AMERICAN COLLEGE of RHEUMATOLOGY
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December 12, 2025

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

*Submitted electronically via regulations.gov*

RE: [CMS-1832-F] 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 American College of Rheumatology (ACR), representing over 10,400 rheumatologists and rheumatology interprofessional team members, is writing to respond to the CY 2026 Physician Fee Schedule and Quality Payment Program final rule released on October 31, 2025. Rheumatologists and rheumatology professionals provide ongoing care to Medicare beneficiaries with complex acute and chronic rheumatic diseases that require specialized expertise.

The ACR thanks the Centers for Medicare and Medicaid Services (CMS) for its continued recognition of the value of complex medical decision-making provided by rheumatologists and other cognitive specialties in treating their patients. As such, we would like to share additional comments on the now-finalized -2.5% adjustment to the work RVUs (Relative Value Units) and the in-service time component for non-time-based services, and its implications for rheumatologists and other cognitive care specialists. We would also like to reiterate our concerns on the inclusion of the maximum fair price (MFP) in the average sales price (ASP) for certain Part B drugs.

***Efficiency Adjustment***

In our response to the proposed rule, we asked CMS to rescind the efficiency adjustment on the grounds that it would nullify the small increase to the conversion factor, and that it did not reflect the time and effort physicians put forth in providing thousands of services. We were concerned that the proposal would erode the significant steps that CMS has taken in recent years to strengthen access to rheumatologists and other cognitive specialists, including improvements to office and outpatient E/M codes, creation of new codes for prolonged and chronic care management, and expanded use of telehealth.

Upon additional review of the proposal, we believe that the rebalancing of relative value toward time-intensive and cognitive services may positively impact rheumatologists and their patients. Many rheumatologic services are time-based (i.e. CPT 96365, 99358) and are designed to reflect

a significant amount of face-to-face time plus care-planning work. Because time-based services are exempt from the -2.5% efficiency adjustment, rheumatologists should not see that reduction applied to those codes. Therefore, this adjustment could, over time, improve the valuation of many services delivered by rheumatologists and increase patient access to rheumatology care.

***Average Sales Price: Units Sold at Maximum Fair Price***

Per the final rule, MFP units for Part B drugs will be included in the calculation of ASP, beginning January 1, 2026. CMS argues that including MFP sales in ASP is consistent with how price concessions are treated under Medicaid's best-price rules. The ACR remains concerned that including MFP in the calculation of ASP could unintentionally weaken the care delivery system that Medicare beneficiaries rely on for infused biologics. With the inclusion of MFP units, private practices may be financially unable to sustain their infusion services. If practices cannot continue to offer these services, access particularly in rural communities will suffer, and patients may be driven towards higher-cost locations.

Our concern is for the sustainability of the buy-and-bill model that ensures timely and efficient access to biologic therapy. Practices purchase, store, and administer these drugs directly, operating on a narrow margin that must cover acquisition cost variability, pharmacy and nursing labor, infusion suite overhead, refrigeration, wastage, and payment delays. Further, a recent analysis concluded that the proposal would cut Part B reimbursement add-ons by 34%, limiting the ability for rheumatologists who frequently administer biologic therapies in office or infusion settings to continue to provide these treatments as a part of their business structure.[1]

There are two ways that including MFP units in the ASP calculation is expected to lower reimbursement below real acquisition costs for rheumatology practices, leaving them "underwater":

First, MFPs are likely to be lower than current ASPs for Part B drugs. Because Part B reimbursement is typically ASP + 6%, including lower-priced MFP units means rheumatology practices may be reimbursed too little to cover the cost of providing those treatments. Despite the fact that community practices do not purchase drugs at MFP levels, their inclusion in the formula would depress ASP benchmarks for all providers.

Second, inclusion of the MFP units could exacerbate preexisting reimbursement discrepancies related to business practices of Pharmacy Benefit Managers (PBMs). PBMs include rebates in their ASP calculations and the PBM-controlled distribution of biologics and biosimilars already challenges the solvency of private practices. Rebates depress the reported ASP on which provider reimbursements are based without consideration that the acquisition cost for the provider may not proportionately reflect such a discount.

**The ACR reiterates its request that CMS create a reimbursement floor so that ASP reductions from MFPs do not push reimbursement below drug acquisition and administration costs. We also request monitoring and reporting requirements from CMS**

[1] https://advisory.avalerehealth.com/insights/ira-medicare-part-b-negotiation-shifts-financial-risk-to-physicians?utm_source=chatgpt.com

**on whether access disruptions (i.e., site-of-care shifts, drug shortages) occur after the ASP declines.**

**Conclusion**

We appreciate CMS's endeavors to place more emphasis on the value of care that rheumatologists and other cognitive care specialists provide. We are concerned, however, that this emphasis will be significantly eroded by the inclusion of the MFP in ASP calculations for Part B drugs. We welcome the opportunity to provide clinical expertise to CMS as these policies are implemented. Please contact Lennie McDaniel, JD, Senior Director of Advocacy and Government Affairs, at LMcDaniel@rheumatology.org if the ACR can be of assistance or if you have questions.

Sincerely,

William F. Harvey, MD, MSc, FACR
President, American College of Rheumatology