AIMPA®

American Independent
Medical Practice
Association®

September 10, 2025

VIA ELECTRONIC DELIVERY
Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: MPFS Proposed Rule (CMS-1832-P)

Dear Administrator Oz:

On behalf of the American Independent Medical Practice Association, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") Calendar Year 2026 Medicare Physician Fee Schedule ("PFS") Proposed Rule (CMS-1832-P) ("Proposed Rule").[1] We thank CMS (and the Trump Administration more broadly) for your commitment to restoring competition and eliminating regulatory burdens for the benefit of all Americans. Our comments focus on actions that CMS can take in finalizing the Proposed Rule that will help realize these goals for Medicare beneficiaries and the physicians and other providers who care for them.

We believe we offer a unique perspective on key issues arising under the Proposed Rule. AIMPA is the country's first national, multi-specialty advocacy organization devoted exclusively to the interests of physicians caring for patients in independent medical practices. AIMPA represents more than 600 independent medical practices in 45 States. These practices include over 12,000 physicians who provide high-quality, affordable health care for approximately 25 million patients each year.

Our comments to the Proposed Rule focus on three issues impacting Medicare beneficiaries' access to care at independent medical practices:

Efficiency Adjustment. We appreciate CMS's desire to improve upon the mechanisms used to establish relative value units ("RVUs") for the codes used for payment under the PFS. Changes need to be made, but we believe that it is premature for CMS to adopt an across-the-board 2.5% downward adjustment to work RVUs ("wRVUs") for all

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

procedures, radiology services, and diagnostic test codes. CMS recognized several times in the Proposed Rule that it is basing the efficiency adjustment on a series of assumptions and does not yet have the empirical data needed to support this one-size-fits-all approach. To make matters worse, if CMS finalizes the downward adjustment for CY 2026, it will disproportionately harm physicians in independent practices and threaten Medicare beneficiaries' ability to access high-quality care in the lower cost community setting. Accordingly, we urge CMS to delay implementation and, then, only apply the efficiency adjustment to those services for which the Agency obtains objective data to support such action.

Direct Supervision via Use of Two-Way Audio/Video Communications Technology. We thank CMS for taking this step to expand access to care delivery. We agree with CMS's proposal to make permanent the COVID-era flexibility for satisfying "direct supervision" via two-way audio/video communications technology.

Fixing the Broken Medicare Payment System for Physicians in Independent Practice. The physician community needs bold leadership from CMS and the Administration, working with Congress, to fix the PFS that has failed to keep track with practice cost inflation for more than two decades. We know that CMS understands the importance of getting physician payment levels right. That concern is the foundation of the Agency's proposed efficiency adjustment. But the proposed adjustment to wRVUs is only one piece of the puzzle and needs to accompany adjustments that account for the fact that physician payments under the PFS are down more than 30% on an inflation-adjusted basis in the last 20 years.

We now turn to our specific comments on each of these issues.

I. CMS Should Not Implement the Proposed wRVU Efficiency Adjustment in CY 2026.

We agree with CMS that the process for establishing accurate valuations for physician services under the PFS needs to be updated. A RUC process that revalues codes once every 17-plus years clearly is not working, and CMS rightly identified limitations in the use of survey data.[2]

What should CMS do about the limitations of survey data that underpin the current valuation process? And on what timeline—and with what information—should CMS make adjustments to the component parts of RVUs for procedures, radiology services, and diagnostic tests when it appropriately expressed "a preference for information with empirical evidence behind it?"[3]

We believe there is a better way than an across-the-board 2.5% downward adjustment that CMS recognized in the Proposed Rule is based on an unverified assumption.[4] Revisions to wRVUs need to be rooted in empirical data and, as such, we urge CMS to delay implementation of the proposed wRVU efficiency adjustment until CMS obtains additional stakeholder feedback, empirical

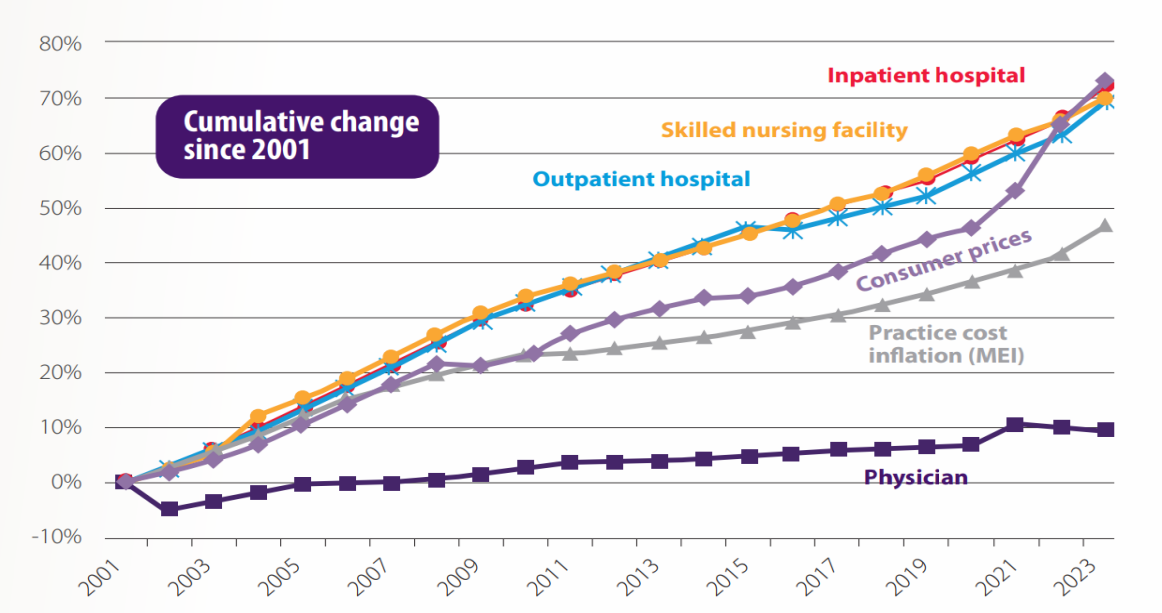
[2] *Id*. at 32400.
[3] *Id*. at 32399.
[4] *Id*. at 32401 ("Our proposal is based on our assumption that both the intra-service portions of physician time and the work intensity…would decrease as the practitioner develops expertise in performing the specific service.").

evidence, and a better understanding of how an across-the-board, downward adjustment to wRVUs would impact physicians in independent medical practices as compared to those employed in the hospital setting. With concrete data in hand, CMS should only adopt an efficiency adjustment for specific procedures, radiology services and diagnostic tests coupled with an Medicare Economic Index ("MEI") adjustment that solves for the more than 30% inflation-adjusted cut in reimbursement that independent medical practices have endured over the last 20-plus years.

A. Any Efficiency Adjustment to wRVUs Should Not be Made Without Simultaneously Solving for the Lack of Inflation Adjustment to Control for the Runaway Costs of Practice Expenses.

Our biggest concern with the proposed efficiency adjustment is that it looks at only one component of the overall payment for physician services—the work RVUs and corresponding updates to the intra-service portion of physician time inputs for non-time-based services. CMS explains that it is taking this step "[t]o take into account changes in medical practice and better reflect the resources involved in furnishing services paid under the PFS."[5] That is a worthy aim, but this change should not happen in isolation, when we know that independent physician practices have not received an inflation-based adjustment to their reimbursement under the PFS in more than two decades.

As the graph below demonstrates, Medicare reimbursement for inpatient hospitals, hospital outpatient centers, and skilled nursing facilities has increased by around 70% over the last two-plus decades, while reimbursement for physicians has increased by less than 10%. At the same time, the costs associated with operating a physician practice have increased by nearly 50%. All told, Medicare payments to physicians have *declined* more than 30% after accounting for inflation.



Credit: American Medical Association

[5] *Id.*

Given these financial headwinds, it is no wonder that many independent physicians have been forced to close their practices or accede to buyout offers from hospitals or large health systems. Medicare reimbursement to physicians simply has not kept up with the cost of staffing, rent, insurance, and other operational expenses.

That reality is what makes it so painful that CMS is proposing to focus exclusively on imposing a downward efficiency adjustment for work RVUs for CY 2026 without taking account of the inflationary pressures that have become an existential crisis for independent medical practices in this country. Moreover, the proposed 2.5% downward adjustment comes against the backdrop of the 2.5% increase in Medicare physician reimbursement for 2026 included in the One Big Beautiful Bill Act, which President Trump signed into law on July 4, 2025. We believe the Administration's clear intent was to provide physicians with a modest increase in payment rates for 2026. Yet, the proposed efficiency adjustment undermines what President Trump and Congress achieved through the One Big Beautiful Bill Act.

We respect CMS's desire to be "conservative in nature" and avoid "making too many changes at once to the current methodology."[6] But that conservative approach means that physicians, particularly those in procedure-intensive specialties, will see downward adjustments in reimbursement for their services without any corresponding adjustments to reflect the inflationary pressures on their medical practices. We do not believe it makes sense to reduce work RVUs via the MEI productivity factor without taking a holistic approach that also looks at practice expense inputs and equipment costs. All these factors should be considered when changing payment rates in the interest of "efficiency."

Accordingly, we urge CMS to delay implementation of the efficiency adjustment until CMS, working with the physician community in the coming year, can devote attention to how increased practice expenses need to be accounted for in establishing more equitable and accurate payment rates under the PFS.

B. The wRVU Efficiency Adjustment Will Disproportionately Harm Physicians in Independent Medical Practices and Drive More Care into the Higher-Cost Hospital Setting.

The across-the-board efficiency cut will be felt most acutely in independent medical practices and will further exacerbate the competitive imbalance between independent practices and large hospitals and health systems. We know the Administration is committed to restoring competition and eliminating anti-competitive regulations. But this wRVU cut will unintentionally harm competition because of the disproportionate adverse effect it will have on independent practices.

As a practical matter, independent medical practices that provide services subject to the efficiency adjustment will be impacted more acutely than health system-affiliated or hospital-affiliated providers. Providers at independent medical practices generally provide ancillary services such as diagnostic testing and radiology services within their own offices, whereas hospital-employed

[6] *Id*.

providers are more likely to refer those same services to higher-cost hospital facilities. Studies consistently show that physicians employed by hospitals perform more services in higher-cost hospital outpatient departments ("HOPDs") than physicians in independent medical practices. For some procedures, hospital-employed physicians were seven times more likely to perform certain services in a higher-cost HOPD than independent physicians. Moreover, when a hospital-affiliated provider refers a procedure, diagnostic test, or radiology service to a hospital, the hospital receives a facility fee that generally far exceeds the technical fee paid to a physician office or the facility fee paid to an ambulatory surgery center ("ASC"). The higher payments that hospitals receive enable them to compensate physicians at significantly higher levels than independent medical practices can offer.

Not so in the independent practice setting where we are already facing significant shortages in various medical specialties as a growing demographic of baby boomers enter the Medicare system. Take ophthalmology as one example in which it is estimated that 49% of ophthalmologists face cuts under the proposed efficiency adjustment.[7] Even before COVID, there were too few ophthalmologists to handle the growing need for cataract surgery. The practical effect of this 2.5% efficiency adjustment—made worse by the 30% cut in Medicare reimbursement that physicians in independent practice have endured, on an inflation-adjusted basis, over the last two decades—is that it will further distort the already stretched supply-and-demand curve for the estimated four million cataract surgeries performed in the United States each year.

This is the wrong moment to hit the physician community with a not-yet-substantiated 2.5% efficiency adjustment, when data show that we need the government to be creating policies that shift more care into the lower cost independent practice setting. A July 2025 peer-reviewed study focusing on the impact of practice affiliation on the cost of care showed that HOPDs were reimbursed by Medicare up to 861% of the reimbursement that independent physician practices in their medical offices and ASCs received for the same services.[8] This disparity was even greater when looking at payments from commercial insurers, with HOPDs receiving as much as 1,346% of the reimbursement that independent practices and ASCs receive.[9] The study also found that Medicare beneficiaries treated by hospital-affiliated physicians had just a 37% chance of receiving care in the lowest-cost setting (either medical office or ASC), further compounding the cost-of-care problem created by the difference in reimbursement.[10]

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[7] See AMA Statement, "Understanding the Proposed Medicare Physician Fee Schedule 2026" (on file).
[8] Deepak Kapoor, et al., *Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures*, Journal of Market Access and Health Policy (2025), available at https://www.mdpi.com/2001-6689/13/3/36 (examining the cost of care for physicians practicing in the specialties of cardiology, gastroenterology, orthopedics, and urology).
[9] *Id.*
[10] *Id.*

C. CMS Should Not Arbitrarily Apply an Across-the-Board 2.5% Downward Adjustment to wRVUs, when the Agency has Acknowledged that It Does Not Have Empirical Data to Support Such Action.

In the same way that CMS has noted that RUC survey data are often inadequate given the low number of responses, we are concerned that CMS does not have sufficient empirical data on which to base such a sweeping 2.5% downward adjustment across all procedures, radiology services, and diagnostic tests. Before CMS adopts such an adjustment, we ask that the Agency pressure test certain of the key assumptions upon which it based its proposal.

For example, CMS explained that its proposal is "***based on the assumption*** that both the intra-service portion of physician time and the work intensity (including mental effort, technical effort, physical effort, and risk of patient complications) would decrease as the practitioner develops expertise in performing the specific service."[11] Although that might be an accurate assumption for certain procedures, radiology services, and diagnostic tests, it is equally likely that there is a significant percentage of these procedures, services, and tests for which this is not the case.[12] And even for a procedure that takes less time as a physician gains experience performing the procedure, those time savings are just as likely to be offset by those same, more experienced physicians taking on more complex cases for sicker patients that require additional time to perform the procedure.

In fact, we know from recently-published, objective data that for the majority of surgical procedures, ***operative times have stayed the same or increased*** from 2019 to 2023 and that patient complexity correspondingly increased over that period.[13] This analysis, published in August 2025, was based on an analysis of the National Surgical Quality Improvement Program registry in 2019 and 2023. The study sample included more than 1.7 million operations across 249 CPT codes and 11 surgical specialties, and the authors found that, "[o]verall, operative times increased by 3.1% (CI 3.0-3.3%, $p<0.001$) in 2023 compared to 2019, or 0.8%/year (CI 0.7-0.8%/year, $p<0.001$)…[and, at] the procedure level, 90% of CPT codes had longer or similar operative times in 2023 compared to 2019."[14] Application of an across-the-board, downward efficiency adjustment cannot be squared with this empirical evidence.

And this says nothing of the distinction between the amount of time a given procedure will take for a less versus more experienced physician. Using the specialty of cardiology as an example,

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[11] 90 Fed. Reg. at 32401 (emphasis added).

[12] As one example, most invasive/interventional procedures in cardiology have reached their maximum efficiency. While a transcatheter aortic valve replacement took four to six hours to perform 10 years ago, the same procedure can now be done in less than two hours; however, it cannot be done faster than that. And yet, CMS proposes that a downward efficiency adjustment would recur every three years. See *id.* at 32403 (proposing to apply the efficiency adjustment to the intra-service portion of physician time and work RVUs every 3 years).

[13] Childers, Christopher P, MD PHD, et al., "Longitudinal Trends in Efficiency and Complexity of Surgical Procedures: Analysis of 1.7 Million Operations Between 2019 and 2023," *Journal of the American College of Surgeons*, 10.1097/XCS.0000000000001588, August 13, 2025. | *DOI:* 10.1097/XCS.0000000000001588, *available at* https://journals.lww.com/journalacs/abstract/9900/longitudinal_trends_in_efficiency_and_complexity.1369.aspx (last accessed Aug. 28, 2025).

[14] *Id.*

some cardiologists can complete a diagnostic coronary angiography in less time than other cardiologists due to their superior "wire skills"—i.e., their ability to manipulate the catheter from the groin into the heart and into the target vessel. We oppose any adjustments to wRVUs that would penalize a more skilled, adept physician by factoring their efficiency into the overall average time it takes to do a given procedure. Moreover, downwardly adjusting wRVUs in the name of technological efficiencies that shorten time spent performing the procedure misses the mark by failing to account for the additional labor of preparing for the procedure, talking to the patient and family in advance of and following the procedure, and documenting operative notes in the patient record. We do not see how a one-size-fits-all downward adjustment across all procedures, radiology services and diagnostic services can work without pressure testing CMS's assumptions on a service-by-service basis.

CMS also notes that "changes in practitioner experience, operational workflows, and new technologies … ***may not*** have been previously accounted for in the valuation of non-time based codes."[15] This ***may*** be the case for certain codes, but it does not justify applying such a blunt instrument across all procedures, radiology services, and diagnostic tests. For example, CMS is undoubtedly right that new technologies have improved efficiencies for certain procedures, but those technological advances are increasingly expensive and not factored into CMS's isolated look at wRVUs.[16]

Moreover, we do not believe that the proposed efficiency adjustment adequately accounts for the RUC's ongoing valuation process or CMS's annual proposed changes to misvalued services under the PFS (including in the Proposed Rule for CY 2026).[17] As such, we are concerned by CMS's proposal to apply the efficiency adjustment even to codes that are being revalued in the normal course this year.[18] CMS's articulated purpose in implementing the 2.5% efficiency adjustment is to reflect efficiencies obtained as services mature over time, but that is the same purpose as the standard examination and revaluing of codes that occurs on an annual basis. We see no justification for cutting wRVUs by an additional 2.5% cut when this year's revaluation process is already capturing such efficiencies.[19] For the same reason, we believe it would be a mistake to apply the 2.5% efficiency adjustment to newly established codes for CY 2026. In both instances, the across-

[15] 90 Fed. Reg. at 32401 (emphasis added).

[16] Two examples from different medical specialties illustrate why it is a mistake to apply an across-the-board 2.5% downward adjustment to wRVUs in the name of "efficiency." As CMS recognizes, there are instances in which efficiencies plateau for certain procedures notwithstanding technological advances. As but one example, cataract surgery time has not changed significantly in more than a decade despite improvements in technology and is not expected to change in the foreseeable future. On the other hand, with the benefit of technological advances, even the most complex electrophysiology ("EP") ablations can be completed in two-and-a-half to three hours in the cath lab, whereas it was not uncommon for some EP ablations to take four to six hours to perform 20 years ago.

[17] 90 Fed. Reg. at 32375.

[18] *Id*. at 32402.

[19] The double hit will have seriously practical consequences across medical specialties. Take urology as an example. Through CMS's standard revaluation process for CY 2026, wRVUs for CPT 52601 (prostatectomy) are set to decrease by 24% from 13.16 to 10.00, but with the efficiency adjustment added on top of that cut, wRVUs will fall an additional 2.5% to 9.75. Similarly, wRVUs for CPT 52648 (laser surgery of prostate) are already set to decrease by 17.3% from 12.15 to 10.05, but if CMS finalizes the proposed efficiency adjustment, wRVUs for the procedure will decrease another 2.5%. And for the reasons we outlined above, these double cuts to high volume procedures that treat men with prostate cancer will be felt most acutely in the independent practice setting.

the-board efficiency adjustment is almost certainly going to be duplicative of cuts occurring in the normal cause through CMS's standard revaluation of codes.

Accordingly, we urge CMS to consider the adverse implications of the "double hit" that will occur for those codes that are proposed to be adjusted downwardly for CY 2026 through the normal revaluation process that will now have an additional 2.5% downward adjustment applied to wRVUs simply because it is a non-time-based procedure, radiology service, or diagnostic test.

More broadly, we have a fundamental concern with the proposal applying the 2.5% reduction in wRVUs regardless of when a CPT code was created or revalued or when the furnishing of a service has become as efficient as it can be. To this end, we ask CMS to reconsider the following choice it made in the Proposed Rule:

> "[W]e believe that applying the efficiency adjustment to non-time-based services more broadly, instead of applying only to certain services that may be more likely to accrue efficiency gains, may help to improve the overall accuracy of our valuation of these services under the PFS."[20]

We would think the opposite would be true, particularly given CMS's "preference for information with empirical evidence behind it."[21]

To that end, CMS is seeking comments that will help the Agency make a more informed decision on the scope and application of any efficiency adjustment. For example, CMS is seeking to gather data as to (i) whether there are specific codes that are expected to accrue efficiencies over time, (ii) whether efficiencies stop accruing for certain services after a predefined number of years, and (iii) whether efficiencies are more likely to be gained over time for services that take less time to perform. We appreciate CMS posing these questions, but we believe that the Agency—given its commitment to basing any efficiency adjustment on empirical evidence—should gather that data and engage with the physician community in a more deliberate approach to applying efficiency adjustments to specific procedures, radiology services, and diagnostic tests that the data show have become more efficient and, in those instances, should have an adjustment made to wRVUs.

AIMPA believes that it would be premature and ill-advised to implement a one-size-fits-all efficiency adjustment in the CY 2026 Final Rule, especially given the disproportionate impact it would have on physicians caring for Medicare beneficiaries in independent medical practices.

[20] 90 Fed Reg. at 32402.
[21] *Id*. at 32399.

II. CMS Should Finalize Its Proposal to Make Permanent the Flexibility to Meet the Immediate Availability Requirement of Direct Supervision via Use of Two-Way Audio/Video Communications Technology.

We appreciate the action CMS took in the March 31, 2020, COVID-19 Interim Final Rule with comment period to change the definition of "direct supervision" as it pertains to a variety of services. That change, allowing for "immediate availability" to be satisfied through virtual presence, "facilitate[d] the provision of telehealth services by clinical staff of physicians and other practitioners incident to their own professional services."[22]

For several years, the physician community has been urging CMS to make this flexibility permanent. We applaud CMS's effort to make this flexibility permanent in the PFS for CY 2026. We believe maintaining this flexibility will promote access to high-quality care beyond the end of the year, especially in underserved and rural communities. We appreciate CMS recognizing that it is time to finally end the annual uncertainty about whether this flexibility will continue.

Since CMS first provided this flexibility more than five years ago, services have been provided safely. For independent medical practices, when there is direct patient contact involved and this flexibility is used, there are appropriately trained personnel providing the services. For example, services incident to a physician, especially those involving advanced practice providers ("APPs"), can be provided by an APP independently without a physician being on site. There are already safeguards for patient safety built in with respect to scope of practice and appropriate treatment protocols for most services. The same is true for "many diagnostic tests under § 410.32, pulmonary rehabilitation services under § 410.47, cardiac rehabilitation and intensive cardiac rehabilitation services under § 410.49, and certain hospital outpatient services as provided under § 410.27(a)(1)(iv)."[23]

Accordingly, **we strongly urge CMS to finalize its proposal to make permanent the flexibility to have virtual presence satisfy the "immediate availability" standard for "direct supervision," under the scope outlined in the Proposed Rule.** If, for whatever reason, CMS decides not to make the flexibility permanent effective January 1, 2026, then we urge the Agency to provide an additional one-year extension through December 31, 2026, given the extent to which the provider community has come to rely on this valuable flexibility to expand access to care.

III. AIMPA Urges CMS—and the Administration More Broadly—to Support Congressional Efforts to Provide the Physician Community with Relief from Statutorily-Required Future Cuts to Physician Pay.

Physicians in independent medical practices are caught in a vicious cycle in which they routinely face significant payment cuts under the PFS because of statutorily-mandated reductions to the PFS conversion factor ("PFS CF"). Although Congress stepped in this year with a 2.5% statutory increase to the PFS CF for CY 2026, that increase comes against the backdrop of yearly cuts in

[22] 88 Fed. Reg. at 52301.
[23] 90 Fed. Reg. at 32394.

the PFS CF while practice cost inflation continues to skyrocket. The CY 2026 fix was only a one-year fix and will not be extended without further Congressional action.

Rather than continue to have Congress enact fixes every year, we urge CMS—and the Administration as a whole—to weigh in with Congressional leadership on both sides of the aisle to emphasize the need for permanent relief under the Medicare payment system. CMS is well positioned to communicate to Congress the serious implications that future cuts would hold for the provider community, with inflation persisting and providers continuing to struggle with staffing shortages, increased staffing costs, and the general uncertainty of payment rates each year.

The structural biases in Medicare reimbursement, if left unaddressed, will accelerate hospital-driven consolidation of the market for physician services. As we shared in Part I, Medicare payments to physicians have *declined* more than 30% over the last two decades after accounting for inflation, while Medicare reimbursement rates for inpatient hospitals, hospital outpatient centers, and skilled nursing facilities have increased by around 70% during the same time period. This is not a sustainable model. It will saddle Medicare beneficiaries—and all Americans—with fewer choices in where they can seek care and higher costs and will continue an inexorable march toward a single-payer system controlled by hospital systems.

According to a 2024 study of five specialties (cardiology, gastroenterology, medical oncology, orthopedics, and urology) conducted by healthcare consulting firm Avalere, total Medicare expenditures per beneficiary per year increased an average of more than $1,300 in the 12 months after the physician caring for a beneficiary moved from an unaffiliated private practice to a hospital affiliation. As described above, patients of hospital-affiliated physicians receive more care in the higher-cost facility setting than patients of independent medical practices.[24]

AIMPA is asking for CMS's—and the Administration's—support in obtaining, through Congressional action, a permanent fix to the vicious cycle of physician payment cuts that has occurred for too many years by applying the MEI inflation adjustment to PFS payment rates.

IV. Request for Action

We thank CMS for the opportunity to comment on the Proposed Rule. We urge CMS to take the following actions as it finalizes the PFS for CY 2026:

- Delay implementation of the proposed wRVU efficiency adjustment until CMS obtains additional stakeholder feedback, empirical evidence, and a better understanding of how an across-the-board, downward adjustment to wRVUs would impact physicians in independent medical practices as compared to those employed in the hospital setting; and, only then, adopt an efficiency adjustment for specific procedures, radiology services and diagnostic tests if that adjustment is coupled

[24] Kapoor, et al., *Physician Practice Affiliation Drives Site of Care Cost Differentials: An Opportunity to Reduce Healthcare Expenditures*, Journal of Market Access and Health Policy (2025), available at https://www.mdpi.com/2001-6689/13/3/36.

with an MEI adjustment that solves for the more than 30% inflation-adjusted cut in reimbursement that independent medical practices have endured over the last 20-plus years.

- Finalize the proposal to make permanent the existing flexibility that enables providers to meet the "immediate availability" requirement for direct supervision via use of two-way audio/video communications technology.

- Support Congressional action to provide the physician community with a permanent fix to the Medicare physician payment system that ties reimbursement to the MEI.

AIMPA looks forward to serving as a resource to CMS as it works to finalize the PFS for CY 2026. Please do not hesitate to reach out to AIMPA President and Board Chair Dr. Paul Berggreen (paul.berggreen@aimpa.us; 602-421-2408) if AIMPA can be of further assistance.

Sincerely,

Dr. Paul Berggreen
AIMPA President and Board Chair

Dr. Jack Feltz
AIMPA Chair, Federal Health Policy