May 8, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Support for Petition for Rulemaking – Refinement of CMS Implementation for the Statutory Multiple Procedure Payment Reduction (MPPR) for Outpatient Therapy Services

Dear Administrator Oz:

The undersigned Attorneys General respectfully write in support of the Petition for Rulemaking submitted by the United Physical Therapy Association (UPTA), requesting refinement of the Centers for Medicare & Medicaid Services' (CMS) implementation of the statutory Multiple Procedure Payment Reduction (MPPR) as applied to outpatient therapy services under the Medicare Physician Fee Schedule.

As the chief legal officers of our respective States, we have a strong interest in ensuring that federal administrative agencies faithfully implement statutory mandates, adhere to sound valuation principles, and avoid unintended consequences that adversely affect beneficiary access, particularly in rural and underserved communities.

The petition does not seek repeal of the statutory requirement that CMS apply a 50 percent practice expense reduction to "second and subsequent" therapy services furnished on the same date. Rather, it requests that CMS exercise its acknowledged discretion in defining how that reduction is operationalized at the claims-processing level. As detailed in the UPTA MPPR Petition, the current methodology aggregates distinct therapy services across disciplines and CPT codes in a manner that assumes practice expense efficiencies that often do not exist in clinical practice.

We are particularly concerned with three interrelated issues.

First, the petition presents evidence that CMS's current application may duplicate efficiencies already embedded in the Relative Value Unit (RVU) valuation framework through the RUC process. If so, continued blanket application across distinct codes and therapy disciplines risks compounding reductions beyond what Congress contemplated when it directed CMS to apply a 50 percent practice expense reduction. CMS has historically exercised sub-regulatory discretion in refining MPPR ordering logic in other service categories. Nothing in the statute requires CMS to aggregate distinct therapy codes or disciplines if such aggregation results in reductions where no genuine practice expense efficiencies exist. Accordingly, refinement of the claims-processing methodology appears well within CMS's delegated authority.

Second, the aggregation of services across GP, GO, and GN plan-of-care modifiers appears to treat services furnished by different licensed professionals, under separate plans of care, and using different clinical resources as though they share duplicative expense inputs. Where measurable cost overlap is absent, extending the reduction beyond identical CPT units may not reflect actual resource use.

Third, the documented impact on rural communities raises serious access concerns. Rural Medicare beneficiaries already experience documented therapy access gaps, longer travel distances, and higher unmet rehabilitation needs. Payment policies that discourage same-day coordinated therapy services or materially constrain small and rural practices may exacerbate disparities and lead to higher downstream Medicare expenditures due to preventable complications, hospitalizations, and opioid utilization.

We respectfully urge CMS to:

1. Include refinement of therapy MPPR implementation in the CY 2027 Physician Fee Schedule Proposed Rule;
2. Consider limiting the 50 percent practice expense reduction to additional units of the identical CPT code furnished on the same date of service; and
3. Reevaluate whether aggregation across distinct therapy plan-of-care modifiers accurately reflects congressional intent and actual resource utilization.

We further encourage CMS to provide transparency regarding its current ordering logic and aggregation methodology to facilitate informed public comment. Our interest is not in altering Congress's directive, but in ensuring its faithful and economically rational implementation. A data-driven refinement that aligns reductions with measurable efficiencies would promote statutory compliance, protect beneficiary access, and advance CMS's prevention and value-based care objectives.

We appreciate your consideration of this important matter,

Liz Murrill

Louisiana Attorney General

Aaron D. Ford

Nevada Attorney General

Raúl Torrez

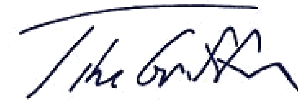
New Mexico Attorney General

Alan Wilson

South Carolina Attorney General

Gwen Tauiliili-Langkilde

American Samoa Attorney General

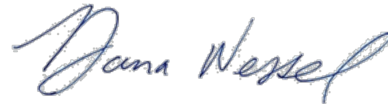


Tim Griffin

Arkansas Attorney General

Rob Bonta

California Attorney General



Dana Nessel

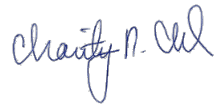
Michigan Attorney General

Dave Yost

Ohio Attorney General

Gentner Drummond

Oklahoma Attorney General



Charity R. Clark

Vermont Attorney General