of codes adjusted based on empirical data. Primary care has received important increases in payment since 2021, but more needs to be done to right size investment and thereby increase equitable access to care.

[2] Massachusetts Health Policy Commission, *A Dire Diagnosis: The Declining Health of Primary Care in Massachusetts and the Urgent Need for Action*, January 2025, *available here* https://masshpc.gov/publications/policyresearch-brief/dire-diagnosis-declining-health-primary-care-massachusetts-and.

The MMS strongly concurs with the AMA proposal to make a prospective increase to the 2026 Medicare conversion factor by back-filling CMS' utilization overestimate on the new G2211 add-on code. CMS' inaccurate estimate caused payment reductions for most physicians, including primary care physicians. CMS should adjust the inaccurate utilization estimates to reflect true expenditures and reinvest the savings back into the conversion factor for all physicians, including primary care physicians. According to the AMA, this would provide a higher increase for primary care than the proposed "efficiency adjustment." And we urge CMS to continue to support the use of physician survey data to accurately reflect physician work RVUs.

INDIRECT COST PRACTICE EXPENSE (PE) METHODOLOGY CHANGE – SITE OF SERVICE PAYMENT DIFFERENTIAL

The MMS appreciates CMS' concerns about the impact of Medicare payment policies related to Site of Service. We agree with CMS' assessment that independent physician practices reimbursed at MPFS indirect practice expense rates are at a competitive disadvantage compared to hospital outpatient department facility fees. The viability of independent practices, particularly primary care, is in jeopardy given the increasing costs of running a practice and the associated administrative burdens which add unnecessary waste and cost.

Studies have demonstrated that consolidation and employment have driven up Medicare costs for taxpayers and Medicare beneficiaries. A 2016 Physicians Advocacy Institute (PAI) study reported that Medicare is paying more for services provided in hospital-owned facilities than when patients receive the care in a physician's office.[3] For instance, the study shows payment for E&M services for new patients is 29% higher in HOPDs and payment for cardiac imaging is 3-4 times higher in HOPDS than physician offices.

We are pleased that CMS acknowledges that private physician practices need more financial investment to stay afloat and compete with hospitals and large health systems. One contributing factor is that hospitals receive annual, inflation-based updates while physicians do not. However, we are concerned that CMS' proposal to reduce indirect practice expense when a service is performed in a facility setting could have the unintended consequence of further incentivizing consolidation by hurting private practice physicians who, by clinical necessity, provide services in hospital outpatient departments or ambulatory surgical centers.

CMS' proposal does not reflect the practical reality that there are vast differences in the arrangements physicians have with hospitals and ambulatory surgery centers. For example, for gastroenterologists many of their most critical services, such as complex, sedation-supported endoscopic procedures vital for cancer prevention, must be performed in a facility setting and cannot be safely moved to an office environment. For these practices, the proposed cuts are not an incentive to shift care, but a financial penalty and a direct threat to the financial stability of their practices and independent endoscopy centers, which could in turn limit patient access to essential care.

According to the AMA, physicians who provide care in office-based settings will receive on average 4% payment increases and other specialists who primarily provide services in facility-based settings will receive an average 7% payment reduction. However, cuts to some specialists, such as Ophthalmology average 13% and the cut to OBGYNS is up to 10%. We are particularly concerned about cuts to OBGYNS given persistent inequities in maternal health outcomes in Massachusetts.

[3] https://www.physiciansadvocacyinstitute.org/PAI-Research/Site-of-Service-Payment-Differentials

While we agree that independent physician practices need more resources to remain viable, this is a complex and dramatic change in payment policy that could have significant unintended consequences.

The combined impact of the efficiency adjustment and the site of service payment differential will have a significant negative impact on the following physician specialties and their patients:

- 37% of oncologists face notable cuts of 10-20%.
- More than 56% of internists face cuts of 5%.
- 49% of ophthalmologists face cuts.
- 80% of infectious disease physicians face cuts of 5 percent or more.
- 37% of obstetricians and gynecologists face cuts.

We recommend further study and refinement to develop a more comprehensive solution to this issue that will support independent physician practices without unintended consequences that could harm access to specialty services like OBGYN.

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

MIPS remains a significant and costly administrative burden to physician practices and has yet to demonstrate better health outcomes for Americans or lower avoidable spending. Research shows that the program disproportionately penalizes small, rural and independent practices, and exacerbates health inequities. Nevertheless, the program continues to imposes steep compliance costs on physicians. We urge CMS to fulfill the Trump Administration's goals of reducing government regulatory burdens by focusing on the excessive red tape associated with MIPS and MIPS Value Pathways (MVP). The MMS supports the comprehensive comments submitted by the AMA that detail key recommendations to improve MIPS.

TELEHEALTH SERVICES

Telehealth has become an essential part of the core health care infrastructure in the Commonwealth. The Medical Society supports and continues to advocate for policies that promote the sustainability of access to virtual care for patients. Massachusetts data demonstrates that telehealth is not additive to overall cost in the health care system, but substitutive, and a proven modality that improves equitable access for marginalized patients by helping them overcome the digital divide, and can reduce no-show rates and improve treatment adherence for many of the state's most vulnerable patients.[4] As such, the MMS strongly urges CMS to work with Congress to permanently extend Medicare telehealth policies through passage of legislation.

In March, Congress extended the following flexibilities through September 30, 2025:

- Waiving originating and geographic sites
- Audio-only coverage
- Expansion of Medicare telehealth list to include therapists

[4] Health Policy Commission, *Telehealth Use in the Commonwealth and Policy Recommendations*, January 2023, *available here* https://www.mass.gov/doc/telehealth-use-in-the-commonwealth-and-policy-recommendations/download.

- Allowing Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as distant sites
- Temporary waiver of telemental health in-person requirement

We urge CMS to work alongside Congress to make permanent or extend these flexibilities for as long as possible before the end of September. Following an extension, it is critical that CMS release regulatory guidance as soon as possible to reduce any potential confusion or disruption. Patients have grown accustomed to the telegraph mode of care and the provider community has adopted it, CMS working with Congress needs to stay the course to protect patient access to equitable care.

We support CMS' proposal to permanently adopt a revised definition of "direct supervision" that would allow supervising physicians to be immediately available via real-time audio/video technology. The MMS also agrees with the plan to lift the frequency limits on providing subsequent hospital inpatient and nursing facility visits and critical care consultations via telehealth. However, we urge CMS not to end current pandemic flexibilities that authorize teaching physicians to supervise virtually in Metropolitan Statistical Areas (MSA), despite the important exception for rural areas. We would refer you to the more detailed comments laid out by the AMA to underscore the importance of maintaining these critical flexibilities. Additionally, we ask that CMS add the telemedicine E/M office visit codes to the authorized Medicare Telehealth Services List effective for 2026. Otherwise, audio-only and audio-visual E/M visits will need to continue being reported with the CPT codes for in-person E/M visits and the appropriate modifiers.

Finally, while not explicit in the proposed rule, the MMS remains very concerned about any potential requirement for physicians who provide telehealth services to report their home address. We urge CMS to permanently remove this requirement and allow physicians to render telehealth services from their homes without reporting their home address on their Medicare enrollment form while continuing to bill from their currently enrolled location. Last year's final rule extended the policy that physicians do not have to report their home address only through the end of CY 2025. Reporting the home address does not serve a clear or compelling purpose, especially in consideration of the significant privacy and safety concern previously raised, which would outweigh any potential benefit of having physician addresses made public. Escalating trends in violence towards physicians and other health professionals demonstrate that they have never been at greater risk of injury due to work-related violence. Given privacy and safety concerns, reporting could disincentivize telehealth services at a time when remote care is used as one necessary tool to address the nationwide physician shortage. For these reasons, efforts to protect and preserve the privacy and safety of physicians must be a top priority for CMS. CMS must not allow this flexibility to expire and should take the additional necessary step of removing this requirement permanently.

SOCIAL DETERMINANTS OF HEALTH (SDOH) RISK ASSESSMENT

CMS proposes to stop covering and paying separately for a SDOH risk assessment, to delete HCPCS code G0136, and to remove this code from the Medicare Telehealth Services List based on the rationale that HCPCS code G0136 is already accounted for in existing codes, such as E/M visits. HCPCS code G0136, covers screenings and assessments for social determinants of health; it does not duplicate existing services and should remain available. Social and structural determinants of health play a key role in health outcomes and health disparities, and addressing these factors, including food and housing insecurity, for patients and communities is critical to the health of our patients, our communities, and a sustainable, effective health care system. The associated resource costs are not comprehensively or adequately accounted for in existing E/M codes. Eliminating the G0136 will undermine efforts to help meet critical health-related social needs for patients and will worsen health disparities.

BEHAVIORAL HEALTH ENHANCED CARE MANAGEMENT

The MMS strongly supports the proposal to encourage complementary behavioral health integration and collaborative care model (CoCM) services provided in the same month as advanced primary care management (APCM) services without time requirements. We applaud the new add-on codes and the reduction in burdensome documentation and time-tracking. Collectively these changes eliminate obstacles for payment of these services and represent a meaningful step to improving access to integrated behavioral heath services.

As always, the Massachusetts Medical Society appreciates the opportunity to provide comment and work with CMS on our shared goal of providing the highest quality health care to patients. Should you have any questions, please contact Casey Rojas, Federal Relations & Health Equity Director, at crojas@mms.org or (781) 434-7082.

Sincerely,

Olivia C. Liao, MD, FACS

President, Massachusetts Medical Society