September 12, 2025

ELECTRONIC SUBMISSION VIA www.regulations.gov

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: CPR Comments in Response to the Contract Year 2026 Medicare Physician Fee Schedule Proposed Rule (CMS-1832-P)

Dear Administrator Oz:

The undersigned members of the Coalition to Preserve Rehabilitation ("CPR") appreciate the opportunity to submit comments to the Centers for Medicare and Medicaid Services ("CMS") in response to the Calendar Year ("CY") 2026 Medicare Physician Fee Schedule ("PFS") Proposed Rule ("Proposed Rule"). We offer our recommendations and comments below regarding various provisions in the proposed rule impacting beneficiaries in need of medical rehabilitation care.

CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients – as well as the providers who serve them – who are frequently inappropriately denied access to rehabilitative care in a variety of settings.

Overview

In the Proposed Rule, CMS offers numerous proposals impacting provider payment under Medicare. CPR focuses its comments on three specific provisions in the rule. First, we offer comments on the proposed CY 2026 Physician Fee Schedule payment update and conversion factor. The second area we focus on in our comments relates to preserving access to rehabilitation through accurate service valuation. Lastly, we focus on the treatment of telehealth and telerehabilitation going forward as the federal government continues to consider how to maintain access to these services on a permanent basis.

Proposed CY 2026 Conversion Factor

For the first time in six years, CMS is proposing an increase to the Medicare PFS conversion factor. This translates into a payment increase for physicians and certain other providers who serve Medicare beneficiaries, encouraging them to continue serving this patient population. Under the Proposed Rule, the CY 2026 conversion factor would be $33.59 for clinicians who meet certain thresholds in advanced Alternative Payment Models ("APMs") and $33.42 for all other clinicians—representing increases of 3.8% and 3.3%, respectively, over the final CY 2025 conversion factor of $32.35. These increases are driven by three key factors:

(1) a statutory update under the Medicare Access and CHIP Reauthorization Act ("MACRA"), providing a 0.75% increase for qualifying APM participants and a 0.25% increase for all other clinicians;

(2) a positive 0.55% budget neutrality adjustment; and,

(3) a one-time 2.5% payment increase authorized by the One Big Beautiful Bill Act ("OBBBA").

CPR supports this proposal and commends CMS for proposing these changes, which mark a notable shift after years of declining or flat payment updates under the PFS.

While CPR is supportive of this proposed update for CY 2026, we note that other aspects of the payment formula temper the impact of this overall increase, depending on the different specialties that provide services under the fee schedule, especially rehabilitation therapists. We also note that providers of rehabilitation care continue to face serious financial strain. Of course, the long-term and residual impact from the COVID-19 pandemic has significantly impacted the financial health of many providers. Further, the Medicare program continues to face a 2% cut in payments due to the impact of sequestration, which came back into full effect beginning July 1, 2022, and will continue until further legislation from Congress. Without additional Congressional action, there will also be a further 4% cut beginning January 1, 2026, relating to the statutory spending rule, Pay-As-You-Go Act ("PAYGO"). Congress must act before the end of the year to address this additional significant cut for 2026.

Additionally, as we have stated in previous regulatory comments, changes in the payment models for many areas of post-acute care, including the Patient-Driven Groupings Model ("PDGM") and the Patient-Driven Payment Model ("PDPM") in the Medicare home health agency ("HHA") and skilled nursing facility ("SNF") prospective payment systems, respectively, continue to result in decreased access to rehabilitation therapies for patients.

CPR continues to encourage CMS to work with stakeholders and policymakers to identify and implement longer-term reform to the Physician Fee Schedule to address this now-annual problem, rather than relying on temporary solutions each year to avoid drastic payment reductions.

Preserving Access to Rehabilitation Through Accurate Service Valuation

CPR appreciates CMS's recognition that Medicare's current code valuation process often fails to account for efficiency gains in procedural services while undervaluing time-intensive, cognitive, and care coordination services. Historically, the Physician Fee Schedule has relied on survey-based estimates of the time required to perform services, many of which are rarely updated—if at all—despite advances in technology and clinical techniques. In contrast, the work of diagnosing conditions, managing multiple chronic illnesses, supporting behavioral change, and coordinating care for medically complex patients does not become more efficient over time. As a result, Medicare has long undervalued the time-intensive services that complex patients with multiple chronic illnesses need, relative to other services. Given the current Administration's emphasis on reducing chronic illness, the proposal appears to undervalue the agency's broad agenda.

The proposed triennial "efficiency adjustment" to the time-related components of payment—Work Relative Value Units ("RVUs") and intraservice time—represents an important first step in addressing this inequity. **CPR strongly supports CMS's proposal to exempt time-based services that are foundational to primary care—including therapy services, care management, and most evaluation and management services—thereby allowing the relative value of these services to grow appropriately over time.**

CPR also commends CMS for proposing to prioritize real-world, empirical data—such as electronic health records, operating room logs, and time-motion studies—when identifying and re-valuing potentially misvalued codes. Incorporating such data can complement existing survey methods and improve the accuracy of estimating the value of physician work and practice expense inputs, which leads to more accurate physician and provider reimbursement levels.

To strengthen this proposal, CPR urges CMS to ensure the efficiency adjustment is implemented in a manner that does not inadvertently reduce payment for complex rehabilitative care. We also encourage CMS to expand efforts to collect and use empirical data for direct practice expense inputs—including equipment, supplies, and clinical labor—so that valuations reflect current costs and resource needs. Lastly, we also urge CMS to revisit and update practice expense inputs more frequently to maintain accurate and equitable payment rates across service categories.

Taken together, these changes will help ensure that the Medicare Physician Fee Schedule more accurately reflects the realities of modern care delivery and supports the intensive, multidisciplinary services needed by patients undergoing rehabilitation for serious injuries, illnesses, and disabilities.

Telehealth Proposals under the Physician Fee Schedule

CPR commends CMS for its continued efforts to expand and support telehealth services under the Medicare program. The continuation of many flexibilities first established during the COVID-19 public health emergency has allowed many Medicare beneficiaries to more safely and easily access medically necessary health care services by avoiding numerous other complications and difficulties that have always been associated with in-person medical care. For example, many beneficiaries with mobility impairments have seen tremendous benefit from their

ability to receive virtual evaluations and other services, given the complications associated with planning, transportation, and accessibility of in-person visits. Mobility impairments themselves limit physical access to in-person visits to health care providers. Telehealth can dramatically ease the burden of mobility impairment while preserving access to care.

Similarly, many patients in need of cognitive and psychological rehabilitation services have found that virtual services may be more accessible and even potentially more effective, with the potential to cut down on distractions associated with receiving care in an unfamiliar environment. We also note that the proliferation of telehealth may allow patients to receive more stable, continued access to therapy and other important services, with telehealth visits occurring between intermittent in-person visits in order to maintain in-person patient care. This is particularly effective for the disability and the rural Medicare populations.

Access to telehealth services will continue to provide these benefits which are particularly valuable for beneficiaries with disabilities and others with illnesses and injuries who are in need of rehabilitation. We therefore support increased access to care through the expanded use of telehealth and telerehabilitation to ensure that patients are able to benefit from advances in technology that make virtual care possible.

However, CPR is concerned that some of these flexibilities are still subject to statutory expiration on September 30, 2025, and that provider types critical to rehabilitation—such as physiatrists, physical therapists, occupational therapists and speech-language pathologists—continue to face uncertainty around their eligibility to furnish telehealth services permanently. Accordingly, **CPR urges CMS to use all available regulatory authorities to ensure that medical rehabilitation providers—including physiatrists, physical therapists, occupational therapists, and speech-language pathologists—can continue to deliver services via telehealth beyond CY 2026. We also encourage CMS to maintain audio-only telehealth options and remote supervision flexibility, which are essential for beneficiaries with mobility and cognitive impairments who lack broadband access.**

As we have noted in previous comments, it is critical that expansion of telehealth services does not come at the expense of in-person care, especially when the services needed by the patient are more effectively and efficiently provided in-person. Beneficiaries with illnesses, injuries, disabilities, and chronic conditions often need the highest levels of medical care in order to maintain, regain, and/or improve their health and function. It is crucial that beneficiaries receiving rehabilitation care are able to access the most appropriate care in the most appropriate settings.

New regulations expanding telehealth long-term must ensure that telehealth is utilized only when clinically appropriate and that beneficiaries who need in-person care do not face additional barriers to access in-person care as a result of telehealth adoption. When either virtual or in-person care is considered to be equivalently appropriate for the patient's clinical needs, Medicare regulations must not promote one over the other, and providers should be prohibited from limiting beneficiaries with disabilities to virtual visits because they cannot or do not wish to accommodate their disability in the context of an in-person visit. At the same time, Medicare

payment policies should not set reimbursement rates for telehealth so low that access to virtual care is significantly limited as well. The decision between virtual and in-person care should be made by the patient and their provider, and both options should be equally available for all Medicare beneficiaries with or without disabilities, including those who need communication or other accommodations to receive equally effective healthcare in person or via telehealth.

We encourage CMS to continue to work under the agency's current authority and with Congress to ensure that patient-centered telehealth is available long-term to as many patients as possible, in as many appropriate forms as possible, while ensuring that telehealth adds to existing forms of available care without replacing or supplanting in-person treatment options.

We greatly appreciate your consideration of our comments on the CY 2026 Physician Fee Schedule Proposed Rule. Should you have any further questions regarding this information, please contact Peter Thomas and Michael Barnett, CPR co-coordinators, by e-mailing Peter.Thomas@PowersLaw.com and Michael.Barnett@PowersLaw.com or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Association of People with Disabilities
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America*
Center for Medicare Advocacy*
Child Neurology Foundation
Christopher & Dana Reeve Foundation*
Disability Rights Education and Defense Fund (DREDF)
Lakeshore Foundation
National Association for the Advancement of Orthotics and Prosthetics
National Association of Rehabilitation Providers and Agencies
RESNA
Spina Bifida Association
United Cerebral Palsy
United Spinal Association*

**** Indicates CPR Steering Committee Member***