AMERICAN PARKINSON DISEASE ASSOCIATION
Strength in optimism. Hope in progress.

September 1, 2026

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

Re: 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 Proposed Rule

Dear Administrator Oz:

On behalf of the American Parkinson Disease Association[1] (APDA), we appreciate the opportunity to provide comments on the 2027 Medicare Physician Fee Schedule proposed rule. We applaud the Centers for Medicare and Medicaid Services (CMS) continued attention to policies that affect how Medicare beneficiaries access high-quality, coordinated care, including care for people living with chronic, progressive neurologic conditions such as Parkinson's disease.

We urge CMS to ensure that payment policy supports timely access to multidisciplinary, patient-centered care. Parkinson's disease requires ongoing monitoring, medication management, rehabilitation, education, caregiver support, and coordination across specialties. For that reason, policies governing remote monitoring, primary care, beneficiary cost-sharing, shared medical

[1] [1]The American Parkinson Disease Association (APDA) is a nonprofit organization dedicated to fighting Parkinson's disease (PD) by providing the support, education, research, and community that helps everyone impacted by PD live life to the fullest. Through a nationwide grassroots network of Chapters and Information & Referral (I&R) Centers, APDA works tirelessly to raise public awareness of this chronic neurologic movement disorder and deliver outstanding patient services, resources, and educational and wellness programs to the approximately one million people living with PD in the United States and their care partners and families. Envisioning a world without PD, APDA's national research program and Centers for Advanced Research aim to provide better treatments and unlock the mysteries of the disease. APDA is also committed to advancing public policy solutions that improve lives and move us toward a cure. Founded in 1961, APDA has raised and invested more than $338 million in its efforts to support the PD community.

appointments and resource overlap between stand-alone and global services are particularly important to people living with Parkinson's disease and their communities.

Remote Physiologic Monitoring and Remote Therapeutic Monitoring

In the 2027 MPFS proposed rule, CMS is proposing to require that remote physiologic monitoring (RPM) and remote therapeutic monitoring (RTM) services be furnished only to established patients following a separately reportable initiating visit. CMS also proposes limiting payment for RPM and RTM services to services delivered by clinical staff employed by the practice associated with the initiating visit.

The APDA supports appropriate clinical oversight and safeguards for remote monitoring services, however we are concerned that an employment-only requirement could significantly restrict access to remote monitoring for beneficiaries with Parkinson's disease, particularly those who receive care from small neurology practices, rehabilitation providers, rural practices, or practices that rely on specialized vendor partners to support remote monitoring infrastructure. Remote monitoring can help clinicians identify changes in mobility, function, adherence, symptoms, and therapy needs between office visits. For people with Parkinson's disease, whose symptoms fluctuate and progress over time, these tools may support earlier intervention and reduce avoidable complications.

We urge CMS to not finalize the proposed employment-only limitation. Instead, CMS should preserve access to qualified third-party support under appropriate supervision, documentation, privacy, and accountability standards. CMS should also ensure that any initiating-visit requirement does not create unnecessary delays or barriers for beneficiaries who would benefit from clinically appropriate monitoring.

Redesigning Primary Care to Support Prevention and Chronic Disease Management

CMS seeks comment on how payment for primary care services can be improved to support prevention, longitudinal care, and broader health system goals. The APDA strongly supports efforts to strengthen primary care and to better integrate technology, care coordination, and prospective payment approaches when they improve outcomes for beneficiaries with chronic and progressive conditions such as Parkinson's disease.

A redesigned approach to primary care should incentivize evidence-based prevention and chronic disease management strategies that improve quality, reduce avoidable utilization, and support beneficiaries before major adverse health events occur. Many current Center for Medicare and Medicaid Innovation (CMMI) models focus on procedural episodes, such as joint replacement or cardiac intervention. While these models are important, CMS should also invest in care models that intervene earlier in the disease course and prevent complications that can lead to emergency department visits, hospitalizations, or procedures.

For people living with Parkinson's disease, prevention must include services that help maintain mobility, independence, medication safety, and caregiver stability. Falls are a significant concern for people with Parkinson's disease and can result in hospitalization, surgery, institutional care, and loss of independence. Hospital stays for people with Parkinson's disease are often longer and associated with higher mortality than for people without Parkinson's disease[2]. Intensive rehabilitation, exercise-based interventions, medication management, fall prevention, and care coordination can help reduce

[2] https://www.medrxiv.org/content/10.1101/2025.08.05.25332959v2.full

avoidable complications and support better outcomes, but these services are not always adequately reimbursed or widely available under the current Medicare fee-for-service system.

In 2025, a national roundtable of people living with Parkinson's disease, movement disorder specialists, former federal agency leaders, and other experts identified improved care coordination and patient outcomes as central goals for transforming Parkinson's disease care[3]. Medicare payment reforms should recognize the time and infrastructure required to deliver longitudinal Parkinson's disease care, including care coordination, exercise as medicine, medication reconciliation, caregiver education and support, cognitive and mental health screening, advance care planning, and timely referrals to physical, occupational, and speech therapy. These services are central to maintaining function and quality of life, yet they may not be appropriately supported when payment is tied primarily to discrete visits or procedures.

Finally, while access to primary care providers is essential for people with Parkinson's disease, it is not a substitute for access to neurologists, movement disorder specialists, rehabilitation professionals, mental health providers, pharmacists, and community-based supports. CMS should design primary care reforms to encourage coordination with specialists rather than unintentionally shifting complex neurologic care into settings that may not have the resources or expertise to manage it. Payment models should support multidisciplinary collaboration and ensure that beneficiaries can receive clinically appropriate services in the care setting that best meets their needs.

Part B Cost-Sharing Flexibility in the Medicare Shared Savings Program

CMS proposes to allow Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) to reduce or eliminate beneficiary cost-sharing for certain Medicare fee-for-service Part B items and services when the beneficiary's overall health is expected to be improved or maintained by receiving the service. Cost-sharing can be a significant barrier to care for beneficiaries living with Parkinson's disease and other chronic conditions.

Reduced cost-sharing is an investment in a healthier future with lower healthcare costs because it can help beneficiaries maintain medically necessary visits, rehabilitation services, care management, and other Part B services that support function, independence, and quality of life. APDA encourages CMS to finalize this proposed policy and to provide clear guidance to MSSP ACOs so that cost-sharing reductions are implemented equitably, transparently, and in a manner that benefits people with chronic and progressive conditions like Parkinson's disease.

Shared Medical Appointments

The APDA supports CMS' proposal to establish payment for shared medical appointments (SMAs). Group-based visits can be especially valuable for people with Parkinson's disease, who benefit from clinical guidance, education, peer support, caregiver involvement, and practical strategies for self-management. SMAs also help address social isolation and loneliness, improve access to clinicians, and support non-pharmacologic approaches that are important in Parkinson's care.

This approach was implemented last year at Vanderbilt University for Parkinson's disease patients through an innovative program designed by Dr. Britt Stone, a Neurologist and Movement Disorders Specialist, who serves as the Medical Director of the Vanderbilt Parkinson's Foundation Center of Excellence. Dr. Stone has found that shared medical appointments can be especially valuable because

[3] https://www.parkinson.org/about-us/news/pd-care-roundtable

patients often need more time to discuss Parkinson's symptoms, non-pharmacological strategies, and day-to-day disease management than a traditional individual visit allows.

When the SMA concept was introduced to Vanderbilt's Parkinson's patient community roughly 170 people expressed interest with about 120 deciding to participate. The SMAs for Parkinson's patients are structured as 90-minute visits via Zoom each month and include individual break-out session for a private physician/patient visit. The program has been met with such enthusiasm that Dr. Stone is developing a curriculum for others in the neurology community to use based on based on patient needs and recurring topics.

Benefits for Patients and Care Partners

Parkinson's symptoms often extend beyond motor symptoms, and non-motor symptoms are a major pain point. Shared visits create more structured time to focus on common concerns that may not fit into a standard appointment. SMAs gives patients an opportunity to learn from clinicians and from one another, ask questions, and build confidence in managing symptoms between visits. Additionally, SMAs can focus on one major symptom or topic at a time, allowing deeper education followed by individual breakouts for patient-specific clinical needs.

Benefits for Clinicians and Health Systems

SMAs allow clinicians to address frequently recurring topics with multiple patients while still preserving individual clinical breakouts. By covering common education and self-management issues in a group setting, clinicians can study whether these issues arise less often during routine one-on-one appointments. Additionally, colleagues can refer appropriate patients into the shared visit model, expanding access to high-demand movement disorder expertise.

CMS should finalize the SMA proposal and ensure that implementation supports broad participation where clinically appropriate. We encourage CMS to allow meaningful participation by qualified health care professionals, clinical staff, and auxiliary personnel under appropriate supervision so that SMAs can reflect the multidisciplinary nature of chronic disease management. CMS should also consider how community-based organizations, including APDA, can support implementation. APDA chapters across the country already host support groups that provide resources, education, and practical tools for disease management, making these settings well positioned to support greater integration of SMAs in the community. Finally, CMS should consider how caregivers may be included, with beneficiary consent, given their central role in supporting people with Parkinson's disease.

Accounting for Evaluation and Management (E/M) Resource Overlap Between Stand-Alone Visits and Global Periods

CMS is proposing to modify payment in which a service with a global designation of 0, 10, or 90 days is provided in combination with a modifier -25 service by paying 100% of the cost of the most expensive service and reducing reimbursement for the less expensive service by 50%. The Agency recognizes that this may force practices to shift appointments to separate dates in order to generate the full reimbursement rate but notes that it will monitor utilization to address this issue.

If finalized this policy has the potential to negatively impact people living with Parkinson's disease who receive Botulinum Toxin Injections (BTI) during a routine neurology visit. Per the chart below, the CPT codes associated with BTI have either 0 or 10 day global designations:

CPT Code	Descriptor	Global Period
64611	Chemodenervation of parotid and submandibular salivary glands, bilateral	10
64612	Chemodenervation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)	10
64615	Chemodenervation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)	10
64616	Chemodenervation of muscle(s); neck muscle(s), excluding muscles of the larynx, unilateral (eg, for cervical dystonia, spasmodic torticollis)	10
64617	Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed.	10
64642	Chemodenervation of one extremity; 1-4 muscle(s)	0
64644	64644 Chemodenervation of one extremity; 5 or more muscles	0
64646	Chemodenervation of trunk muscle(s); 1-5 muscle(s)	0
64647	Chemodenervation of trunk muscle(s); 6 or more muscles	0

People living with Parkinson's disease frequently require BTI to address overactive muscle movement and reduce glandular secretion. It is a well-established, guideline-supported treatment for several PD-associated conditions, including cervical and focal limb dystonia, spasticity, chronic sialorrhea, blepharospasm, and neurogenic bladder overactivity. Patients requiring BTI usually receive treatment every three- months which frequently coincide with regular appointments with their neurologists or a member of the neurology care team.

The proposed policy change would result in a 50% reduction in reimbursement for the less expensive service, in this case the E/M associated with the routine visit, despite the distinct nature of that visit. By applying this policy to the example shared above, CMS is making the argument that same day E/M and procedures involve shared administrative overhead which is incorrect. The time, decision making, and documentation required for an office visit is completely independent from the work of injecting BTI.

While this policy may reduce out of pocket expenses for the patient, it creates an incentive for the practice to split the combined appointment into two distinct visits to collect full reimbursement for the services delivered. People living with Parkinson's disease experience significant mobility issues and frequently must travel great distances to see a neurologist who specializes in Parkinson's movement disorders. APDA does not believe that neurologists would intentionally shift towards multi-day appointments, however the multidisciplinary practices and systems that employ them are likely to make a policy change in an effort to shore up revenue losses associated with this policy.

The APDA urges CMS not to pursue this policy, rather CMS should explore more targeted approaches to addressing concerns about overlap in care delivery.

Again, the APDA appreciates the opportunity to provide comments in response to the 2027 MPFS proposed rule. We look forward to working with CMS to ensure that Medicare payment policy supports access to high-quality, coordinated, and person-centered care for people living with Parkinson's disease. If you have any questions regarding our comments, please contact Emma Plourde, Director of Health Policy at eplourde@apdaparkinson.org or 202-763-6801.

Sincerely,

Leslie A. Chambers
President & Chief Executive Officer
American Parkinson Disease Association