The Hospital + Healthsystem Association of Pennsylvania

September 14, 2026

The Honorable Mehmet Oz, MD
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: CMS-1848-P, Medicare Program; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies…; July 16, 2026.

Dear Administrator Oz:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), representing more than 235 hospitals and health systems statewide, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) physician fee schedule (PFS) and other changes to part B payment coverage policies proposed rule for calendar year (CY) 2027.

HAP is disappointed that CMS is proposing to reduce payments for physicians for CY 2027, while acknowledging this is the result of the expiration of the one-year statutory increase of 2.50 percent that was in effect for only CY 2026. We are strongly opposed to the reduction in the PFS conversion factor and the proposed reduction in payment for evaluation and management (E/M) services reported with Modifier 25.

We remain concerned about the overall inadequacy of Medicare physician payments and its potential impact on access to and quality of care, particularly at a time when hospitals are facing a significant nationwide staffing shortage, additional administrative burdens and an aging beneficiary population. Since 2001, Medicare physician payment rates, when adjusted for inflation, have declined 33 percent, thus forcing practices to operate on extremely thin margins as costs continue to rise. This directly threatens patient access to timely, high-quality care, particularly in underserved areas.[1] As such, we urge the agency to work with Congress to prioritize meaningful physician payment reform, including a reformed annual update under the PFS.

In addition, we incorporated additional comments provided in the American Hospital Association's response to the proposed rule by reference.

Thank you for your consideration of HAP's comments about this proposed rule regarding physician payments and other provisions related to physician practices and the patients they serve in Pennsylvania.

[1] 2025 Medicare updates compared to inflation chart | AMA

If you have any questions, contact **Brooke Bowers**, HAP's director, financial reimbursement and analysis.

Sincerely,

Jolene H. Calla, Esq.
Vice President, Finance & Legal Affairs

Attachment

HAP Comments—Physician Fee Schedule
Proposed Rule for Calendar Year 2027

PROPOSED PAYMENT UPDATE

As required by law, CMS would implement two separate conversion factors: one for qualifying alternative payment model participants (QP) and one for physicians and practitioners who are not QPs. Overall, the rule would decrease payments to physicians by reducing the QP conversion factor by a net 1.19 percent and the non-QP conversion factor by a net 1.68 percent in CY 2027 as compared to CY 2026. These conversion factors reflect positive updates required by statute of 0.75 percent and 0.25 percent, respectively, as well as an increase of 0.53 percent that CMS states is necessary to account for proposed changes in the work relative value units (RVU). However, they are offset by the fact that the one-year statutory conversion factor increase of 2.50 percent for CY 2026 will no longer be in effect for CY 2027.

While the conversion factor reductions are relatively modest, the cumulative effect of underwhelming annual updates, budget neutrality adjustments, and specialty-specific RVU changes remains material. Combined with the rising costs of staff salaries, malpractice insurance, and medical supplies and drugs, physician reimbursement continues to fall behind inflation. **Pennsylvania physicians are reimbursed only 40 cents for every dollar spent caring for Medicare fee-for-service (FFS) patients.** Continued erosion of physician reimbursement threatens the financial viability of physician practices and jeopardizes patients' access to timely, high-quality care, particularly in underserved and rural communities. **HAP urges CMS to abandon the proposed reduction and work toward a stable, predictable physician payment system that supports both physicians and the Medicare beneficiaries they serve.**

OFFICE/OUTPATIENT EVALUATION AND MANAGEMENT VISITS

CMS states that it believes there is overlap and duplication of payment between E/M services included in a global surgical package and any additional E/M services billed under the modifier 25 as significant and separately identifiable. The agency states that there are efficiencies when the same physician (or a physician in the same group practice) provides an E/M service for the same patient in conjunction with a procedure with a global period.

To address this potential overvaluation, it proposes to reduce payment when a separately identifiable O/O 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. The highest paid service (either surgical or E/M visit) would be paid at 100 percent and all other services furnished on the same day would be paid at 50 percent.

Modifier 25 is appropriately reported when a physician performs a significant, separately identifiable evaluation and management service on the same day as a medically necessary procedure. These encounters require additional physician work, independent medical decision making, documentation, patient counseling, medication management, and care coordination. This policy ignores clinical reality: physicians frequently must evaluate, diagnose, and manage a

distinct problem during the same encounter as a procedure because that is medically appropriate and, in the patient's, best interest—not because of billing abuse. Penalizing this practice will force patients into additional appointments, delaying care, raising costs, and adding unnecessary burden to already-strained practices.

CMS should withdraw this proposal entirely. If CMS believes modifier 25 is being misused, it should rely on targeted audits and education using its existing program integrity tools, not an indiscriminate payment reduction. Physicians who appropriately bill a significant, separately identifiable E/M service with a same-day procedure should continue to receive full payment for both services.

MEDICARE PRESCRIPTION DRUG INFLATION REBATE PROGRAM 340B DATA REPOSITORY

CMS proposes to require mandatory reporting of Medicare Part D claims data for drugs purchased under the 340B program so the agency can ensure these drugs are removed from the calculation for Medicare Part D inflation rebates. The agency indicates that it has built the claims data repository needed to support this reporting and that it will go live this fall. Mandatory submission would begin January 1, 2027

HAP has significant concerns about the timeline for mandatory reporting and the timing of this proposal given the numerous concurrent policy changes impacting the 340B program. Under the proposed timeline, CMS would spend a mere three months testing a newly built repository before making reporting mandatory. Three months is not enough time to implement the new workflows required to support this reporting or provide staff training on the new requirements. The agency has also not given the cost of implementation the appropriate consideration. The agency has released a request for information on the estimated cost burden of this proposal at the same time it is proposing to finalize it.

The proposed requirement for Medicare Part D claims reporting under the 340B program is also blind to the number of changes 340B covered entities are navigating. HRSA's 340B Drug Rebate Model Pilot Program, estimated to cost hospitals close to a billion dollars in its first year and imposing extreme financial and operational burden would be effective the same day as mandatory Medicare Part D claims reporting. The rebate model is layered on top of mandatory reporting requirements unlawfully imposed by drug manufacturers and proposed cuts to reimbursement rates for hospital outpatient departments for drugs purchased under the 340B program.

In addition to all of the above, the proposed penalty for non-compliance is extreme. CMS indicates that failure to provide data could result in revocation of Medicare enrollment. The proposed reporting requirement is new and operationally complex. Revocation of the provider's Medicare enrollment is disproportionately punitive during the first year of reporting. CMS must consider a phased implementation period or safe harbors for good-faith reporting errors.

HAP and our member 340B hospitals are deeply concerned by CMS' strategy to require Medicare Part D claims data reporting on such a short timeline. The agency would be better

served to delay implementation of this proposal until further testing can be completed, and the financial and operational impacts of the proposal can be considered.

BEHAVIORAL HEALTH

The proposed rule

- Increases work relative value units (RVU) for the Psychiatric Collaborative Care Model and other behavioral health integration models—evidence-based models which expand access to behavioral health services through integration with primary care;
- Increases payment for timed psychotherapy and additional behavioral health codes such as smoking and tobacco use cessation, screening and brief intervention, and referral to treatment services); and
- Establishes new, separate coding for shared appointments with multiple beneficiaries, allowing beneficiaries to receive multidisciplinary support in a group setting.

The proposals as a package reflect an increased emphasis (or increased investment) in preventative and early behavioral health interventions. These early, upstream interventions address behavioral health concerns before they escalate, improve recovery, and reduce reliance on more costly services like hospitalization and emergency room visits.

While HAP supports the proposed changes, these individual code increases are undermined by the broader systematic cuts.

TELEHEALTH SERVICES—REMOTE MONITORING
CMS pays for remote physiologic monitoring (RPM) and remote therapy monitoring (RTM) services under the PFS. The agency currently requires that RPM services be furnished only to an established patient, and in this rule, it proposes to expand this established patient requirement to RTM services.

CMS proposes that practitioners billing for RPM or RTM services must furnish a separately reportable initiating visit in association with the onset of these services, and that the services must be initiated by the billing practitioner during a face-to-face (in-person or telehealth) visit. This does not stop fraud. It builds a barrier in front of the patients who need monitoring most: the homebound, the rural, the mobility limited, and the frail. Those are precisely the people for whom an in-person visit is hardest, and precisely the people remote monitoring exists to reach. A physician's order and documented patient consent already establish medical necessity. A forced face-to-face visit delays care, and for many patients it denies it.

It also proposes to allow payment for RPM and RTM services only when they are performed by clinical staff employed by the billing practitioner and not by a contractor. This strikes at a delivery model that CMS itself authorized. In the CY 2021 Physician Fee Schedule, CMS expressly confirmed that auxiliary personnel furnishing remote monitoring may be employees of a third party under contract with the billing practitioner, working under that practitioner's general supervision. Reversing that position now, without evidence that the staffing structure

itself causes improper billing, would not stop bad actors. It would strand the rural, small, and understaffed practices that rely on partners to deliver monitoring they could never staff on their own. The result would be fewer monitored patients, not fewer fraudulent claims.

Finally, it proposes updates to the valuation of these services to reflect the potential reduced costs of the associated devices and seeks comments on bundling the RPM and RTM codes. CMS proposes to revalue the device supply codes downward, on the theory that the devices now cost less. The crosswalk behind that cut does not reflect the real cost of delivering monitoring: FDA cleared connected devices, cellular connectivity, secure logistics, and a clinical team reviewing patient data every day. Cutting payment below the cost of the service does not make programs more efficient. It closes them.

CMS is weighing collapsing the distinct remote monitoring codes into a small set of new bundled G-codes. Setup, device supply, and treatment management are different services, performed at different times, requiring different work. Bundling them obscures that work, destabilizes the economics of every compliant program, and forces practices to rebuild billing they spent years getting right. It addresses no documented problem.

Remote patient monitoring gives clinicians a daily line of sight into the health of Medicare patients living with chronic conditions such as hypertension, heart failure, and diabetes. It is one of the most meaningful advances in preventive care in a decade. CMS should hold bad actors accountable through real enforcement and not implement structural changes that punish compliant providers and their patients. CMS did not propose stronger enforcement. It proposed cuts and restrictions that fall hardest on the responsible majority.

HAP supports aggressive enforcement against bad actors and genuine fraud, but the provisions outlined in the proposed rule target a compliant care model, an at-risk patient population, and a payment structure that reflects the real cost of care. We strongly urge CMS to withdraw all four and to replace them with enforcement efforts.