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Coalition of State Rheumatology Organizations

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September 8, 2025

Mehmet Oz, MD
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

RE: 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,

The Coalition of State Rheumatology Organizations (CSRO) is comprised of over 40 state and regional professional rheumatology societies whose mission is to advocate for excellence in the field of rheumatology, ensuring access to the highest quality of care for the management of rheumatologic and musculoskeletal disease. Our coalition serves the practicing rheumatologist.

Medicare Physician Payment Update

CSRO appreciates that the CY 2026 Medicare Physician Fee Schedule reflects positive updates to physician payment and results in conversion factors that exceed CY 2025 by more than 3%. Private practicing rheumatologists welcome this increase, a change from the usual proposed reduction. However, the bulk of this increase rests on short-term measures: the 2.5% increase provided by Congress through the *One Big Beautiful Bill Act* (H.R. 1) applies only for CY 2026 year, and the positive budget neutrality adjustment – also limited to CY 2026 – is tied to an efficiency adjustment policy that poses numerous challenges, as discussed below. Further, the modest statutory updates provided under the Medicare Access and CHIP Reauthorization Act (MACRA), while positive, creates a disparity between practices that are able to join and participate in an Advanced Alternative Payment Model (APM) (qualifying participants, or QPs) and those who cannot (non-QPs), which is not always within their control.

At the same time, overall Medicare physician payments have declined by 33% since 2001, while practice costs continue to rise. The Medicare sequester (2%) and the impending Pay-As-You-Go (PAYGO) sequester (4%) add further pressure. The looming threat of cuts each year are steadily eroding the viability

of independent practices and driving physicians toward consolidation, which increases costs for the Medicare program, its beneficiaries, and taxpayers.

CSRO urges CMS to work with Congress on a long-term fix that links annual updates to the Medicare Economic Index (MEI). We also recommend a more comprehensive evaluation of how coding and payment changes influence budget neutrality and the conversion factor. To help offset the cost of a permanent physician payment solution, we also urge CMS to impose a higher coding intensity adjustment for Medicare Advantage plans beyond the current 5.9% minimum.

Efficiency Adjustment

CSRO recognizes CMS' goal of improving the accuracy of work RVUs and time inputs to better reflect the resources required to furnish services. We also appreciate the agency's intent to rebalance the fee schedule in support of cognitive specialties, recognizing that evaluation and management (E/M) visits and care management services do not lend themselves to efficiency gains. However, we share broader concerns about the premise of a blanket efficiency adjustment, which is inconsistent with the principles of the Resource-Based Relative Value Scale (RBRVS), designed to reflect the actual resources required to furnish a service. A uniform 2.5% reduction assumes efficiencies that may not exist across specialties and risks distorting relative values.

These concerns are especially acute for rheumatologists with respect to drug administration services. **These services are time-bound and dictated by FDA label instructions** that specify infusion rates and monitoring requirements. No amount of physician experience or efficiency can shorten the intraservice time or reduce the work intensity without compromising patient safety. The rationale CMS applies to procedural codes, that familiarity leads to efficiency, simply does not apply to drug administration. For rheumatologists, infusions and injections are not only core to our service mix but are also among the most resource-intensive and risk-laden services we provide. Applying the efficiency adjustment to these codes will undercut practices already struggling with costs and will directly threaten beneficiary access to biologics and other infused therapies.

If CMS moves forward with this policy, it must exclude all time-based services — including hydration, therapeutic, and chemotherapy administration (CPT 96360–96381, 96365–96377, 96401–96450, 96521–96542). This approach would preserve CMS' goal of rebalancing toward cognitive care, while ensuring that patient safety and access to treatment are not compromised.

Practice Expense (PE)

CSRO appreciates CMS' proposal to adjust the allocation of indirect practice expense values, which appropriately directs resources to help sustain office-based care. For rheumatologists, who deliver the vast majority of care in the office setting, this policy is especially important to maintaining access to infused and injected biologics – the most cost-effective and clinically appropriate site of care for drug administration services central to rheumatology practice.

For our rheumatology colleagues who provide care in hospitals or academic centers but maintain an independent practice, we are concerned that patient access could be undermined under the proposal. We urge CMS to consider ways to ensure that the indirect expenses borne by these independent physicians are still captured, while also addressing potential duplicate payments for those who are hospital- or health system–employed and do not face the same overhead costs.

Beyond this year's proposal, CSRO remains concerned about the broader structural issues within the practice expense methodology. The transition to updated clinical labor pricing reduced the value of drug administration services at a time when practice costs were rising, leaving some services undervalued. ***We appreciate CMS' recognition that long delays in updating direct practice expense inputs are problematic and recommend establishing a regular four-year review cycle for clinical labor, supplies, and equipment.***

ASP and Part B Drugs

CMS is proposing clarifications and guidance that would impact the Average Sales Price (ASP); specifically, CMS clarifies that the Maximum Fair Price (MFP) for negotiated drugs will be included in ASP, and provides guidance regarding price concessions and bona fide service fees (BFSFs). CMS admits these clarifications and guidance may lower Medicare reimbursement for physician-administered drugs.

CSRO is deeply concerned that these policies risk further misaligning Medicare reimbursement with the real-world acquisition costs faced by rheumatology practices. As we have shared previously, many of the infused and injected therapies we provide, such as biosimilars, are already reimbursed below cost, leaving practices financially "underwater." For small and community practices, this creates added strain and threatens patient access to life-saving therapies. Any policy that disconnects reimbursement from acquisition cost must be approached with extreme caution.

As we have noted in prior comments, the root of this problem lies in rebate-driven formulary design. Manufacturer rebates paid to insurers and their pharmacy benefit managers (PBMs) to secure "fail-first" or preferred formulary placement do not lower the acquisition costs that physicians face. Instead, they artificially depress ASP and thereby reduce Medicare reimbursement. The result is a perverse incentive structure in which the drug most favored on a formulary may also be the least financially accessible for physicians to administer. This dynamic undermines patient care and threatens the integrity of the Medicare program.

Because CMS lacks the statutory authority to reform ASP methodology or address PBM rebate practices, Congress must intervene. We strongly support legislative efforts to modernize the ASP payment system, address PBM-driven distortions, and protect patient access to biologics and biosimilars. In the meantime***, we urge CMS to exercise caution in finalizing ASP-related policies that could exacerbate existing access barriers.***

Last, ***we urge CMS to continue publishing ASP data. Private payers may continue to reimburse based on ASP, and our practices use these data for other purposes.***

Request for Information: Prevention and Chronic Disease Management

CSRO appreciates the opportunity to provide feedback on ways CMS can bolster prevention and chronic disease management in line with this Administration's "Make America Healthy Again" efforts. Rheumatologists care for patients with complex, chronic autoimmune and musculoskeletal conditions, where timely access to specialty care and evidence-based therapies is essential to maintaining health, preventing disease escalation, and enabling patients to engage in lifestyle changes that improve outcomes.

We caution, however, that prevention efforts cannot succeed if patients are unable to access the specialty medical care and treatment central to managing their illnesses. Increasingly, Medicare beneficiaries face barriers such as prior authorization, step therapy, and non-coverage of clinically appropriate care. These utilization management practices delay or deny medically necessary services, undermine disease prevention efforts, and increase the risk of avoidable complications, including

hospitalizations. Voluntary commitments by payers are insufficient; regulatory action is needed to meaningfully address overly restrictive utilization management requirements.

In addition, certain CMS policies themselves impede access to therapies. The Self-Administered Drug (SAD) Exclusion List is one such example. Under CMS' current interpretation, drugs may be excluded from coverage even for beneficiaries who cannot physically or cognitively self-administer them, forcing patients to either pay out of pocket or forego treatment. This issue is not hypothetical. In *Beitzel v. Becerra*, Medicare patients were harmed when Stelara (ustekinumab) was added to the SAD List without notice, leaving beneficiaries with unexpected bills exceeding $40,000 per infusion. While CMS acknowledged concerns with the SAD List in its CY 2024 Medicare PFS RFI, revisiting this policy is critical to ensuring patients can access the full range of appropriate treatments needed to prevent disease progression, reduce complications, and maintain quality of life. ***CSRO strongly urges CMS consider the recommendations we have put forward, as supported by a broad coalition of patient and provider organizations.***

Quality Payment Program

CSRO remains opposed to the inclusion of the Rheumatoid Arthritis (RA) Cost Measure in the Advancing Rheumatology Patient Care MVP, which began with the 2025 performance period. This measure received a "do not recommend" vote from CMS' consensus-based entity, reflecting widespread concern about its validity. CMS' decision to proceed despite this feedback is deeply troubling.

Rheumatologists are not opposed to cost measurement. We have long championed efforts to develop targeted, specialty-specific measures that evaluate costs within the physician's control. However, the RA Cost Measure penalizes physicians for drug costs beyond their control and fails to generate meaningful insights for improving care. Fair cost measurement and attribution would require CMS to remove a number of barriers that limit the therapies rheumatologists can select for Medicare beneficiaries — including rescinding the 2018 Step Therapy Memorandum, establishing a bypass mechanism for medications on the Self-Administered Drug (SAD) Exclusion List, eliminating restrictive Part D formulary practices and prohibiting non-medical switching, and ensuring reasonable payment for biosimilars that remain "underwater." ***Until these actions are taken or accounted for, CSRO must oppose the inclusion of the RA Cost Measure.***

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Thank you for considering our feedback on these important issues to practicing rheumatologists who care for Medicare beneficiaries. Please do not hesitate to contact us at info@csro.info should you require additional information.

Sincerely,

Alabama Society For the Rheumatic Diseases
Alaska Rheumatology Alliance
Arizona United Rheumatology Alliance
California Rheumatology Alliance
Florida Society of Rheumatology
Georgia Society of Rheumatology
Kentuckiana Rheumatology Alliance
Maryland Society for the Rheumatic Diseases
Massachusetts, Maine & New Hampshire Rheumatology Association
Michigan Rheumatism Society

Mississippi Arthritis and Rheumatism Society
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State of Oklahoma Association of Rheumatology
State of Texas Association of Rheumatologists
Tennessee Rheumatology Society
Virginia Society of Rheumatology
Washington Rheumatology Alliance
Wisconsin Rheumatology Association