



Arizona Dermatology Society

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September 10, 2026

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

Submitted electronically via regulations.gov

RE: 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 Arizona Dermatology Society appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) in response to the calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule.

We share the Administration's emphasis on prevention, early detection, and access to high-quality care. Consistent with the Administration's priority of promoting preventive care, we are concerned that policies included in the CY 2027 Medicare PFS proposed rule would have unintended consequences and decrease beneficiaries' access to timely skin cancer detection and treatment.

On behalf of our 120 member dermatologists across Arizona, we write to urge CMS to withdraw proposals in the CY 2027 Medicare PFS proposed rule that severely reduce payment for dermatology care and jeopardize Medicare beneficiaries' access to timely skin cancer detection and treatment.

Outpatient dermatology serves as a premier model of cost-effective, preventive care. Skin cancer is the most common cancer in the United States,^{1,2} disproportionately impacting seniors aged 65 and older, who account for 71.4% of non-melanoma skin cancer and 60.3% of melanoma cases.³ When caught early in an outpatient setting, melanoma carries a 100% 5-year survival rate for localized disease in patients 65 years or older, with in-office treatment costing approximately \$1,000.^{4,5} Conversely, if diagnosis is delayed and the disease metastasizes to distant sites, 5-year survival drops sharply to approximately 35% in this age group,⁶ and systemic treatment costs

¹ American Academy of Dermatology. (2026, March 2). *Skin cancer: Media statistics*. <https://www.aad.org/media/stats-skin-cancer>

² Centers for Disease Control and Prevention. (n.d.). *United States cancer statistics: Data visualizations*. cdc.gov

³ American Academy of Dermatology. (2018). *Skin disease briefs: Skin cancer by the numbers* (Doc. No. 18-346). (Original work published 2017)

⁴ Horn, D., Alpert, A. E., Duggan, M., & Jacobson, M. (2025, October). *The impact of immunotherapy on reductions in cancer mortality: Evidence from Medicare* (NBER Working Paper No. 34317). National Bureau of Economic Research. doi.org

⁵ Gogebakan, K. C., Mukherjee, K., Berry, E. G., Sonmez, K., Leachman, S. A., & Etzioni, R. (2021). Impact of novel systemic therapies on the first-year costs of care for melanoma among Medicare beneficiaries. *Cancer*, 127(16), 2926–2933. doi.org

⁶ Surveillance Research Program, National Cancer Institute. (2025). *SEER*Explorer: An interactive website for SEER cancer statistics* [Data set]. SEER Incidence Data, November 2025 Submission (1975–2023), SEER 21 registries excluding Illinois; Expected Survival Life Tables by Socio-Economic Standards. Custom query: Melanoma of the Skin, recent trends in SEER

balloon to hundreds of thousands of dollars per patient annually.⁷ Proposed payment cuts threaten this highly effective model of early detection and preventive care, risking care delays that compromise patient outcomes and drive-up long-term Medicare expenditures.

According to the Centers for Disease Control and Prevention (CDC), approximately 71% of all melanoma deaths occur in adults aged 65 and older.⁶ Preserving access to immediate, same-day in-office evaluations is directly tied to saving senior lives in Arizona.

Specifically, **two core proposals** drive these severe payment reductions: a proposed 50% payment reduction on lower-cost services billed on the same day as an evaluation and management (E/M) visit (Modifier 25), and the proposed changes to the practice expense methodology, including the two-year phaseout of the Indirect Practice Cost Index (IPCI). It is estimated that the fully implemented combined annual impact by 2028 of the reduction in the Medicare conversion factor, the Modifier 25 cuts, and the practice expense changes, including phasing out the IPCI, would be a 16% payment cut (internally calculated awaiting third party verification).

Compounding Payment Reductions & Access Strain: These proposed Medicare cuts take effect within a payment system that has long failed to keep pace with operational inflation. Adjusted for practice expenses, Medicare physician payment declined 33% from 2001 to 2026.⁸

Threat to Independent, Small-Business Medicine: Dermatology stands as a premier model of independent, small-business medicine. While much of healthcare has consolidated into large hospital systems, 68% of dermatologists continue to practice in private, non-hospital settings, including 54% in physician-owned practices and approximately 15% in private equity-backed firms.⁹ Federal data confirms this vulnerability: CMS's own Quality Payment Program data shows that over 50% of Merit-based Incentive Payment System (MIPS)-eligible dermatologists are officially designated as practicing in small practices.¹⁰ As independent small businesses, these practices bear full responsibility for operational overhead, making severe payment reductions far harder to absorb. Unlike hospital systems that offset physician losses through facility fees, small practice owners must absorb rising labor and supply costs directly. Deep cuts threaten the financial viability of these small businesses, accelerating forced consolidation into hospital outpatient departments where Medicare incurs significantly higher facility fees. In Arizona, where each physician supports an average of 14 local jobs, these reductions threaten both healthcare employment and patient access.¹¹

Crossing the Medicaid Threshold: Kaiser Family Foundation (KFF) data indicates that proposed 2027 Medicare payment rates would reduce physician reimbursement below current Medicaid levels in multiple states.¹² Because many state Medicaid fee schedules benchmark directly against Medicare, a collapse in Medicare rates will trigger cascading Medicaid cuts, further exacerbating access barriers for vulnerable populations.

Severe Access Bottlenecks for Seniors: Medicare beneficiaries reasonably expect their coverage to be accepted, and current data supports that expectation. In a national secret-shopper study of

relative survival rates, 2004–2022, by stage at diagnosis, 5-year relative survival, both sexes, all races and ethnicities, ages 65+. Retrieved September 9, 2026, from <https://seer.cancer.gov/statistics-network/explorer/>

⁷ Alexandrescu, D. T. (2009). Melanoma costs: A dynamic model comparing estimated overall costs of various clinical stages. *Dermatology Online Journal*, 15(11), Article 1.

⁸ American Medical Association. (2026, January). *Medicare physician updates compared to inflation in practice costs (2001–2026)* [Infographic]. <https://www.ama-assn.org/system/files/2026-medicare-updates-inflation-chart.pdf>

⁹ American Academy of Dermatology Association. (2025). *Practice profile* [Unpublished raw data].

¹⁰ Centers for Medicare & Medicaid Services. (n.d.). *Quality Payment Program public use file, performance year 2024* [Data set].

¹¹ IQVIA. (2018). *The national economic impact of physicians: National report*. American Medical Association. <https://www.ama-assn.org/sites/default/files/media-browser/public/2018-ama-economic-impact-study.pdf> [1]

¹² KFF. (2025). *Medicaid-to-Medicare fee index*. KFF State Health Facts. <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/>

dermatology clinics, appointment success rates were 94% for Medicare compared to 17% for Medicaid.¹³ In a separate audit of visits for a changing pigmented lesion, only 11 to 13% of community dermatology practices accepted Medicaid, compared with more than 90% that accepted commercial coverage.¹⁴ These access barriers carry severe clinical consequences: peer-reviewed data demonstrates that Medicaid beneficiaries are more than twice as likely to present with advanced, thicker melanomas and face an 83% higher mortality risk compared to non-Medicaid patients,¹⁵ driven largely by specialist access bottlenecks and surgical delays. If Medicare payment falls to or below current Medicaid levels, the Arizona Dermatology Society is concerned that seniors will face these same severe access constraints and compromised health outcomes in Arizona.

Disproportionate Impact on Rural Communities: Decreased access to essential skin cancer and dermatologic services will fall hardest on rural seniors who already operate with severely limited care options. More than 60% of U.S. counties lack a practicing dermatologist,^{16,17} leaving rural areas with a density of less than 0.1 dermatologists per 100,000 residents compared to over 4 per 100,000 in metropolitan counties.¹⁸ Because of these severe geographic barriers, rural seniors travel 40 or more miles one-way for care.^{19,20} Rural residents face a 54% higher rate of distant metastatic melanoma diagnoses and a 55% higher mortality risk compared to their urban counterparts.²¹ If local practices serving rural areas are forced to restrict their Medicare panel sizes or opt out of Medicare participation due to these proposed cuts, rural seniors, who have virtually no alternative local specialists, will face immediate care delays. In non-metropolitan areas where patients cannot simply drive to another local clinic, restricting Medicare access converts manageable, early-stage skin cancers into late-stage, high-cost medical crises.

Documented Clinical Risks of Care Delays: Real-world data underscores the dangerous link between delayed access and disease progression.^{22,23} Peer-reviewed research evaluating care delays during the COVID-19 pandemic demonstrated a statistically significant upstaging of cutaneous melanoma, with delayed presentations directly driving higher tumor thickness (Breslow depth) and advanced-stage diagnoses. Policies that restrict office-based practice capacity will reproduce these exact access bottlenecks, delaying early detection and leading to late-stage cancer diagnoses that harm patients and increase Medicare spending.

Commercial and Medicare Advantage Spillover: These proposed cuts will not be isolated to traditional

¹³ Creadore, A., Desai, S., Li, S. J., Lee, K. J., Bui, A. N., Villa-Ruiz, C., Lo, K., Zhou, G., Joyce, C., Resneck, J. S., Jr., Seiger, K., & Mostaghimi, A. (2021). Insurance acceptance, appointment wait time, and dermatologist access across practice types in the US. *JAMA Dermatology*, 157(2), 181–188. <https://doi.org/10.1001/jamadermatol.2020.5173>

¹⁴ Cortez, J. L., Fadadu, R. P., Konda, S., Grimes, B., & Wei, M. L. (2022). Disparities in access for melanoma screening by region, specialty, and insurance: A cross-sectional audit study. *JAAD International*, 7, 78–85. <https://doi.org/10.1016/j.jdin.2022.02.008>

¹⁵ Amini, A., Rusthoven, C. G., Waxweiler, T. V., Jones, B. L., Fisher, C. M., Karam, S. D., & Raben, D. (2016). Association of health insurance with outcomes in adults ages 18 to 64 years with melanoma in the United States. *Journal of the American Academy of Dermatology*, 74(2), 309–316.

¹⁶ Vaidya, T., Zubritsky, L., Alikhan, A., & Housholder, A. (2018). Socioeconomic and geographic barriers to dermatology care in urban and rural US populations. *Journal of the American Academy of Dermatology*, 78(2), 406–408.

¹⁷ Ashrafzadeh, S., Peters, G. A., Buzney, E. A., Lee, H., & Asgari, M. M. (2021). Gender differences in dermatologist practice locations in the United States: A cross-sectional analysis of current gender gaps. *International Journal of Women's Dermatology*, 7(4), 435–440.

¹⁸ Feng, H., Berk-Krauss, J., Feng, P. W., & Stein, J. A. (2018). Comparison of dermatologist density between urban and rural counties in the United States. *JAMA Dermatology*, 154(11), 1265–1271.

¹⁹ Larson, E. H., Andrilla, C. H. A., Garberson, L. A., & Evans, D. V. (2021, September). *Geographic access to health care for rural Medicare beneficiaries: A national study* (Policy Brief). WWAMI Rural Health Research Center, University of Washington. <https://www.ruralhealthresearch.org/publications/1452>

²⁰ U.S. Government Accountability Office. (2020, December 22). *Rural hospital closures: Affected residents had reduced access to health care services* (Report No. GAO-21-93). <https://www.gao.gov/products/gao-21-93>

²¹ Shellenberger, R. A., Johnson, T. M., Fayyaz, F., Swamy, B., Albright, J., & Geller, A. C. (2023). Disparities in melanoma incidence and mortality in rural versus urban Michigan. *Cancer Reports*, 6(2), e1713.

²² Trepanowski, N., Chang, M. S., & Zhou, G. (2022). Delays in melanoma presentation during the COVID-19 pandemic. *Journal of the American Academy of Dermatology*, 87(5), 1217–1219.

²³ Soni, A., Purcell, E., Lim, B., Marcaccini, G., Seth, I., & Rozen, W. M. (2025). The Silent Spread: A systematic review of delayed melanoma diagnosis and disease progression during the COVID-19 pandemic. *JEADV Clinical Practice*, 4(5), 982–1006. <https://doi.org/10.1002/jvc.2.70154>

Medicare, as commercial payers and Medicare Advantage plans in Arizona frequently tie their contracted fee schedules to the Medicare PFS and adopt CMS billing policies, including same-day service reductions for Modifier 25. If CMS finalizes a 50% same-day reduction, private payers and Medicare Advantage plans will quickly adopt the policy, compounding these losses across a practice's entire payer mix and threatening the financial survival of local independent clinics.

1. Proposed Modifier 25 (Same-Day Care Reductions): 50% payment reduction on lower-cost services furnished on the same day as an E/M visit.

- **Modifier 25 Usage Reflects Clinical Reality Medicine:** Modifier 25 utilization in dermatology is a natural outcome of high-quality care, where direct examination routinely reveals both general medical evaluation needs and distinct procedural needs during a single visit. Addressing both evaluation and procedural care in the same encounter represents standard, comprehensive care, and flat utilization data over time confirms a stable, compliant baseline. Proposed payment reductions that fall below direct practice costs threaten overall practice sustainability, creating access barriers that risk delaying early detection and driving higher long-term costs for Medicare.
- **Appropriate & Stable Utilization:** Modifier 25 utilization in dermatology has been stable and does not reflect an accelerating rate of billing. An independent analysis by the Academy using CMS Physician/Supplier Procedure Summary (SPSP) for CY2022 and CY2025, finds that dermatology's Modifier 25 utilization rate on office visits was 61.91% in CY2022 and 61.69% in CY2025.

While the total count of Modifier 25 visits in dermatology rose 5.7% during this period, the increase is accounted for by growth in dermatology's own office visit base, which rose 6.3%, and not by any change in how often dermatologists append the modifier. Independent work by the HHS Office of Inspector General (OIG) found a Modifier 25 rate of approximately 61.5% for dermatology in CY2019 and CY2020 and concluded that dermatologists generally met Medicare requirements, with 90 of 100 sampled services compliant.²⁴ OIG measured claims and this analysis measures services, so the two are separate instruments rather than one continuous series. Read together, they indicate dermatology's Modifier 25 rate has sat at roughly the same level since 2019. Slight aggregate shifts in the Modifier 25 rate were largely driven by a change in coding mix rather than altered billing behavior.

Dermatologists' propensity to use Modifier 25 has not changed materially in any year observed since 2019. Beyond stable utilization, federal oversight confirms high billing integrity, confirming that dermatologists overwhelmingly met Medicare documentation requirements for same-day procedures.

- **Targeted Program Integrity Alternatives:** If the Agency seeks to address potential coding compliance or over-utilization concerns, the appropriate remedy is targeted auditing, education, and data-driven oversight. Broad, across-the-board payment reductions penalize compliant practices that appropriately use Modifier 25 to deliver efficient care. CMS should utilize focused program integrity tools rather than implementing a blunt policy that harms compliant physicians and restricts patient access.
- **Existing RUC De-Duplication:** The American Medical Association (AMA) Relative Value Scale Update Committee (RUC) valuation process already systematically strips out overlapping physician work and practice expenses for procedures frequently performed on the same day as an E/M visit. Imposing an additional 50% payment reduction arbitrarily discounts the exact same operational efficiency twice.
- **Overall Impact on Specialties (Modifier 25):** Across all specialties, a third-party financial analysis commissioned by the American Academy of Dermatology Association (AADA) estimates that the

²⁴ U.S. Department of Health and Human Services, Office of Inspector General. (2025, November 18). *Dermatology providers generally met Medicare requirements for evaluation and management services performed on same day as minor surgical procedures* (Report No. A-04-21-04083).

proposed policy would reduce Medicare fee-for-service (FFS) allowed amounts for billing-group days (prior to any redistribution for purposes of Medicare PFS budget neutrality and excluding other policy proposals for CY 2027) by approximately \$969 million in 2024 terms, or approximately 0.6% of total physician/supplier Part B allowed and 1.0% of total Medicare PFS allowed.²⁵ A “billing-group day” is defined as a unique combination of beneficiary, date of service, and billing provider group that includes at least one eligible modifier 25 office/outpatient (O/O) E/M service and at least one eligible same-day 0-, 10-, or 90-day global procedure.

- **Disproportionate Specialty Impact (Modifier 25):** Dermatology is the specialty with the largest estimated allowed reduction in absolute dollars, accounting for approximately \$290 million of the estimated allowed reduction or approximately 30.0% of all specialty reductions, despite dermatology representing approximately 4.1% of total Medicare PFS allowed spending. The proposed policy would reduce total Medicare PFS allowed spending by approximately 7.0% across roughly 6.4 million billing-group days – among the highest modeled reduction allowed amounts of any specialty.
- **Concentration in Dermatology Services (Modifier 25):** A small number of common services provided by dermatology practitioners drive a large share of the estimated dermatology impact. Billing-group days with five global procedure code combinations account for approximately 62% of the modeled dermatology reduction:
 - **17000:** Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement) of premalignant lesions (e.g., actinic keratoses); first lesion
 - **11102:** Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette); single lesion
 - **17110:** Destruction (e.g., laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
 - **11102 + 17000:** as defined above
 - **17000 + 17110:** as defined above

Table 1. Proposed Modifier 25 Policy for Top 5 Dermatologic Procedures: Medicare Payment vs. Direct Practice Costs by CPT Code

Proposed Modifier 25 Policy for Top 5 Dermatologic Procedures Billed with Modifier 25: Medicare Payment vs. Direct Practice Costs by CPT Code					
Volume Rank	CPT Code(s)	Estimated 2027 Payment: Current Policy	Estimated 2027 Payment: Proposed Policy	Direct Practice Expense Cost (Net Loss)	Used for Skin Cancer or Pre-Cancer
#1 Most Common	17000	\$62.73	\$31.36	\$31.37 (-\$0.01)	Yes

²⁵ Total physician/supplier Part B allowed refers to Medicare allowed amounts for all services in the Part B carrier claims file, including final claims submitted by suppliers (excluding durable medical equipment (DME) suppliers) to the Medicare Administrative Contractor (MAC) on the professional claim form (CMS-1500). It excludes Part B DME services billed by DME suppliers and Part B services billed by providers, such as hospital outpatient services paid under the Outpatient Prospective Payment System (OPPS). Total MPFS allowed is the subset of those physician/supplier Part B services payable under the Medicare Physician Fee Schedule and excludes services priced under other methodologies, such as provider-administered drugs and clinical laboratory services.

#2	11102	\$89.98	\$44.99	\$56.82 (-\$11.83)	Yes
#3	17110	\$104.76	\$52.38	\$70.24 (-\$17.86)	No
#4	11102 + 17000	\$89.98 + \$31.36 = \$121.34 <i>*MPPR applies in this scenario</i>	\$44.99 + \$31.36 = \$76.35	\$56.82 + \$31.37 = \$88.19 (-\$11.84)	Yes
#5	17000 + 17110	\$31.36 + \$104.76 = \$136.12 <i>*MPPR applies in this scenario</i>	\$31.36 + \$52.38 = \$83.74	\$31.37 + \$70.24 = \$101.61 (-\$17.87)	Yes

**Note: Values reflect non-facility, non-qualifying alternative payment model (APM) participant CY 2027 payment rates. A 50% payment reduction is applied to the lower-valued code, with the Multiple Procedure Payment Reduction (MPPR) applied where applicable.*

The Arizona Dermatology Society is particularly concerned that the proposed reduction would, in many instances, result in Medicare payment that does not cover the direct practice expense required to furnish the service, much less the physician work involved or associated indirect costs. Payment at levels that fail to cover the resources required to furnish care is unsustainable for physician practices. As a result, this policy severely compromises practice viability, making it increasingly difficult for independent practices to remain open to Medicare beneficiaries.

2. Practice Expense Methodology & IPCI Elimination

- Calculations Ignore Practice Overhead:** CMS proposes to eliminate the Indirect Practice Cost Index (IPCI) over two years without empirical justification. Under current policy, IPCI scales practice expense relative value units (RVUs) to account for specialty-specific overhead. Non-facility dermatology practices carry high clinical staff-to-physician ratios, significant technical support needs, and facility-like infrastructure. Eliminating IPCI strips away accurate accounting for these costs. RAND analysis conducted for CMS demonstrated that indirect practice costs have low or negative correlations with direct inputs, confirming that increasing reliance on direct inputs distorts real-world care costs.²⁶
- Practice Expense Cuts Impact Codes Used for Skin Cancer:** The top 50 dermatology procedure codes represent almost all the procedures dermatologists bill to Medicare (98% of all payments).²⁷ Of these top 50 codes, 91% of the payments are used for the detection and treatment of skin cancer.²⁷

Specific Policy Asks

We urge CMS to protect Medicare beneficiary access by taking the following actions in the final rule:

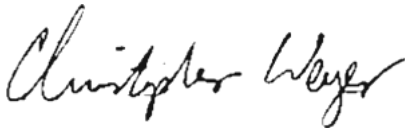
²⁶ Burgette, L. F., Liu, J. L., Miller, B. M., Wynn, B. O., Dellva, S., Malsberger, R., Merrell, K., Nguyen, P., Nie, X., Pane, J. D., Qureshi, N., Ruder, T., Zhao, L., & Hussey, P. S. (2018). *Practice expense methodology and data collection research and analysis* (Research Report No. RR-2166-CMS). RAND Corporation. doi.org

²⁷ Centers for Medicare & Medicaid Services. (2026). *Medicare physician & other practitioners public use file, by provider and service*, 2024. <https://data.cms.gov/provider-summary-by-type-of-service/medicare-physician-other-practitioners/medicare-physician-other-practitioners-by-provider-and-service>

- **Modifier 25:** Withdraw the proposed 50% payment reduction for same-day services appropriately reported with Modifier 25.
- **Practice Expense Methodology:** Withdraw the proposal to eliminate the IPCI from the practice expense methodology.
- Should CMS decline to accept the above recommendations, we request that CMS delay implementation of significant changes until the Agency provides greater transparency regarding its methodology and data, conducts a thorough specialty-level impact analysis, and establishes safeguards to prevent disproportionate payment reductions.

Thank you for considering the impact of these proposals on Arizona dermatologists and the seniors who depend on us for timely, life-saving skin cancer detection and care.

Sincerely,

A handwritten signature in black ink, appearing to read "Christopher Weyer". The signature is fluid and cursive, with the first name "Christopher" written in a larger, more prominent script than the last name "Weyer".

Christopher Weyer, DO, FAAD

President, Arizona Dermatology Society