CONSUMERS F1RST
The Alliance to Make the Health Care System Work for Everyone

September 14, 2026

The Honorable Mehmet Oz, M.D.
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1848-P
P.O. Box 8016 Baltimore, MD 21244–8016

Re: CMS-1848-P: 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

Submitted electronically via Regulations.gov

Dear Administrator Oz:

On behalf of *Consumers First*, thank you for the opportunity to respond to the calendar year (CY) 2027 Medicare Physician Fee Schedule (MPFS) proposed rule. *Consumers First* is an alliance that brings together the interests of consumers, employers, working people, and primary care clinicians working to change the fundamental economic incentives and design of the health care system. Our goal is to ensure the nation's health care system fulfills its obligation to the people it serves by providing affordable, high-quality, cost-effective care to everyone.

Medicare payment policy often establishes a standard that is then adopted by commercial payers and Medicaid. *Consumers First* offers these comments both to strengthen Medicare physician payment itself, and because the policy changes reflected in this comment letter represent an important step toward realigning the fundamental economic incentives throughout the health care system to meet the needs of all families, children, seniors, adults, workers, and employers across the nation. If adopted, the recommendations outlined below will improve the accuracy of health care payments, including for primary care, and accelerate the transition to alternative payment models in Medicare.

The comments detailed in this letter represent the consensus views of the *Consumers First* steering committee as well as other signers and interested parties. We ask that these comments, and all supporting citations referenced herein, be incorporated into the administrative record in their entirety.

Our comments focus on the following three sections of the proposed rule:

- II.B. Determination of PE RVUs
- II.E. Request for Information: Redesigning Primary Care to Make America Healthy Again
- IV.A.3. Transforming MIPS: MIPS Value Pathway (MVP) Strategy

II. Provisions of the Rule for the PFS; B. Determination of PE RVUs; 2. Practice Expense Methodology; b. Indirect Practice Expense per Hour Data

Consumers First **applauds CMS's proposal to phase out the Indirect Practice Cost Index over a two-year period, which would work to improve the accuracy of Medicare payment.** This proposal represents an important step toward ensuring Medicare payments are based on objective, current, and independently verifiable information rather than relying primarily on self-reported survey responses.

Indirect practice expenses (PE) relative value units (RVUs) are intended to reimburse for the overhead costs of operating a physician practice, including expenses such as rent, utilities, and administrative costs that cannot be assigned to an individual health care service. Under the current methodology, CMS estimates indirect practice expenses using a combination of direct practice expense inputs and physician work.[1] The resulting indirect PE RVUS are then adjusted using the Indirect Practice Cost Index (IPCI), which rescales payments so that specialty-level indirect practice expenses align with costs estimates reported through American Medical Association (AMA) physician practice survey data.

While the IPCI was designed to account for differences in overhead costs across specialties, it also means that a significant portion of Medicare's physician payment methodology remains anchored to specialty-specific survey data rather than objective, independently verifiable measures of practice costs.[2] Consequently, even when CMS accurately estimates the resources required to deliver a service, the final indirect practice expense payment is adjusted to align with historical survey responses.[3]

The survey data underlying the IPCI have limitations that weaken the ability of the IPCI to accurately re-scale provider payment rates. Most notably, the index is based on the nearly two-decades old AMA ***2007*** Physician Practice Information Survey (PPIS).[4] While the PPIS was updated in early 2025, CMS chose not to adopt the updated survey data due to longstanding concerns with sample sizes and sampling variation, low response rates and incomplete data submission.[5] As physician practice structures, technologies, and care delivery models have evolved, such outdated survey data have become an increasingly unreliable basis for determining Medicare payment.[6] **As a result,** ***Consumers First*** **supports CMS's proposal to phase out the IPCI and recommends CMS continue to strengthen practice expense RVU methodology through the use of empirical evidence, such as that derived directly from practices.[7]** By reducing reliance on outdated, self-reported survey data and instead relying

more heavily on empirically derived resource costs, CMS will improve the accuracy of indirect practice expense payments and better align physician reimbursement with the actual costs of delivering care. We believe this change represents an important modernization of the Physician Fee Schedule and advances CMS's and *Consumers First's* shared goal of ensuring Medicare payment more accurately reflects health care service resource costs.

Importantly, if this proposal is finalized, certain physician payment rates will experience significant volatility, including significant reductions in RVU allocation.[8] In an effort to help stabilize physician payment as the IPCI is phased out, CMS is also proposing a new practice expense stabilization adjustment that will prevent PE RVU allocations for any code from increasing or decreasing more than 5% each year.[9] This adjustment will help ensure that changes to the codes most significantly impacted by PE RVU reforms are phased in over time, better enabling providers to adapt to the changing payment methodology and associated reimbursement rates. **As a result, we strongly support and urge CMS to finalize the PE stabilization adjustment as proposed.** Continuing to improve the methodology used to calculate Medicare payment rates, including by developing better data sources and valuation tools, is critical to ensuring physician payment is reflective of true costs. It is also essential in order to rebalance long-term distortions in payment that have overvalued — and thus overpaid — select specialties at the expense of undervaluing or under-reimbursing others, particularly primary care.[10]

II. Provisions of the Proposed Rule for the PFS; E. Request for Information: Redesigning Primary Care To Make America Healthy Again

***Consumers First* applauds CMS's continued efforts to reform and improve primary care payment including through improvements to how primary care is valued and thus reimbursed in the Physician Fee Schedule. We urge CMS to continue its efforts to correct for the longstanding undervaluing and underpayment of primary care, and to advance meaningful policy solutions to increase primary care payment and to establish alternative payment methodologies as the core reimbursement for primary care through Medicare.** To that end, *Consumers First* offers further thoughts related to the following requests for information:

- **1. Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule***: If CMS were to propose longitudinal or primary care visit types, what should the service period be? Should subsequent care management services be bundled in? If so, for what period of time? Which care management services might be included?*
- **2. Care management Code 'Family':** *We seek feedback on whether a different payment structure might be more appropriate as well as what might be done to further simplify the code set and associated requirements.*
- **3. Developing Prospective Payment in the Shared Savings Program. B. Primary Care Capitated Payment Arrangements Considerations for the Shared Savings Program:** *We*

are seeking feedback regarding potential primary care capitated payment arrangements in the Shared Savings Program.

Shifting from Primary Care Code Adjustments to Population Based Payments

Fee-for-service (FFS) payments in the Physician Fee Schedule have long run counter to the structure and goals of primary care delivery. As acknowledged by CMS in the MPFS CY 2027 proposed rule, Medicare payments for primary care services, which have been overwhelmingly made through outpatient Evaluation and Management (E/M) codes, have historically failed to capture the resource demands associated with providers' ability to deliver effective primary care, including the time intensity and clinical judgment required for longitudinal primary care.[11] Additionally, primary care providers spend significant time providing care that typically goes uncompensated under the MPFS, such as communicating with patients through the patient portal or coordinating with other providers.[12] Over the past several years, CMS has worked within the confines of the Physician Fee Schedule to increase primary care payment and to pay for historically uncompensated services by incorporating new codes, such as the G2211 code, or attempting to increase payments for E/M services.[13] Unfortunately, these efforts alone have not sufficiently ensured adequate compensation for primary care providers, nor have they transformed Medicare primary care payment to be more compatible with efficient and effective primary care delivery.[14]

The FFS payment model, by design, reimburses primary care providers based on the delivery of discrete, time-based services rather than the longitudinal relationships and intensive care coordination that defines comprehensive and effective primary care.[15] While improving E/M payments is critical to more accurately reimbursing primary care providers through the Physician Fee Schedule, FFS payment incentives still do not adequately account for, or appropriately incentivize, the scope of services provided by family physicians— including patient education, patient messaging, research, and remote monitoring.[16] This means that even under a strengthened Physician Fee Schedule, Medicare's core reimbursement structure through FFS payment incentives will not support the delivery of comprehensive primary care services. This misalignment in primary care payment, and subsequent longstanding and chronic underpayment, has contributed to the increasing primary care workforce shortage.[17]

Efforts to improve E/M reimbursement and develop new codes that capture the full scope of primary care services have continued to demonstrate that primary care delivery necessitates more flexible payment systems that enable and incentivize providers to customize care delivery to the needs of their patients. By contrast, population-based payments — prospective, ongoing payments coupled with strong population health outcome performance measures — are better aligned with delivering comprehensive health care tailored to meet the needs of patients while

ensuring providers receive predictable payments that allow them to keep their doors open.[18] To that end, ***Consumers First*** **supports CMS's intent to improve the accuracy of primary care payment through the MPFS, but ultimately urges CMS to go further and advance prospective population-based payments for primary care providers, including through a hybrid or fully capitated payment system, through the Physician Fee Schedule.**

Capitated Primary Care Payments

In the CY 2027 MPFS proposed rule, CMS explores shifting towards a hybrid primary care payment that combines prospective payments and the ability for providers to bill fee-for-service. ***Consumers First*** **strongly supports CMS developing prospective primary care payment.** As described above, efforts to establish new primary care billing codes through the MPFS have been wholly inadequate in ensuring that primary care providers have the predictability and flexibility of payments and financial resources to sustain their practices and meet the needs of the patients and consumers they serve. The Medicare Payment Action Committee and National Academies of Science, Engineering, and Medicine have long recommended the use of population-based payments, including hybrid or fully prospective payments, to promote beneficiary-centered care that both improves patient health and reduces program expenditures.[19] ***Consumers First*** **strongly supports the development of a prospective hybrid payment model for primary care and considers it a critical first step to transitioning primary care payment away from fee-for-service with the ultimate goal of moving all primary care providers into a population-based, per-member per-month payment system.**

Under a prospective hybrid payment model, primary care providers receive up-front reliable payments intended to cover a core set of primary care services, but are also able to bill through traditional FFS for services not captured under the capitated payment.[20] A hybrid model would provide primary care practices with a glidepath that prepares them to eventually transition to a full population-based payment model over time by offering predictable and flexible payments needed to meet the needs of our nation's families. **Importantly, a transition to capitated primary care payments must be coupled with an increased investment in primary care in order to ensure that lump-sum payments do not perpetuate the longstanding underpayment of primary care.**

As the potential foundation for a hybrid payment, CMS is *considering* leveraging the Advanced Primary Care Management (APCM) bundled codes established through the CY 2025 MPFS final rule, which bundle care management and communication services into streamlined codes, to develop a prospective hybrid payment available in the Medicare Shared Savings Program (MSSP). APCM payments attempt to capture many of the services that primary care providers provide outside of appointments with patients, such as care plan management, digital communication, and care coordination.[21] **However, care management services included in the**

APCM codes should not be the only services ultimately captured in a hybrid payment model. CMS should explore the development of a hybrid payment model that captures more services, including annual wellness visits for attributed patients.

Additionally, the hybrid primary care payment should be made broadly available to all primary care providers as a core reimbursement model in the Medicare program. Ultimately, hybrid-primary care payments should serve as a glidepath to full, population-based payments. Hybrid primary care payments hold the opportunity to both promote increased and sustained investments in primary care and prepare primary care providers across the country to move into advanced alternative payment models (AAPMs). In the Request for Information, CMS is seeking feedback on whether to limit eligibility to receive hybrid primary care payments to accountable care organizations (ACOs) in downside risk arrangements, specifically MSSP BASIC tracks C, D, E, and the ENHANCED risk track. In these tracks, providers not only keep a percentage of savings but are also responsible for paying back any financial losses. While limiting hybrid payments based on risk level can ensure greater financial accountability for the prospective payments, such a restriction will only undermine efforts to move more clinicians into advanced alternative payment models.

Currently, 24% of all ACOs participate in BASIC tracks A and B and therefore take on no financial risk.[22] Providers that are hesitant to move into higher risk tracks, often because they lack experience and the financial security to confidently take on risk, are the same providers that would benefit the most from the flexibility and consistency of hybrid payment.[23] A hybrid payment system would help these practices become familiar with prospective payment systems and greater financial accountability, ultimately better preparing them to move into more advanced payment models.

Critically, a hybrid payment system is not the end goal. Such a system should serve to shift core Medicare reimbursement for primary care away from FFS and towards full population-based payment, under which providers are truly accountable for cost, quality, and health outcomes. Because of this, ***Consumers First*** **believes a future hybrid primary care payment system should be made broadly available to primary care providers and be designed to move ready providers into more advanced payment models, including fully prospective, population-based payment models.**

<u>IV. Updates to the Quality Payment Program; A. CY 2027 Modifications to the Quality Payment Program Reporting and Data Submission; 3. Transforming MIPS: MIPS Value Pathway (MVP) Strategy</u>

Consumers First **implores CMS to work with policymakers to reform MIPS and MACRA broadly to accelerate provider transition into Advanced Alternative Payment Models.** In the

CY 2027 MPFS proposed rule, CMS is proposing to fully transition all providers in the Merit-Based Incentive Payment System (MIPS) to MIPS Value Pathways (MVPs) by CY 2029. CMS introduced MVPs in performance year 2023 as a new, streamlined reporting option under the Quality Payment Program. MVPs were designed to improve the complex and generalized MIPS reporting structure that has widely failed to prepare providers to move into more advanced payment models. Under traditional MIPS, participating providers must choose from broad reporting options across four performance categories: quality, improvement activities, cost, and interoperability. MVPs attempted to streamline this process by developing specialty-specific pathways that curate measure sets that are clinically relevant, benchmarked against similar specialties, and easier for providers to report.[24] While MVPs make modest improvements to the poorly designed MIPS program, the transition to MVPs is not enough to achieve the program's ultimate goal of shifting from volume to value.[25]

Under both MIPS and the updated MVPs, clinicians receive a score and either a positive payment, a payment penalty or no payment adjustments to their traditional fee-for-service payment based on how well they perform on selected measures.[26] Evidence has demonstrated that these types of payment bonus programs — often referred to as pay-for-performance (P4P) programs — do little to nothing to reorient financial incentives away from FFS and produce mixed results on improving care quality or affordability, despite claims about value.[27] MIPS was never intended to be the long-term way to reimburse providers, instead it was intended to serve as a glidepath to provider participation in advanced alternative payment models (AAPMs), allowing physician practices to become more experienced in meeting the care delivery, data and technology, and administrative requirements needed to be successful under payment models with greater accountability for cost and health outcomes.[28] Instead, research shows that providers are not incentivized to leave MIPS and that the program continues to fail to prepare clinicians for taking on full financial accountability for the care they deliver and the health outcomes of the patients they treat.[29] Transition to MVPs does not solve this problem:

- MVPs still offer limited ability to compare quality and outcome metrics across clinicians working within the same specialty.[30]
- MVPs fail to promote accountability for both cost and quality due to limited specialty-specific cost measures.[31]
- Two-year delays in performance measurement make it difficult for clinicians to adjust behavior in response to performance. [32]
- Providers have little financial incentive to move out of MVPs and into AAPMs.

Experts across the health care industry agree that MIPS is failing and changes to MVPs have done little to adequately reform the program and help it meet its intended goal of preparing and moving providers away from fee-for-service into a system that drives quality and affordability.[33] **Ultimately, we urge CMS to develop fundamental reforms to MIPS that**

transform the program into one that adequately prepares and swiftly transitions providers into AAPMs.

On behalf of *Consumers First* and our undersigned partners, we thank you again for the opportunity to comment on the Medicare Physician Fee Schedule proposed rule for calendar year 2027, and for considering the above recommendations. Please contact Alicia Camaliche, Senior Policy Analyst at Families USA, acamaliche@familiesusa.org for further information.

Sincerely,

***Consumers First* Steering Committee**

American Benefits Council
American Federation of State, County, and Municipal Employees
Families USA
Purchaser Business Group on Health

Partner Organizations

American Association on Health and Disability
American Institute on Disparities in Public Health
Coalition of California Welfare Rights Organizations
Colorado Consumer Health Initiative
Community Catalyst
Consumers for Affordable Healthcare, Maine
Democratic Disability Caucus of Florida
Equality California
Equitas Health
Hebrew Immigrant Aid Society, Pennsylvania
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Ohio Federation for Health Equity and Social Justice
Serving At-Risk Families Everywhere (SAFE)
Small Business Majority
Society for Public Health Education
Tennessee Health Care Campaign
Treatment Communities of America
Voices of Health Care Action

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