Niskanen Center

September 14, 2026

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 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Oz,

The Niskanen Center is grateful for the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) 2027 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 primary care and other effective, 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.

Since last year's rule which made significant improvement to primary care payment through the Efficiency Adjustment and the reallocation of Practice Expense payments toward office-based care, this year's rule builds on that progress by continuing to reduce Medicare's reliance on industry-supplied data and self-interested valuation processes, replacing them with more objective standards and expanding support for primary care. We commend the agency for its focus on improving payments to primary care settings and revisiting how Medicare determines the value of 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 respond to one Request for Information regarding Medicare's reliance on organized medicine:

- Practice Expense methodology: Fixing how Medicare calculates practice expenses
- Primary Care Exception (PCE) for residents: Reducing supervision burdens in primary care residencies
- CPT and RUC Request for Information: Curbing organized medicine's control over coding and payment

Practice Expense methodology: Fixing how Medicare calculates practice expenses

There are three components that together make up Medicare's physician payments: the work of the doctors, the expense of the practice, and malpractice liability. As one of those three, practice expenses and how they are calculated have important implications for reimbursement rates across specialties.

CMS has relied heavily on the AMA's survey data to determine practice expenses and other inputs, but in recent years, CMS has been working to phase out using those surveys where it can. This largely stems from longstanding concerns that the AMA surveys suffer from small sample sizes, lower-than-expected response rates, measurement errors, and incomplete submissions, among other flaws. In the case of the practice expense data, CMS believes that the surveys are not only "unreliable… with low response rates," but also that they more importantly "present significant discrepancies with alternative empirical data sources."[1] By using empirical data, CMS can improve the accuracy of Medicare's payments and offer a more complete valuation of physician services broadly.

In this rule, CMS is proposing two key reforms to how they will calculate practice expenses moving forward.

First, CMS plans to phase out the Indirect Practice Cost Index (IPCI) over a two-year transition, a tool used to align CMS' own cost reporting with the AMA's specialty-level survey data. Under current policy, CMS estimates indirect practice expenses but then the IPCI rescales that estimate to fit the AMA survey data, essentially trumping CMS' estimates where there is a discrepancy between the two. The IPCI was intended to help CMS account for differences in overhead costs between specialties, but doing so has anchored payment rates to this unreliable survey data. Moving on from the IPCI and instead relying on CMS' own estimates is an important step toward more accurate and more reliable valuations.

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[1] Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule. *Centers for Medicare and Medicaid Services (CMS)*. July 14, 2026.

Second, CMS is proposing to fix a structural imbalance in the way indirect costs are counted towards different types of services that has inadvertently disadvantaged primary care specialties. CMS uses a different method to calculate the indirect cost allocation (overhead, essentially) for office visits such as primary care services than it does for services billed with separate professional and technical components, like imaging. Currently, these services have their indirect costs allocated by adding up clinical labor costs and physician work costs. But all other services, including office visits, use the greater of those two figures instead of the sum, a much lower overhead allocation, and therefore lower payment.[2] CMS reports that this was an "unintended advantage of the arithmetic required" rather than being reflective of true costs.[3] Accordingly, we support CMS' effort to correct this mistake and in so doing, fix one of many ways Medicare's payment policies disadvantage primary care specialties.

Primary Care Exception (PCE) for residents: Reducing supervision burdens in primary care residencies

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.[4] The PCE allows 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.[5] In May of 2023, with the expiration of the public health emergency, these services were again removed from the PCE.

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[2] Crespin DJ, Burgette L, Zhao L, and Merrell K. Expanding Technical and Professional Components to all Medicare Physician Fee Schedule Services. *RAND*. July 2026.
[3] 91 Fed. Reg. 43846 (July 16, 2026)
[4] 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.
[5] Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. *Centers for Medicare and Medicaid Services.* Nov 6, 2023.

In our comment on last year's proposed rule, we noted that failure to expand the PCE was a "missed opportunity" to support primary care. Thankfully, in this year's proposed rule, CMS is proposing to expand the PCE to include level 4 and 5 outpatient E/M services. Expanding the PCE to include higher level services will make primary care slots more attractive in two ways: 1) a lower supervision burden placed on primary care residents and programs and 2) higher, more accurate reimbursement. Amidst the primary care shortage, it is critical that residency programs and prospective medical students have stronger incentives to pursue primary care residency slots.[6] We strongly support this change and urge CMS to retain the PCE expansion in its final rule.

CPT and RUC Request for Information: Curbing organized medicine's control over coding and payment

We are encouraged to see CMS include a Request for Information (RFI) on its reliance on the AMA, both for the CPT coding system that the AMA owns and the process for valuing physician payments which the AMA separately helps determine through the Specialty Society Relative Value Scale Update Committee (RUC).

Niskanen has written previously about the outsized role the AMA plays in valuing physician services through the RUC.[7] 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

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[6] Furr S. RE: Recommendations for the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (MPFS). *American Academy of Physicians.* Feb 5, 2025.

[7] Niskanen Center Comments on Anticompetitive Laws and Regulations in Energy, Healthcare, and Housing (Docket No. ATR-2025-0001). *Niskanen Center*. May 23, 2025.

Mansell L. Shifting the balance: How CMS's 2026 rules target higher-value care. *Niskanen Center*. September 11, 2025.

physician services has contributed to this distortion in the PFS.[8] 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.[9] Faced with this disparity, more new doctors choose higher-paying specialties, reducing the pipeline of primary care providers. At a minimum, the RUC should ensure fair and equal input from each type of specialty to avoid any bias. But primary care physicians hold only 19 percent of RUC seats, despite handling 35 percent of all patient visits.[10]

But this rule's request for information extends a similar concern to a different part of the same system: the AMA's ownership and licenses of the coding standard itself.

To address the questions CMS is raising, we focus our comments on three areas: the harms of AMA's licensing monopoly over coding, how CMS can counteract that harm, and alternatives to the RUC valuation process.

The problem with the AMA's monopoly over coding

In this RFI, CMS asks, "What, if any, evidence is there for CMS to consider regarding the harms or challenges associated with AMA's monopoly over CPT–4 licenses for health care entities?" CPT codes are the five-digit codes providers attach to every procedure or service performed by a healthcare professional. They provide the foundation of our medical billing system, allowing different types of providers and health plans to use a common language to understand the standards of care and how different kinds of treatments are defined and then billed. As

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[8] Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy. *Government Accountability Office.* May 21, 2015.

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.

Herman B. Experts urge Medicare to overhaul secretive panel that helps determine doctors' pay. *STAT News.* Sep 12, 2022.

Calsyn M & Twomey M. Rethinking the RUC. *Center for American Progress.* Jul 13, 2018.

Cohrs Zhang R. RFK Jr. is exploring a plan to upend Medicare's physician payments system. *STAT News.* Nov 20, 2024.

[9] 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.

[10] Muhlestein D, Pathak Y, and Imtiaz S. Improving Payments for Primary Care Physicians. *The Commonwealth Fund.* September 11, 2025.

Composition of the RVS Update Committee (RUC). *American Medical Association*. May 20, 2025.

noted above, this system was created by and is still privately owned and licensed by the AMA.

Private ownership of CPT codes, even by the association representing doctors, is not inherently a problem. In fact, the authorizing statute (HIPAA) explicitly allows for private ownership of these codes — the AMA's monopoly is government backed.[11] The value of having a single coding system that all understand and use is evident. The harms of this system lie at the intersection of the AMA's monopoly and licensing model: the unnecessary duplication of costs for all parties using the software and the perverse financial incentives the CPT coding system creates for the AMA.

In response to criticism of the AMA's monopoly by Sen. Bill Cassidy (R-LA), the AMA argued that they do not charge "exorbitant fees," as the per-user, per-year license fee is $18.50 for providers and the per-member, per-year fee is $0.24 for health plans.[12] While these fees might not seem exorbitant on their face, the AMA's revenue from this licensing model has seen a marked increase in recent years. In 2011, the AMA reported $65.8 million in royalty revenue (22.6 percent of their total revenue).[13] In 2025, that number ballooned to $340.9 million, making up 63 percent of their total revenue.[14] This increase is not because the core product is getting more expensive or the costs to produce it are rising. Rather, because their model is per-user, the revenue scales with the size and complexity of the healthcare system. When a doctor sees a patient, that single visit generates a chain of entities that each have to legally use CPT codes to do their job. As more and more healthcare entities (billing companies, clearinghouses, analytics firms, etc.) are created to manage this complexity, the AMA's royalty revenue increases in turn.

Every one of those licensing fees paid by a variety of entities in one single billed service becomes an administrative cost for each entity. Those duplicative administrative costs are embedded in the system, ultimately passed through to patients whether through higher provider overhead, higher plan premiums, or higher program spending.

Addressing the harm of the AMA's monopoly over coding

But CMS does have statutory authority to address the high and unnecessary costs associated with the AMA's monopoly over CPT codes. The CPT code authorizing statute in HIPAA directs the Secretary to "establish efficient and low-cost procedures for distribution (including

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[11] 42 U.S.C. § 1320d-2(c)(1)
[12] AMA Response Letter to Bill Cassidy. *American Medical Association.* October 23, 2025.
[13] American Medical Association Form 990, published by *ProPublia*. Accessed September 9, 2026.
[14] Ibid.

electronic distribution) of code sets and modifications made to such code sets."[15] In a 2002 report, the General Accounting Office (now the Government Accountability Office) found that the AMA's CPT model met the criteria HHS's HIPAA implementation teams recommended for adopting standard code sets, including "low additional costs and administrative burdens associated with implementation."[16] As costs associated with the AMA's monopoly over these codes have risen alongside technological advances and more complexity, it is critical that CMS actually uses this statutory authority to revisit the CPT code system to improve the cost and efficiency of medical coding.

The agency could use its statutory authority to establish "efficient and low-cost procedures for distribution" by developing regulations that require the AMA to publish an annual breakdown of its CPT-specific revenue, distribution costs, and pricing methodology. CMS could also use its ongoing contracting relationship with the AMA to make that same disclosure a condition of continued reliance on CPT in the interim, benchmarked against the "efficient and low-cost" standard Congress wrote into 1173(c)(2) of the Social Security Act. CMS has the authority to reduce costs here and should quickly act to do so.

Alternatives to the RUC valuation process

If control over the coding system itself were not concerning enough, the AMA holds an even more consequential form of leverage: through the RUC, it also determines payment for doctors based on those codes. In this RFI, CMS asks, "What objective alternatives exist, or could be developed, to maintain a more objective process to the current AMA CPT and RUC committee processes? How would these alternatives support or inhibit innovation?"

Unlike CPT coding, the RUC has no statutory basis at all. CMS has broad authority to accept or reject the RUC's recommendation or even establish entirely new and separate ways to decide on Relative Value Units (RVUs), the inputs that ultimately determine reimbursement rates for doctors. However, CMS still accepts about 87 percent of the RUC's recommendations, and in 2025, 91 percent of rates were set at or above the RUC's recommendations.[17] The RUC exists simply because CMS chose to use the AMA's help to determine RVUs.

The RFI rightly acknowledges the longstanding concerns about the AMA's "obvious conflict of interest" in "providing information on the time and resource requirements to conduct physician

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[15] 42 U.S.C. § 1320d-2(c)(2)
[16] HIPAA STANDARDS: Dual Code Sets Are Acceptable for Reporting Medical Procedures. *Government Accountability Office (GAO)*. August 2002.
[17] RUC Update Booklet. *American Medical Association*. 2026.

services when this information may influence their own payment."[18] As noted above and well-documented in health policy research, the RUC lacks sufficient primary care representation and has consistently over-valued procedural codes that specialties bill while undervaluing the cognitive, visit-based work of primary care.

Fixing this system will require reducing CMS' reliance on the AMA survey data that is used to develop the RVUs and building a decision-making process that does not depend on the same organization whose members' payment is at stake.

In 2016, CMS partnered with the Urban Institute to address "potentially misvalued services in the Medicare Physician Fee Schedule (PFS)" and to develop a system to help replace AMA survey data.[19] In their attempt to gather empirical data on physician intraservice time, they found that CMS's current approach, relying on specialty society surveys and the RUC, does not reliably produce accurate estimates of physician time, and recommended that CMS move toward empirical data collection for the most common, high-dollar-volume services instead.[20] While the pilot drew on a limited number of sites, CMS should build on this prior pilot and adopt EHR-derived and direct-observation time data as the primary input for RVU-setting, rather than defaulting back to AMA-administered specialty society surveys.

To further disconnect from the industry's influence, CMS should stand up a separate, independent, technical panel to provide CMS with unbiased valuation recommendations, staffed by experts without a financial stake in the services being valued. This panel would not replace the RUC, but would work alongside CMS staff to support and improve the agency's own fee-setting process, an approach CMS can implement using its existing authority under section 1848(c)(2)(M) to collect and use information on physicians' services in determining relative values.[21]

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 both develop the foundational billing infrastructure and corresponding valuations. We commend CMS for directly confronting these distortions by continuing to shift payments toward higher-value care while also curbing the influence of

[18] 91 Fed. Reg. 43952 (July 16, 2026)
[19] Zuckerman S, Merrell K, Berenson R, Mitchell S, Upadhyay D, and Lewis R. Collecting Empirical Physician Time Data. *Urban Institute*. 2016.
[20] Ibid.
[21] Berenson R. Modernizing The Medicare Physician Fee Schedule, Part 1: The Role Of A Technical Expert Panel. HealthAffairs Forefront. July 8, 2025.

organized medicine in the process. We strongly encourage the agency to include these changes in their final rule, and build on this rule by taking concrete steps to further reduce the agency's reliance on the AMA.

Thank you for your time and consideration.

Respectfully submitted,

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