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ACA CHIROPRACTORS



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September 11, 2025

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

Dear Dr. Oz:

RE: File Code CMS-1832-P; Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

The American Chiropractic Association (ACA) submits the following comments regarding the Centers for Medicare and Medicaid Services (CMS) proposed regulation to implement changes to the Medicare physician fee schedule (MPFS), Medicare Part B payment policies, and other areas of the Medicare program. ACA comments are directed specifically to the rule's physician payment policy, flawed implementation of the Medicare Economic Index (MEI), the Ambulatory Specialty Model (ASM) revising the MIPS Value Pathway (MVP) reporting for certain providers, specifically chiropractors, and issues involving the referral and ordering of services. ACA greatly appreciates the opportunity to comment on the proposed rule and offer the perspectives of our members who specialize in diagnosing and treating chronic and acute pain.

ACA is the largest professional organization in the United States representing doctors of chiropractic (DCs). ACA members lead the chiropractic profession through collaborative relationships in public health, support for research and evidence-based practice, and the active reporting of functional outcome assessment measures to ensure the health and well-being of the estimated 35 million Americans who seek chiropractic care each year.

Physician Fee Schedule/ Medicare Economic Index (MEI)

In the proposed rule, CMS proposes to include a new -2.5% efficiency adjustment to work Relative Value Units (RVUs) and intra-service times for most non-time-based services, reflecting an annual productivity adjustment calculated using five years of MEI data. While the MEI was projected to be a 2.7% increase in physician costs, this is counteracted by the new efficiency adjustment and the separate conversion factors for Advanced Alternative Payment Model (APM) participants and non-participants, which would result in a final conversion factor increase of approximately 3.83% and 3.62%. The adjustment impacts most specialties, including chiropractic, by reducing overall payment by one percent. The only specialties or professions to gain at least one percent from this proposal are clinical psychology (3%), clinical social work (4%), geriatric medicine (1%), and psychiatry (1%), the individuals who perform a more significant amount of telehealth services, which CMS has exempted from efficiency adjustments. We find this proposal inconsistent with congressionally passed language which looked to stabilize provider payment rates in 2026.

Additionally, the proposed payment reduction will coincide with an expected 3.5% increase in medical practice cost inflation, as measured by the MEI. Consequently, when adjusted for inflation, Medicare physician payments have declined by 33% from 2001 to 2025.¹ This is clearly not a sustainable trajectory. The failure of the MPFS to keep pace with the true cost of providing care, combined with year-over-year cuts resulting from the application of budget neutrality, sequestration, and a paucity of available alternative payment model/value-based care models, clearly demonstrates the Medicare payment system is seriously flawed. The addition of an inflationary update will provide budgetary stability as chiropractors—many of whom are small business owners—contend with a wide range of shifting economic factors, such as increasing administrative burdens, staff salaries, office rent and purchasing essential technology. ACA urges CMS to work with Congress to implement a reimbursement system that accounts for inflation, benefits patients, and supports providers.

New Ambulatory Specialty Model

Designed to begin in 2027, CMS is proposing a mandatory Alternative Specialty Model (ASM) for low back pain (LBP) to determine whether adjusting payment for those treating this malady can improve management of chronic conditions. ACA appreciates CMS acknowledging the role of chiropractors in addressing LBP; however, the proposed rule does not include them as eligible participants. As illustrated by the development of the low back pain episode cost measure, the most common provider type where Medicare beneficiaries first seek care is the chiropractic physician.

Given that 78% of U.S. MDs are employed by hospitals, health systems, or corporate entities,² the proposed model risks being implemented primarily within large, consolidated delivery systems that can absorb downside risk. Without safeguards, smaller independent practices and integrative providers—often critical for prevention, functional improvement, and patient choice—will be excluded, skewing both participation and outcomes toward corporate-owned models.

Instead of the model proposed in the MPFS, ACA recommends the following:

- Implement a one- to two-year upside-only participation period for smaller or independent practices. This phase-in period would allow these practices to build infrastructure and reporting capacity before being held financially liable for negative results.
- Adjust attribution and benchmarks to reflect smaller practice realities.
- Ensure measures capture patient-reported outcomes and functional improvements, not just cost/utilization.
- Require inclusion of multiple entry points into care beyond MD-owned practices.

Rehabilitative Support for Musculoskeletal Care MVP

For 2026, CMS is again proposing to modify an episode-based cost measure MVP regarding Rehabilitative Support for Musculoskeletal Care. The proposal adds quality measures available for reporting around depression and functional outcomes assessments, adds new improvement activities supporting patient/caregiver engagement, promoting self-management, and preventative care, and proposing the removal of measures related to screening for social drivers of health and staff uptake of COVID-19 vaccination.

As we have repeatedly commented, ACA is pleased that chiropractors are specifically designated as a provider group that can perform this measure. However, while chiropractors utilize Evaluation and Management (E/M) codes as part of their standard course of care, by federal statute the codes are not payable under Medicare. This limitation in the model would severely limit the ability of chiropractors practicing in Medicare to demonstrate the true value they would provide by participating in the proposed MVP.

¹ <https://www.ama-assn.org/system/files/2025-medicare-updates-inflation-chart.pdf>

² <https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Study-on-Physician-Employment-Practice-Ownership-Trends-2019-2023>

Additionally, as we have commented in past years, ACA has concerns that the MVP as currently proposed is exclusionary to data collection due to attribution obstacles. The future shortage of “Medical” providers to include access issues will require recognition of qualified health professionals (non-MD) to deliver care through an access point. The system proposed is top-down driven and geared to large clinic organizations. Attribution needs to take into consideration all access points inclusive of modern healthcare delivery options if we are to measure the outcomes of care across all provider groups. Value-based reimbursement obtained through advances in data systems and data analytics has changed dramatically. Integration of qualified healthcare providers are now able to implement value-based contracting critical to a provider’s ability to function and thrive in the coming years. The concern is exclusionary language within current Medicare regulations, established more than 50 years ago, which creates a barrier for Clinically Integrated Networks (CINs) to take substantial steps over time to integrate their clinical functions in a meaningful manner that enables them to engage in value-based contracts with payers. The ACA welcomes the opportunity to highlight the value chiropractors can provide to the Medicare program, but these extreme limitations must be addressed before considering further participation.

Telehealth Services

The proposed rule makes permanent the use of real-time audio and visual interactive telecommunications for direct supervision in telehealth, with the exception of global surgery services. While chiropractors are not currently eligible to provide telehealth services to Medicare beneficiaries, the decision not to include Current Procedural Terminology (CPT) telemedicine E/M codes on the Medicare Telehealth List for 2026 raises concerns about whether these services will be covered by Medicare in the future.

Ordering/Referring Beneficiary Services

We again applaud CMS for initiatives focused on expanding access to services that align with modern standards of care, which increasingly include integration and collaboration, such as chronic pain management (CPM) services and those that strive toward increased value delivery. DCs are increasingly practicing in integrated care delivery settings and more commonly participating in coordinated care through collaboration within and from outside health systems. However, Medicare beneficiaries are unable to receive this type of efficient and effective care because chiropractors remain omitted as an approved provider specialty for ordering or referring beneficiary services.

Physician Practice Information Survey (PPI)

CMS chose not to use the data from the American Medical Association's (AMA) Physician Practice Information Survey (PPI) for 2026 rate setting, citing concerns about sample size, response rates, and data validity. This is not surprising given the onerous nature of the survey. ACA urges CMS to delay the implementation of proposed changes to MEI methodology until a valid, thorough PPI survey is completed. A thorough survey is sorely needed in order to recognize greater indirect costs for office-based practitioners compared to those in facility settings.

In closing, ACA appreciates the opportunity to provide comments on the proposed CMS rule. If you have any questions regarding our remarks, please contact John Falardeau, ACA Senior Vice President for Public Policy and Advocacy at jfalardeau@acatoday.org or (703) 812-0214.

Sincerely,

A handwritten signature in black ink, appearing to read "Marcus Nynas, DC". The signature is fluid and cursive, with the initials "DC." at the end.

Marcus Nynas, DC
President