NISKANEN CENTER

September 11, 2025

The Honorable Mehmet Cengiz Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard, Mail Stop DO-01-40
Baltimore, Maryland 21244-1850

Re: Medicare and Medicaid Programs; CY 2026 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 [CMS-1832-P]

Dear Administrator Oz,

The Niskanen Center is grateful for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) 2026 proposed rule to revise the physician fee schedule (PFS) and other adjustments to Medicare Part B reimbursements.

The Niskanen Center is a nonprofit organization that advocates for public policies that foster innovation, competition, and effective governance. In accordance with that mission, we support regulatory efforts to expand access to lower-cost healthcare options. Across the healthcare industry, market distortions that restrict the availability of lower-cost care increase costs for patients and taxpayers without adding quality improvements.

We commend the agency for its focus on improving payments to primary care settings and revisiting how Medicare determines the value of specific services by reducing the outsized role of organized medicine. In this comment, we will focus on two proposals the agency should ensure are included in the final rule and one missed opportunity to further strengthen primary care:

1) The efficiency adjustment: Rebalancing reimbursement rates between primary care and procedural specialties.

2) New Practice Expense (PE) methodology: Aligning payments with the actual costs of delivering care in each setting.
3) Missed opportunity: Expand the primary care exception (PCE) for residents to better safeguard the financial sustainability of primary care practices.

The efficiency adjustment: Rebalancing reimbursement rates between primary care and procedural specialties.

Paying procedural specialties at higher rates than time-based fields such as primary care has helped fuel the nation's shortage of primary care physicians. Because reimbursement rates are higher in other specialties, neither medical students nor residency programs have strong financial incentives to choose primary care. Inadequate payment also pushes existing primary care providers to sell their practices to larger systems that can command higher reimbursements and offer better salaries. In the worst case, Medicare's devaluing of primary care services has resulted in primary care doctors leaving the field altogether or leaving Medicare, further exacerbating patient access issues.[1]

But the rates that Medicare sets for physician services are heavily influenced by the American Medical Association's (AMA) Specialty Society Relative Value Scale Update Committee (RUC). This 32-member committee is made up of physicians from 22 different specialties who annually review procedural codes and recommend to Medicare the relative value of each service, based on the time and intensity required. In 2025, 91 percent of rates were at or above the RUC's recommendations.[2] Historically, Medicare has accepted about 87 percent of the group's proposals.

While the proposed 2026 rule also follows the trend and accepts approximately 90 percent of the RUC's recommendations, CMS is directly challenging organized medicine's influence over reimbursement by introducing a new "efficiency adjustment" to address what it calls historically "overinflated" valuations.[3] This adjustment will reduce reimbursement for the physician portion of non-time-based services by 2.5 percent, affecting procedures like imaging and surgeries. Time-based specialties like psychiatry and primary care will see an increase as a result, likely between 1 and 4 percent.[4]

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[1] Littrell A. More physicians are leaving traditional Medicare, with primary care hit hardest. *Medical Economics.* Jul 21, 2025. https://www.medicaleconomics.com/view/more-physicians-are-leaving-traditional-medicare-with-primary-care-hit-hardest.
[2] AMA/Special Society RVS Update Committee: An overview of the RUC process. *American Medical Association.* 2025. https://www.ama-assn.org/system/files/ruc-update-booklet.pdf.
[3] Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule (CMS-1832-P). *Centers for Medicare and Medicaid Services.* Jul 14, 2025. https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2026-medicare-physician-fee-schedule-pfs-proposed-rule-cms-1832-p.
[4] Bendersky A. RVU Updates for 2026: Which Medical Services Face the Biggest Impact on Physician Reimbursement?. *SPRY.* Aug 11, 2025. https://www.sprypt.com/blog/rvu-updates-for-2026.

Medicare's rate-setting has long incentivized the overuse of costly specialty procedures while undervaluing time-based services like primary care visits. Many health policy experts, the Government Accountability Office (GAO), and the current administration have all argued that CMS's reliance on the RUC to determine the value of physician services has contributed to this distortion in the PFS.[5] For example, while a skin lesion removal code is listed by the RUC as taking 29 minutes to perform, experts found that the service instead takes only seconds.[6]

Inflated time valuations chronically undervalue primary care, which is less procedure-based and more cognitive in nature. The result is a stark earnings gap: primary care physicians earn roughly half as much as specialists.[7] Faced with this disparity, more new doctors choose higher-paying specialties, reducing the pipeline of primary care providers. This shortfall limits access to the kind of continuous, relationship-based care patients need to manage their chronic conditions.

We commend CMS for taking meaningful steps to rebalance reimbursement rates between primary care and procedural specialties through the new efficiency adjustment.

New Practice Expense (PE) methodology: Aligning payments with the actual costs of delivering care in each setting.

CMS has proposed an additional change that moves the agency away from using the AMA's data reporting and calculations. Rather than adopting the AMA's survey data — typically used by CMS to measure the practice expenses which help determine reimbursements — CMS has

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[5] Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy. *Government Accountability Office.* May 21, 2015. https://www.gao.gov/products/gao-15-434#:~:text=For%20example%2C%20GAO%20found%20that,in%20inaccurate%20Medicare%20payment%20rates.

Laugesen MJ, Wada R, & Chen EM. In setting doctors' Medicare fees, CMS almost always accepts the relative value update panel's advice on work values. *PubMed Central.* May 2012. https://pubmed.ncbi.nlm.nih.gov/22566435/.

Herman B. Experts urge Medicare to overhaul secretive panel that helps determine doctors' pay. *Stat News.* Sep 12, 2022. https://www.statnews.com/2022/09/12/medicare-secretive-panel-overhaul-ruc-ama/

Calsyn M & Twomey M. Rethinking the RUC. *Center for American Progress.* Jul 13, 2018. https://www.americanprogress.org/article/rethinking-the-ruc/.

Cohrs Zhang R. RFK Jr. is exploring a plan to upend Medicare's physician payments system. *Stat News.* Nov 20, 2024. https://www.statnews.com/2024/11/20/rfk-jr-ama-medicare-doctor-pay-ruc/

[6] Herman B. Experts urge Medicare to overhaul secretive panel that helps determine doctors' pay. *Stat News.* Sep 12, 2022. https://www.statnews.com/2022/09/12/medicare-secretive-panel-overhaul-ruc-ama/.

[7] Hsiang WR, Gross CP, Maroongroge S, & Forman HP. Trends in Compensation for Primary Care and Specialist Physicians After Implementation of the Affordable Care Act. *PubMed Central.* Jul 28, 2020. https://pmc.ncbi.nlm.nih.gov/articles/PMC7388019/.

offered its own changes to practice expense methodology. In the 2026 rule, CMS proposes to redistribute payments by lowering the share of indirect costs allocated to facility-based services (such as those provided in hospitals) and increasing the share for non-facility, primarily office-based, services. Reimbursement for facility-based care could drop as much as 7 percent,[8] while office-based care would likely experience a proportional increase.

This change reflects longstanding concerns about the survey data the AMA collects to help determine practice expenses. CMS notes that the surveys suffer from small sample sizes, lower-than-expected response rates, measurement errors, and incomplete submissions, among other flaws. A 2015 GAO investigation found that the RUC's low response rates could produce inaccurate payment recommendations.[9]

This methodology change will ensure that physician reimbursement rates better reflect the growing share of doctors employed by large hospital systems. By shifting more of the indirect payment value to office-based care, where physicians bear all operational expenses directly, Medicare can more accurately align payments with the actual costs of delivering care in each setting.

In the long run, these kinds of payment shifts toward office-based and primary care are helpful to stem the tide of rising hospital consolidation, which Medicare reimbursement rates have long incentivized.[10] By making office-based and primary care more financially viable, Medicare can help reduce the market distortions that plague the healthcare system and add more competition.

Missed opportunity: Expand the primary care exception (PCE) for residents to better safeguard the financial sustainability of primary care practices.

In the 2025 MPFS rule, CMS included a Request for Information about expanding the codes included in the "Primary Care Exception (PCE)" for residency programs.[11] The PCE allows

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[8] O'Reilly KB. AMA urges alternative approaches for two flawed CMS proposals. *American Medical Association.* Aug 27, 2025. https://www.ama-assn.org/practice-management/medicare-medicaid/ama-urges-alternative-approaches-two-flawed-cms-proposals.

[9] Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy. *Government Accountability Office.* May 21, 2015. https://www.gao.gov/products/gao-15-434#:~:text=For%20example%2C%20GAO%20found%20that,in%20inaccurate%20Medicare%20payment%20rates.

[10] Mansell L. Addressing Medicare spending and hospital consolidation with site-neutral payments. *Niskanen Center.* Mar 4, 2024. https://www.niskanencenter.org/addressing-medicare-spending-and-hospital-consolidation-with-site-neutral-payments/.

[11] Medicare and Medicaid Programs; CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments. *Federal Register.* Dec 9, 2024. https://www.federalregister.gov/documents/2024/12/09/2024-25382/medicare-and-medicaid-programs-cy-2025-payment-policies-under-the-physician-fee-schedule-and-other.

residents in primary care specialties who have completed more than six months of their residency program to provide certain services with indirect supervision, rather than the physical presence of a teaching physician. The PCE, established by rule in 1996, was designed in part to help ensure the financial viability of family medicine residency programs.

Since 1996, CMS has permanently added only three new service codes to what residents may provide under the PCE—despite major advances in technology and monitoring capabilities as well as the introduction of competency-based residency program requirements.

Currently, the PCE restricts residents mainly to lower- and mid-level complexity codes (level 1-3 evaluation and management (E/M) services). But during the public health emergency in 2020, CMS expanded to include level 4 and 5 outpatient E/M services, preventive services, and patient continuity and integration of care codes.[12] In May of 2023, with the expiration of the public health emergency, these services were again removed from the PCE.

Expanding the PCE to include higher level services would make primary care residency slots more attractive by reducing the opportunity costs tied to added supervision.This change is critical to sustaining the long-term financial viability of primary care residency programs. Many nurse practitioners across the country can perform level 4 and 5 outpatient E/M services without direct supervision. Evidence also suggests that primary care residents are frequently delivering services that qualify as a Level 4 or 5 E/M visit, but are forced to either bill under a lower code rather than stop a visit to call in a supervising physician.[13]

CMS should reconsider expanding the PCE to ensure that, amidst the primary care shortage, residency programs and prospective medical students have stronger incentives to pursue primary care residency slots.[14]

Conclusion

Medicare reimbursement policy has long contributed to the market distortions in healthcare by reimbursing procedural specialists higher than primary care doctors, while also relying heavily on organized medicine to develop those valuations. We commend CMS for directly confronting

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[12] Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. *Centers for Medicare and Medicaid Services.* Nov 6, 2023. https://www.cms.gov/files/document/physicians-and-other-clinicians-cms-flexibilities-fight-covid-19.pdf.

[13] Cummings A, Chiu N, Evans DV, Andrilla CHA, & Cawse-Lucas J. Impact of Primary Care Exception Expansion on Family Medicine Resident Billing During the COVID-19 Pandemic. *Family Medicine.* 2023. https://journals.stfm.org/familymedicine/2023/november-december/cummings-2022-0442/.

[14] Furr S. RE: Recommendations for the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (MPFS). *American Academy of Physicians.* Feb 5, 2025. https://www.aafp.org/dam/AAFP/documents/advocacy/payment/medicare/LT-CMS-2026MPFSRecommendations-020525.pdf.

these distortions by shifting payments toward primary care while also curbing the influence of organized medicine in the process. We strongly encourage the agency to include these changes in their final rule, and build on the support for primary care by expanding the PCE for primary care residents. Thank you for your time and consideration.

Respectfully submitted,

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