U.S. SMALL BUSINESS ADMINISTRATION
OFFICE OF ADVOCACY
REGULATION • RESEARCH • OUTREACH

September 11, 2025

VIA ELECTRONIC TRANSMISSION

The Honorable Mehmet C. Oz, M.D.
Administrator
The Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Comments on 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 [Docket No. CMS-1832-P]

Dear Dr. Oz:

On July 16, 2025, the Centers for Medicare and Medicaid Services (CMS) published a Notice of Proposed Rulemaking (NPRM) in the *Federal Register* seeking comments on the CY 2026 Payment Policies, Shared Savings Program Requirements, and the Prescription Drug Rebate Program.[1] This letter constitutes the Office of Advocacy's (Advocacy) comments on the Payment Policies and their role in affecting the viability of independent physician practices.

In short, the proposal to markedly reverse the cut in physician payment rates is welcome news for independent physician practices. On behalf of small stakeholders impacted by the proposed rule, Advocacy urges CMS and the U.S. Congress to consider, in future proposed rules or draft legislation, further steps to level the regulatory playing field, such as the adoption of site-neutral payment policies.

I. Background

[1] 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, 90 Fed. Reg. 32352 (July 16, 2025).

A. Office of Advocacy

Congress established the Office of Advocacy under Pub. L. 94-305 to represent the views of small entities before federal agencies and Congress. Advocacy is an independent office within the U.S. Small Business Administration (SBA). As such, the views expressed by Advocacy do not necessarily reflect those of the SBA or the Administration. The Regulatory Flexibility Act (RFA),[2] as amended by the Small Business Regulatory Enforcement Fairness Act (SBREFA),[3] gives small entities a voice in the rulemaking process. For all rules expected to have a significant economic impact on a substantial number of small entities, the RFA requires federal agencies to assess the impact of the proposed rule on small entities and to consider less burdensome alternatives.[4] If a rule is not expected to have a significant economic impact on a substantial number of small entities, agencies may certify it as such and submit a statement of the factual basis to Advocacy for such a determination that adequately supports its certification.[5]

The Small Business Jobs Act of 2010 requires agencies to give every appropriate consideration to comments provided by Advocacy.[6] The agency must include a response to these written comments in any explanation or discussion accompanying the final rule's publication in the *Federal Register*, unless the agency certifies that the public interest is not served by doing so.[7]

Advocacy's comments are squarely in the spirit of the RFA, which emphasizes recognizing that "differences in the scale and resources of regulated entities have in numerous instances adversely affected competition in the marketplace, discouraged innovation and restricted improvements in productivity" and that "unnecessary regulations create entry barriers in many industries and discourage potential entrepreneurs from introducing beneficial products and processes."[8]

B. Physician Fee Schedules over Time

The Medicare Physician Fee Schedule (PFS) is the primary mechanism by which CMS reimburses physicians and other health professionals for services provided to Medicare beneficiaries. It sets a national "conversion factor" that translates relative value units (RVUs), based on physician work, practice expense, and malpractice costs, into payment rates.

Over the past decade, the PFS has been shaped by statutory changes, budget-neutrality requirements, and shifting policy priorities.

- The Affordable Care Act (ACA) of 2010 introduced multiple payment reforms that put downward pressure on physician payments, including productivity adjustments to the annual payment update. These provisions restrained fee growth.
- In 2015, the Medicare Access and CHIP Reauthorization Act (MACRA) permanently replaced the Sustainable Growth Rate (SGR) system, which had long

[2] Pub. L. No. 96-354, 94 Stat. 1164 (1980) (codified at 5 U.S.C. §§ 601-612).
[3] Pub. L. No. 104-121, tit. II, 110 Stat. 857 (1996) (codified in scattered sections of 5 U.S.C. §§601-612).
[4] 5 U.S.C. § 603.
[5] *Id.* § 605(b).
[6] Small Business Jobs Act of 2010, Pub. L. No. 111-240, §1601, 214 Stat. 2551 (codified at 5 U.S.C. § 604).
[7] *Id.*
[8] Regulatory Flexibility Act, Pub. L. No. 96-354, 94 Stat. 1164 (1980) (codified at 5 U.S.C. §§ 601-612).

threatened double-digit payment cuts and required repeated congressional "doc fixes." MACRA provided for small statutory annual updates (generally 0.5%) and created new pathways: Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs). However, budget-neutrality adjustments, misvalued code corrections, and ACA-mandated productivity adjustments often offset these modest increases.

- From 2016 onward, the conversion factor has remained flat or declining in real terms. Nominal rates have edged downward in multiple years due to statutory adjustments and budget neutrality constraints.
- Especially in the 2024 rulemaking, CMS reduced the factor by 2.83% for calendar year 2025, despite rising input costs.[9]

Taken together, these trends show that Medicare physician payments have failed to keep pace with practice expenses and inflation, leaving many small and independent practices struggling to remain viable.

C. Physician Fee Schedules in the Proposed Rule

Against this backdrop, the proposed upward adjustments for 2026 mark an important and welcome reversal. Advocacy is pleased to see CMS propose positive adjustments for 2026. Specifically:

- For qualifying Alternative Payment Model (APM) participants (QPs), CMS proposes raising the conversion factor to $33.59, a projected 3.83% increase over the CY 2025 rate of approximately $32.35.
- For non-APM clinicians, the proposed conversion factor is $33.42, reflecting a 3.62% increase.

These are meaningful improvements and represent the first upward adjustment to the conversion factor in several years.

President Trump and Congress have played pivotal roles in enabling CMS to restore physician reimbursement for 2026. Notably, the recent budget reconciliation package included a temporary 2.5% increase to the Physician Fee Schedule conversion factor.[10] This temporary boost, combined with the annual statutory updates (0.75% for APM participants and 0.25% for non-APM clinicians) mandated by MACRA, creates the legal foundation for the proposed increases in the CY 2026 rule.

II. Historical Regulatory Bias Against Small Physician Practices

In recent years, small independent physician practices have faced increasing challenges from the cumulative effects of federal regulations and administrative requirements. They are too small to

[9] Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments, 89 Fed. Reg. 97710 (Dec. 9, 2024).
[10] One Big Beautiful Bill Act, Pub. L. No. 119-21, § 71202, 139 Stat. 72, 320 (2025).

employ personnel dedicated to compliance or to discovering alternative ways of navigating complex regulatory and reimbursement protocols. A great many physicians have reluctantly given up independent practice to become employees of large hospital systems. Other independent practices have been absorbed into large integrated care management systems.

By 2024, three quarters of physicians were employed by hospitals, health systems, or corporate entities. In the previous decade, independent practice was more common. Advocacy notes that the nationwide revenue share of firms with less than 20 employees in NAICS industry 621111 ("Offices of Physicians (except Mental Health)") declined by a factor of 1.7 between 2012 and 2022, according to the Statistics of U.S. Businesses. Other data show that 40 percent of independent practices in rural areas have closed or have been acquired by hospitals, health systems, insurers, or private equity groups between 2019 and 2024.[11]

Payment policies have further biased the market toward the large hospital systems. Although hospital reimbursement is also related to physician fee schedules, hospitals can make up some of the revenue from other associated fees and charges. Particularly, under current Medicare policy, the same outpatient services routinely performed in hospital outpatient departments (HOPDs) are reimbursed at substantially higher rates than those delivered in independent physician offices, even when the level of care is identical. This discrepancy has provided a strong financial incentive for hospital systems to acquire independent practices and convert them into HOPDs, driving consolidation, inflating costs, and reducing competition. Site-neutral payment reform aims to eliminate the payment disparities by aligning reimbursement based on the service, not the setting, thereby saving Medicare and its beneficiaries billions and preserving independent practice options.

III. Advocacy Outreach to Independent Physicians Regarding Medicare Payment Burdens and Other Areas Where They Report Regulatory Obstacles.

When Congress created Advocacy, it charged the office with being the voice of small business. To comply with this congressional mandate, Advocacy has created multiple outreach mechanisms designed to hear directly from small entities about federal regulatory burdens that impact their ability to thrive. Advocacy often engages with small independent physicians and their representatives concerned about the downward pressure caused by Medicare policies, and uncertainties associated with reimbursement rates. These concerns hinder independent physicians' ability to remain in private practice. The concerns they cite include:[12]

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[11] *See* Physicians Advoc. Inst., *PAI-Avalere Report: Rural Areas Face Steep Decline in Independent Physicians and Practices*, https://www.physiciansadvocacyinstitute.org/PAI-Research/Rural-Physician-Employment-and-Acquisition-Trends-2019-2024 (last accessed Sept. 11, 2025). *See also* Georgia Garvey, Am. Med., Ass'n, *Smaller Share of Doctors in Private Practice Than Ever Before* (June 24, 2025), https://www.ama-assn.org/practice-management/private-practices/smaller-share-doctors-private-practice-ever.

[12] Advocacy cited many of these independent physician issues in its July 14, 2025, comments to the Department of Health and Human Services' Request for Information seeking deregulatory suggestions from the public pursuant to Executive Order 14192. See U.S. Small Bus. Admin., Off. of Advoc., Comment Letter on Health and Human Services' Request for Information: Ensuring Lawful Regulation and Unleashing Innovation to Make America Healthy Again (July 14, 2025), https://advocacy.sba.gov/2025/07/16/advocacy-files-comments-on-hhs-request-for-information-on-its-deregulatory-effort/.

- Medicare payments updates do not keep up with inflation. In addition, conversion factor cuts tied to budget neutrality rules reduce reimbursement rates.
- Prior authorization abuses by Medicare Advantage Plans result in administrative burdens and affect patient care.
- Quality reporting through the Merit-based Incentive Payment System (MIPS) is very expensive for solo practitioners and should be improved.
- Medicare Recovery Audit Contractors (RACs) audits and reviews are often unwarranted and result in excessive paperwork and cost burdens for independent physicians.
- The trend toward Accountable Care Organizations (ACOs) is impacting independent practitioners who lack economies of scale to compete against these often hospital driven practices forcing many to join larger group practices.
- Technology mandates driven by Medicare electronic record requirements are expensive and administratively burdensome.

IV. Conclusion

Advocacy and small businesses are supportive of CMS' proposed rule. Advocacy is prepared to assist CMS in reducing regulatory burdens faced by small independent physicians on this issue and the others raised in this comment letter. If you have any questions or require additional information, please contact me or Linwood Rayford at (202) 205-6533 or by email at linwood.rayford@sba.gov.

Sincerely,

/s/

Dr. Casey B. Mulligan
Chief Counsel
Office of Advocacy
U.S. Small Business Administration

/s/

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Copy to: Mr. Jeffery B. Clark, Sr., Acting Administrator
Office of Information and Regulatory Affairs
Office of Management and Budget