MEDICARE RIGHTS CENTER
Getting Medicare right

266 West 37th Street, 3rd Floor
New York, NY 10018
212.869.3850/Fax: 212.869.3532

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VIA ELECTRONIC SUBMISSION

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

Re: RIN 0938-AV50: CY26 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P)

The Medicare Rights Center (Medicare Rights) appreciates this opportunity to comment on the **CY26 Medicare Physician Fee Schedule (PFS)** proposed rule. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable and equitable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Each year, Medicare Rights provides services and resources to over three million people with Medicare, family caregivers, and professionals.

General Comments

Our comments are informed by our work helping beneficiaries, including callers to our National Helpline, navigate, understand, access, and afford their care. Based on this experience, we know many people with Medicare want and need to maintain deep and trusting relationships with their providers. Finding the right provider fit, spending time with that provider, and staying with that provider over the years is a priority for many people across Original Medicare and Medicare Advantage.

These learnings drive us to support efforts within this rule to rebalance payment and bolster primary care and freestanding physician offices. We urge the Centers for Medicare & Medicaid Services (CMS) to prioritize increased access to and financial support of these providers to avoid having yet more practices swallowed up by large health systems and private equity—a trend that is disruptive and expensive for beneficiaries.

We also support the efforts to use more empirical, repeatable data for payment instead of erratic self-reporting and polls that measure only a fraction of participating providers.

But we strenuously object to any attempt to end or reverse efforts to build up the diversity of the health care workforce, to remove equity components from quality measures, to lessen requirements around language access, or to backslide on the promise of making Medicare coverage and the health system as a whole places where the dignity and worth of individuals, as well as their families and communities, can thrive.

II. Provisions of the Proposed Rule for the PFS
B. Determination of PE RVUs
5. Development of Strategies for Updates to Practice Expense Data Collection and Methodology
c. Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

The current payment system devalues primary care and behavioral health services, fuels provider shortages, and benefits acute facility specialists at the expense of relationship-based, whole-person, and freestanding preventive and primary care.[1] Payment distortions result in Medicare overpaying for services delivered in facility settings, incentivizing consolidation.

CMS proposes to adjust how it allocates indirect practice expense reimbursement by reducing the relative value units (RVUs) for clinicians in facility-based settings to half the RVUs allocated to providers in office-based settings. This is appropriately intended to better reflect the true overhead expenses as typically hospitals cover the indirect expenses for employed clinicians.

We support CMS's goal of rebalancing payments to eliminate such distortions and bolster primary and behavioral health care. But we caution that the existing health care landscape has already shifted in response to the current arrangement. Many primary care providers (PCPs) have already shifted to be under a hospital system to help alleviate rising costs and infrastructure needs. Over the past 15 years, hospital-affiliated PCPs have doubled and now account for almost half of all PCPs.[2] In rebalancing the payment, CMS should strive to protect under-resourced practitioners like PCPs who have transitioned to facility settings.

d. Use of OPPS data for PFS ratesetting

CMS proposes to move away from an overreliance on Relative Value Update Committee (RUC) recommendations and American Medical Association (AMA) surveys in favor of auditable, routinely updated, and reproducible data sources like the Outpatient Prospective Payment System (OPPS). This shift would promote price transparency across settings, offer more predictable ratesetting outcomes, and limit the influence of anecdotal/survey data.

[1] Kiera Peoples, Sarah Coombs & Sinsi Hernández-Cancion, National Partnership for Women and Families, "Ensuring Primary Care for All: The Urgent Case for RUC Reform" (May 2025), https://nationalpartnership.org/wp-content/uploads/urgent-case-for-ruc-reform.pdf.
[2] Yashaswini Singh, *et al.*, "Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications" (January 17, 2025), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2829224.

We support this shift and recommend the use of a blend of robust data sources to minimize distortions and capture fine details that would inform logical payment rates.

D. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act
1. Payment for Medicare Telehealth Services Under Section 1834(m) of the Act
b. Proposal to Modify the Medicare Telehealth Services List and Review Process

CMS proposes to simplify the procedure to add services to the Medicare telehealth services list. We support this proposal. Telehealth services provide essential access to people with Medicare and, where used appropriately, are a means to reduce both costs and barriers. Simple, frequently utilized systems of active review can ensure that all appropriate services can be provided via telehealth while also ensuring that in-person services remain available when needed or preferred. Reducing the procedural burdens in reviewing services for inclusion in the telehealth services list is a step towards its effective management.

b. Proposed Efficiency Adjustment

CMS proposes to apply an efficiency adjustment to correct longstanding distortions in the fee schedule. We support this adjustment but urge CMS to base any further downward adjustments on regularly updated empirical time data and to ensure that any future downward adjustments are tied to quality safeguards, such as patient experience and access measures, to prevent unintended harm to patients and protect quality of care.

G. Enhanced Care Management
2. Behavioral Health Integration Add-On Codes for APCM (HCPCS codes GPCM1, GPCM2, GPCM3)

CMS proposes to add three optional add-on codes for advanced primary care management (APCM) to bill for behavioral health integration (BHI) and psychiatric collaborative care model (CoCM) services delivered in the same month to reduce duplicative time documentation. CMS also proposes that rural health clinics (RHCs) and federally qualified health clinics (FQHCs) be permitted to use these codes to better align Medicare policy across care settings. We support these additions.

4. Request for Information related to APCM and Prevention

CMS requests information about cost sharing for APCM codes because of their inclusion in bundles that may be a mixture of curative and preventive services. We urge CMS to maximize the accessibility and affordability of these services, as well as reduce the documentation burden on providers, by waiving cost sharing on bundled services which include preventative services, even if they also include curative or diagnostic services.

I. Policies to Improve Care for Chronic Illness and Behavioral Health Needs
2. Prevention and Management of Chronic Disease – Request for Information

CMS requests information on how to better support prevention and management, including self-management, of chronic disease.

First, we urge more effort in connecting Medicare enrollees to essential resources. Even when people have the tools and knowledge to manage their own care, systemic factors—like inadequate income, food insecurity, housing instability, and gaps in coverage—create barriers that make effective self-management extraordinarily difficult. Policies must take these economic realities into account. A substantial portion of Medicare enrollees have low incomes; one in four Medicare enrollees have an income of less than $24,600 a year, with one in three reporting delayed care due to costs.[3]

Preventing and managing chronic conditions is an expensive and complex endeavor, which is why access to resources beyond Medicare coverage is often critical. For example, Medicaid plays an essential role in combatting chronic conditions. It makes Medicare more affordable by paying for premiums and out-of-pocket costs for Medicare enrollees with low incomes, allowing them to cover other necessities like rent, groceries, and utilities.

Medicaid also fills in gaps in Medicare coverage, including, notably, home and community-based services (HCBS). People who do not receive adequate HCBS are more likely to have difficulty leaving the house or shopping for groceries, experience more medication errors, and are five times more likely to go into a nursing facility.[4]

Similarly, among dually eligible individuals, enrolling in the Supplemental Nutrition Assistance Program (SNAP) can have dramatic impacts on health—including fewer hospitalizations, reduced emergency department utilization, delayed skilled nursing facility admission, in addition to lowering annual health care costs by over $2,000.[5] Access to this vital food assistance can lead to better health and free up resources that would otherwise be devoted to basic survival.

Thus, CMS can improve both the incidence of healthy behavior, and overall health outcomes, by ensuring that eligible Medicare enrollees are connected to services addressing basic needs—including

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[3] Alex Cottrill, *et al.*, "Income and Assets of Medicare Beneficiaries in 2024" (August 25, 2025), https://www.kff.org/medicare/income-and-assets-of-medicare-beneficiaries/.

[4] Kathryn G. Kietzman & Lei Chen, "Unmet Needs for Help at Home: How Older Adults and Adults with Disabilities are Faring in California" (August 2022), https://healthpolicy.ucla.edu/our-work/publications/unmet-needs-help-home-how-older-adults-and-adults-disabilities-are-faring-california; Jane Tavares & Marc Cohen, "Impact of HCBS on Nursing Home Use and Impact of HCBS Cutback on Beneficiaries Living in the Community at a Nursing Home Level of Care" (April 2025), https://www.ltsscenter.org/wp-content/uploads/2025/04/Impact-of-HCBS-Cutbacks-on-Nursing-Home-Care-Utilization-April-2025.pdf.

[5] Laura J. Samuel, *et al.*, "Does the Supplemental Nutrition Assistance Program Affect Hospital Utilization Among Older Adults? The Case of Maryland," Population Health Management (April 2018), https://hilltopinstitute.org/wp-content/uploads/publications/DoesSNAPAffectHospitalUtilization-PopulationHealthMgmt-2018.pdf (Seniors dually enrolled in both Medicaid and Medicare saw a decrease in hospitalization following receipt of SNAP benefits); Sarah L. Szanton, *et al.*, "Food Assistance is Associated with Decreased Nursing Home Admissions for Maryland's Dually Eligible Older Adults" (2017), https://app.amanote.com/v4.4.1/research/note-taking?resourceId=wq7lAnQBKQvf0BhiPuRA (Seniors dually enrolled in both Medicaid and Medicare are less likely to need nursing facility care when enrolled in SNAP); Seth A. Berkowitz, *et al*., "Supplemental Nutrition Assistance Program Participation and Health Care Use in Older Adults," Annals of Internal Medicine 174:12 (2021), https://pubmed.ncbi.nlm.nih.gov/34662150/ (Higher enrollment by older adults in the Supplemental Nutrition Assistance Program (SNAP) is associated with fewer hospital and long-term care admissions as well as emergency room visits – and an estimated Medicaid cost-savings of $2,360 per person annually).

Medicaid, food, housing, and income supports. Doing so gives Medicare enrollees more financial security and autonomy, which in turn leads to better health outcomes.

In addition, access to dental care is associated with improved chronic disease prevention and management, including lower incidences of hypertension.[6] Recent clinical studies show the bidirectional link between oral health and chronic diseases such as dementia, cardiovascular disease, and diabetes.[7] Moreover, research links oral health access with decreases in overall health care costs.[8] CMS can help beneficiaries prevent and manage chronic disease in a proven, cost-effective way by expanding and implementing Medicare coverage of inextricably linked medically necessary dental services, as discussed in more detail in Section J, below.

The Administration for Community Living (ACL) and the aging and disability network it supports are essential in this space and coordination with ACL's assessment and administration of evidence-based practices is vital. We often hear from community-based organizations about the critical work that ACL has championed and engaged in over the past decade, and the positive impact the agency's services and programs have had in the lives of older adults and people with disabilities, including dually eligible individuals, as well as families and caregivers. We continue to support ACL's mission, existence, and role in helping Medicare enrollees live with health, dignity, and independence, including by preventing and managing chronic conditions. We urge CMS to continue this work and expand coordination with and uptake of ACL programming and practices.

4. Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health
a. Policies to Improve Care for Chronic Illness and Behavioral Health Needs
(1) Social Determinants of Health Risk Assessment (HCPCS code G0136)

CMS proposes to remove the code for HCPCS code G0136: Administration of a standardized, evidence-based social determinants of health risk assessment tool. We do not support this removal. The connection between an individual's health and their social determinants of health is empirically supported. Ceasing to measure these connections and effects will not make them go away; they will continue to drive chronic health issues and health spending.

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[6] Rodrigo Martin-Cabezas, *et al.*, "Association Between Periodontitis and Arterial Hypertension: A Systematic Review and Meta-Analysis" American Heart Journal 180, pp. 98-112 (October 2016).
[7] U.S. Department of Health and Human Services, "Oral Health in America: Advances and Challenges," National Institutes of Health § 3B (2021), https://www.nidcr.nih.gov/sites/default/files/2021-12/Oral-Health-in-America-Advances-and-Challenges.pdf#page=411.
[8] Bijan J Borah, *et al.*, "Association Between Preventive Dental Care and Healthcare Costs for Enrollees with Diabetes or Coronary Artery Disease: 5-Year Experience," Compendium of Continuing Education in Dentistry, 43(3):130-139, (March 2022), https://pubmed.ncbi.nlm.nih.gov/35272460/; *see also* Madhuli Thakkar-Samtani, *et al.*, "Periodontal Treatment Associated with Decreased Diabetes Mellitus-Related Treatment Costs: An Analysis of Dental and Medical Claims Data," Journal of the American Dental Association, 154(4): 283-292, (April, 2023), https://jada.ada.org/article/S0002-8177(23)00022-3/fulltext?dgcid=PromoSpots_ADAorg_ADANews_AprilJADA; Ilya Okunev, *et al.*, "The Impact of Underutilization of Preventive Dental Care by Adult Medicaid Recipients," Journal of Public Health Dentistry, 82(1):88-98, (January 2022), https://pubmed.ncbi.nlm.nih.gov/35014702/.

CMS proposes changing some "social determinant of health" language to "upstream drivers" as a more comprehensive term. We urge CMS to work with stakeholders to make sure that this terminology change is genuinely more comprehensive and expansive.

J. Provisions on Medicare Parts A and B Payment for Dental Services Inextricably Linked to Other Covered Services

We applaud CMS's ongoing work to clarify and implement "inextricably linked" oral health coverage in Medicare, recognizing that oral health is essential to maintaining overall health. As part of this effort, we urge the agency to adopt definitions that best reflect the current consensus that oral health is tied to whole-body health in an interrelated system, and to support payment for dental care that is vital to the effective management and treatment of serious conditions, including diabetes, autoimmune disorders, sickle cell disease, and hemophilia. Failing to address oral health components of these conditions results in higher Medicare spending and beneficiary suffering.[9]

We also commend CMS's implementation efforts to create the user-friendly "Medicare Dental Coverage" webpage, to adopt the 837D dental claim form and enable dental providers to submit the form electronically, and to provide the use of the GY and KX modifiers that simplify the process of seeking reimbursement of inextricably linked dental services.[10] We urge CMS to build on this progress and continue implementation and education strategies. For example, we urge CMS to ensure that Medicare Administrative Contractors (MACs) act promptly to update and correct the information on their websites about Medicare's dental payment policy. We also request that CMS require MACs to assign designated trained staff to answer inquiries from providers about dental coverage, billing, enrollment, and to help troubleshoot problems. MACs should provide dental providers with contact information for these designated trained staff.

With more than half of all Medicare eligible individuals enrolled in Medicare Advantage, we encourage CMS to provide more guidance and oversight on access to inextricably linked medically necessary dental coverage in Medicare Advantage plans.[11] Medicare Advantage plans, including Dual Eligible Special Needs Plans (D-SNPs), must provide access to all Medicare covered benefits including inextricably linked medically necessary dental services.[12] However, we have concerns that Medicare enrollees in plans are not able to access these services. A persistent barrier is that plans are permitted to contract with dental providers who are not enrolled in the Medicare program and who therefore cannot bill for medically necessary dental services that meet the coverage criteria.[13] We respectfully ask the agency to correct

[9] Edward Murphy, *et al.*, "Association Between Preventive Dental Care and Healthcare Cost for Enrollees With Diabetes or Coronary Artery Disease: 5-Year Experience" (March 1, 2022), https://compendiumlive.com/2022/03/association-between-preventive-dental-care-and-healthcare-cost-for-enrollees-with-diabetes-or-coronary-artery-disease-5-year-experience?q=.
[10] Centers for Medicare & Medicaid Services, "Medicare Dental Coverage" (last accessed September 11, 2025), https://www.cms.gov/medicare/coverage/dental.
[11] Nancy Ochieng, *et al.*, "Medicare Advantage in 2025: Enrollment Update and Key Trends" (July 28, 2025) https://www.kff.org/medicare/medicare-advantage-enrollment-update-and-key-trends/
[12] 42 C.F.R. § 411.15(i)(3); 87 FR 69404.
[13] 42 CFR § 422.220; 86 FR 5864.

this and to comprehensively evaluate the extent to which Medicare Advantage plans are carrying out their statutory obligation to provide coverage—by furnishing, arranging, or making payment—for inextricably linked dental services under 42 C.F.R. § 411.15(i). CMS should also update the Medicare Managed Care Manual to reflect coverage rules and ensure plans and frontline staff understand this coverage, including how it should be coordinated with any supplemental dental coverage these plans are offering.[14] The explanation of this coverage should also be integrated into the evidence of coverage and described in plan Member Handbooks; provider directories should be up to date, accurate, and include dental providers who can bill Medicare for inextricably linked medically necessary dental services.

We also strongly urge CMS to issue guidance on how this coverage interacts with Medicaid dental coverage. More often than not, when Medicare and Medicaid coverage intersect, dually eligible individuals face significant barriers in obtaining care. Coordination of dental coverage may be especially complex for some dually eligible individuals enrolled in Medicare Advantage plans because they may need to navigate three types of dental coverage: Medicare coverage of inextricably linked dental care, Medicare Advantage supplemental dental benefits, and Medicaid dental coverage.

Lastly, we strongly urge CMS to track these implementation efforts by analyzing Medicare claims data for covered dental services across fee-for-service and managed care paired with demographic characteristics of those receiving services (e.g., race, ethnicity, age, disability, and dual eligibility status) and publicly report this data in future rule making and on CMS data dashboards.

K. Payment for Skin Substitutes

CMS proposes to pay for certain skin substitute products as "incident-to supplies" and set a single, standardized rate for the use of such products. This change would address a key distortion in skin substitute payment that has led to excessive cost and inconsistent care. We support this proposal.

Conclusion

Thank you again for the opportunity to provide comment. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Counsel for Federal Policy at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

[14] Chapter 4 of the Medicare Managed Care Manual covering benefits and beneficiary protections was last updated in April 2016 and does not include information about Medicare's coverage of dental services inextricably linked to other Medicare medical services.

Lindsey Copeland
Director of Federal Policy
Medicare Rights Center