AACOM
American Association of Colleges of Osteopathic Medicine

September 14, 2026

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

Re: CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1848-P)

Dear Administrator Oz:

The American Association of Colleges of Osteopathic Medicine (AACOM) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed payment reduction for separately identifiable office/outpatient evaluation and management (E/M) visits billed with modifier 25 and its proposed expansion of services available under the primary care exception (PCE).

AACOM represents all 48 colleges of osteopathic medicine (COMs) in the United States, which educate more than 40,000 future physicians — nearly 30 percent of all U.S. medical students — across 75 campuses, as well as osteopathic graduate medical education professionals and trainees nationwide.

AACOM recommends CMS:

- Fully withdraw its proposed payment reductions for E/M services and global procedures furnished on the same date; work with stakeholders to systematically identify misvalued services and potential overlaps in valuation; and take a targeted, code-specific approach to addressing misvalued services rather than applying a uniform payment reduction across affected same-day services.
- Amend 42 C.F.R. § 415.174(a)(1) to add a third eligible site category under the PCE: "a site that serves as a training site for an approved graduate medical education program for which payments are made under section 340H of the Public Health Service Act (42 U.S.C. 256h)" thereby allowing qualified Teaching Health Center Graduate Medical Education (THCGME) training sites to use the exception.

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Modifier 25 Payment Reduction

AACOM recommends withdrawal of CMS's proposal in section II.D.58.b and urges a more targeted approach.

The CMS proposal would reduce payment when a separately identifiable office/outpatient 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. CMS would pay the most expensive service at 100 percent and each additional surgical procedure or E/M visit at 50 percent.

Modifier 25 currently requires that the E/M service is significant and separately identifiable from the procedure. A uniform reduction would therefore discount properly documented, distinct physician work without a code-specific showing that the same resources are being paid twice. Existing valuation and misvalued-code review processes already provide mechanisms to identify and address specific overlaps when supported by evidence.

The proposal has particular implications for osteopathic medicine because it could reduce payment when a DO provides both a separately identifiable E/M service and medically necessary osteopathic manipulative treatment (OMT) during the same visit. For example, a DO may manage a patient's chronic conditions while also performing OMT for a distinct musculoskeletal condition. Because these services address separate clinical needs and require distinct physician work, each should be appropriately reimbursed when the requirements for modifier 25 are met.

By discouraging physicians from providing multiple medically necessary services during the same visit, the proposal could lead to delayed care and additional burdens for Medicare beneficiaries. These effects would be especially significant in rural communities, where access is already limited and patients often travel long distances for care. Medicare policy should support—not discourage—comprehensive, coordinated care in a single visit. More than half of DOs practice in primary care[1], and 88 percent of COMs have a stated commitment to rural health.[2] Additional financial pressure on small, rural and independent practices could further undermine their ability to provide this care.

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[1] American Osteopathic Association. 2025 Osteopathic Medical Profession Report. https://osteopathic.org/about/aoa-statistics/. Accessed September 9, 2026.
[2] AACOM. AACOM Research Data. https://www.aacom.org/news-reports/ome-research. Accessed September 9, 2026.

The proposal could also weaken community-based clinical training. More than three-quarters of medical schools have reported concerns about the availability of clinical training sites and the supply of qualified preceptors.[3] This challenge is especially important for osteopathic medical education: 64 percent of COMs require rotations in rural and underserved communities[4], where community physicians already absorb substantial time and productivity costs to supervise students, complete evaluations and provide feedback. Reducing professional-fee revenue could leave these practices with even less capacity to teach OMT during same-day visits or continue serving as preceptors in communities with the greatest workforce needs.

Accordingly, AACOM urges CMS to fully withdraw the proposed payment reductions for E/M services and global procedures furnished on the same date; work with stakeholders to identify misvalued services and potential valuation overlaps; and address any demonstrated duplication through targeted, code-specific solutions rather than a uniform payment reduction.

Primary Care Exception for Teaching Health Center Graduate Medical Education Programs

AACOM requests that CMS use the CY 2027 PFS final rule to address the site-eligibility restrictions in 42 C.F.R. § 415.174(a)(1), which exclude most THCGME training sites from using the PCE.

AACOM supports CMS's proposal to modernize the PCE by expanding the scope of covered evaluation and management (E/M) services. However, most teaching health centers (THCs) funded through the THCGME program remain unable to use the exception, creating significant operational consequences for these programs and the patients they serve.

Under the standard Medicare teaching physician rule, a teaching physician must be physically present during the key portion of every billable resident encounter. Without PCE

[3] Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL). Sixteenth Annual Report to the Secretary of the U.S. Department of Health and Human Services and the U.S. Congress, Enhancing Community-Based Clinical Training Sites: Challenges and Opportunities. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/community-based-linkages/reports/sixteenth-2018.pdf. Published January 2018. Accessed September 10, 2026.
[4] AACOM. AACOM Research Data. https://www.aacom.org/news-reports/ome-research. Accessed September 9, 2026.

access, THCGME programs cannot staff a continuity clinic session the way hospital-affiliated programs do: one attending supervising multiple residents seeing established patients simultaneously, with the attending immediately available, reviewing each case, and stepping in when complexity warrants it. Instead, the attending must personally conduct the key portion of every billable encounter, one resident at a time.

To address this barrier, AACOM joins the American Association of Teaching Health Centers (AATHC) and other organizations in recommending a new prong (iii) to the current PCE regulation: "The services must be furnished in a center that is located in (i) an outpatient department of a hospital; (ii) another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under §§ 413.75 through 413.83; or (iii) a site that serves as a training site for an approved graduate medical education program for which payments are made under section 340H of the Public Health Service Act (42 U.S.C. 256h)."

We understand that most THCGME programs cannot satisfy either (i) or (ii) and thus are ineligible for the PCE, regardless of how fully they satisfy the remaining five conditions of 42 C.F.R. 415.174(a). THCs are not hospital outpatient departments and therefore cannot satisfy (i) to qualify for the PCE. Similarly, THCs can't satisfy (ii) because resident salaries and fringe benefits are paid through HRSA Section 340H grants that flow directly to the sponsoring program, not to an affiliated hospital, as required by (ii).

Extending the PCE to qualifying THCGME sites would support the osteopathic profession's strong commitment to community-based training and better align physician education with where patients receive care. Currently, 80 percent of physician training takes place in academic hospitals, although only 20 percent of hospital admissions occur there.[5] Addressing workforce shortages requires expanding training beyond centralized hospitals into lower-cost, community-based sites that better reflect patient and community needs.

Training location is also closely tied to physician retention. More than 73 percent of DOs practice in the state where they complete residency, and more than 86 percent of osteopathic medical students who attend medical school and complete residency in the same state remain there to practice.[6] Supporting sustainable community-based

[5] Burke LG, Frakt AB, Khullar D, Orav EJ, Jha AK. Association between teaching status and mortality in US hospitals. JAMA. 2017;317(20):2105-2113. doi:10.1001/jama.2017.5702
[6] AACOM. AACOM Research Data. https://www.aacom.org/news-reports/ome-research. Accessed September 9, 2026.

residency training is therefore an important part of strengthening the physician workforce in high-need areas.

Accordingly, the proposed amendment is essential to bring parity to community-based physician training locations. AACOM urges CMS to finalize its proposed expansion of services available under the PCE and amend § 415.174(a)(1) to include qualifying THCGME training sites.

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Thank you for your consideration. If you have questions or require further information, please contact David Bergman, JD, Senior Vice President of Government Relations and Health Affairs, at dbergman@aacom.org or (301) 968-4174 or Katherine Ramer, MPH, Health Affairs and Government Relations Manager, at kramer@aacom.org or (301) 968-4163.

Respectfully,

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AACOM