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September 11, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: File Code CMS-1848-P; Medicare Program; CY 2027 Payment Policies Under the Physician Payment Schedule and Other Changes to Part B Payment and Coverage Policies; (July 16, 2026)

Dear Dr. Oz:

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; 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)

Under the 2027 MPFS proposal, physician payment will decline overall despite 2026 congressional-mandated updates. Expiration of the temporary 2.5 percent statutory payment increase results in proposed conversion factor reductions of 1.19 percent for qualifying Alternative Payment Model

(APM) participants and 1.68 percent for other clinicians, including chiropractors. ACA is encouraged that the 2027 proposal would phase out reliance on outdated specialty-level survey data, revise indirect practice expense (PE) allocation, and introduce a stabilization adjustment intended to reduce annual payment volatility while redistributing payments across specialties. The ACA strongly supports annual payment updates to reflect the growth in physician practice costs as measured by the Medicare Economic Index (MEI), which CMS projects will be 2.5 percent.

In its 2026 report, the Medicare Payment Advisory Commission (MedPAC) recommended increasing payment rates for physician services “to bring fee for service Medicare’s overall payment levels closer in line with providers’ costs.”¹ The 2026 Medicare Trustees Report likewise warned that the 2015 Medicare Access and CHIP Reauthorization Act (MACRA) “raises important long-range concerns that will almost certainly need to be addressed by future legislation ... physician payment updates ... do not vary based on underlying economic conditions, nor are they expected to keep pace with ... physician cost increases ... Absent a change in the delivery system or level of update by subsequent legislation, the Trustees expect access to Medicare-participating physicians to become a significant issue in the long term.”²

To this end, ACA urges CMS to support the latest legislative proposal introduced by Reps. John Joyce, Greg Murphy, and Kim Schrier, the Patients First Act (HR 9693),³ a comprehensive, bipartisan bill that includes an inflation-based update tied to MEI, budget neutrality reform, a Merit-based Incentive Payment System (MIPS) replacement, APM reforms, and a new primary care payment pilot that would not impact budget neutrality. According to the authors, the Patients First Act:

- Ties physician reimbursement to an inflationary measure.
- Establishes a primary care hybrid payment pilot program that pays PCPs a per-member-per-month payment along with regular services, better capturing the work PCPs do.
- Establishes the POINTS program, which creates a physician and clinician-led task force at CMS to develop quality metrics that are streamlined and reduce administrative burden.
- Freezes A-APM participation thresholds for three years and creates notice and comment periods for CMMI mandatory models.
- Increases the budget neutrality threshold from \$20 million to \$54.3 million.

Again, ACA believes CMS should work with Congress to implement this innovative approach to strengthening the incentives for independent practice and reversing decades of consolidation that drives up the cost of care, especially in rural and underserved areas. Consequently, when adjusted for inflation, Medicare physician payments have declined by 33% from 2001 to 2026.⁴ 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,

¹ https://www.medpac.gov/wp-content/uploads/2026/06/Jun26_Ch1_MedPAC_Report_To_Congress_SEC.pdf

² <https://www.cms.gov/oact/tr/2026>

³ <https://johnjoyce.house.gov/issues/key-issues/health/patients-first-act/section-section>

⁴ <https://www.ama-assn.org/system/files/2026-medicare-updates-inflation-chart.pdf>

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.

In a typical chiropractic clinic, the doctor reviews patient data and monitors the patient's progress and participation in the prescribed plan of care. For example, if the doctor identifies that a patient has stopped performing prescribed exercises or is not following the treatment plan, the doctor or chiropractic assistant may contact the patient by telephone or text to address the issue, provide appropriate guidance, and encourage compliance. The staff member then documents the communication and any resulting action in the patient's record.

This is not hypothetical or administrative activity—it represents actual clinical staff time that is integral to effective treatment management. It is precisely the type of work that should be reflected in the practice expense methodology.

We therefore ask CMS to provide the underlying workflow data, utilization assumptions, and other evidence used to conclude that treatment management requires essentially no clinical staff time or practice expense. If CMS' proposed valuation is based on an assumed workflow that does not reflect how these services are actually delivered in chiropractic practices, the resulting practice expense values should be reconsidered.

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) Services Reform

CMS is proposing sweeping changes for Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) services in the proposed rule, ending third-party outsourcing, and thereby requiring clinical staff providing RPM and RTM to be direct employees of the billing practitioner. Additionally, CMS proposes cutting practice-expense RVUs for setup and supply codes while exploring the consolidation of 17 codes into four G-codes.

If the above 17 codes are collapsed, ACA is concerned as to what is the mechanism to reimburse for the codes? This is not spelled out in the proposed rule. CMS needs to be more specific with this proposal.

In addition, CMS needs to clarify what "outsourcing" actually entails. If a practice licenses a technology platform and its own team is reviewing the information, communicating with the patient and managing the care, that practice is still delivering the service. CMS needs to clearly spell that out. ACA also asks CMS to clarify what happens with smaller practices using part-time or contracted clinicians. Does "direct employee" literally mean W2 only? Or can a licensed 1099 or leased clinician who is working under the practice's direction and supervision qualify? Any such flexibility should require that contracted or leased clinicians meet applicable Internal Revenue Service and state worker classification standards. ACA believes this clarification is critical.

Requiring an initiating visit and an established patient relationship is not a hardship on responsible practices and makes it much harder for enrollment mills to operate. ACA supports this concept; however, there remain concerns. First, the initial evaluation should establish the patient relationship. CMS shouldn't create an artificial situation where the patient gets evaluated and then has to come back for another visit just to qualify for RTM. Second, ACA believes a synchronous telehealth visit should count as face to face when clinically appropriate. That matters for rural patients and for patients who have legitimate barriers physically getting into the office.

Finally, chiropractors should not be excluded from RTM services. CMS is redesigning an entire care model around monitoring patient adherence to home therapeutic programs. That is literally part of what chiropractors do every day.

Advancing Chronic Care with Effective, Scalable Solutions (ACCESS) Model

The ACCESS (Advancing Chronic Care with Effective, Scalable Solutions) Model tests an outcome-aligned payment approach in Original Medicare to expand access to new technology-supported care options that help people improve their health and prevent and manage chronic disease. The [voluntary model](#) focuses on conditions affecting more than two-thirds of people with Medicare, including high blood pressure, diabetes, chronic musculoskeletal pain, and depression. If CMS continues to want participation in value-based models, then the payments need to support the providers delivering services. Since the program is voluntary, providers risk carrying a disproportionate share of higher-acuity patients. Smaller practices, like many chiropractic clinics, fear this will accelerate consolidation, forcing clinics into large risk-bearing health systems. Additionally, those who enroll are no longer eligible for fee-for-service reimbursements, which makes this additionally risky for small practices that might be interested but lack the ability to make reasonable calculations to transition their practice from Fee for Service (FFS) to Per Member Per Month (PMPM) payments.

General Beneficiary Access

Medicare's laws governing chiropractic services are based on a healthcare system that no longer exists. The statutory and regulatory restrictions governing chiropractic care were established more than six decades ago, at a time when organized medicine was strongly opposed to competition from the chiropractic profession. Those policies were designed not simply to define Medicare coverage, but also to restrict the growth and scope of the chiropractic profession and to place other Medicare providers in the position of serving as gatekeepers for services that chiropractors are trained and qualified to identify as medically necessary.

Those historical restrictions have become increasingly difficult to justify in today's healthcare environment. Chiropractic physicians are no longer practicing in isolation from the broader healthcare system. Chiropractors increasingly participate as members of multidisciplinary healthcare teams in large medical centers, hospitals, academic medical centers, universities, and integrated health systems. In these settings, chiropractors routinely collaborate with physicians, physical therapists, nurses, and other health professionals to coordinate care for patients with musculoskeletal and spinal conditions.

Yet federal Medicare law continues to treat chiropractic physicians differently from other health professionals in ways that impede this type of collaboration. The current Medicare framework effectively prevents chiropractors from fully participating in coordinated care by limiting their ability to order ancillary diagnostic services that they are qualified to determine are medically necessary. For example, when a chiropractic physician determines that a Medicare beneficiary needs an X-ray, laboratory test, or other diagnostic service, current Medicare policy does not permit the chiropractor to order that covered service. Instead, the beneficiary may be required to see another Medicare provider solely to obtain an order for a service that the chiropractor has already determined is necessary. This creates unnecessary delays as well as additional appointments, travel, copayments, and other out-of-pocket costs for beneficiaries. In many cases, the second provider simply orders the same diagnostic service, creating administrative duplication without adding meaningful value to the patient's care.

This gatekeeper structure is particularly difficult to reconcile with modern approaches to team-based health care. If chiropractors are trusted to evaluate patients, establish a diagnosis within their scope of practice, and provide treatment, it is difficult to justify a system in which they are prohibited from initiating an appropriate diagnostic service while another provider must authorize the same service solely because of the provider's professional designation.

The result is a Medicare policy that effectively preserves a six-decade-old barrier to professional collaboration. Rather than allowing qualified health professionals to work together according to their respective education, training, and scope of practice, the current law creates artificial distinctions that can fragment care and increase costs for beneficiaries.

Modernizing Medicare's chiropractic provisions would not require Congress to endorse one profession over another. It would simply bring federal policy into alignment with the way health care is actually delivered today. Chiropractors already work alongside other health professionals in many of the nation's largest healthcare organizations and universities. Removing outdated statutory barriers would allow these professionals to participate more effectively in integrated care models while preserving appropriate safeguards, clinical accountability, and Medicare program integrity.

There is also a significant beneficiary-access and cost consideration. Medicare beneficiaries with spinal and musculoskeletal conditions should have access to the full range of appropriate, evidence-informed treatment options without being unnecessarily directed through a particular provider solely because of outdated Medicare rules. Chiropractic physicians can provide a noninvasive treatment option that, in many circumstances, may be less costly⁵ and safer than more invasive approaches, including the use of prescription drugs, spinal injections, or surgery. Chiropractic care is already routinely incorporated into coverage and care-delivery models used by private insurers, the Department of Veterans Affairs, the Department of War health care delivery systems, and Medicaid.

Congress should therefore modernize Medicare's chiropractic provisions to reflect contemporary healthcare delivery. At a minimum, qualified chiropractic physicians should be permitted to function as active participants in coordinated care and to order appropriate ancillary diagnostic

services within their scope of practice, subject to the same reasonable program-integrity requirements applicable to other qualified health professionals.

Medicare should not continue to enforce healthcare policy designed around professional competition from the 1960s when today's healthcare system increasingly depends upon professional collaboration.

The goal is not to give chiropractors special treatment. The goal is to remove outdated barriers that prevent qualified health professionals from working together to provide Medicare beneficiaries with timely, coordinated, cost-effective care.

Since 1972, Medicare has limited the services DCs are allowed to provide or order for their patients. This limitation has persisted for more than 50 years with no scientific or valid policy basis. DCs are currently not allowed to furnish existing covered Medicare services that fall within their scope of practice to their patients. This artificial limitation restricts chiropractors from providing patients continuity of care as they age into Medicare, putting beneficiaries at a distinct health disadvantage.

Beneficiaries seeking to obtain chiropractic care must first obtain certain services from another provider in order to have them covered by Medicare. This requires the beneficiary to experience delays, inconveniences, and the added expense (copays, time, travel, etc.) of seeing a second provider when such visits are unnecessary. If a DC determines that the beneficiary needs an x-ray, laboratory test or other diagnostic procedure, current policy does not even allow DCs to “order” those covered services. Thus, in such instances, further unnecessary visits and beneficiary expenses are required to obtain the needed “order” from a second Medicare provider, who will often turn around (especially in the case of diagnostic imaging, for example) and order the service from a third Medicare provider.

As a result of Medicare's chiropractic policy being stuck in 1970-era health policy, patients are in effect channeled to other providers whose standard treatment regimen may involve the use of drugs, spinal injections, or surgery for a range of spinal conditions. Services provided by chiropractic physicians have shown to be a less costly⁵ and safer alternative in many of these situations.

In the wake of the opioid crisis and as policymakers seek to prevent the use of unnecessary drugs, DCs are poised to assist in this effort by providing nondrug pain management options and lowering the reliance on pain medications—especially in cases related to spinal related pain. To the extent that current policy arbitrarily restricts access to chiropractic services, it severely hampers the ability of the chiropractic profession to contribute meaningfully to ongoing efforts to reduce opioid overuse and abuse.

⁵ <https://pubmed.ncbi.nlm.nih.gov/38448998/>

Doctors of chiropractic are licensed in all 50 states as portal-of-entry providers who treat the “whole body” and whose scope of practice—as defined by state law in every state—allows for the provisioning of a broad range of services. A typical state scope recognizes the ability and training of DCs to examine, diagnose, treat, and refer. Legislation needed to ensure Medicare beneficiaries have access to chiropractic care would not require adding any new reimbursable services to Medicare that are not already covered services and delivered by existing providers. Legislation would simply need to seek a modification of existing statute to ensure doctors of chiropractic are allowed to furnish and order “existing covered services” that they are currently permitted to do under state law.

In July 2026, HHS Secretary Robert F. Kennedy Jr. publicly came out in support of enhanced access to chiropractic services for Medicare beneficiaries.⁶ The Chiropractic Medicare Coverage Modernization Act, bipartisan legislation to allow Medicare beneficiaries full access to current services chiropractors are allowed to provide under their state licensure, has been introduced in both the House and the Senate in the 119th Congress. The House bill, H.R. 539, was introduced concurrently with the Senate bill, S.106, on Jan. 16, 2025. We urge CMS to support this legislation.

Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods

ACA has joined with more than 100 national healthcare organizations in opposition to the proposed policy to reduce payment by 50 percent when a separately identifiable office/outpatient (O/O) evaluation and management (E/M) service reported with modifier -25 is furnished on the same day as a procedure with a 0-, 10-, or 90-day global period. CMS advances this policy on an unsubstantiated assumption of “likely” duplication, without the evidence a change of this magnitude requires, and without addressing concerns that led the agency to decline a substantially similar proposal in 2019. We appreciate the administration’s emphasis on keeping independent physician practices sustainable, yet we believe the unintended consequence of CMS’ proposed policy will make it extremely difficult for those practices to remain viable. We respectfully request that CMS:

- Not finalize the proposed 50 percent payment reduction for services furnished on the same date as a separately identifiable O/O E/M visit reported with modifier -25;
- Not extend the policy to procedures furnished on the same date as inpatient or other E/M services; and
- Address any genuine overlap through the established misvalued code and AMA/Specialty Society RVS Update Committee (RUC) valuation processes on a code-specific basis—rather than through a uniform, payment-level reduction—working with stakeholders where CMS believes specific codes do not fully account for overlap.

Updates to the 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

⁶ <https://www.facebook.com/watch/?v=948795924918850>

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 82% of U.S. MDs are employed by hospitals, health systems, or corporate entities,⁷ the model risks being implemented primarily within large, consolidated delivery systems that can absorb downside risk. Without safeguards, smaller independent practices and integrative providers—who are often critical for prevention, functional improvement, and patient choice—will be excluded, skewing both participation and outcomes toward corporate-owned models.

In the MPFS for 2027, CMS proposes the following:

- Adding a claims-based measure of potentially unnecessary lumbar MRI use and replacing a retiring functional-status measure with MIPS Measure Q182 (Functional Outcome Assessment) for the low back pain cohort;
- A voluntary patient-reported outcome submission option with a scoring incentive;
- A rural adjustment for participants in rural areas; and
- Clarification that quality will be scored in deciles relative to peers within each disease cohort rather than against a national benchmark.

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 MVP

For 2027, CMS is again proposing to modify an episode-based cost measure MVP regarding Rehabilitative Support, a name change from 2026 when it was called the Rehabilitative Support for Musculoskeletal Care. The proposal adds three additional Value Pathways available for reporting assessments; new improvement activities supporting patient/caregiver engagement, promoting self-management; and preventative care.

As we have repeatedly commented, ACA is pleased that doctors of chiropractic are specifically designated as a provider group that can perform this measure. However, while chiropractors utilize

⁷ <https://www.physiciansadvocacyinstitute.org/PAI-Research/PAI-Avalere-Health-Report-on-Physician-Employment-Trends-and-Practice-Acquisitions-2018-2026>

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.

Additionally, 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 proposed system 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. Integrating qualified healthcare providers in the implementation of value-based care will be 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 clinical functions in a meaningful manner that enables them to engage in value-based contracts with payers. 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.

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. Modernizing Medicare policy to recognize DCs as qualified members of the healthcare team and to permit them, when authorized under applicable state law, to order medically necessary diagnostic services, would better align federal policy with contemporary healthcare delivery. It would reduce unnecessary barriers, delays, and costs for beneficiaries while promoting more coordinated, efficient, and patient-centered care—without requiring a beneficiary to see an additional provider solely to obtain an order that is already supported by a qualified treating professional.

In summary, ACA respectfully urges CMS to:

1. Support the Patients First Act (H.R. 9693) to tie physician payment to inflation and reform budget neutrality.

2. Provide the workflow data behind eliminating practice expense for chiropractic treatment-management/setup codes, and reconsider that cut.
3. Clarify RPM/RTM reimbursement mechanics for any G-code consolidation; define "outsourcing" and "direct employee"; allow a single initiating visit to establish the patient relationship; count synchronous telehealth as face-to-face; and include chiropractors as eligible RTM providers.
4. Adjust the ACCESS Model's payment structure and risk adjustment for smaller, independent practices to avoid accelerating consolidation.
5. Modernize chiropractic scope-of-practice restrictions to let DCs order and furnish medically necessary diagnostics, and support the Chiropractic Medicare Coverage Modernization Act (H.R. 539/S. 106).
6. Decline the proposed 50% payment cut for modifier -25 E/M services on global-period days; address overlap through the RUC process instead.
7. Include chiropractors in the mandatory Ambulatory Specialty Model for low back pain, with an upside-only phase-in, adjusted benchmarks for smaller practices, and multiple non-MD entry points.
8. Resolve the statutory bar on chiropractic E/M reimbursement and CIN attribution barriers so DCs can meaningfully participate in the Rehabilitative Support MVP.

Together, these changes would align Medicare policy with modern, team-based musculoskeletal care while protecting independent practice viability. ACA thanks CMS for its consideration and welcomes further dialogue. 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 "Kris Anderson, DC". The signature is fluid and cursive, with the initials "DC" written at the end.

Kris Anderson, DC, MS
President
American Chiropractic Association