September 12, 2025 **\*\*\*DRAFT SUBJECT TO CHANGE\*\*\***

The Honorable Mehmet Oz, MD

Administrator

Centers for Medicare & Medicaid Services

Hubert H. Humphrey Building

200 Independence Ave., SW

Washington, D.C. 20201

**SUBJECT: 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, Proposed Rule, Federal Register (Vol. 90, No. 134), July 16, 2025**

Dear Administrator Oz:

Certain aspects of the Centers for Medicare & Medicaid Services’ (CMS’) calendar year (CY) 2026 physician fee schedule (PFS) proposed rule would simplify operations and increase telehealth opportunities. However, the California Hospital Association (CHA), on behalf of nearly 400 hospitals and health systems, has concerns about several provisions that would significantly impact hospitals and the physicians who provide care in them.

**Practice Expense Methodology**
In the CY 2026 PFS proposed rule, CMS proposes to significantly change the calculation of practice expense (PE) relative value units (RVUs). Specifically, CMS proposes to reduce indirect PE allocations by approximately 50% for services provided in a facility setting. CMS cites studies showing the growing number of physicians employed in hospital-owned practices and the shrinking number of private practices as its rationale, reflecting the agency’s belief that physicians who provide services predominately in the hospital-owned facility no longer maintain a separate office and are essentially overpaid for indirect costs under the PFS and hospital outpatient prospective payment system. CMS argues that the adjustment is intended to better align PE inputs with current cost structures and improve relativity across codes.

**CMS should reconsider its PE methodology proposal, as it substantially underestimates administrative costs incurred by physicians providing services in facility settings.** Many hospitalists and other specialists maintain office-based practices and continue to incur the full range of overhead expenses — rent, staffing, equipment, and administrative support — that CMS’ methodology seeks to capture. It is therefore inappropriate to reduce their practice expense inputs by half when those costs remain real and ongoing. Hospitals and physician practices are already operating under severe financial strain, and arbitrary reductions of this magnitude will only compound existing pressures. In fact, the American Medical Association (AMA) estimates that physician payment for services performed in a facility will drop by 7% as a result of this proposal.[[1]](#footnote-1)

In addition, the proposed 50% reduction appears to be arbitrary. CMS has not provided sufficient detail on how this figure was derived, whether it is supported by reliable cost data, or whether it accounts for the variations across physician specialties. Without clear justification, such a sweeping reduction undermines the PFS’ credibility and risks distorting payment accuracy.

Finally, this adjustment’s sharp reimbursement reductions may accelerate consolidation of physician groups, as the increased pressure and burden on independent physicians may prompt them to seek resources and support through acquisition or affiliation with larger organizations — an outcome CMS itself has identified as concerning.

**Accordingly, CMS should withdraw or substantially revise the 50% PE reduction until it can demonstrate with current, robust data that such a reduction accurately reflects physician practice costs.**

**Efficiency Adjustment**

CMS proposes applying a 2.5% downward efficiency adjustment to the work RVUs and intra-service physician time for most PFS services, which the agency justifies by claiming that physicians have gained efficiency over time and their time values may be inflated. The adjustment would apply to nearly 9,000 services, including some that were newly surveyed within the past year. Under the proposal, CMS would exempt certain time-based services (such as evaluation and management, care management, maternity care, and telehealth); in practice, only 393 codes are exempted. This proposal would result in an average 1% reduction across most specialties.

**While hospitals recognize CMS’ goal of improving PFS efficiency, this policy is overly broad, arbitrary, and risks distorting the valuation of physician services**. The adjustment is not targeted to specific codes or services where efficiency gains are demonstrable, but instead applies broadly to thousands of codes — including brand new services for which time and work were recently surveyed. Applying a blanket 2.5% reduction in this way is not evidence-based and risks undermining the physician work RVU system’s integrity.

Moreover, CMS’ methodology is circular and unfounded. The 2.5% figure is based on tallying the “productivity adjustments” from the Medicare Economic Index (MEI) over the past five years. Yet, unlike hospitals and other Medicare providers, physicians do not actually receive MEI-based updates in the PFS. Imposing a retroactive productivity cut on work RVUs without any corresponding MEI-based updates creates an inequitable policy that further erodes physician payment rates.

This proposal also dismisses the importance of physician survey data. CMS criticizes survey-based measures of physician time as “inflated,” but these surveys — conducted under protocols developed by researchers and federal officials — remain the best available source for real-world information. As the AMA notes, excluding or minimizing input from practicing physicians undermines the Medicare payment policy’s credibility and could harm patients by disconnecting valuation from the realities of clinical care.[[2]](#footnote-2)

**CMS should not only narrow the efficiency adjustment’s application to a targeted set of services — ones where efficiency gains are both measurable and material — but also identify other ways to narrow this reduction’s scope and impact.** CMS should also work closely with the AMA Specialty Society Relative Value Scale Update Committee to ensure adjustments are grounded in reliable, specialty-specific data and reviewed regularly. A phased-in approach would help mitigate volatility and avoid sudden, disproportionate cuts.

**Telehealth Services
Medicare Telehealth Services List**

**Hospitals support CMS’ proposals to simplify the process for reviewing appropriate Medicare telehealth services**. Specifically, CMS proposes to revise the current process for reviewing Medicare services for the telehealth list from five steps to three, eliminating the distinction between provisional and permanent services. CMS would also limit its review to whether the service can be delivered using an interactive, two-way audio/video (A/V) telecommunications system rather than considering whether there is a specific clinical benefit to performing the service via telehealth. Hospitals agree that physicians and other practitioners — using their professional judgment and knowledge of their patients’ clinical needs — are best positioned to determine whether a service can be safely furnished via telehealth.

**Telehealth Frequency Limitations on Critical Care Consultations and Inpatient, Nursing Facility Care**
**Hospitals strongly support CMS’ proposal to permanently remove frequency limitations for codes related to subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations**. Existing regulations limit how often practitioners may, for certain services on the Medicare telehealth services list, furnish the service via Medicare telehealth. These limits include:

* One subsequent hospital care service furnished through telehealth every three days
* One subsequent nursing facility visit furnished through telehealth every 14 days
* One critical care consultation service furnished through telehealth per day

Since the COVID-19 public health emergency (PHE), however, CMS has waived these limitations. Permanently removing them would allow physicians and other practitioners to use their clinical judgement to determine the appropriate timing of these telehealth services.

**Expanding Telehealth Services to Medicare Beneficiaries**

While hospitals appreciate CMS’ efforts to expand access to telehealth services, significant statutory and regulatory changes are required to ensure Medicare beneficiaries do not lose access to the telehealth services they have come to rely on over the past five years. Understanding the agency’s statutory limits, **CMS should work with Congress to permanently extend telehealth flexibilities that have been in place since 2020 by:**

* Permanently eliminating originating- and geographic-site restrictions, which would allow telehealth visits to occur wherever the patient is located, including urban areas and the patient’s home
* Permanently eliminating in-person visit requirements for tele-behavioral health, which would ensure that patients do not need an in-person visit before initiating virtual treatment
* Permanently removing distant site restrictions on federally qualified health centers and rural health clinics, which would ensure that they can continue to provide telehealth services
* Permanently allowing payment and coverage for audio-only telehealth services
* Permanently expanding eligible telehealth provider types to include physical therapists, occupational therapists, speech-language pathologists, and audiologists

Waiving these requirements since 2020 has allowed technology to transform care delivery, expanded health care access for Californians, and increased convenience for patients — especially those with transportation or mobility limitations. As CMS works to unlock the power of modern technology to help seniors and their families take control of their health and well-being, manage chronic conditions, and access care more efficiently, it is imperative that these patients maintain their access to telehealth services. Under current law, however, the previously mentioned waivers will expire on Sept. 30 — and the piecemeal approach to extending them over the last several years has created uncertainty for patients, caregivers, and providers. **CMS and Congress should permanently expand access to Medicare telehealth services.**

**Provider Enrollment for Telehealth Services**
In the proposed rule, CMS does not address the looming expiration of the flexibility that allowed practitioners to render telehealth services from their homes without reporting their home address on their Medicare enrollment and continue to bill from their enrolled location. CMS most recently extended this flexibility for 2025 but, absent additional clarification in the final rule, the flexibility will end on Jan. 1, 2026.

**CMS should revise its regulations so providers who perform telehealth services from their home may permanently report practice addresses instead of their home addresses.** If not addressed, physician home addresses may be publicly available on sites like Medicare Care Compare without providers’ knowledge or consent, raising serious concerns about privacy and security for clinicians providing telehealth services. With telehealth’s expansion over the past five years, hospitals, health systems, and providers have increasingly moved to hybrid schedules in which some physicians and staff work remotely. This flexibility fosters improved retention during times of significant staffing shortages nationwide, but requiring clinicians to publicly list their home address could significantly reduce access to telehealth services. **At a minimum, CMS must implement a mechanism to automatically mask the home address from all public sites and directories.**

**Other Services Involving Communications Technology under the PFS**
**Direct Supervision via Use of Two-Way A/V Communications Technology**

During the COVID-19 PHE, CMS allowed providers to satisfy “direct supervision” requirements for diagnostic tests, services incident to physician services, and some hospital outpatient services through virtual presence using real-time A/V technology. Previously, supervision required the supervising practitioner’s immediate in-person availability; since the PHE’s end, CMS has continued to extend these flexibilities temporarily through rulemaking. In response to overwhelming stakeholder requests to permanently expand virtual supervision flexibilities, CMS proposes to modify the regulation at Code of Federal Regulations Title 42, Section 410.26(a)(2) to state that the direct supervision requirement may include the physician’s (or other practitioner’s) virtual presence through A/V real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator. **Hospitals support this proposal.**

**Teaching Physician Billing for Services Involving Residents with Virtual Presence**

In the CY 2021 PFS final rule, CMS established that, after the COVID-19 PHE, teaching physicians could meet requirements for key or critical portions of services through virtual presence (real-time A/V communications technology), but only for services furnished in residency training sites in non-metropolitan service areas (MSAs). During the COVID-19 PHE, CMS extended flexibilities for virtual supervision to include MSAs. CMS subsequently extended this flexibility in rulemaking through 2025.

CMS now proposes to revert to its CY 2021 policy, which maintains this flexibility in rural settings; for services furnished in MSAs, however, supervision of services — even those provided to the patient virtually — will require the teaching physician’s physical presence. **While hospitals appreciate that this flexibility is available in rural settings, CMS should reconsider its proposal to require physical presence for urban settings, particularly for telemedicine services.**

Over the past five years, residents have safely and effectively provided virtual care with the teaching physician present virtually. During the service’s key and critical portions, the appointment becomes a three-way telehealth visit with the patient, resident, and teaching physician in separate locations, and both the teaching physician and resident have access to the patient’s electronic health record. Teaching physicians render personal and identifiable physician services and manage the care for which payment is sought, and the medical record documents how and when the teaching physician was virtually present during the service’s key and critical portions, along with a notation describing these specific portions.

As CMS seeks to unlock technology’s potential to support improved care outcomes and chronic disease prevention, it is essential that the next generation of physicians have experience providing telehealth services. Virtually supervising these services will expand access to care, as the resident and teaching physician can provide telehealth services safely and effectively from different locations, helping to overcome logistical and operational barriers that could reduce access if the resident and physician were required to be in the same physical location. CMS has recognized the benefit of this flexibility in rural settings, where workforce shortages and geographic distance are significant barriers to training physicians. However, workforce shortages and other barriers exist also in MSAs, and CMS’ proposed policy would unnecessarily limit patient access to telehealth services. This would be especially detrimental to CMS’ goals of preventing chronic disease, as research has shown that patients are more likely to keep up with their follow-up appointments when provided virtually. **CMS should revise its regulations to extend virtual supervision flexibilities in MSAs.**

**Remote Patient Monitoring and Remote Therapeutic Monitoring**
**Hospitals strongly support CMS’ proposal to establish billing codes for remote therapeutic monitoring and remote patient monitoring services that include two to 15 days of data transmission.** Previously, CMS only allowed billing for these services when there were at least 16 days of data transmission in 30-day period. CHA has long argued that the 16-day threshold was an arbitrary limit, and fewer days of monitoring are often clinically appropriate depending on the individual’s plan of care. For example, patients with chronic hypertension are often monitored on a weekly basis, with more frequent blood pressure data monitored only when necessary, such as when medication changes. Hospitals appreciate that CMS has responded to stakeholder feedback and urge the agency to explore additional policies that will expand access to these services.

Thank you for your consideration. If you have any questions, please contact me at mhoward@calhospital.org or (202) 488-3742, or Michelle Millerick, vice president, federal policy, at mmillerick@calhospital.org or (771) 224-7224.

Sincerely,

/s/

Megan Howard

Vice President, Federal Policy

1. <https://www.ama-assn.org/practice-management/medicare-medicaid/ama-urges-alternative-approaches-two-flawed-cms-proposals> [↑](#footnote-ref-1)
2. <https://www.ama-assn.org/system/files/2026-mpfs-proposed-rule-summary.pdf> [↑](#footnote-ref-2)