ALLIANCE of SAFETY-NET HOSPITALS

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The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
P.O. Box 8016
Baltimore, MD 21244-8016

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

Dear Administrator Oz:

On behalf of the Alliance of Safety-Net Hospitals, we appreciate the opportunity to provide feedback in response to the Centers for Medicare & Medicaid Services (CMS) CY 2026 Physician Fee Schedule (PFS) proposed rule published in the *Federal Register* on July 16, 2025.

The Alliance of Safety-Net Hospitals (ASH) represents a network of hospitals and health care providers dedicated to helping American families stay healthy, working, and independent. Our members are committed to delivering strong, reliable care that families can count on when it matters most. We play a critical role in the health care system, providing essential services to those who rely on Medicaid and other public programs for access to care.

In this letter, we offer comments on the following areas of the proposed rule:

- Proposed Rate Update
- Other PFS Rate and Coding Adjustments
- Medicare Telehealth Services List
- Mandatory Ambulatory Specialty Model

Proposed Rate Update

ASH appreciates the proposed increase to the PFS conversion rate included in this rule, as mandated by Congress. Previous rules have failed to keep pace with rising practice costs, leaving physicians and other advocates to plead with Congress to intervene with a more sustainable rate update. We thank CMS for working with Congress to develop an initial proposal that creates more financial certainty for providers. Unfortunately, this update is all but negated by other proposals in the rule that if finalized would bring payments down in 2026 despite Congress's intent to make physicians whole this year after continued decreases proposed by the agency.

Other Rate & Coding Adjustments

ASH is concerned about how two other reimbursement policy changes will impact PFS reimbursement rates, particularly safety-net providers and their facility-based physician groups. For many communities striving to get ahead, hospitals and hospital-based physicians are the only sources of primary care and chronic care management. If these hospitals were not present in these hard-working communities, there would be no primary care access. Without preventative care from a physician in the hospital's clinic or a hospital-owned physician practice group, these individuals would simply go without care until their needs are exacerbated beyond control and they are forced to turn to the emergency department for care. ASH does not believe it is appropriate to cut reimbursement rates for these facility-based primary care providers that serve the same role as a small-town physician practicing in an office – they are a lifeline for their neighbors.

Relative Value Unit Changes

For services valued in the facility setting under the PFS, CMS proposed for 2026 to reduce by half the portion of the facility practice expense (PE) relative value units (RVUs) allocated based on work RVUs. The agency also requested comment on the specific types and magnitude of indirect PE costs incurred that are attributable to physicians who practice in part or exclusively in a facility setting and any variables that affect whether and to what extent a practice would incur them. We urge CMS to withdraw this change and instead focus on collecting up-to-date information on the true cost of practicing in a facility vs. non-facility setting before assuming that the differences call for a 50 percent reduction to facility payments.

As CMS stated in the rule, the agency continues its engagement with the RAND Corporation to analyze and develop alternative methods for measuring PE and related inputs and the American Medical Association (AMA) is also engaged in a data collection effort to help inform this process. We appreciate the need to balance payment stability and predictability with incorporating new data in the PFS through more routine updates. Under the current calculation, both the facility and non-facility RVUs are treated independently to help incorporate the differences between practice settings and the facility RVUs are generally lower than non-facility RVUs. Applying an arbitrary 50 percent cut to the facility values has not been substantiated by current data. Until a clear source of valid data is identified, we ask CMS to maintain the current PE RVU methodology.

Efficiency Adjustment

CMS proposed a 2.5 percent downward adjustment to non-time-based codes to account for the idea that the value of these codes is no longer as high as when the codes were added to the fee schedule since practitioners have been able to gain efficiencies over time. While we agree that clinicians have gained efficiencies in providing certain services, the time and costs of providing those services have not necessarily decreased over the years. We understand that the current process to add PFS codes can lead to a lag of two to three years between the time the practice expense data is collected and the time the code is given a relative value. However, during that time – as practitioners are gaining experience with the procedure, technology is improving, and operational workflows are established – there are new time and costs being added that we believe balances the lag in time between data collection and value attribution. That is, new

documentation requirements are added through regulatory changes or revised code descriptions, new patient complications arise that require additional time than was initially contemplated by the code, and the overall practice of medicine is constantly becoming more costly. For safety-net providers, the rate of changes in patients' economic pressures, everyday factors that affect health, and complex chronic needs certainly outpace the lag in PE data. In fact, year-over-year growth in the Medicare Economic Index (MEI) is generally between 3 and 5 percent. That means the MEI change alone would compound the proposed 2.5 percent reduction to a more than 5 percent cut in non-time-based codes each year. This efficiency adjustment is not the appropriate way to bring more timeliness to the RVU process. We instead encourage CMS to work to improve the process of moving codes through Relative Value Scale Update Committee (RUC) review to ensure the underlying data is not stale by the time the code enters the PFS.

Telehealth and Virtual Care

Modern Medicare beneficiaries have come to rely on telehealth services and seek new opportunities to receive care in the setting of their choice. ASH thanks CMS for all the agency has done to continue the pandemic-era telehealth flexibilities, which our members have credited with improving patient access and overall outcomes over the last several years. We encourage CMS to continue working with Congress to find more ways to improve telehealth access into the future, including extending the statutory flexibility to bring telehealth services into the patient's home and the opportunity to participate in the Acute Care Hospital at Home program, which will both expire later this year without congressional action. We offer further comments on the telehealth and virtual care provisions of this proposed rule below.

Telehealth Services List

We applaud CMS's efforts to simplify access to Medicare telehealth services with the proposed changes in the telehealth list review process that will focus on the practitioner's own professional judgement. We agree that clinicians are in the best position to determine whether a service can be safely furnished via telehealth.

Physician Home Addresses

To further promote telehealth options for our seniors and other Medicare beneficiaries, providers need clarification on whether telehealth clinicians that practice exclusively from their own home have any option to shield from the public their home address, especially when offering behavioral health services. CMS has advised providers in sub-regulatory guidance that full-time home practicing physicians must use their home address as the place of service on the claim, but we feel this presents an unnecessary risk to those individuals whose services are so critical to expanding telehealth to underserved and rural areas. If the home address of the practitioner needed to be listed as the place of service, practitioners' personal information would be vulnerable to being accessed by beneficiaries and anyone privy to accessing publicly available claims data. Many providers have determined the risk to clinicians' personal information far outweighs the benefit of continuing to offer this type of telehealth option for Medicare beneficiaries and they would simply need to discontinue some telehealth offerings if this issue is not corrected through further CMS guidance.

Resident Supervision

We disagree with CMS's proposal to return to a pre-pandemic policy that will prohibit teaching physicians in non-rural settings from supervising the services of their residents via audio/video technology after December 31, 2025. While certainly this educational scenario is not occurring with the frequency that it did during the pandemic, teaching hospitals all over the country still have occasional need for virtual supervision of residents to help maintain patient access in areas that are not considered rural. Restricting this virtual option to rural areas misses the mark on advancing the current rural workforce shortage crisis. Large academic health systems provide a workforce pipeline that feeds rural communities even when the teaching location itself is not rural. To meet CMS's goal of "recognizing the unique challenges and importance of expanding medical education opportunities in rural settings," the agency should continue to permit options for non-rural teaching physicians to virtually supervise their students. At the least, CMS should permit teaching physicians an off ramp to lean away from this option over the next fiscal year and delay the outright prohibition in metropolitan areas until 2027.

Ambulatory Specialty Model

In this rule, CMS outlines a new mandatory risk-based payment model called the Ambulatory Specialty Model (ASM) that would require participation from specialists treating heart failure and lower back pain if it is finalized. We support innovative payment and care management programs, but these models tend not to account for the unique challenges of safety-net provider groups. We appreciate that the proposed model would add support for small practice physicians and solo practitioners with add-on points for the physicians' performance scores. We urge CMS to also give scoring consideration to physicians practicing in low-income communities or those that serve a disproportionate number of Medicaid and uninsured patients. These practitioners, even if they are part of a larger clinical group, have compounded costs and pressures from their patients to meet more than just primary care needs. They are helping individuals and families connect to social services, such as nutrition support and counseling, that are necessary scaffolding to control their heart health and lower back pain. We recommend CMS offer 10 or 15 performance add-on points for clinicians practicing in challenged economic areas, such as those with a high score in the area deprivation index.

Even with a performance add-on for safety net providers, ASH believes many clinicians will not be well prepared to begin the ASM program and take on up to 9 percent downside risk by January 2028, after receiving just six months' notice of their mandated participation. We urge CMS to adopt upside risk only for the first performance year in 2027 to allow physicians time to evaluate their own data and make changes to guard against downside risk in the second performance year.

Conclusion

Thank you for the opportunity to provide feedback on the proposed physician fee schedule regulation. We

hope you find our input informative. For more information about the views we have expressed, please contact me at *Ellen@debrunner.us* or 703-444-0989.

Sincerely,

Ellen Kugler, Esq.
Executive Director
Alliance of Safety-Net Hospitals