COMMITTEE *for a* RESPONSIBLE FEDERAL BUDGET

August 21, 2026

Representative John Joyce, M.D.
2102 Rayburn House Office Building
Washington, DC 20515

Representative Greg Murphy, M.D.
407 Cannon House Office Building
Washington, DC 20515

Representative Kim Schrier, M.D.
1110 Longworth House Office Building
Washington, DC 20515

Re: Request for Information: Strengthening the Medicare Physician Payment System

Dear Representative Joyce, Representative Murphy, and Representative Schrier:

The Committee is grateful for the opportunity to provide feedback on the fiscal implications of the Patients First Act, the available offsets, and incentives that could improve the sustainability of the Medicare program.

The Medicare Physician Fee Schedule (PFS) sets reimbursement rates for services provided by physicians and other clinicians in Part B of traditional Medicare (TM). The PFS articulates amounts for more than 10,000 individual procedures, tests, and imaging codes. In 2023, the Medicare Payment Advisory Commission (MedPAC) estimated that PFS services accounted for 17% of overall spending in TM.[1]

Federal health spending represents the largest area of the budget and a significant contributor to the deficit. Indeed, federal health care spending can explain the entirety of the federal deficit, projected to total *$1.9 trillion* this year and rise to *$3.1 trillion* by the end of the decade.[2] Over the next decade, Medicare costs are on course to *double* while other health care spending will grow more than one-third.[3] Meanwhile, the Medicare Hospital Insurance (HI) trust fund is projected to reach insolvency in 2033.[4]

Any changes to the PFS could exacerbate these fiscal challenges and should be considered in a fiscally responsible manner. In 2025, we estimated that indexing the PFS to MEI-1% would increase federal spending by **$25 billion** over a decade and increase beneficiaries' premiums and cost sharing by **$15 billion** over a decade. If the PFS were indexed to MEI, those amounts would total **$65 billion** and **$30 billion**, respectively. In contrast, reforms to the PFS would improve payment accuracy and limit the distortions in the value of different services. This in turn could help to moderate and partially offset long-term cost growth.

Reforms to Improve the PFS

It is critical that policymakers offset increased federal costs, and the Committee welcomes the opportunity to suggest offsets that would improve the Medicare program while also improving the efficiency and effectiveness of the PFS.

We agree with lawmakers that it is time to modernize the PFS, and we urge them to do so in a fiscally responsible manner. Drawing on our Health Savers Initiative, we recommend policy and technical changes that could improve the fairness of the fee schedule while also helping to partially offset the costs of across-the-board increases. These recommendations are adapted from our paper, "*Fixing Medicare Physician Payment*."

Expand the Centers for Medicare & Medicaid Service's (CMS) Work on Misvalued Codes

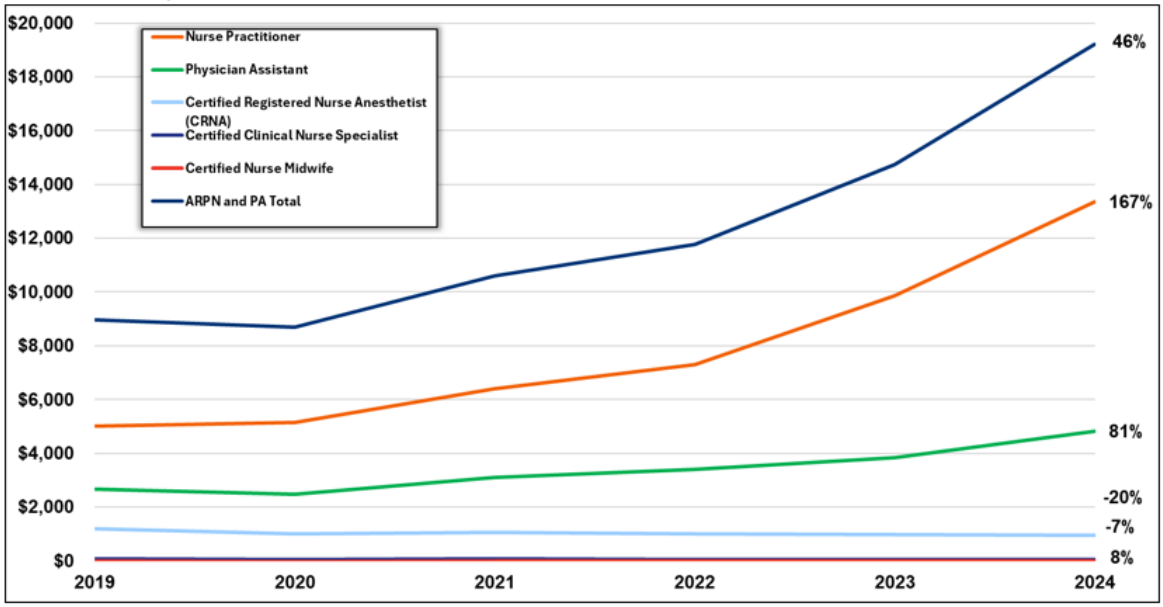
From the inception of the fee schedule's relative value system, CMS has had to grapple with how to ensure each code's values remain accurate in their relation to each other using clinically appropriate assumptions and transparent data. In response to concerns about outdated code valuations, CMS implemented two changes. First, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) began reviewing certain physician services rather than only new codes. Second, in the Affordable Care Act, Congress directed the Secretary of Health and Human Services to focus on "potentially misvalued services" within several code categories. These include codes that have experienced the fastest growth or most substantial changes in practice expense as well as codes describing new technologies or services.[5]

In response, CMS began the misvalued code initiative, which still stands today. The agency estimates that it has reviewed more than 1,700 potentially misvalued codes, but excluding never-before reviewed codes, they estimate it takes approximately 17 years between reviews of each code.[6] The process has drawn significant scrutiny over time for failing to fairly value office visits as opposed to procedures and for focusing too much on increasing the value of undervalued codes rather than reducing the value of existing overvalued codes.[7]

CMS can do more to actively and transparently manage the PFS values. Congress should establish a more automated and sufficiently resourced approach to the misvalued initiative. In addition to its routine reviews, CMS could annually publish codes that grew the fastest over a period of time (e.g., three consecutive years) in billing volume or other factors.[8] If more than five years elapse since the service's resource inputs (work or PE) were last reviewed, then CMS would be required to immediately propose an updated service valuation. Congress could also specify that if the code were misvalued by more than a certain percentage, CMS would make an automatic payment adjustment until the service valuation review was complete.[9] These options are designed to automate and target actions to address excessive spending on certain codes.

The role of Advanced Practice Providers (APPs) has expanded in recent years, but the lack of information on their activities warrants further analysis to better understand the current state of care delivery.[10] APPs include Advanced Practice Registered Nurses (APRNs), Nurse Practitioners (NPs), and Physician Associates (PAs) and have been providing more care to Medicare beneficiaries over time. The amount APPs have billed directly (as opposed to under the supervision of a physician, called "incident to" billing) increased by 46% between 2019-2024 from about $8.9 billion in 2019 to $19 billion in 2024.[11]

Direct Billing, in Millions, by APRNs and PAs for Services Furnished to Medicare FFS Beneficiaries, 2019-2024



Source: 2019-2024 Physician Procedure Summary

CMS's "incident to" billing rules also limit understanding of the care furnished by APPs to Medicare beneficiaries. Services provided by the APP may be billed to Medicare under the supervising physician's identification number (the National Provider Identifier [NPI]), appearing in claims data as if the physician furnished the care and prompting reimbursement at the full PFS payment amount. When billed independently – or not under the physician's NPI – services performed by APPs are reimbursed at a rate of 85% of the PFS rate for physicians.

When the same APPs bill "incident to," the rate is 100% of the physician rate. For this reason, the "incident to" billing model incentivizes physicians to obtain higher reimbursement at lower costs by shifting patient follow-up care to non-physician practitioners. MedPAC recommended Congress eliminate "incident to" billing and require APPs to submit claims under their own NPIs rather than the supervising physician's. As part of their recommendation, the Commission outlined "substantial benefits" of billing reform including budgetary savings, estimating several years ago that eliminating "incident to" could reduce program spending by **$50-$250 million** in the first year and accumulate to a **$1-$5 billion** spending reduction over the first five years.[12]

Offsetting PFS Changes

Health care spending represents the largest portion of federal spending – higher than Social Security, defense, and interest costs. To avoid a debt spiral or a fiscal crisis, policymakers will need to offset important priorities. Even better, they could apply the super PAYGO approach: double the offsets to reduce the deficit. Luckily, policymakers seeking to index the PFS have a wide variety of offsets to choose from in the Medicare program. Some policies that have long held bipartisan support include site-neutral payment reform and changes to Medicare Advantage.

TM fee schedules often set the standard for payment rates in other programs as well, including Medicaid, Medicare Advantage, and commercial insurance. As such, Congress should feel comfortable looking to other federal programs to address inefficiencies that lead to savings. There are plenty of opportunities for savings in the commercial market, the Affordable Care Act marketplaces, and Medicaid. Below is a list of offsets in those programs.

Finally, offsets should improve the overall health care system broadly. Reforms can improve incentives, lower overall health care costs for both the federal government and beneficiaries, and make health care spending more effective. Many would improve the programs' finances, reduce beneficiary cost sharing, and provide incentives that drive health care consolidation and higher prices outside of the Medicare program.

We listed below some additional options for offsetting this priority and reducing the deficit. Please note that the cost estimates represent different windows of time and have not been updated.

Policy Options	10-Year Savings
Medicare Advantage	
Expand MA Coding Intensity Adjustment from 5.9% to 20%	$1.4 trillion
Decrease Benchmarks by 10%	$670 billion
Expand MA Coding Intensity Adjustment from 5.9% to 8%	$200 billion
Use 2 Years of Data & Exclude HRAs for Risk Scores	$150 billion
Reform the MA Quality Bonus System to Add 2-Sided Risk	$140 billion
Medicare Provider Payments	
Adopt Site-Neutral Payments for Most Services	$190 billion
Extend Medicare 340B Reimbursements at ASP-33.4%	$120 billion
Replace Graduate Medical Education with Block Grant	$150 billion
Reform and Reduce Post-Acute Care Payments	$100 billion
Extend Medicare Sequester by Rebasing Payment Rates	$100 billion
Eliminate Medicare Coverage of Bad Debt	$65 billion
Medicare Cost Sharing and Premiums	
Restrict Medigap Plans from Covering “First-Dollar” Costs	$165 billion
Expand Means-Tested Premiums	$100 billion
Modernize Medicare Benefit Design	$30 billion
Hospital Reform	
Cap Commercial Hospital Prices at 2x Medicare	~$300 billion
Repeal or Reform Tax-Exempt Status of Nonprofit Hospitals	Up to $300 billion
Medicaid Reform	
Reduce Matching Rate for Administrative Costs to 50%	$80 billion
Impose Scheduled Medicaid Disproportionate Share Hospital Cuts, Make Permanent	$65 billion
Restrict Use of Intragovernmental Transfers to Boost Medicaid Payments to Public Providers	$50 billion
Close Various OBBBA Provider Tax and State Directed Payment Loopholes	>$50 billion
Other Payment Reform	
Adopt Site-Neutral Payments in Commercial Insurance	~$150 billion
Implement Reference Pricing at 2x Medicare for Federal Employee Health Benefits Program	$60 billion
Directly Fund ACA Cost-Sharing Reductions	$50 billion
Require Price Transparency and Establish Claims Database	~$20 billion
Drug Pricing Reform	
Expand Medicare Drug Price Negotiation	$200 billion
Equalize Payments for Similar Part B Drugs	$120 billion
Restrict “Evergreening” of Name-Brand Drug Exclusivity	$15 billion
Revenue Increases	
Limit Employer-Based Health Insurance Exemption to 75th Percentile of Premiums Starting in 2028	$630 billion
Increase Taxes on Alcoholic Beverages to $16 per proof gallon	$90 billion
Rationalize and Increase Tobacco Taxes by 50%	$50 billion

Conclusion

At a time of high and rising deficits, we appreciate the focus on fiscal responsibility when looking to fund important priorities in the Medicare program. There is no shortage of offsets, especially in the Medicare program, with a wide range of savings. This is an important opportunity to not only offset the cost of these changes, but also to reduce the deficit and to improve incentives in the Medicare program.

Congress should also be mindful of the spillover effects of increasing PFS rates. Beneficiary premiums and cost sharing will increase as well. A $1 billion increase in Medicare Part B spending means a $250 million increase in premiums. And because other payers – such as Medicaid, MA, and commercial insurers – often use the PFS as the basis for their clinical payment rates, PFS increases will increase national health expenditures nationwide.

The Committee commends the Doctors Caucuses for requesting input from the public on ways to provide offsets to this legislation. There are plenty of offsets within Medicare and outside of the program that could be used to do so.

Sincerely,

Marc Goldwein, Senior Vice President and Senior Policy Director
Anna Bonelli, Director of Health Policy

[1] Medicare Payment Advisory Commission (MedPAC), "June 2025 Report to the Congress, Medicare and the Health Care Delivery System, Chapter One: Reforming Physician Fee Schedule Updates and Improving the Accuracy of Relative Payment Rates," June 12, 2025, Page 9, https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf.
[2] Congressional Budget Office, "The Budget and Economic Outlook: 2026 to 2036," February 2026, https://www.cbo.gov/publication/62105.
[3] Ibid.
[4] Medicare Board of Trustees, "2026 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," June 9, 2026, https://www.cms.gov/oact/tr/2026.
[5] Section 3134(a) of the Patient Protection and Affordable Care Act (P.L. 111-148).
[6] CMS, "Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule," at 32400. Note that, for the 2025 misvalued code process, CMS only received five public nominations for a series of codes. CMS, "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," Centers for Medicare & Medicaid Services, December 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.
[7] Robert Berenson and Kevin J. Hayes, "The Road To Value Can't Be Paved With A Broken Medicare Physician Fee Schedule," *Health Affairs*, Vol. 43, No. 7, July 2024, https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.00299.
[8] For example: utilization by new specialty, unexplained geographic variances, site of service, etc.
[9] When considering codes that may be appropriate for an automatic value adjustment, CMS should also look to recommendations from the HHS Office of the Inspector General. For example: U.S. Department of Health and Human Services Office of Inspector General, "Additional Oversight of Remote Patient Monitoring in Medicare Is Needed," OEI-02-23-00260, Department of Health and Human Services, September 24, 2024, https://oig.hhs.gov/reports/all/2024/additional-oversight-of-remote-patient-monitoring-in-medicare-is-needed/, U.S. Department of Health and Human Services Office of Inspector General, "Medicare Part B Payments for Incident-To-Services," OAS-25-01-003, Department of Health and Human Services, November 2024, https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000901.asp.
[10] Also referred to as non-physician providers (NPPs), including Physician Associates (PAs), Advanced Practice Registered Nurses (APRNs), Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), certified registered nurse anesthetists (CRNAs), and Certified Nurse Midwives (CNMs) among other nonphysician practitioners. NPs, PAs and CNSs are paid at 15% of the PFS rate when independently billing. CRNAs and CNMs are paid at 100%.
[11] These figures do not account for services furnished by APPs and billed under a physician's supervision, known as "incident to" rules.
[12] MedPAC, "June 2019 Report to the Congress: Medicare and the Health Care Delivery System," June 14, 2019, Page 162, https://www.medpac.gov/document/http-www-medpac-gov-docs-default-source-reports-jun19_medpac_reporttocongress_sec-pdf/. Other researchers arrived at similar single-year estimates of fiscal savings. For example, one study found that if APPs billed direction, Medicare could save $270 million annually. John F. Mulcahy, Sadiq Y. Patel, Ateev Mehrotra, et al., "Quantifying Indirect Billing

Within the Medicare Physician Fee Schedule," JAMA Health Forum 2025; 6 (4): e250433. doi:10.1001, https://jamanetwork.com/journals/jama-health-forum/fullarticle/2832435. An earlier study found that Medicare could save $194 million in 2018; Sadiq Y. Patel, Haiden A. Huskamp, Austin B. Frakt, et al., "Frequency of Indirect Billing to Medicare For Nurse Practitioner and Physician Assistant Office Visits," *Health Affairs (Milwood)*, Volume 41, Number 6, 805-813, June 2022, https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.01968?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed.