PARAGON HEALTH INSTITUTE

September 14, 2026

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Administrator Oz,

Paragon Health Institute appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule CMS–1848–P, RIN 0938–AV82, titled "Medicare and Medicaid Programs; CY 2027 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." This rule advances fiscal responsibility, program integrity, and a more market-based approach to physician payment.

Paragon is a nonprofit health policy research institute committed to reforming government programs and restoring Americans' control over their health care. We believe that empowering patients, rather than expanding government control, is the key to lowering costs and improving health outcomes. Because of its size, Medicare's administered prices are the single largest source of distortion in American health care markets; when those prices diverge from real resource costs, the result is misallocated resources, excessive utilization of low-value services, and consolidation. We write to support two particular sets of provisions in this rule — the modernization of the practice expense methodology and the program-integrity reforms to remote monitoring — that take meaningful steps to correct these distortions, and we offer recommendations to strengthen both.

Modernizing Practice Expense: Moving Beyond the 2007 Physician Survey

Medicare pays for each physician service using three relative value units (RVUs) — physician work, practice expense (PE), and malpractice — which are summed, adjusted for geographic cost differences, and multiplied by a conversion factor to produce a payment rate. Practice expense, which reflects the cost of running a practice, includes rent, clinical and administrative staff, supplies, and equipment. CMS relies on physician survey data collected in 2007 — the American Medical Association's Physician Practice Information Survey — to set the specialty-level cost weights that shape PE payments.1

[1]Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 91 Fed. Reg. 43842 (proposed July 16, 2026) (CMS–1848–P). https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other

This reliance creates two problems. First, the agency lacks current information on what it actually costs to operate a practice; costs and patterns of care have changed substantially in nearly two decades. Second, and more fundamentally, the survey approach allows the physicians being paid to influence their own payment rates through self-reported data that is untethered from market forces—an inherent conflict of interest that tends to reward the specialties best positioned to work the process rather than those incurring the greatest real costs.

We therefore strongly support CMS's proposal to reduce its reliance on this outdated survey, to phase out the indirect practice cost index that anchors PE values to 2007-era data, and to begin a multi-year transition toward "more objective, routinely updated, and auditable cost data." Basing PE payments on current, market-derived costs will make the fee schedule more responsive to market pressures, more transparent to practitioners and beneficiaries, and less vulnerable to manipulation.

As CMS builds out this transition, we support the agency's efforts to anchor the new methodology in objective, external data sources rather than provider-reported surveys. Auditable government and commercial data—for example, Bureau of Labor Statistics wage data for clinical and administrative labor, together with comparable market sources for rent, supplies, and equipment—would tie PE payments to actual market costs while removing the self-interest embedded in survey responses. Consistent with our prior comments on physician valuation, we encourage CMS to look to what the market reveals about the cost of furnishing care, including the prices charged by clinicians who do not accept Medicare, as it finalizes and extends this reform.

Strengthening Program Integrity in Remote Monitoring (RPM and RTM)

CMS first established payment for remote physiologic monitoring (RPM) during the first Trump administration and, outside the temporary pandemic waiver, conditioned that payment on an existing clinician-patient relationship established through a qualifying visit before monitoring began. When the companion remote therapeutic monitoring (RTM) code family was created in the following administration for CY 2022, it was not subject to the same guardrails: RTM carried neither an established-patient requirement nor an initiating-visit requirement.

For CY 2027, CMS proposes to close these gaps. The rule would require a separately reportable initiating visit—furnished in person or via telehealth—before RPM or RTM services begin; extend to RTM the established-patient requirement that already applies to RPM; and limit payment to monitoring furnished by clinical staff who are direct employees of the billing practice rather than outside contractors. CMS also proposes to revalue these services and seeks comment on consolidating the existing codes into four new HCPCS G-codes.

These reforms respond to well-documented abuse. The HHS Office of Inspector General reported in 2024 that remote monitoring has grown rapidly with inadequate oversight, that 43 percent of enrollees who received remote patient monitoring did not receive all three components of the service—education and setup, device supply, and treatment

management—and that some third-party monitoring companies solicit beneficiaries, including through cold calls, into services they may not need.2 Re-establishing a genuine clinician-patient relationship at the outset, and ensuring that the clinical work is performed by the practice accountable for the patient's care, directly targets this waste and the unnecessary utilization it drives.

Paragon broadly supports these changes; they will improve patient care and reduce unnecessary utilization and the program spending that follows from it. We caution CMS, however, that a permanent blanket prohibition on contracted clinical staff may distort markets by effectively reducing access to legitimate remote monitoring—particularly for smaller and rural practices that lack the scale to bring all monitoring functions in-house and that responsibly rely on contracted clinical support. We suggest that CMS consider, including in future rulemaking if need be, accountability mechanisms, including robust supervision and documentation requirements, stringent enforcement of the proposed initiating-visit and established-patient requirements, verification of medical necessity, and targeted enforcement against abusive marketing that would make contracted clinical support less prone to the concerns underlying the current proposal. These efforts would hold both third-party vendors and billing practitioners accountable without effectively restricting RPM and RTM to large practices, while still protecting against the outsourced, volume-driven models the Inspector General identified.

Conclusion

On the whole, we strongly support the proposed rule's provisions related to practice expense and remote monitoring as they move Medicare toward payments grounded in real market prices and toward greater program integrity, thereby reducing waste, curbing fraud and abuse, and improving the quality of care. We encourage CMS to finalize both sets of provisions and to consider the refinements described above.

Thank you for considering our views on this important matter.

Sincerely,

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[2]U.S. Department of Health and Human Services, Office of Inspector General, "Additional Oversight of Remote Patient Monitoring in Medicare Is Needed," OEI-02-23-00260 (September 2024). https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/