AIMPA®

American Independent
Medical Practice
Association®

September 12, 2026

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

RE: MPFS Proposed Rule (CMS-1848-P)

Dear Administrator Oz:

On behalf of the American Independent Medical Practice Association ("AIMPA"), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' ("CMS") Calendar Year 2027 Medicare Physician Fee Schedule ("PFS") Proposed Rule (CMS-1848-P) ("Proposed Rule").[1] We focus our comments on issues that will have a profound impact on the ability of Medicare beneficiaries to access high-quality, timely and cost-efficient care in the independent medical practice setting. As we explain below, certain proposals, especially those relating to modifier -25 and remote patient monitoring, pose an existential threat to care delivered in independent practices.

AIMPA offers 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 2,000 independent medical practices in 48 states. These

[1] 91 Fed. Reg. 43842 (July 16, 2026).

practices include over 14,000 physicians who provide high-quality, affordable health care for approximately 40 million patients each year.

Our comments focus on the following issues:

- **Proposed Changes to Payments Using Modifier -25:** We join a chorus of voices, including a bipartisan group of 74 Members of Congress and over 130 national and state medical associations,[2] in opposing CMS's proposal to cut reimbursement by 50% for all but the highest paid E/M or global procedure service furnished by the same physician (or another physician in the same group practice) on the same day. CMS proposed this change for CY 2019 but wisely withdrew the proposal in that year's final rule. The resurrected proposal poses an existential threat to the viability of independent medical practices and the patients they serve and should be withdrawn.

- **Remote Patient Monitoring:** We support CMS's proposals (i) to extend the "established patient requirement" that already exists for remote physiologic monitoring ("RPM") services to remote therapeutic monitoring ("RTM") services and (ii) to require an initiating visit prior to furnishing RPM and RTM services, but we urge CMS not to finalize its proposal to limit payment for RPM and RTM services when furnished by clinical staff employed by the practice. That proposal, if finalized, would effectively eliminate RPM and RTM for patients of independent medical practices.

- **Replacing HCPCS Code G2211:** AIMPA supports CMS's proposal to replace HCPCS Code G2211 with a flat rate modifier of 16% of the base E/M Code but asks that CMS develop training materials and facilitate education sessions to prepare physicians and their practices for this change.

[2] Letter from the Honorable John Joyce, M.D. the Honorable Gregory F. Murphy, MD, and 72 Additional Members of Congress to CMS Administrator Mehmet Oz, M.D. (Sept. 11, 2026) (urging CMS not to finalize proposal to reduce payment when medically necessary, separately identifiable E/M services are furnished on the same day as procedures with 0-, 10-, or 90-day global periods); Letter from American Medical Association et al. to Administrator Oz re: MPFS Proposed Rule for CY 2027 (Aug. 27, 2026).

- **Fixing the Broken PFS Payment System:** We urge CMS to work with the White House and Congress on statutory reforms that would allow CMS to reallocate savings from the 340B program toward the PFS and the ASC Payment System and to establish a Medicare Economic Index ("MEI") inflationary adjustment that independent practices need to remain viable. At the same time, it is critical that CMS move quickly to expand site-neutral payment for a broader range of services that can be performed safely in the medical office setting and use the savings from reduced payments to hospital outpatient departments to fund an inflationary adjustment to the PFS.

We now turn to our analysis of each of these four issues.

I. CMS's Proposed Change to Payments Using Modifier -25 Is Arbitrary and Capricious and Should Be Withdrawn to Protect Comprehensive Care, Including Cancer Prevention, for Medicare Beneficiaries.

Without any supporting data, CMS is proposing to slash reimbursement when a separately identifiable outpatient/office E/M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global procedure. Under the proposal, the most expensive service (either surgical or E/M visit) would be paid 100%, and all other surgical procedure(s) or E/M visit(s) would be paid 50 percent.[3]

The proposal is shocking and dangerous. CMS proposed a narrower version of this proposal for CY 2019 but withdrew it in response to significant opposition from physician organizations and patient advocacy groups.[4] In resurrecting the proposal, CMS presents no new data or analysis. The proposal also runs counter to the Make America Healthy Again initiative championed by President Trump and

[3] 91 Fed. Reg. at 43908-09.

[4] For CY 2019, CMS proposed to reduce payment by 50% for the least expensive 0-day global procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, identified on the claim by an appended modifier -25. MPFS Proposed Rule for CY 2019, 83 Fed. Reg. 35704, 35840-41 (July 27, 2018). With no data or new analysis, CMS is proposing for CY 2027 an even broader application of the 50% cut that would also cover 10- and 90-day global procedures.

Secretary Kennedy and, as we show in Part I(B) below, is inconsistent with Administrator Oz's recent statements on the modifier -25 issue.[5]

Not surprisingly, a bipartisan group of 74 Members of Congress have urged CMS to withdraw the modifier -25 proposal, including 15 members of the House Energy & Commerce Committee, 13 members of the House Ways & Means Committee, and every member of the GOP and Democratic Doctors Caucuses.[6] The American Medical Association and more than 130 other national and state medical associations also have gone on record in opposition to the proposal.[7]

There are three primary flaws with CMS's proposal—all of which threaten to jeopardize access to comprehensive and convenient care for millions of Medicare beneficiaries in independent medical practices, especially in rural and underserved communities. First, the proposal fails to account for the fact that E/M services billed with a modifier -25 are, by definition, "significant and separately identifiable" from other services furnished by the physician on the same day. Below, we provide concrete examples from across medical specialties of how E/M services billed with modifier -25 are fundamentally different than procedures performed on the same day as the E/M visit and, as such, do not warrant a payment cut for either the E/M service or the global procedure. Second, CMS errs by analogizing the proposed change in payments using modifier -25 to the Agency's multiple procedure payment reduction ("MPPR") policies. Third, it would be arbitrary and capricious for CMS to implement a blanket 50% payment cut without having offered any data or other evidence to substantiate the reduction.

[5] See Letter from Dr. Mehmet Oz, Administrator, Centers for Medicare & Medicaid Services to Carla J. Lewis, Acting Deputy Inspector General for Audit Services, Office of Inspector General, Department of Health and Human Services (Sept. 3, 2025) responding to HHS-OIG, Office of Audit Services, A-04-21-04083, "Dermatology Providers Generally Met Medicare Requirements for Evaluation and Management Services Performed on Same Day as Minor Surgical Procedures" (Nov. 2025) (Addendum D) ("Administrator Oz 9/3/25 Letter").

[6] Letter from the Honorable John Joyce, M.D. the Honorable Gregory F. Murphy, MD, and 72 Additional Members of Congress to CMS Administrator Mehmet Oz, M.D. (Sept. 11, 2026).

[7] Letter from American Medical Association et al. to Administrator Oz re: MPFS Proposed Rule for CY 2027 (Aug. 27, 2026).

A. CMS Incorrectly Assumes There Is Duplication of Payment between an E/M Service Billed with Modifier -25 and a 0-, 10-, or 90-day Global Procedure.

The purpose of the existing modifier -25 payment system is to identify E/M services that are "*significant and separately identifiable*" from the procedure performed on the same day. These E/M services address separate and unrelated diagnoses from those connected to the pre-, intra-, and post-operative work included in reimbursement for the same-day procedure.

The following examples—drawn from patient experiences across specialties—demonstrate the fundamental distinction between an E/M service billed with a modifier -25 and a 0-, 10-, or 90-day global procedure. There is no principled basis for making a sweeping, across-the-bord cut in reimbursement for the procedure or E/M service, yet all this care will be jeopardized if CMS finalizes its proposal.

- Patient with personal history of Stage II melanoma seen for six-month exam. Dermatologist identifies multiple benign growths and manages patient's chronic, stable psoriasis with creams and education but also identifies one lesion worrisome for a new malignant melanoma. A shave-removal is done that day and sent for pathology. In this instance, the lesion was a melanoma in-situ that, once the pathology report came back, was completely cured by local excision in a subsequent office visit with total cost to Medicare of less than $500 compared to at least $500,000 for a patient with advanced melanoma requiring surgery and months of immunotherapy.

- A patient comes in for scheduled injection in right eye but reports new decreased vision in left eye. For injection of the right eye, the left eye would not normally be examined. New complaint in left eye requires full exam of that eye, including refraction, anterior segment evaluation, pupil function, and dilation. The exam of the left eye is unrelated to the planned injection.

- Patient seen for planned ENT procedure but reports a new problem—unilateral nasal obstruction, recurrent epistaxis, acute ear symptoms, or worsening sinonasal disease. The otolaryngologist separately evaluates that problem, determines whether it changes the safety or appropriateness of the scheduled procedure, and formulates an independent diagnostic and

treatment plan. That evaluation is not inherent in the pre-, intra-, or post-operative work assigned to the scheduled procedure. The patient leaves with two unrelated problems addressed.

- During a routine in-office cystoscopy performed on a patient with microscopic hematuria, the urologist identifies a bladder mass. The physician proceeds with a separate discussion advising the patient of the new diagnosis (e.g., bladder neoplasm) and presents recommendations for surgical resection, biopsy, and often at least one dose of topical intravesical chemotherapy. In this separate provision of care, the urologist educates, answers questions, discusses risks and alternatives, allays fears, and sets expectations.

- A diabetic patient comes in for a scheduled anti-vascular endothelial growth factor (VEGF) injection and reports new double vision. Evaluation reveals a new nerve problem caused by diabetes. This requires a separate, extensive examination that is unrelated to the treatment of diabetic retinopathy for which the injection had been scheduled.

- Patient with long history of skin cancer seen for routine skin examination and complains of a new, large, tender boil on their back. Patient did not go to the ER, even though the boil looked very angry, because patient was coming to the dermatologist for routine skin exam. Skin exam performed with multiple benign lesions but none concerning for new malignancy. The large, infected boil is treated same day with incision, drainage, packing, culture, and oral antibiotics.

- A patient presents for the second of three scheduled intravitreal injections in the left eye for proliferative diabetic retinopathy. Patient reports new flashes and floaters in the right eye that prompt evaluation with a dilated exam of the right eye and a new diagnosis of posterior vitreous detachment. The scheduled injection in the left eye is also performed.

- A patient presents with chronic nasal obstruction, impaired sleep, or difficulty breathing through the nose. Otolaryngologist performs medically necessary history, examination, differential diagnosis, and medical decision-making across multiple potential causes—septal deviation, turbinate hypertrophy, nasal valve dysfunction, inflammatory disease, and

> chronic rhinosinusitis. Based on findings, diagnostic nasal endoscopy is deemed medically necessary that day to assess anatomy not visible on routine examination. The endoscopy is the procedure. Establishing the differential diagnosis, interpreting endoscopic findings in clinical context, and developing treatment plan are distinct E/M work required regardless of whether a procedure follows.

In each instance, an E/M visit was billed with an appended modifier -25 to identify the E/M service as significant and separately identifiable. The work done in connection with the E/M service and the associated practice expense are fundamentally different than the pre-, intra-, and post-operative work done and practice expenses associated with the same-day procedure. CMS does not provide a single example of redundancy between the payment for an E/M service billed with modifier -25 and a same day global procedure, but the Agency proposes a sweeping 50% payment cut to all but the highest paid service furnished same day.

Where overlap exists, a mechanism already exists for backing out duplicative physician work and practice expense. The misvalued code initiative commonly identifies and revalues E/M services billed with a modifier -25. Thus, overlap is already addressed—and should continue to be addressed—on a code-by-code basis rather than through an unsubstantiated, blanket 50% cut.

B. CMS's Rationale for Changing Payments Using Modifier -25 Is Deeply Flawed and Contradicts Administrator Oz's Recent Statements Regarding Modifier -25.

CMS offers no support for the 50% cut other than to say that "we are likely duplicating payment" and that the proposal "aligns with our previous proposal from CY 2019 PFS proposed rule (83 FR 35840 through 35841) and matches the longstanding surgical MPPR."[8]

It is true that the new proposal aligns with what CMS proposed for CY 2019, but that earlier proposal was roundly criticized and withdrawn. In this year's Proposed Rule, CMS has not offered any new arguments, data, or other evidence to explain why the proposal it withdrew eight years ago should be implemented now.

[8] 91 Fed. Reg. at 43908.

CMS wrongly analogizes its proposal to its multiple procedure payment reduction ("MPPR") policies. As CMS recognized when it first proposed to change payments using modifier -25 in the Proposed Rule for CY 2019, the "longstanding policy to reduce payment by 50 percent for the second and subsequent surgical procedures furnished to the same patient by the same physician on the same day [is] largely based on the presence of efficiencies in PE and pre- and post-surgical physician work."[9] Efficiencies that might exist with respect to multiple procedures done on the same day do not necessarily translate to an E/M visit billed with modifier -25. In withdrawing the proposal in the Final Rule for CY 2019, CMS acknowledged that the E/M code appended with modifier -25 "is based on rates generally developed under the assumption that these services are typically furnished independently."[10]

CMS's proposal is also at odds with a 2025 audit by the HHS Office of Inspector General on the billing of E/M services performed on the same day as 0-, 10-, and 90-day global surgery procedures and Administrator Oz's response to that audit.[11] In its 2025 audit, OIG examined Medicare paid dermatology claims for E/M services in 2019 and 2020 that included a surgical procedure performed on the same day by the same dermatologist to ensure that Medicare was appropriately paying for the E/M service. Only one of the 100 claims sampled was deemed erroneous because the E/M service was not significant and separately identifiable from the surgical procedure.[12] Thus, ***in 99% of the reviewed claims, the E/M was properly billed as significant and separately identifiable from the same-day procedure***.[13]

In responding to the OIG audit, Administrator Oz reached the following conclusion:

> "[OIG's findings] do not support increasing reviews of these claims at this time. The OIG's audit covered evaluation and management services that dermatologists provided on the same day as a minor procedure during

[9] 83 Fed. Reg. at 35841.
[10] MPFS Final Rule for CY 2019, 83 Fed. Reg. 59452, 59639 (Nov. 23, 2018).
[11] HHS-OIG 2025 Audit, *supra* note 5, at 6; Administrator Oz 9/3/25 Letter (Addendum D to HHS-OIG 2025 Audit).
[12] The other nine claims were deemed erroneous for unrelated reasons (e.g., failure to submit medical records to support the E/M service; E/M service level was not supported by medical record; key components for the E/M service were not supported). HHS-OIG 2025 Audit p. 7.
[13] HHS-OIG 2025 Audit, *supra* note 5, at 6.

> calendar years 2019 and 2020 and found that the vast majority of dermatology providers met Medicare requirements."[14]

In response to OIG's recommendation that CMS work with Medicare Administrative Contractors to educate dermatologists on Medicare requirements for billing E/M services, including maintaining sufficient information to support that the E/M services were performed and billed at the appropriate service level and using modifier -25 appropriately when billing E/M services performed on the same day as a minor surgical procedure, Administrator Oz deemed CMS's education efforts sufficient, specifically flagging the Medicare Learning Network (MLN) booklets, along with other educational materials, that include information about the "proper use of modifier 25 when billing evaluation and management services performed on the same day as a minor surgical procedure."[15] Administrator Oz did not express any concern that payments for the E/M service and global procedure were duplicative of one another.

OIG's findings and Administrator Oz's response further demonstrate that CMS's proposal to reduce payment by 50% for all but the highest-paid E/M or same-day global procedure is unwarranted.

C. CMS's Application of a Blanket 50% Cut to Payments Using Modifier -25 Would Constitute Arbitrary and Capricious Agency Action.

CMS's proposal ultimately comes down to its unsubstantiated statement that "we are likely duplicating payment under the current payment methodology."[16] No data is offered. No argument is made to justify an across-the-board 50% cut. All CMS offers is that the 50% cut aligns with its prior (but withdrawn) proposal for CY 2019 and the 50% figure used to reduce payment for the second and subsequent surgical procedures furnished on the same day to the same patient.

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[14] Administrator Oz 9/3/25 Letter (Addendum D to HHS-OIG 2025 Audit).

[15] *Id.*

[16] 91 Fed. Reg. at 43908; see also *id.* (stating, without any evidentiary support, that "we continue to believe that there are efficiencies when the same physician (or a physician in the same group practice) provides and E/M service for the same patient in conjunction with a procedure with global period").

With the economic pressures independent practices are confronting, including the fact that their Medicare payments are down 33% on an inflation-adjusted basis over the last 25 years,[17] an unsubstantiated 50% cut in reimbursement for all but the highest-paid E/M service or same-day global procedure will pose an existential threat to independent practices remaining access points for high-quality, cost-efficient care for Medicare beneficiaries and all Americans.

In short, the unsubstantiated 50% payment cut was wrong when CMS proposed it eight years ago, and it is wrong today. We urge CMS not to include the proposal in the Final Rule and, instead, address any overlaps in valuation that exist through the RUC valuation process on a code-specific basis.

II. AIMPA Supports Most of CMS's Proposals with Respect to Remote Patient Monitoring but Urges the Agency not to Finalize Its Proposal to Allow Payment for RPM or RTM Services Only When Furnished by Clinical Staff Employed by the Practice.

AIMPA commends CMS for proposing a series of additional safeguards to ensure that remote patient monitoring is used and billed appropriately.[18] Although we support most of those proposals, we urge CMS not to finalize its proposal that would "only allow payment for RPM or RTM services when furnished by clinical staff employed by the practice."[19] That restriction, if finalized, would threaten patient access to these life-improving, and potentially life-saving, services in independent medical practices. At the very least, CMS should delay implementing this restriction until the Agency can evaluate whether the other safeguards being implemented for CY 2027 address the Agency's concerns with respect to the delivery and billing of RPM and RTM services.

Remote Physiologic Monitoring ("RPM") and Remote Therapeutic Monitoring ("RTM") services align with President Trump's and Secretary Kennedy's Make America Healthy Again initiative. In 2024, alone, nearly a million Medicare beneficiaries received these remote patient monitoring services.[20] RPM and RTM have helped patients through improved care management for chronic conditions

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[17] *Jan. 30, 2026: Medicare Payment Reform Advocacy Update*, American Medical Association (Jan. 30, 2026).
[18] 91 Fed. Reg. at 43892-95.
[19] *Id.* at 43893.
[20] *Id.*

(especially among high-risk patients), better communication between patients and physicians, and more timely interventions as physicians are better equipped with the data needed to react quickly.[21]

In 2024, "more than half of enrollees who received remote patient monitoring received it for hypertension."[22] Known as the "silent killer," untreated hypertension "increases the risk of having a heart attack, stroke, brain aneurysm, heart failure, kidney failure, clogged arteries . . . and dementia."[23] Studies show that "RPM is associated with improved [hypertension] control" and that "sustained patient engagement in the RPM program over an extended period may be instrumental in successfully managing [hypertension]."[24] RTM services similarly "demonstrated significant improvements across all measured outcomes, including pain, function, and mental health" for patients suffering from chronic pain.[25]

Given the benefits of RPM and RTM for patients and providers and the expansion of telehealth services necessitated by the COVID-19 pandemic, it is unsurprising that "the number of enrollees who received [remote patient monitoring] was more than 10 times higher" in 2022 than in 2019, one year after RPM services were approved for payment by Medicare.[26] As OIG noted, with increased utilization comes the potential for fraud, waste, and abuse with respect to the billing of RPM and RTM services, including the dubious practices of "'cold calling' beneficiaries to solicit them for a remote patient monitoring device . . . providing devices but not having sufficient staff to properly monitor enrollees, not monitoring for as many hours as are being billed, or not training enrollees to use the devices."[27]

Given the benefits of RPM and RTM services, it is important that CMS strike the right balance between the competing priorities of improving beneficiary outcomes

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[21] HHS, *Telehealth and Remote Patient Monitoring: Benefits of remote patient monitoring* (Aug. 28, 2024).
[22] HHS-OIG, *Additional Oversight of Remote Patient Monitoring in Medicare Is Needed* (Sep. 2024) ("2024 OIG Report") at 7.
[23] Marc Eisenberg, *Why High Blood Pressure is Known as the Silent Killer*, Columbia Doctors (May 9, 2023).
[24] Wesley Smith et al., *Remote Patient Monitoring is Associated with Improved Outcomes in Hypertension: A Large, Retrospective, Cohort Analysis*, 12 Healthcare at 1, 6 (Aug. 9, 2024).
[25] One Hyuk Ra et al., *Reviewing the Advances in Remote Therapeutic and Physiological Monitoring and Applicability for Chronic Pain Management*, 18 J. Pain Research 3757, 3758 (July 30, 2025).
[26] 82 Fed. Reg. 52976, 53014 ("activating CPT code 99091 for separate payment").
[27] 2024 OIG Report at 10.

(and, thereby, decreasing overall healthcare expenditures) and minimizing the risk of fraud, waste, and abuse. AIMPA believes that the Proposed Rule presents a responsible balance through the proposed addition of established patient and initiating visit requirements that make the more extreme proposal of requiring direct employment of clinical staff furnishing RPM and RTM services unnecessary.

A. AIMPA Supports CMS's Proposals to Extend the "Established Patient Requirement" for RPM Services to RTM Services and to Require an Initiating Visit Prior to Furnishing RPM and RTM.

AIMPA supports CMS's proposal to require that RTM services only be furnished to established patients. This is a reasonable means of curbing abuse without limiting the ability of independent medical practices to safely provide access to RTM services for their patients. Practitioners with an established patient relationship are far more likely to have the clinical history and information necessary to evaluate whether RTM services should be furnished. This preexisting relationship is essential for effectively managing a patient's care through RTM. It was appropriate for CMS to impose an established patient requirement for RPM services in 2021, and it is equally appropriate for the Agency to extend that requirement to RTM services under the Proposed Rule.[28]

We also support CMS's proposal to require an initiating visit at the onset of RPM or RTM services.[29] Prior to ordering RPM and RTM services, physicians must perform a thorough evaluation of the patient's needs and educate them on how to participate in the monitoring process, requiring a face-to-face (in-person or telehealth) discussion with the patient. We agree that such an initiating visit will enhance care coordination that RPM and RTM services are designed to support.[30]

Although we support the proposal to require an initiating visit, we urge CMS to clarify that the initiating visit need not be a distinct visit but can occur simultaneously during the visit in which the condition requiring RPM or RTM services is diagnosed or otherwise addressed. The Proposed Rule states that a separately reportable initiating visit must be "in association with the onset of RPM or RTM services."[31] We believe—but ask CMS to confirm—that the initiating visit

[28] 91 Fed. Reg. at 43892.
[29] *Id.*
[30] *Id.*
[31] *Id.*

need only involve, in relevant part, discussion with the patient that RPM or RTM services are appropriate. Requiring a distinct initiating visit prior to the onset of RPM or RTM services would decrease the likelihood of RPM or RTM services being initiated, as patients would be required to make a second appointment—a step they might not take. Accordingly, we recommend that CMS clarify in the Final Rule that the initiating visit can occur during the same appointment in which the underlying condition is diagnosed or otherwise addressed, allowing RPM or RTM services to be incorporated into the patient's care plan efficiently as a low-cost intervention with a proven track record of improving outcomes.

B. CMS's Proposal to Allow Payment for RPM or RTM Services Only When Furnished by Clinical Staff Employed by the Practice Would Effectively Eliminate RPM and RTM for Patients of Independent Medical Practices.

Requiring independent practices to directly employ clinicians who furnish RPM and RTM services[32] would limit access for RPM and RTM services to large health systems that have the resources to employ monitoring clinicians. Practically, the proposal, if finalized, would end the ability of independent medical practices to offer these services, which runs counter to CMS's commitment to preserve independent practices as lower-cost access points for health care services.

For most independent medical practices, partnering with a third-party RPM or RTM vendor is the only way they can afford to offer such services to their patients. Furnishing RPM and RTM services requires specialized infrastructure, as well as monitoring coverage by clinical staff who may need to rapidly triage patient needs based on the receipt of adverse data. It is impractical for an independent practice to build out these capabilities and the corresponding expertise needed to provide the appropriate level of coverage.

As discussed in Part I(A) above, we share CMS's concerns with the potential for abuse related to the provision of RPM and RTM services. However, we believe that CMS's other proposals—requiring that RPM and RTM services can only commence after an established patient has an initiating visit with their physician—sufficiently limit the risk of abuse. For example, the requirement that a patient have an initiating visit with their physician will prevent RPM and RPM services from being initiated by a "cold call" from a third-party vendor to a Medicare beneficiary.

[32] *Id.* at 43893.

Requiring a face-to-face visit with established patients is a valuable check and will facilitate the "longitudinal, patient-centered care" that CMS believes is lacking in many existing third-party relationships.[33]

Notably, in examining remote patient monitoring, OIG did not recommend that CMS take such a drastic step by limiting delivery of RPM or RTM services to clinical staff employed by the practice. Instead, OIG recommended CMS engage in (1) better data collection to identify bad actors; (2) individual investigation and prosecution to deter misconduct; and (3) more provider education to deter unintentional waste.[34] OIG also recommended CMS "monitor [companies that bill for RPM] to help ensure that they are billing appropriately"—a recommendation that inherently presumes such companies will continue to exist.[35]

Accordingly, we urge CMS not to finalize its proposal to limit payment for RPM and RTM services to those furnished by clinical staff employed by the practice. Such a requirement would significantly harm patient access to these critical services in the independent practice setting without meaningfully advancing CMS's objective of curbing abuse. The proposed established patient and initiating visit requirements would provide sufficiently robust safeguards against the concerning practices identified by OIG, rendering the direct employment mandate unnecessary and disproportionate.

III. AIMPA Supports CMS's Proposal to Replace HCPCS Code G2211 with a Flat Rate Modifier of 16% of the Base E/M Code but Asks that CMS Develop Training Materials and Facilitate Educational Sessions to Prepare Physicians and Their Practices for This Change.

AIMPA commends CMS for its continued commitment to appropriately recognizing the resource costs associated with longitudinal care and generally supports the Agency's proposal to replace HCPCS code G2211 with a flat rate increase to the base E/M code via a modifier.[36] Longitudinal care and the services associated with it, recognize the ongoing relationship between patient and physician, who assumes responsibility for the long-term care of the patient. Given that the longitudinal care

[33] *Id.* at 43892.
[34] *See* 2024 OIG Report at 15-17.
[35] *Id.* at 17.
[36] 91 Fed. Reg. at 43898-43902.

furnished is an "inherent part of the visit,"[37] shifting from a distinct code, G2211, to a modifier will more accurately reflect "variation in work of the various E/M visit levels" as the payment scales proportionately.[38] Accordingly, we encourage CMS to finalize its proposal to replace G2211 with a flat rate modifier valued at 16% of the base E/M code.

We agree that by "not requiring the submission of a separate claim line," this proposal has the potential to be more operationally efficient in the long term. But we are concerned that changing the coding for longitudinal care just three years after CMS began paying for code G2211 will create operational friction and confusion among physicians in the near team. Physicians and their billing staff will need to be trained regarding the proposed change and how to use the modifier, and electronic health record software and billing systems will need to be updated. These changes, while necessary, are not trivial—and will come at a cost for physicians in the form of added practice expense, time spent away from providing patient care, and the risk of accidental denials, as systems are changed from use of G2211 to a modifier-based approach to base E/M codes. To reduce the burden for physician practices, CMS should develop training materials and facilitate educational sessions to better prepare physicians for this change.

IV. We Urge CMS to Work with the White House and Congress to Tie the MPFS to an Automatic Inflationary Adjustment and to Use Savings from Other Areas of Medicare to Pay for the Needed Payment Increase.

So long as independent medical practices and hospital outpatient departments are paid differently for providing the same services, hospital acquisitions of physician practices will continue to drive up the cost of care. To slow such consolidation, we encourage CMS to work with the White House and Congress to tie MPFS payment to the Medicare Economic Index ("MEI") inflationary update factor. This action is needed to save independent medical practices as viable sites of service for high-quality, affordable care.

It takes an act of Congress each year to prevent budget neutrality rules from effectively cutting physician pay, and it is rare that these congressional acts keep pace with inflation. In fact, ***over the last 25 years, physician pay has decreased***

[37] *Id.* at 43898.
[38] *Id.* at 43899.

by 33% when adjusted for inflation.[39] Yet despite these pay cuts, healthcare expenditures continue to grow. According to CMS's projections, national healthcare expenditures are projected to outpace the growth of gross domestic product, "resulting in an increase in the health spending share of GDP from 18.0 percent in 2024 to 20.6 percent in 2034."[40]

Americans are acutely aware of this. Healthcare affordability is at the top of their minds, with a recent Pew Research Center survey finding that 73% of Americans consider healthcare affordability a "very big problem" for the country.[41] And yet, the Medicare program has a built-in structural disparity that is driving care out of more affordable independent medical practices and into higher-cost hospital outpatient departments. Not surprisingly, this competitive advantage for hospitals has resulted in the share of physicians employed by hospitals more than doubling since 2012, from approximately 25% to 59.7%.[42]

That consolidation has serious consequences for Medicare and its beneficiaries. According to a 2024 Avalere study of five medical specialties, total Medicare expenditures increased by an average of more than $1,300 per beneficiary per year in the twelve months after a physician moved from an unaffiliated private practice to a hospital-affiliated model.[43]

Hospital consolidation also has significant consequences for patients. According to a 2025 study, Medicare beneficiaries treated by hospital-affiliated physicians had just a 37% chance of receiving care in the lowest-cost setting (either a medical office or an ASC).[44] The 20% coinsurance obligation that most beneficiaries must pay out of pocket means that they, too, must increasingly bear these rising costs, and are less likely to be referred to physicians in a lower-cost setting. They often need to

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[39] *Jan. 30, 2026: Medicare Payment Reform Advocacy Update*, American Medical Association (Jan. 30, 2026).
[40] CMS, *NHE Fact Sheet* (June 24, 2026).
[41] Shania Grace & Steven Shepard, *Americans See Health Care Costs, Deficit, Inflation as Big Problems Facing the Nation*, Pew Research Center (May 11, 2026).
[42] Physicians Advocacy Institute, *PAI-Avalere Health Report on Physician Employment Trends and Practice Acquisitions: 2018-2026* (April 2026).
[43] *Medicare Service Use and Expenditures Across Physician Practice Affiliation Models*, Avalere (Sep. 2024).
[44] 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) (examining the cost of care for physicians practicing in the specialties of Cardiology, Gastroenterology, Orthopedics, and Urology).

travel farther or wait longer to obtain the same services as hospitals consolidate care on their own campuses to take advantage of more favorable reimbursement. Every year that physician reimbursement fails to keep pace with inflation feeds this vicious cycle—driving more care into higher-cost settings and jeopardizing the viability of independent practices.

The consequences of leaving this structural defect unaddressed reach far beyond physician income. In addition to raising concerns about hospital consolidation, MedPAC has raised concerns that the lack of meaningful MPFS reform could cause "clinicians to reduce the number of Medicare beneficiaries they treat" or "stop participating in Medicare entirely."[45] Addressing this issue requires not only policy reform but also viable funding mechanisms to support an inflationary adjustment that would preserve access to care for Medicare beneficiaries.

One potential source of funding for an MEI-linked inflationary adjustment already exists. As we explained in our comments to the CY 2027 OPPS/ASC Proposed Rule,[46] CMS's proposal to pay ASP minus 33.4% for 340B-acquired drugs would reduce OPPS payments for those drugs by approximately $4.85 billion.[47] Current budget neutrality requirements, however, mandate that those savings be reallocated to non-drug payments under the OPPS, effectively reallocating the financial windfall to hospitals through a payment increase for non-drug services. Similarly, site-neutrality proposals—such as CMS's proposal to pay for imaging without contrast on a site-neutral basis—are estimated to reduce Part B spending by $7.2 billion from 2027 through 2036.[48] Imaging without contrast is just the tip of the iceberg of services that are appropriate candidates for similar treatment.[49]

Without a statutory fix, CMS lacks authority to allocate these and other savings to the historically under-resourced PFS. Therefore, we encourage CMS to work with the White House and Congress on statutory reforms that would allow CMS to

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[45] Michael E. Chernew, *Report to the Congress: Medicare and the Health Care Delivery System*, MedPAC at xii (June 2025).

[46] AIMPA, Comment Letter, OPPS/ASC Proposed Rule for CY 2027, CMS-2026-2344-1739 (Aug. 31, 2026) ("AIMPA OPPS/ASC Comment Letter").

[47] 91 Fed. Reg. at 41763.

[48] *Id.* at 41916.

[49] *See* AIMPA OPPS/ASC Comment Letter, *supra* note 46, at 8-10 (identifying common procedures in Cardiology, Gastroenterology, Ophthalmology, Orthopedic Surgery, Otolaryngology, and Urology that can be safely performed in lower-cost settings but are paid at substantially higher rates when performed in hospital outpatient departments).

reallocate savings from the 340B program toward the PFS and the ASC Payment System and to establish an MEI-inflationary adjustment that independent practices need to remain viable. At the same time, it is critical that CMS move quickly to expand site-neutral payment for a broader range of services that can be performed safely in the medical office setting and use the savings from reduced payments to hospital outpatient departments to fund an inflationary adjustment to the PFS.

V. Request for Action

We thank CMS for the opportunity to comment on the Proposed Rule. To preserve access to care in the independent medical practice setting, we ask CMS to take the following actions as it finalizes the PFS for CY 2027:

- Withdraw the modifier -25 proposal through which CMS would cut reimbursement by 50% for all but the highest-paid E/M or global procedure furnished by the same physician (or another physician in the same group practice) on the same day;

- Finalize the proposals to extend the "established patient requirement" that already exists for RPM services to RTM services and to require an initiating visit prior to furnishing RPM and RTM services, but withdraw the proposal that would limit payment for RPM and RTM services to those furnished by clinical staff employed by the practice;

- Finalize the proposal to replace HCPCS Code G2211 with a flat rate modifier of 16% of the base E/M Code but develop training materials and facilitate education sessions to prepare physicians and their practices for this change;

Finally, we urge CMS to work with the White House and Congress to establish an MEI-inflationary adjustment to the PFS so that independent medical practices can remain viable access points for high-quality, affordable care outside the hospital and health system setting. Application of an MEI adjustment can be paid for, at least in part, by reallocating savings from the 340B program to the PFS and by expanding site-neutral payment to a broader range of services that can be performed safely in the medical office setting.

AIMPA stands ready to serve as a continued resource to CMS as you work to finalize the Proposed Rule. Please do not hesitate to reach out to AIMPA President Dr. David Eagle (david.eagle@aimpa.us), if we can be of further assistance.

Sincerely,

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