MSMS
MICHIGAN STATE MEDICAL SOCIETY

PO Box 950 | East Lansing, Michigan 48826
517-337-1351 | msms@msms.org | www.msms.org

September 14, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244-8016.

Re: File Code CMS-1848-P; Medicare and Medicaid Programs; CY 2027 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 Michigan State Medical Society (MSMS) appreciates the opportunity to comment on the calendar year 2027 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP)proposed rule. MSMS is a professional association representing Michigan physicians, residents, and medical school students from all specialties and practice settings.

MSMS and other state and national physician organizations have consistently shared concerns about practice sustainability under a payment system that has prevented Medicare physician pay from keeping up with inflation and the cost of operating a medical practice for more than two decades. In fact, from 2001 to 2025, Medicare physician pay has declined 33 percent when adjusted for inflation in practice costs. It is also important to note that reduction has a broader impact as many states like Michigan use Medicare as the benchmark for reimbursement in other areas such as worker's compensation, motor vehicle injuries, surprise billing, etc. Therefore, when Medicare payments continue to decline, so do payments in other areas of practice.

While we recognize that a legislative solution is necessary to permanently address this funding inequity between physician reimbursement and other Medicare payment systems receiving annual, inflation-based updates, MSMS is concerned that several proposals in the MPFS will further exacerbate the financial feasibility of operating independent physician practices, as well as providing timely and convenient access to care to Medicare beneficiaries.

On behalf of our members, MSMS offers the following positions regarding various proposals within the proposed 2027 Medicare PFS and QPP updates:

Global Procedure and Same-Day E/M Visit
The provisions proposed would reduce payment when a separately identifiable E/M visit is furnished by the same physician (or a physician in the same practice) on the same day as a 0-, 10-, or 90-day global procedure and pay the most expensive service, whether surgical or E/M visit, at 100 percent and the other surgical procedure or E/M visit furnished on the same day at 50 percent. We respectfully request the Centers for Medicare & Medicaid (CMS) not finalize either of these policy proposals in the CY 2027 Medicare Physician Fee Schedule.

Changing policies based on a perceived overlap in economic components represents a misunderstanding of the code valuation process. Existing Medicare valuation rules already adjust for shared overhead during same-day visits. Together, CMS and the Relative Value Scale Update Committee (RUC) adjust reimbursement for procedure codes typically reported with E/M codes to account for any overlapping costs. Because the RUC has already adjusted code valuations to account for overlap, the proposal to reduce reimbursements by 50 percent for the least expensive surgical procedure or E/M visit furnished on the same day constitutes a duplicative and unjustified further reduction in physician payment for legitimate, necessary services.

Our members are not asking for more reimbursement, just to be paid appropriately for services that are actually provided, documented, and medically necessary. Additionally, we are advocating for the retention of Medicare's current policy, which supports efficient, single-visit care; thereby reducing unnecessary return visits, related costs, and inconveniences to patients while helping to keep total healthcare costs under control.

When a similar policy was proposed and paused in Michigan earlier this year, many of our members shared examples that underscored the financial risks to physicians and independent practices. For example, diagnostic laryngoscopy (CPT 31575), reported with an E/M service approximately 94 percent of the time, is already valued to reflect overlap; however, its direct practice expense (approximately $74) could exceed reimbursement under the proposed policy, leaving no payment for physician work or indirect costs. Similarly, reimbursement for impacted cerumen removal (CPT 69210) could fall below the cost of care. It is important to recognize that each separately billable service requires physicians to perform extra work and utilize additional resources which may include distinct staff and supplies. These are essential components of patient care and not duplicative.

If CMS is concerned about potential inappropriate uses of modifier 25, there are more equitable ways to address the correct usage of modifier 25 than an unwarranted across the board reduction. For example, a coordinated education awareness campaign or the identification and re-evaluation of specific codes thought to contain residual overlaps.

Practice Expense Methodology

CMS is proposing major reforms to the methodology for determining practice expense (PE) RVUs including eliminating the Indirect Practice Cost Index (IPCI) from its PE calculations. This would negate steps 12 through 17 of its 18-step process. The transition would occur over a two-year period. If adopted as proposed, there would be a new indirect PE allocator formula to align with work and clinical labor RVUs, as well as a new PE stabilization adjustment to limit annual increases or decreases in PE RVUs to +/- five percent for most services.

MSMS recommends CMS consider the comments submitted by the Medical Group Management Association (MGMA) to delay implementation of Practice Expense (PE) RVU methodological changes due to the lack of clarity into the effect of these policies. As noted by the MGMA, the complexity of PE RVU calculations and its multi-step process makes it difficult to discern the ultimate impact on medical groups due to these proposed changes. Additionally, they state the following:

"These proposals will have a disproportionate impact on certain specialties, but again CMS' discussion of their impact overlaps with other proposed changes in the PFS, making it difficult to understand each change and their lasting impact. We urge CMS not to move forward with these PE changes and to provide the appropriate analyses needed for medical

groups and the public to understand each proposed change and have an opportunity to comment. Making sweeping, highly technical changes that have a lasting impact with little discussion of their effects does not foster confidence in their long-term viability and could lead to numerous unintended consequences to medical group operations."

HCPS Code G2211 Redesign
Under the proposed Rule, HCPS Code G2211 would transition to a modifier (MOD1 or MOD2) that would be appended to an evaluation and management (E/M) base code. MOD1 would increase payment of the associated E/M code by 16 percent and MOD2 by 32 percent. However, only practitioners in the Medicare Shared Savings Program (MSSP) or in the ACO LEAD model would be eligible to use MOD2.

While MSMS appreciates CMS's efforts to recognize the resource costs of longitudinal care, we are concerned that the current proposal needs more time for vetting to ensure the avoidance of unintentional consequences such as the impact on the current 0.33 wRVU productivity credit if G2211 is no longer reported as a separate code. Additionally, it is not clear if and how this change would impact cost-sharing for Medicare beneficiaries. Should CMS decide to move forward with this proposal, we would urge CMS to consider a mechanism to ensure physicians continue to receive RVU credit for this work, as well as a timely and transparent public reporting of MOD1 and MOD2 utilization disaggregated by specialty, care setting, and E/M visit level to determine whether the modifiers are functioning as intended or whether future adjustments are warranted.

Maternity Care Services
MSMS supports CMS's proposal to adopt the American Medical Association's revised maternity care services coding structure beginning January 1, 2027. These changes reflect modern obstetric practice by providing greater specificity and clarity across antepartum, labor and delivery, and postpartum care. We agree that this approach can improve transparency, increase our knowledge of the complexity of maternity care, and generate meaningful data to support efforts to understand and address maternal health conditions, pregnancy-related complications, morbidity, and mortality.

However, MSMS does not agree with CMS's proposal to establish 15 HCPCS G-codes that would preserve a structure comparable to the existing global maternity billing model. We share the American College of Obstetricians and Gynecologists' (ACOG) concerns that maintaining parallel coding systems could create confusion and increase the burden on clinicians, administrators, and healthcare organizations. Continuing both bundled and unbundled approaches could create differences in reimbursement and administrative processes based on a patient's insurance coverage, possibly contributing to inequities in access to and delivery of maternal healthcare. Therefore, MSMS encourages CMS to transition clearly to the updated maternity coding structure rather than maintain competing global and non-global approaches through the proposed HCPCS G-codes.

We also support ACOG's recommendation that payers implementing the revised maternity care coding framework, including the use of Evaluation and Management codes for antepartum and postpartum care, do so without limiting the number of antepartum visits or requiring prior authorization. Care should remain flexible and tailored to individual clinical needs, particularly for patients with high-risk pregnancies or pregnancy-related complications that require more frequent monitoring and follow-up.

Telehealth
MSMS supports appropriate data collection to better understand utilization of telehealth services in the Medicare program. However, as CMS implements the statutorily required telehealth payment modifiers, we urge the agency to ensure that these requirements are narrowly tailored to their intended purpose and do not impose unnecessary administrative burdens on physician practices that use telehealth as an integrated component of patient care.

Specifically, MSMS urges CMS to:

- Clearly and narrowly define "virtual platform" to distinguish standalone or direct-to-consumer virtual care arrangements from physician practices and health care organizations that use telehealth as one modality within an established care delivery model.
- Exclude, to the fullest extent permitted by statute, telehealth services furnished as part of an established or hybrid care relationship, including follow-up services for existing patients and services furnished by physicians or organizations that also provide in-person care.
- Exclude or otherwise appropriately distinguish telehealth services furnished as part of coordinated care, including services resulting from a referral, services coordinated with an in-person or facility-based provider, and second-opinion consultations associated with an existing course of treatment.
- Avoid interpreting the modifier requirements in a manner that captures routine technology used by physician practices to furnish telehealth services. An overly broad definition of "virtual platform" could cause the modifier to apply to a substantial portion of Medicare telehealth services without providing CMS with meaningful information about the utilization Congress intended to evaluate.
- Minimize additional documentation, billing, and compliance requirements associated with the modifiers and provide clear guidance sufficiently in advance of implementation to allow physician practices, billing vendors, and other affected entities adequate time to make necessary operational and system changes.

MSMS also urges CMS to exercise caution in implementing the statutorily required modifier for incident-to services furnished through telehealth. Collecting telehealth-specific incident-to data without comparable information regarding services furnished in person could provide an incomplete picture of utilization and lead to unintended policy conclusions. CMS should evaluate telehealth incident-to utilization alongside comparable in-person services and should not use modifier data in isolation to inform future payment, coverage, or program-integrity policies. More broadly, MSMS encourages CMS to continue recognizing telehealth as a modality for delivering medically necessary care rather than as a separate category of clinical service.

Telehealth Critical Care Consultations
MSMS also encourages CMS to reduce unnecessary complexity in the coding of telehealth critical care consultations. Where an existing CPT code adequately describes the same clinical service, maintaining a separate telehealth-specific coding pathway can create unnecessary billing and compliance burdens without providing additional clinical value. MSMS urges CMS to eliminate duplicative telehealth-specific coding where existing CPT codes adequately describe the service and to align telehealth and in-person critical care coding wherever clinically appropriate.

Remote Monitoring
MSMS supports continued Medicare coverage and appropriate payment for remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM), which can help physicians manage patients with chronic and acute conditions between in-person visits and support timely interventions when a patient's condition changes. We are concerned, however, that several of

CMS's proposed changes for CY 2027 could unnecessarily restrict physician practices' ability to provide these services and undermine patient access to effective remote monitoring.

MSMS urges CMS not to finalize its proposal to limit payment for RPM and RTM services to clinical staff employed directly by the billing physician or practice. Physician practices increasingly rely on a range of staffing arrangements to deliver coordinated care, including appropriately supervised contracted clinical staff. Requiring direct employment could disproportionately affect small, independent, rural, and other practices that may lack the resources or patient volume necessary to employ dedicated remote monitoring staff. CMS should instead maintain appropriate physician supervision and accountability requirements while allowing practices flexibility in determining how qualified clinical staff are employed or contracted to furnish these services.

MSMS also urges CMS to reconsider requiring a separately reportable initiating visit each time RPM or RTM services are initiated. Where a physician already has an established relationship with the patient and sufficient clinical information to determine that remote monitoring is medically necessary and appropriate, requiring an additional initiating visit may add cost and administrative burden without improving the quality of care. CMS should provide physicians with the flexibility to initiate remote monitoring within an established care relationship when clinically appropriate.

MSMS is also concerned about CMS's proposed reductions in practice expense valuation for RPM and RTM services. Remote monitoring requires more than the underlying device, including technology infrastructure, clinical workflows, patient education and support, data review, and ongoing practice resources necessary to incorporate remotely collected information into patient care. CMS should not finalize significant reductions in RPM and RTM payment without sufficient data demonstrating that the proposed valuations accurately reflect the resources required to furnish these services. We encourage CMS to work with the physician community and the AMA/Specialty Society RVS Update Committee (RUC) to develop appropriate valuations based on current, reliable cost and utilization data.

Finally, MSMS does not support replacing the existing RPM and RTM CPT code families with four broadly defined HCPCS G-codes at this time. Consolidating these services may reduce coding specificity, obscure meaningful differences among remote monitoring services, and create additional disruption for physician practices while the underlying CPT code set continues to evolve. MSMS urges CMS to maintain the existing CPT coding structure and allow the RUC's forthcoming review of remote monitoring services to inform future valuation and coding decisions before considering substantial restructuring of these services.

MSSP/ACO Enhancements

CMS proposes numerous changes to the Medicare Shared Savings Program (MSSP), such as modifying the financial methodology, updating beneficiary assignment methodology, allowing all MSSP accountable care organizations (ACOs) to reduce or eliminate Part B cost sharing, and adding a new modifier for providing longitudinal care. MSMS supports efforts to ease the burden of moving to higher-risk arrangements especially for physicians who are newer to value-based care models. MSMS encourages CMS to finalize its proposal to increase the shared savings rate for BASIC Track Level E participants from 50 percent to 60 percent. We also strongly support the ability of eligible participants to reduce or eliminate beneficiary Part B cost-sharing. Finally, we are hopeful the proposal to increase the prior savings adjustment scaling factor to 75 percent will be included in the final rule.

Transitioning of MIPS to MVP

The proposed rule proposes to sunset traditional MIPS beginning with the CY 2029 program year (CY 2031 payment year). As a result physicians will eventually need to transition to a MIPS Value Pathways (MVPs) or APM pathway. Due to ongoing concerns that MIPS is unduly burdensome and disproportionately harmful to small, rural, and independent practices, MSMS opposes mandating MVPs starting in 2029 until there is evidence of a more clinically relevant, patient-centered reporting framework. We agree with other physician organizations that CMS should work to reform MVPs while keeping them voluntary to ensure physician practices can succeed in the program.

Additionally, MSMS supports recommendations from the American Academy of Family Physicians that CMS:

- Delay mandatory MVP participation until sufficient data demonstrates that MVP reporting is less burdensome and more meaningful than traditional MIPS.
- Continue offering traditional MIPS as an alternative reporting pathway during a longer transition period.
- Establish clear benchmarks for determining MVP readiness before eliminating traditional MIPS.

Primary Care Service Valuation

MSMS supports state and national initiatives to strengthen preventive, relationship-oriented primary care. Since primary care physicians account for more than half of all office visits, it is surprising that primary care is responsible for only about five percent of total healthcare spending. Michigan has considerable geographic disparities in access to primary care, and the state is expected to need 862 more primary care physicians by 2030. To address this ongoing lack of investment, MSMS is advocating for a primary care spending target of 12 percent of total medical expenditures so primary care physicians can employ care teams comprised of RN Care Managers, advanced practice practitioners, community health workers, and other health care team members as appropriate for the practice panel and encourages CMS to commit to the same.

Second, CMS should support technologies that enhance population health management, care coordination, remote monitoring, and documentation. Small, independent, and rural practices should have access to specific financial and technical assistance. The technologies in question should integrate with existing electronic health records, reduce the need for repetitive data entry, and be subject to continuous review for safety, effectiveness, bias, and interoperability.

MSMS also supports a hybrid primary care payment system that includes risk-adjusted prospective payments, fee-for-service payments for suitable services, and incentives linked to key outcomes. In order to support care provided outside of traditional office visits, the CMS could make use of its Advanced Primary Care Management codes (G0056–G0058). Moreover, CMS should carry out measures to make sure that funding reaches the individual practices, as was the case in Michigan's Primary Care Transformation demonstration, where at least 80 percent of the payments had to go directly to the participating practices.

Current Procedural Terminology (CPT)

Regarding CMS's request for information in response to its concerns with the current CPT coding system and AMA/Specialty Society Relative Value Scale (RVS) Update Committee (RUC), MSMS joins with other national physician associations in urging caution on any major reforms that would result in widespread disruption, significant new costs, additional administrative burdens, and impediments to patients' access to care.

The MGMA states, “Replacing the current system would require extensive and far-reaching changes to almost every facet of healthcare operations. Simply focusing on medical groups, any proposed changes to coding and valuation (beyond impacting payment rates) would likely require medical groups to expend significant funds to update billing systems, coding workflows, staff training, and related administrative processes. This transition would likely increase claims delays, coding errors, and compliance risks, among many other consequences. EHRs, practice management systems, health IT products, and more would have to be updated.”

While MSMS agrees that all systems can benefit from process improvement, at this time MSMS supports the use of CPT as the standard medical code set for physician services. We encourage CMS to carefully consider the supporting documentation presented by the American Medical Association and MGMA in their respective comments on the CY 2027 Medicare Physician Fee Schedule proposed rule.

Thank you for your consideration of our comments.

Sincerely,

Tom M. George, M.D.

Tom M. George, MD
Chief Executive Officer
Michigan State Medical Society