September 12, 2025

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Submitted electronically via 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:

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2026 Medicare Physician Fee Schedule (MPFS) proposed rule. We appreciate your consideration of our comments on the following topics in the proposed rule. We include a concise summary of our recommendations at the end of this letter.

SGIM is a member-based medical association of more than 3,300 of the country's leading general internal medicine physicians, who are dedicated to delivering high-quality clinical care for adults of all ages, especially those with multiple chronic diseases who would benefit from having a physician to coordinate a comprehensive approach to their care. Our members are committed to delivering high quality care and ensuring patients have access to a well-trained physician workforce. Therefore, the policies in this proposed rule are important to our members who provide care for Medicare beneficiaries.

We appreciate your consideration of our comments on the following topics in the proposed rule:

- Conversion Factor for 2026
- Valuation of Primary Care Services
- Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential
- Proposed Efficiency Adjustment
- Payment for Medicare Telehealth Services under Section 1834(m) of the Act
- Evaluation and Management (E/M) Visit Complexity Add-on
- Enhanced Care Management
- Policies to Improve Care for Chronic Illness and Behavioral Health Needs
- Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health

Conversion Factor

Key Recommendation: Work with Congress to explore long-term solutions for updating Medicare physician payments.

2026 marks the first year that there are two separate conversion factors: one for practitioners working in a qualifying advanced APM and the other for those not participating in a qualifying APM. The conversion factor for

the former will increase to $33.59, an increase of 3.83%, and the latter to $33.42, an increase of 3.62%. These increases reflect the 2.5% increase to the 2026 conversion factor included in the *One Big Beautiful Bill Act* recently adopted by Congress.

SGIM recognizes that CMS does not have the statutory authority to update the conversion factor on its own. While we appreciate the positive increase provided by Congress, we recognize that unless Congress acts again, the 2.5% increase will expire at the end of CY 2026, resulting in a cut in payments for CY 2027. These cuts will have a detrimental impact on general internal medicine physicians, potentially jeopardizing their ability to provide quality care to Medicare beneficiaries. **Therefore, we will be working with Congress to explore long-term solutions for updating Medicare physician payments and recommend that the agency do so as well.**

Valuation of Primary Care Services

Key Recommendation: Establish a Technical Expert Panel (TEP) dedicated to improving the valuation of E/M services within the MPFS.

SGIM shares the administration's goals to reduce the burden of chronic diseases and improve the health of Americans. However, those goals cannot be achieved without a strong primary care workforce. While CMS has implemented policies to support primary care in recent years, additional changes must be made in short order to build the primary care workforce necessary to support prevention and elimination of chronic diseases. The services provided by general internal medicine physicians and other primary care practitioners continue to be undervalued. The first step to doing this is correcting the longstanding deficiencies in the MPFS. Such corrections are needed to reverse the decline in the primary care workforce and support innovative payment models, such as hybrid payments and accountable care organizations.

While the proposed rule acknowledges flaws in the current process for valuing physician services – primarily through reliance on the American Medical Association's (AMA) Relative Value Scale Update Committee (RUC) – it does not address the fundamental issue of ensuring that evaluation and management (E/M) and other high-value services are appropriately valued. For this discussion, we will focus on E/M services, which are central to stabilizing and expanding access to primary care, the foundation of a high-value health care system that will reduce the burden of chronic disease.

To meet CMS's stated goal of creating *"a health care system that results in better quality, efficiency, empowerment, and innovation for all Medicare beneficiaries,"* SGIM urges CMS to establish a Technical Expert Panel (TEP) dedicated to improving the valuation of E/M services within the MPFS.[1] The current E/M code structure does not adequately capture the cognitive work and resources required to care for Medicare beneficiaries, particularly those with multiple chronic conditions. Existing valuation mechanisms, which are better suited to procedural services, have perpetuated inequities that undervalue cognitive care. As new hybrid and alternative payment models use MPFS rates as their foundation, these flaws threaten to undermine broader reforms.

A **TEP focused on E/M valuation** would bring a research-based, transparent, and sustainable approach to this process. Specifically, the panel could:

- Define the full range of cognitive work performed by primary care and other non-procedural clinicians.
- Establish reliable, data-driven approaches to valuing these services.

[1] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-pfs-proposed-rule-cms-1832-p

- Recommend processes for regular reassessment of E/M codes to prevent stagnation.
- Ensure valuations serve as accurate building blocks for hybrid and innovative payment models.

This approach would provide the long-overdue attention needed to strengthen primary and cognitive care. Importantly, better reimbursement for E/M services would improve care for beneficiaries with complex conditions such as diabetes, heart failure, and kidney disease, while helping to stabilize the declining primary care workforce.

The use of expert panels to inform clinical practice and health care delivery is well-established. For example, Khodyakov et al. described the TEP process and its use in developing patient care guidelines.[2] Rubenstein et al. applied the approach in creating a primary care productivity model for Veterans Affairs (VA) clinics.[3] Most recently, the National Academies of Sciences, Engineering, and Medicine (NASEM) applied a similar methodology in its 2025 report, *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule*. This report outlines flaws in the current system and highlights promising new data sources and methodologies that a TEP could apply in addressing CMS's most pressing questions about E/M valuation and the questions raised in their *Request for Information on Prevention and Management of Chronic Disease*.[4]

As the U.S. population ages, Medicare must take the lead in supporting comprehensive, patient-centered care. Establishing a TEP on E/M valuation presents a timely and practical opportunity to ensure that payment accurately reflects the work clinicians perform, reinforces primary care, and maximizes the success and sustainability of payment reforms. Additionally, SGIM believes that a TEP could play a role in ensuring that empiric data is used to evaluate misvalued code nominations.

SGIM stands ready to support CMS in convening this panel and ensuring appropriate representation from researchers, clinicians, and experts in Medicare payment policy.

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

Key Recommendation: Do not finalize this policy as proposed. Instead, develop a reliable evidence base to inform any revisions to the indirect PE per hour calculation.

CMS had delayed proposing any updates to the indirect PE methodology as it waited for the AMA to complete a new Physician Practice Information Survey (PPIS), which has formed the basis for each medical specialty's indirect practice expenses per hour. Indirect practice expenses include costs for rent, utilities, and administrative staff responsible for scheduling and coding. Upon receipt of the new survey, CMS believed that there were significant limitations in the data and chose not to use it to update the indirect practice expenses per hour. Instead, the agency proposes to reduce the allocation of facility indirect PE relative value units (RVUs) based on work RVUs to half the amount allocated to non-facility PE RVUs.

---

[2] Khodyakov D, Grant S, Denger B, Kinnett K, Martin A, Peay H, Coulter I. Practical Considerations in Using Online Modified-Delphi Approaches to Engage Patients and Other Stakeholders in Clinical Practice Guideline Development. Patient. 2020 Feb;13(1):11-21. doi: 10.1007/s40271-019-00389-4. PMID: 31544219; PMCID: PMC6957573.

[3] Rubenstein LV, Newberry SJ, Ghai I, Motala A, Curtis I, Shekelle PG, Wagner TH, Tran LD, Fihn SD, Nelson KM. Measuring Primary Care Productivity in the Era of Interprofessional Team Care: Stakeholder, Scoping Review, and Implementation Perspectives. Milbank Q. 2025 Aug 9. doi: 10.1111/1468-0009.70044. Epub ahead of print. PMID: 40782372.

[4] https://nap.nationalacademies.org/download/29069

SGIM strongly opposes this proposal and believes that the unintended consequences for general internal medicine practices will be significant. We recognize that many physicians, including general internal medicine physicians, no longer own or practice in office-based settings. However, the agency proposes to arbitrarily reduce the indirect PE RVUs, and therefore reimbursement, to these facility-based primary care practices. CMS does not present any data to support this proposed reduction. Based on anecdotal information from our members, facility-based physicians have varying levels of responsibility for reimbursing their institutions for these indirect costs with some paying rent and salary support while others do not believe they are responsible for these costs. The policy as proposed will be destabilizing for many physicians who have faced 30 years of stagnant reimbursement under the MPFS, and particularly for primary care practitioners whose services are undervalued. SGIM is particularly concerned about the impact on our members, the majority of whom practice in academic medical centers. As discussed, their work, which is critical to advancing the agency's goals to improve Americans' health, is already undervalued. Arbitrarily reducing their reimbursement will move the agency further from appropriately reimbursing for the longitudinal, high-quality primary care, which is vital to reducing the burden of chronic disease in this country, that they deliver to Medicare beneficiaries.

Furthermore, this policy change will destabilize primary care clinics that serve as training sites for internal medicine residencies. Should the financial viability of these sites erode, we anticipate that it will undermine the primary care training pipeline. SGIM and other organizations are already struggling to make primary care a more appealing career path for medical students who see the current workforce struggle to meet the demands of today's practice with lower rates of reimbursement than other specialties. Reducing reimbursement for these clinics may exacerbate the already severe workforce shortages in general internal medicine and other primary care disciplines.

SGIM urges CMS not to finalize this policy as proposed. Instead, we recommend that the agency develop a reliable evidence base to inform any revisions to the indirect PE per hour calculation.

Proposed Efficiency Adjustment

Key Recommendation: Use empiric data sources to inform an efficiency adjustment that addresses the longstanding disparity in reimbursement between E/M and procedural services.

CMS proposes to apply an efficiency adjustment to the resource-based RVUs and intraservice physician time inputs to all codes, except those that are time-based; E/M services, care management services, behavioral health services, services on the Medicare telehealth list, and maternity codes with a global period (designated by global period indicator MMM) would be excluded from this policy. This adjustment would address the efficiencies that CMS believes providers gain over time delivering certain procedures, tests, and radiology services. CMS proposed a -2.5% adjustment based on five years of data using the Medicare Economic Index's (MEI) productivity adjustment.

SGIM strongly supports the implementation of an efficiency adjustment to address the longstanding disparity in reimbursement between E/M and procedural services. Any policy targeting efficiency gains should exempt E/M and other time-based services for which one would not expect to see the efficiency gains that occur with procedures. **However, we do believe that CMS should consider certain improvements to this policy.**

As proposed, the efficiency update will be applied to applicable services every three years based on the MEI's productivity adjustment. Rather than rely on this productivity adjustment when the MPFS does not include an inflationary adjustment based on MEI or another metric, SGIM urges the agency to use empiric data sources to determine the amount of the adjustment. While we are proposing CMS implement a TEP to value E/M and other

cognitive work, the TEP or a similar panel could be used to identify an appropriate efficiency adjustment. **Furthermore, we urge the agency to use empiric data sources to inform the adjustment whenever possible.** SGIM shares the agency's concerns about the convenience sample that underpins the RUC's recommendations and recommends that the agency ensure that decisions about the efficiency adjustment are based on appropriate data.

Finally, SGIM believes that any efficiency adjustments should be based on data rather than assumptions about gains in efficiency occurring in perpetuity. The current RUC process does not reflect actual physician work and time and has perpetuated the reimbursement disparity between cognitive and procedural work. This is another reason why empiric data sources would more accurately reflect efficiency gains in procedural work.

Payment for Medicare Telehealth Services under Section 1834(m) of the Act

Proposed Changes to Teaching Physicians' Billing for Services Involving Residents with Virtual Presence

Key Recommendation: Do not finalize this proposal. Instead, allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings.

CMS proposes to transition back to the pre-Public Health Emergency (PHE) policy and not to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings beginning in CY 2026. The agency maintains the rural exception, which was in place before the PHE, and allows teaching physicians in rural areas to utilize audio/video real-time communications technology to fulfill the presence requirement. **SGIM urges CMS to reconsider this proposal and continue to allow teaching physicians to have a virtual presence during the key portion of the Medicare telehealth service for which payment is sought, through audio/video real-time communications technology, for all residency training locations.**

This flexibility is an important tool to expand access to care in rural and urban settings, particularly in shortage specialties like general internal medicine. Virtual supervision will continue to sustain clinical capacity, allowing teaching physicians to directly supervise residents, ensuring that the patient receives safe, high-quality care. Regardless of the geographic setting, enabling virtual supervision supports primary care access and quality by expanding and diversifying the ways in which appropriate and safe supervision can be provided. In urban settings, there are frequently cases where a supervising physician is unable to be on site but is otherwise available for dedicated, safe supervision of resident patient care within an appropriate scope. Additionally, without this flexibility, practitioners in urban settings would have less time for appointments, adversely impacting primary care access and quality as well as primary care training for residents.

Due to ongoing shortages in primary care, patients—even in urban areas—often wait weeks to months for an appointment. Preserving this flexibility enables clinics to see more patients more quickly and better meet community needs. Virtual appointments are particularly valuable for individuals with chronic disabilities that limit ambulation (e.g., wheelchair users, amputees, older adults, or those with spinal injuries), regardless of whether they live in urban or rural settings. Patients with limited financial resources, long transit times, or inflexible work schedules also benefit. Virtual supervision helps sustain primary care practices so they can continue serving these diverse populations.

Just as contemporary and innovative models of primary care integrate virtual care, effectively integrating virtual supervision is critical to supporting contemporary teaching practices, where virtual supervision can be a valuable tool for both supervising physicians and trainees in providing safe, efficient, and effective care. Many residency programs, including those in urban settings, have residents practicing in multiple sites. Virtual supervision

enhances the ability to supervise residents in multiple sites and helps to minimize the number of supervising physicians needed each day, thereby reducing the number of physicians that need to be diverted from delivering care to their own patients.

Our members, many of whom serve as the primary internal medicine faculty of medical schools and major teaching hospitals in the United States, have found that teaching models continue to evolve and incorporate remote supervision into practice while maintaining safe and high-quality care. Given the growing shortage of general internal medicine physicians, this flexibility is critical to ensuring Medicare beneficiaries have access to comprehensive primary care. It is also essential for addressing the growing burden of chronic disease – a priority of this administration – as patients require consistent, longitudinal management that is difficult to achieve without adequate access to primary care services.

Evaluation and Management Visit Complexity Add-on
Key Recommendation: Finalize the proposal to broaden the applicability of HCPCS code G2211.

The agency proposes to broaden the applicability of HCPCS code G2211 to include home and residence-based E/M visits**. SGIM supports this expansion because this complexity add-on code is one of the few existing mechanisms within the current Medicare payment system to more appropriately recognize the complex, longitudinal care our members provide to Medicare beneficiaries.** Strengthening this code is a modest but meaningful step toward addressing the chronic undervaluation of primary care services.

Enhanced Care Management
Request for Information Related to Advanced Primary Care Management (APCM) and Prevention
Key Recommendation: Finalize the proposal to classify APCM codes as preventive services.

To align with the new administration's priorities to better address chronic disease, CMS acknowledges the essential role of a primary care practitioner in chronic care management and the importance of proper coding and payment for APCM services to promote team-based primary care models. CMS proposes categorizing APCM services as preventive services, although they were previously against it. APCM services already combine preventive and treatment services. CMS has requested comments on how Medicare beneficiary cost sharing will affect the use of these services, specifically, if CMS were to integrate additional preventive services in the APCM bundles.

SGIM strongly agrees with the proposal to classify APCM codes as preventive services, thereby ensuring they are not subject to beneficiary cost-sharing. In primary care settings, prevention and treatment are linked. It would be administratively burdensome to require primary care practices to collect cost sharing for the treatment portion of the service only. Furthermore, we believe imposing cost-sharing for longitudinal, wraparound care coordination and care management services between billable E/M visits fundamentally contradicts the principles

of chronic care management embodied by APCM services. Research highlights the significant harm that out-of-pocket costs inflict on patients with chronic conditions.[5,6,7,8,9,10,11]

Policies to Improve Care for Chronic Illness and Behavioral Health Needs

Key Recommendation: Ensure that patients have consistent access to primary care and coverage of non-pharmacological interventions.

SGIM appreciates that CMS is soliciting feedback on how it can better support prevention and management of chronic disease. To achieve this goal, patients must have consistent access to primary care, and providers must be equipped with the resources necessary to effectively manage chronic conditions.

1. *How could the agency better support prevention and management, including self-management, of chronic disease?*

While CMS and private insurers routinely reimburse pharmacological therapies for chronic disease management, coverage of non-pharmacological interventions remains limited. This imbalance impacts access to services that can prevent disease progression, reduce complications, and lower costs.

Nutrition Services: Currently, CMS reimburses medical nutrition therapy only for certain conditions such as diabetes and end-stage renal disease, with strict limits on the number of hours covered per year.[12] **Expanding coverage to include additional diagnoses (e.g., heart failure, hypertension, obesity) and allowing more hours of coverage for complex patients with multiple chronic conditions would strengthen chronic disease prevention and reduce exacerbations.**

Additionally, many older adults with multiple, uncontrolled chronic conditions – particularly those in underserved areas – primarily consume processed foods because of the high cost and lack of access to nutritious alternatives. This worsens beneficiaries' existing conditions and drives avoidable hospitalizations. Providing reimbursement for healthy, home-delivered meals for high-risk beneficiaries would address gaps in care, reduce morbidity, and lower system-wide costs.

Finally, SGIM members care for patients with multiple chronic conditions in short appointment windows with limited time to address each issue thoroughly. Many patients would benefit from additional support from professionals such as dietitians; however, smaller practices often cannot support their services. For patients already burdened by transportation, childcare, or eldercare challenges, the absence of on-site resources like dietitians only deepens the difficulty of effectively managing chronic disease.

---

[5] https://pmc.ncbi.nlm.nih.gov/articles/PMC6016939/

[6] https://pubmed.ncbi.nlm.nih.gov/20068489/#:~:text=Results:%20Respondents%20with%20cardiovascular%20disease,underuse%2C%20P%20%3C%200.001

[7] https://pubmed.ncbi.nlm.nih.gov/31760784/

[8] https://pubmed.ncbi.nlm.nih.gov/24929799/

[9] https://diabetesjournals.org/care/article/34/9/1891/38631/Recurrent-Diabetic-Ketoacidosis-in-Inner-City?searchresult=1

[10] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2760437

[11] https://pmc.ncbi.nlm.nih.gov/articles/PMC3514993/

[12] https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?ncdid=252

Dental Care: Poor oral health is well-documented as a contributor to multiple comorbidities and increased mortality risk. Yet Medicare dental coverage is restricted to beneficiaries in very specific medical circumstances, such as certain cancers or high-risk surgeries.[13] Providing access to routine and preventive dental care for all Medicare beneficiaries could significantly improve health outcomes and reduce avoidable hospitalizations. Under current Medicare statute, dental coverage must be inextricably linked to the other Medicare-covered services. SGIM recognizes that a change in statute would be required to cover routine dental care; however, **we encourage the agency to work with Congress to cover these dental services, which could greatly reduce the health and financial burdens of chronic diseases**.

Mental Health Services: Current reimbursement structures often make high-risk prescription psychotropic medications more affordable than psychotherapy, creating perverse incentives that drive reliance on medications over evidence-based therapy. **Increasing reimbursement rates for psychotherapy and cognitive behavioral therapy (CBT) could improve access to mental health providers, reduce adverse drug events, and enhance overall care**.

2. *Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.*

SGIM values CMS' commitment to appropriately reimbursing primary care within Medicare's fee-for-service system. However, significant gaps remain.

Patients are generally willing to follow recommendations – whether related to diet, exercise, or medications – when they receive clear, consistent guidance. The challenge lies not in patient motivation, but in the constraints of the current system: primary care physicians often lack the time and resources needed for meaningful conversations during routine visits. As a result, much of this essential chronic disease management is pushed into informal interactions, such as phone calls for prescription refills or lab results – work that is critical to patient health yet goes unrecognized and unreimbursed through fee-for-service payment.

Moreover, many integrated services essential to chronic disease management are inadequately funded – including, but not limited to, those provided by dietitians, integrated behavioral health providers, clinical pharmacists, care managers, social workers, and care coordinators. This is compounded by the broader undervaluation of primary care services, which, as discussed, contributes to the ongoing shortage of general internal medicine physicians nationwide. To rectify these shortcomings, CMS should make the APCM's per-beneficiary-per-month payment more robust.

While CMS' creation of the APCM codes was an important step to strengthen primary care in traditional Medicare, SGIM believes the values for the APCM codes are insufficient and do not accurately reflect the resource costs required to deliver these services. Adjustments are needed to ensure the compensation for APCM codes aligns with the actual expenses incurred in providing high-quality primary care services. **We recommend that CMS conduct an empirical investigation to more accurately measure these costs. Additionally, CMS could consider adding additional G-codes – similar to its current proposal to strengthen team-based care in primary care settings for beneficiaries with chronic physical and mental health conditions – to expand the scope of eligible services to ensure dietitians, social workers, pharmacists, and care managers are supported within**

[13] https://www.cms.gov/medicare/coverage/dental

primary care teams. Without these refinements, the APCM payment will fall short of its intended goal to strengthen primary care.

3. *Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?*

Medicare coverage for physical therapy, whether home-based or in an institutional setting, is typically limited to just a few weeks. Many older adults – especially those deconditioned after hospitalizations or medical complications – require ongoing, long-term therapy that is not covered by Medicare. While older adults with strong social support or financial resources may be able to pay out-of-pocket for additional therapy, those with limited means cannot. To address this gap, **Medicare could cover exercise programs at local fitness centers and community facilities. We recognize that these services are currently non-covered because they are not deemed medically necessary and that a change in statute would be required**. However, such programs would help older adults maintain functionality, prevent disability progression, and reduce long-term healthcare costs.[14]

4. *Should CMS consider creating separate coding and payment for medically tailored meals, as an incident-to service performed under general supervision of a billing practitioner? If so, what would be the appropriate description of such a service, and under what patient circumstances (that is, after discharge from a hospital)?*

CMS should provide payment for medically tailored meals for high-risk older adults with cognitive or functional limitations or food insecurity, particularly those with conditions such as diabetes, heart failure, or dementia.

5. *Do community-based organizations providing medically tailored meals currently employ a physician, nurse practitioner, physician assistant, or other practitioner who could both bill Medicare and supervise a medically-tailored meal service? Should CMS consider allowing billing providers to refer to community-based organizations to deliver and ensure quality of medically-tailored meals while under general supervision of the referring billing provider?*

Billing practitioners should be permitted to refer patients to community-based organizations that offer medically tailored meals, just as they are able to refer patients to other medical providers for procedures. While these organizations typically do not employ medical providers, they could strengthen their services by employing registered nutritionists to assist in developing medically tailored menus.

<u>Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health</u>
Key Recommendation: Preserve HCPCS code G0136.

CMS proposes to delete HCPCS code G0136 (Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes, not more often than every 6 months) created by the agency in 2024 to capture work and provide payment for services associated with the administration of a standardized, evidenced based social determinants of health risk assessment tool. The agency believes that the work associated with G0136 may already be accounted for in other types of services like E/M visits.
SGIM respectfully disagrees with CMS' proposal to eliminate separate payment for HCPCS code G0136. CMS' assertion that the work associated with this code is already captured in existing E/M codes does not reflect the

[14] https://bmjopensem.bmj.com/content/7/1/e001038

realities of clinical practice. As discussed, E/M visits are already insufficient, with physicians struggling to address multiple chronic conditions and other patient needs within limited time. The intent of G0136 was to acknowledge that screening for upstream drivers of health can be conducted by interdisciplinary team members – not solely by physicians. Collapsing this work into the E/M visit undervalues the role of the care team and creates a financial disincentive for practices to do this important work. Maintaining this code is particularly important for addressing chronic conditions, where unmet social needs, like food insecurity and housing instability, directly impact health outcomes. **Therefore, SGIM urges the agency to preserve HCPCS code G0136.**

Summary of Recommendations

Conversion Factor: SGIM appreciates the modest increases in conversion factors for 2026 but stresses that these will expire at the end of the year, leading to payment cuts in 2027. SGIM urges CMS to collaborate with Congress on long-term solutions to stabilize physician payment and prevent disruptions to beneficiary access to primary care.

Valuation of Primary Care Services: SGIM highlights the chronic undervaluation of E/M services. We recommend establishing a TEP to develop evidence-based, transparent methods for valuing cognitive work.

Practice Expense Methodology: SGIM strongly opposes CMS's proposed reduction in indirect practice expense RVUs for facility-based services, warning it could destabilize academic medical centers and primary care training sites. SGIM recommends CMS develop a reliable evidence base before making changes.

Efficiency Adjustment: SGIM supports the principle of an efficiency adjustment to reduce disparities between E/M and procedural services but urges CMS to rely on empiric data, not assumptions, when setting adjustment levels.

Payment for Medicare Telehealth Services: SGIM opposes reverting to pre-PHE rules that prohibit teaching physicians from billing for services supervised virtually. We emphasize that virtual presence supports access to care, workforce capacity, and resident training in both rural and urban settings.

E/M Visit Complexity Add-On: SGIM supports CMS's proposal to broaden HCPCS code G2211 to include home and residence-based E/M visits.

Enhanced Care Management: SGIM strongly supports classifying APCM services as preventive, ensuring no cost-sharing burden on patients.

Chronic Illness and Behavioral Health: SGIM urges CMS to improve reimbursement for non-pharmacologic services (e.g., nutrition, dental, behavioral health) and ensure robust support for primary care.

Upstream Drivers of Health: SGIM opposes eliminating HCPCS code G0136 for screening for upstream drivers of health, as this work is not adequately captured by E/M codes. Preserving the code would encourage team-based approaches and address upstream drivers of health that impact chronic disease outcomes.

Thank you for the opportunity to submit these comments. We welcome the opportunity to meet with you to discuss our comments. Should you have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,

Mark D. Schwartz, MD, FACP
Incoming President, Society of General Internal Medicine

1500 King Street • Suite 303 • Alexandria • VA 22314
Tel: 202.887.5150 • 800.822.3060
Web: http://www.sgim.org