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

September 12, 2025

The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Attention: CMS-1832-P,
P.O. Box 8016
Baltimore, MD 21244–8016

Re: CMS-1832-P: 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

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) 2026 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 in the health care system to meet the needs of all families, children, seniors, adults, and employers across the nation. If implemented, the payment changes being recommended by *Consumers First* have the potential to catalyze the transformational reform that is needed to drive high value care into the health care system and across all health care markets in the United States.

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 sections of the proposed rule:

- II.B.5.c – Determination of PE RVUs
- II.B.5.d – Use of OPPS Data for PFS Rate Setting
- II.E.2.b – Proposed Efficiency Adjustment
- II.G.2 – Behavioral Health Integration Add on Codes for APCM
- III.C – Ambulatory Specialty Model (ASM)
- III.F.2.C – Proposal to Limit Participation in a One-sided Model to an ACOs First Agreement Period Under the Basic Track's Glidepath

II. Provisions of the Proposed Rule for the PFS; B. Determinations of PE RVUs; 5. Development of Strategies for Updates to Practice Expense Data Collection and Methodology; c. Updates to Practice Expense (PE)

***Consumers First* supports CMS' continued efforts to address payment distortions in the Medicare Physician Fee Schedule, including by proposing adjustments to reduce physician payments for professional services delivered in the facility setting.**

In the CY2026 proposed rule, CMS proposes to revise Medicare payment rates for certain physician and other professional medical services by changing how CMS calculates the relative value of services delivered in the facility setting. Specifically, CMS proposes to reduce the amount of indirect practice expense relative value units (RVUs) allocated to services delivered in the facility settings by half.

For decades, CMS has periodically updated direct Practice Expense (PE) RVUs based on observable, service-specific inputs such as non-clinical labor, equipment, and supplies. These updates are critical to maintaining the accuracy and integrity of the Physician Fee Schedule (PFS).[1] However, indirect PE RVUs - which represent essential but generalized overhead costs like rent, utilities, and administrative labor - have not received the same level of scrutiny or modernization. Instead, CMS has historically relied on outdated survey data from the AMA Physician Practice Information (PPI) Survey.[2]

As a result, the current indirect PE methodology has not kept pace with changes in the way health care is delivered today. For example, physician employment patterns, practice structures, and the location of where health care is delivered have changed significantly over the last two decades.[3]A growing share of physicians are now employed by large hospital systems or facilities, where many indirect expenses are covered by the facility or hospital system, not the individual clinician.[4] Despite this shift, the indirect PE RVUs have remained largely unchanged, resulting in duplicative payment: once to the facility (through the Hospital Outpatient Prospective Payment System) and again to the physician through inflated indirect PE RVUs reimbursed under the physician fee schedule.[5]

This payment distortion has resulted in overpaying for services delivered in facility settings where indirect costs are already accounted for, has fueled consolidation by giving hospital-

owned practices a payment advantage, and contributed to the persistent undervaluation of primary care, behavioral health and other community-based services which are essential to any high-value health care system.[6]

Through the Medicare physician fee schedule (MPFS), CMS sets the payment rate for each health care service through the resource-based relative value scale (RBRVS), which identifies the "relative value" of each of the almost 14,000 services reimbursed under the MPFS through the allocation of relative value units (RVUs).[7] These RVUs account for the cost of the inputs used to provide a given medical service relative to all other services. By statute, the relative value of each coded service is calculated by adding together the RVUs of three components: physician work, practice expenses (PE) and professional liability insurance which then gets multiplied by a conversion factor to establish the price or fee for each service.[8] Practice expense relative value units consist of both the direct costs of running a practice (i.e. medical supplies and equipment, non-clinical labor time) and the indirect costs (i.e. rent, utilities, and information technology).[9] Together, indirect and direct practice expense RVUs make up the final allocation of the PE RVUs which account for 45% of the service's total price. [10]

Under the MPFS, CMS sets payment rates for physician services delivered in facility-based settings, such as a hospital or ambulatory surgical center lower than for those services provided in a non-facility-based settings, such as an independent physician practice by reducing direct PE RVUs used to calculate the final reimbursement rate for facility-based physician services.[11] This lower direct PE RVU adjustment is made for two key reasons 1) facilities, not physicians, pay for many of the direct resources (i.e. medical supplies or equipment) needed to deliver services in a facility or hospital-based setting; and 2) CMS reimburses facilities for the cost of delivering those services through other payment systems including the hospital Outpatient Prospective Payment System (OPPS).[12] As a result, lowering the direct PE RVU ensures CMS avoids double payment for the same resources and improves the accuracy of Medicare payment.[13]

While CMS has reduced the *direct* practice expense RVUs used to calculate reimbursement for facility-based physician services, it has *not,* until now*,* adjusted the level of *indirect* PE RVUs when calculating reimbursement rates for physician services delivered in facility settings. *Indirect* PE RVUs used to calculate physician fee schedule rates for services delivered across health care settings have historically been set using outdated AMA survey data to inform indirect cost allocations.[14] This survey data is often the only data CMS relies on in making adjustments to physician payments.[15] As a result, CMS has become overly reliant on this survey data despite its clear limitations in accurately and fully informing needed changes to physician payment. Ultimately, this overreliance on AMA survey data has constrained CMS's willingness to adapt and modernize payment methodologies in alignment with changes in how health care is being delivered and where patients and consumers receive care.[16]

Moreover, because CMS pays the same amount of indirect PE RVU to physicians regardless of their site of service (i.e. a hospital vs a doctor's office), hospital-based providers are often overpaid. For example, hospital-employed physicians, which now account for 77% of physicians, who bill the Physician Fee Schedule are reimbursed for indirect costs like office rent or utilities they never incur because those costs are typically borne by the hospital, not the physician.[17] In addition, Medicare separately pays the hospital or facility for those same resources under the Outpatient Prospective Payment System (OPPS) which results in Medicare paying for the indirect costs of health care services twice.[18] At the same time, because independent, non-facility-based physicians actually bear the full cost of overhead due to operating their own practices, they are often underpaid relative to their actual costs making it more difficult for these independent physician practices to remain financially stable, particularly in underserved areas.[19]Ultimately, this payment distortion creates a financial incentive for hospitals and health systems to purchase independent practices where hospitals can earn a higher total reimbursement from Medicare by employing physicians and billing Medicare under both the Physician Fee Schedule and the hospital payment system.[20]

Adjusting indirect PE RVUs is an important step in increasing the efficiency of Medicare payment, reducing broken economic incentives for further health care consolidation and ultimately helps to increase payment for independent physician practices including primary care which have historically been undervalued and underpaid through Medicare payment.[21] Importantly, because the Medicare Physician Fee Schedule is required by statute to be budget neutral, a reduction in PE RVUs for MPFS facility payments must be offset by increases in PE RVUs for non-facility payments, ultimately increasing payments for independent providers including primary care.[22]

As a result, Consumers First strongly supports CMS' proposal to halve the number of PE RVUs for facility-based physician services and recommends that CMS take steps to ensure this proposed change does not negatively harm those physicians who work both in the facility setting while also maintaining a separate physician practice. To that end, CMS should assess the number of providers that maintain independent physician practices while also being employed by a facility or hospital based setting to further understand which clinical services the most vulnerable to changes in PE RVUs, such as maternity services, where significant portion of the care is provided in the office setting.[23] For example, CMS should consider utilizing Medicare claims data to determine whether a clinician primarily practices in a facility, whether a service is primarily delivered in a facility, or a combination of both, to inform any future adjustments to indirect PE RVUs, as recommended by MedPAC.[24]

<u>II. Provisions of the Proposed Rule for the PFS; B. Determinations of PE RVUs; 5. Development of Strategies for Updates to Practice Expense Data Collection and Methodology; d. Use of OPPS Data for PFS Rate Setting</u>

***Consumers First* applauds CMS' move away from an overreliance on Relative Value Update Committee (RUC) recommendations and American Medical Association (AMA) surveys.** For the first time, CMS is proposing *not* to implement updates to the practice expenses per hour recommended by the AMA as a result of the CY 2026 PPI survey responses and is largely planning to deviate from AMA survey data to inform PFS rates. Instead, CMS plans to use auditable, routinely updated hospital (OPPS) data to set and update payment rates. This approach limits the influence of anecdotal survey data in favor of more reliable cost information.[25]

Under the current system, direct PE RVUs are determined based on recommendations made by the AMA's RUC and indirect PE RVUs are informed by responses to the AMA's Physician Practice Information Survey (PPIS) which are reported as the indirect practice expenses per hour (PE/HR) for each medical specialty.[26] Physician surveys have significant limitations due to historically low response rates, high rates of variability in responses, low total numbers of responses, and little transparency into the survey process.[27] Additionally, experts have long raised concerns that primary care has been undervalued historically compared to specialist care, with downstream implications on the primary care workforce and how primary care relates to the rest of the health care system.[28] For instance, evidence demonstrates that fees for time spent with patients, referred to as evaluation and management (E/M) services and office-based services, are priced too low, creating a longstanding undervaluing and underpayment of primary care through the Medicare Physician Fee Schedule.[29] **To ensure health care payments are truly reflective of the value of primary care and the costs associated with providing a comprehensive version of it (i.e., "Advanced Primary Care Management"), *Consumers First* recommends CMS leverage a diverse set of data sources to inform physician payment rates, including hospital data (as used in OPPS), physician surveys, and routinely collected empirical data.**

<u>II. Provisions of the Proposed Rule for the PFS; E. Valuation of Specific Codes; 2. Methodology for Establishing Work RVUs; b. Proposed Efficiency Adjustment</u>

***Consumers First* supports CMS' efforts to address longstanding flaws in work RVU valuation through the implementation of a new efficiency adjustment.**

CMS is proposing to update work RVUs to account for gains in efficiency through a 2.5% reduction in intraservice time inputs for all non-time-based codes. Work RVUs quantify the time and effort needed for preservice, intraservice, and postservice activities.[30] As previously noted, CMS has historically relied on AMA survey data to estimate the practitioner time, work intensity, and practice expenses associated with furnishing a service.[31] In addition to inherent survey limitations and the over-representation of specialty interests in survey responses, research also confirms that changes to RVUs often keep payment rates for specialty services artificially high by not considering developments in technology and increased utilization of midlevel practitioners that would otherwise warrant decreases in payments for high-cost

procedures, such as surgeries.[32] This means that reliance on surveys alone often results in the misvaluing of select services. At the same time, RVU changes often do not account for increasing resource demands associated with providers' ability to deliver effective primary care, including the time-intensity required to meet patients' needs and critical thinking and judgement required to manage the health and wellbeing of an increasingly medically complex and aging population — factors that would otherwise warrant increases in primary care payments.[33]

To address this, CMS plans to use the Medicare Economic Index (MEI) productivity adjustment to reduce the intraservice work RVUs, which values physician work during the delivery of the actual service, for all non-time-based services by 2.5%. The MEI is a measure of medical cost inflation that uses several inputs – including physician time, non-physician compensation, and overhead costs – to measure year to year changes in prices.[34] As a part of its methodology, MEI includes a productivity adjustment that accounts for changes in overall efficiency across industries, known as multifactor productivity.[35] This adjustment is calculated based on private non-farm business productivity as calculated by the Bureau of Labor Statistics and leverages a 10-year moving average to account for annual spikes or decreases in productivity attributed to normal business cycles.[36] ***Consumers First*** **applauds CMS' move away from the overreliance on AMA surveys as well as the integration of MEI in RVU update methodology. We also recommend that CMS continue to examine the accuracy of data sources used to inform and ensure that updates to provider payment rates are both accurate and adequate based on robust and reliable data sources.**

The 2.5% reduction reflects the total annual MEI productivity adjustment from 2022 to 2026. While CMS plans to apply this reduction broadly to all non-time-based codes, not all services benefit equally from industry efficiency gains.[37] For example, some services may see significant improvements in efficiency due to the introduction of a new technology while others may have more modest efficiency gains attributed to greater experience delivering a service. CMS notes that the greatest efficiency gains often apply to services that take less time to perform.[38] This blunt approach to the efficiency adjustment could result in payment reductions for services that have not benefited from notable productivity improvements, leading to excess financial strain for vulnerable providers, which is why we caution CMS to evaluate the implementation of the efficiency adjustment and provide exemptions when necessary.

If finalized, CMS would conduct an efficiency adjustment every three years, with the next adjustment occurring in CY2029. Most notably, this reduction would not apply to time-based codes, with CMS explicitly excluding evaluation and management (E/M) visits, care management, behavioral health services, and select maternity codes. Because any changes to MPFS must be budget neutral, CMS is instituting a 0.55% positive adjustment to the conversion factor to offset the reductions in RVUs to thousands of codes. As a result, many providers not represented in the RVU reductions will see a significant increase in payments for CY2026. Most notably primary care providers and behavioral health providers, who have experienced historic underpayment for their services, could see significant payment increases[39] ***Consumers First***

applauds these efforts to rebalance physician payments and allocate more resources to historically undervalued providers. CMS must ensure that the 2.5% reduction in intraservice work RVUs does not impact services that have not benefited from improvements in efficiency and should make exemptions where appropriate.

II. Provisions of the Proposed Rule for the PFS; G. Enhanced Care Management; 2. Behavioral Health Integration Add-On Codes for APCM

Consumers First **strongly supports the adoption of three new add-on codes related to behavioral health integration and psychiatric collaborative care model services for Advanced Primary Care Management (APCM) service codes.**

CMS is proposing to establish three new behavioral health integration G-codes as add-on services to APCM: GPCM1, an add-on code for initial psychiatric collaborative care management; GPCM2, an add-on code for subsequent psychiatric collaborative care management; and GPCM3, an add-on code for care management services for behavioral conditions. Under Section III.B Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) of this proposed rule, CMS also proposes to allow these three add-on codes to be provided by auxiliary personnel and also by physicians in the RHC and FQHC setting. These add-on codes alleviate time-based billing requirements associated with current behavioral health integration CPT codes to promote access to expanded collaborative care management services.[40]

In the MPFS CY2025 final rule, CMS established three APCM service codes: G0556, G0557, G0558. These codes bundle together a set of care management and communication technology-based service codes that providers previously billed separately. The APCM codes include 24/7 patient access to their clinical care teams, services that ensure the continuity of care, comprehensive care management services, care transition services, and asynchronous communication services. The development of APCM codes worked to alleviate billing restrictions, such as time-based billing requirements and patient eligibility determinations, to grant primary care providers more flexibility to deliver advanced, team-based primary care services.[41]

Expanding APCM bundled payments through new behavioral integration add-on codes builds off the benefits of the original APCM codes that grant primary care providers and auxiliary personnel the opportunity to be better compensated for their role in delivering collaborative and integrated psychiatric care. Adoption of payment codes for APCM services continues to be a crucial step in moving away from fee-for-service (FFS) economics for primary care delivery and toward hybrid or population-based payments that provide more sustainable payment for primary care providers and ultimately drives higher value health care. Patients receiving APCM services receive more, important primary care services such as annual wellness visits and chronic care management than patients not participating in these models.[42] By reducing the administrative burden of billing for individual care management services for behavioral health,

providers will have more time to spend with patients rather than navigating complex billing codes. Further, patients — who report that they want better access to their doctors, better communication between providers, and more personalized care —continue to benefit from APCM services including 24/7 access to the care team, continuity of care, and comprehensive care management. Inclusion of behavioral health services as add-on codes affords providers additional flexibility to deliver the services that best meet patients' needs while ensuring that primary care providers and auxiliary personnel are adequately compensated for all of the work they do to meet patients' physical and behavioral health needs.

Additionally, CMS included a request for information related to the APCM and preventive services. We thank CMS for taking into consideration the preventive nature of APCM and seeking ways to reduce the cost-sharing burden. **We believe that cost sharing is the greatest barrier to increased utilization of these important codes and that the codes, as they are currently defined, align closely with preventive care, particularly elements of the Annual Wellness Visit (AWV), and should therefore be exempt from patient cost-sharing without further modification.**

Consumers First **strongly supports the adoption of new three new add-on codes related to behavioral health integration and psychiatric collaborative care model services for APCM codes.** Over the past several years, CMS has demonstrated a continued commitment to recognizing the value that APCM service payments provide for patients and providers. Ultimately, the future of primary care payments should not solely rely only on code-based reimbursement. We see the addition and improvement of payment codes for APCM services as both an important achievement and a stepping stone to transition away from traditional FFS economics toward a payment system built on capitated, population-based payments that ensures providers have sustainable, predictable payment to run their businesses and meet the health needs of the patients they serve.[43] As a result, we recommend that **CMS continue efforts to invest in primary care, streamline billing processes, and move away from the inefficiencies of traditional FFS through the advancement of more hybrid and population-based payment models.[44]**

III. Other Provisions of the Proposed Rule; C. Ambulatory Specialty Model (pg. 207)

CMS is proposing to implement and test the Ambulatory Specialty Model (ASM), a new mandatory alternative payment model for specialists treating heart failure and low back pain, with 5 performance years beginning January 1, 2027. Participation in this model is determined at the individual clinician level, meaning providers in designated regions are included in the model if they treat more than 20 cases of heart failure or low back pain annually. ASM would test whether adjusting payment for specialists based on their performance across a set of health care quality, cost, care coordination, and meaningful use of Certified Electronic Health Record Technology (CEHRT) measures results in increased quality of care and reduced costs for Medicare beneficiaries. This is important because chronic pain management and cardiac care

make up a significant portion of Medicare spending, and many interventions recommended to address low-back pain for seniors are considered low-value care.[45]

As a result, *Consumers First* strongly supports the testing of an alternative payment model at the individual physician level to test cost and quality incentives to improve care for patients with heart failure and low back pain. This model takes a new approach to evaluating provider performance by comparing providers at the individual provider level. The intention of this approach is to be able to identify high versus low performing providers, particularly in larger practices with hundreds of clinicians. This approach stands in contrast to models that aggregate provider performance data at the ACO level. Further, under this model each individual clinician's payment will be directly tied to their performance, rather than the overall performance of the practice. Ultimately, this approach aims to test whether measuring clinician performance at the individual level serves as a strong enough incentive for clinicians to achieve cost savings and quality improvement.

Under this approach, it is critical for CMS to take additional steps to remove barriers that have historically made participation in alternative payment models more feasible and more lucrative for consolidated health systems and group practices in comparison to individual practices.[46] For example, smaller providers without access to dedicated billing professionals have traditionally faced an increased administrative burden to implement new payment models into their practice.[47] **As a result, CMS should offer technical assistance to small and independent physician practices to assist them in transforming their practices to participate in the model and developing the infrastructure necessary to report cost and quality data, to increase readiness for being held accountable for health care costs and improved quality.**

Separately, CMS should note that in comparing data from individual providers, issues related to small sample sizes may arise given that some participants may treat only 20-30 cases per year. As a result, their performance over the course of one year on cost and quality metrics could be skewed heavily by a small number of outliers. **CMS should monitor issues related to small sample sizes and consider making changes if participants are impacted.**

Payment Adjustment

***Consumers First* supports the use of a two-sided risk model in ASM, but we strongly advocate that CMS change payment incentives for participants to move away from traditional fee-for-service Medicare and toward population-based payments for primary care.**

CMS proposes to establish ASM as a two-sided risk model, in which participants may receive positive, negative, or no payment adjustment based on their performance on cost and quality metrics. The maximum adjustment is equivalent to the risk level, beginning at 9% in 2027 and increasing incrementally to 12% by 2031. Participants would receive these adjustments on future Medicare Part B payments for covered professional services with a two-year lag time after the ASM participation year.

Consumers First **supports the use of a two-sided risk model in ASM, but we have concerns about the mechanics of payment through Medicare Part B adjustments with a two-year lag time.** As the healthcare system continues to shift toward greater accountability for cost and quality performance, many providers have voluntarily entered into two-sided risk arrangements, including a majority of Medicare Shared Savings Program participants.[48] Participation in two-sided risk models is associated with an increased likelihood of achieving savings.[49] The potential for negative payment adjustments resulting from poor performance acts as a significant financial incentive for providers to engage in meaningful practice transformation to deliver high-quality care at lower costs.[50] As discussed in further detail below, CMS should work to ensure smaller, more vulnerable providers and practices have the resources needed to be successful under two-sided risk arrangements.

Like adjustments for physicians participating in Merit-based Incentive Payment System (MIPS), ASM participants would be compensated through a percentage increase to Medicare Part B payments. Structuring bonus payments in this way creates competing financial incentives for participants. The ASM rewards providers who successfully lower the costs of treating their patient populations. But this reward – a percentage increase to Part B payments – acts as a financial incentive for these providers to deliver a higher volume of Part B services, especially costly services.[51] ***Consumers First*** **recommends that CMS explore alternative incentives for alternative payment models that move away from FFS, such as lump-sum rewards not tied to Part B payments, or capitated payments.**[52] Achieving long-term payment reform hinges on moving away from FFS economics and creating new financial incentives that reward health care providers for keeping patients healthy and for addressing illness effectively, without waste and price gouging.[53] Alternative payment models such as ASM should establish and test new, viable business models for provider payment, including population-based payments. To align the outcomes of the ASM with its goals of reducing unnecessary spending in care for heart failure and low back pain, the economic rewards of the ASM for successful participants must change.

Additionally, the two-year lag time between the ASM performance year and the ASM payment year can make it challenging for successful practices to reinvest savings into further practice transformation. For example, the National Association of ACOs estimates that start-up Accountable Care Organizations (ACOs) may need $4 million of startup capital until there is recoupment in savings.[54] While larger providers may have enough financial resources to take immediate action, smaller practices may need to tap into that pool of shared savings as soon as possible. ***Consumers First*** **recommends that CMS reduce the time between ASM performance year and ASM payment year from two years to one year or provide financial resources for smaller practices to begin transforming their practices for the ASM in the first year.**

Scoring

***Consumers First* supports CMS making changes from traditional MIPS scoring for the ASM, but asks that CMS closely monitor these changes to ensure that potential edge cases, as discussed below, do not present a recurring issue for participants in the ASM.**

CMS proposes to evaluate participants' performance through a combination of weighted cost and quality metrics, adjustments for improvement activities and promoting interoperability, and bonus complex patient and small practice adjustments. Overall, this formula contains the same scoring factors as the Merit-based Incentive Payment System (MIPS) with some differences in application.[55]

On quality metrics, unlike traditional MIPS, ASM requires clinicians to select quality measures from a specific set designed to be relevant to their specialty type and to the chronic condition. Clinicians will only be evaluated against other clinicians who treat the same condition (heart failure or low back pain). Quality and cost metrics are not adjusted for risk factors impacting patient populations. Like MIPS, a complex patient adjustment is added separately, determined by the Hierarchical Condition Category (HCC) risk score and the proportion of dual-eligible enrollees. In the ASM, the small practice bonus is larger in comparison to MIPS and an additional bonus is granted to solo practitioners.

Without risk adjustment in the cost or quality metrics, physicians treating higher-risk populations will face more difficulty in consistently achieving high scores on cost and quality, which constitute a majority of the formula to determine payment adjustment. But scoring bonuses afforded to clinicians supporting these high-risk populations, as well as clinicians working as solo practitioners or in small practices, serve to balance out the cost and quality metrics. Ultimately, CMS must maintain the correct balance between these two pieces to ensure that all participants have a fair chance to achieve a positive payment adjustment.

Under MIPS, all providers are evaluated against a static target score announced in advance. For ASM, CMS will instead calculate a median score based on the final score of all providers in each cohort (heart failure and low back pain). Providers who score above the median will receive positive payment adjustments, while providers who score below the median will be subject to negative payment adjustments.

***Consumers First* supports the use of a cohort median as the basis for payment adjustment, but we urge CMS to closely monitor the results of each cohort in the ASM to ensure that the complex patient scoring adjustment and small practice scoring adjustment are properly sized.** After selecting the cohort of participants for the ASM, CMS should consider examining participants with high-risk patient populations and their past performance on cost and quality metrics to determine if the proposed model scoring can adequately account for these risk factors. It is critical that these two scoring adjustments are properly sized such that providers

from small practices as well as providers treating higher-risk populations are not unfairly punished or rewarded for these circumstances.

One could conceive of a number of edge cases that negatively impact a smaller subset of providers among all participants. If, for example, a solo provider supporting a high-risk population has no feasible way to achieve cost and quality results to generate a total score equivalent to the median score of providers supporting low-risk populations, CMS *must* increase the magnitude of these scoring adjustments to make that possible. Otherwise, providers might begin "cherry picking" more favorable patient populations.[56] On the other hand, if many providers struggle to deliver high-quality, low-cost care and the median cohort score is too low, high-achieving participants may not be incentivized to improve further.

If these and other edge cases occur and cannot be resolved through the current scoring system, CMS must consider reworking the risk adjustment methodology to apply risk factors to cost and quality metrics. Ultimately, all providers deserve a fair chance to achieve a positive scoring adjustment. Otherwise, the ASM will only further entrench disparities in performance between providers on the basis of characteristics inherent to the practices to which they belong and the patients they treat, rather than the quality of the care they deliver.

III. Other Provisions of the Proposed Rule; F. Medicare Shared Savings Program; 2. Shared Savings Program Participation Options Under The Basic Track; C. Proposal to Limit Participation in a One-sided Model to an ACO's First Agreement Period Under the Basic Track's Glidepath

Consumers First **supports reducing the amount of time MSSP ACOs can spend in one-sided models from seven to five years, but recommends CMS allow ACOs to remain in the MSSP Basic Track glidepath through their second agreement period.**

CMS is proposing to limit participation in one-sided arrangements in the MSSP BASIC track levels A and B to five years, or one agreement period, and require ACOs to move directly into high risk MSSP arrangements, specifically BASIC track level E or ENHANCED downsided risk models.

The Medicare Shared Savings Program (MSSP) is the most widely adopted value-based care model, with 476 accountable care organizations (ACOs) spanning 655,725 providers serving over 11 million traditional Medicare beneficiaries.[57] To accommodate providers with varying experience and ability to withstand financial risk, MSSP offers two participation tracks: BASIC or ENHANCED. The BASIC track allows providers to gradually move from one-sided risk to downside risk— with levels A and B representing one-sided models, in which an ACO keeps some savings but is at no risk for financial losses, and levels C, D, and E offering increasing levels of downside risk.[58] ACOs who join the ENHANCED track have the highest opportunity for savings and losses.[59] Currently, inexperienced ACOs eligible for the full BASIC track are able to stay enrolled in one-sided models (level A or B) for up to 7 performance years before being

required to take on increasing levels of risk through participation in levels C, D and E, with levels C and D offering ACOs a lower-risk opportunity to gain experience with risk-bearing arrangements.

Once an ACO moves into a risk-bearing level, they are no longer considered inexperienced in performance-based risk and are therefore only eligible for the BASIC level E or ENHANCED tracks during their next agreement period. Ultimately this means an ACO can spend up to 10 years on the BASIC track, seven of which the ACO may not be required to take on any risk at all.[60] Under the current proposal, ACOs would only be able to participate in level A or B for the first five-year performance agreement. After that, ACOs would be required to move directly to downside risk in BASIC level E or ENHANCED. As a result, ACOs who choose to spend all five years in one-sided risk will be pushed directly into high-risk-bearing models. Skipping over the lower-risk levels that allow ACOs to become more familiar with risk-bearing arrangements.

Risk-bearing arrangements are a critical component to shifting away from FFS towards a business model that incentivizes providers to improve patient health, reduce disparities, and ensure affordability. When providers are at risk for poor quality and wasteful care, it is in their best interest to address whole-person health care needs while reducing the total cost of patient care.[61] This is why ***Consumers First*** **supports moving more providers into risk-bearing arrangements by shortening the period providers can participate in one-sided arrangements to five years.**

However, not every provider or ACO is ready to take on high levels of risk, and accelerating glidepaths to risk-bearing arrangements can work to harm more vulnerable provider groups or prevent provider participation in MSSP altogether.[62] Evidence continues to show that independent, physician-led ACOs perform better on average than hospital-led ACOs but may face more barriers to taking on risk. Physician-led ACOs often consist of small, solo physician offices developed and managed by an independent practice organization.[63] Compared to hospital-led ACOs, physician-led ACOs often lack the financial capital and centralized management system needed to reasonably take on risk and face greater challenges developing the skills necessary to manage large groups of providers.[64] To ensure ACOs are properly equipped to participate in BASIC track level E or ENHANCED track, ACOs must have a clear glidepath and sufficient time to adapt to high levels of risk.[65] Additionally, because participation in MSSP is optional, providers must be incentivized to join participation tracks. By restricting participation options and accelerating the path to risk, CMS risks isolating providers that are hesitant to participate in MSSP.[66] In order to move more providers into VBC arrangements, CMS must ensure providers are encouraged to participate in MSSP tracks. Because of this, ***Consumers First*** **recommends that CMS allow providers to maintain participation in BASIC track levels C and D during their second agreement period prior to being required to participate in level E or ENHANCED tracks.**

In addition to the sections above, *Consumers First* offers abbreviated comments on CMS' proposals in three other key areas:

- **We strongly <u>support</u> CMS' proposals under Section II.D to simplify the review process for adding services to the Medicare Telehealth Services List and eliminating "provisional" status for telehealth services. We also <u>support</u> CMS' proposal to permanently remove frequency limitations on Medicare telehealth services for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations.** *Consumers First* has long supported expanded access and reimbursement for telehealth services through the Physician Fee Schedule.[67] Granting all services permanent status on the Medicare Telehealth Services List is particularly important because it provides stability to ensure that providers investing in telehealth technology will be able to continue billing those codes in future years.
- **We strongly <u>support</u> CMS' proposal under Section II.F to expand billing for the G2211 add-on codes to include home and residence visits.** *Consumers First* strongly supported adoption of the G2211 code in the MPFS CY2024 proposed rule in order to value and empower primary care physicians.[68] Today, essential medical care is delivered across a wide variety of settings, including patients' homes and nursing facilities. Adoption of this proposal would grant primary care physicians additional payment flexibilities that would allow them to provide coordinated, longitudinal care to more patients across the country.
- **We <u>support</u> CMS' proposal to pay for certain skin substitute products as "incident to supplies" and setting a single, standardized rate for the use of such products.** This change would address a key distortion in skin substitute payment that has led to excessive cost and inconsistent care. Because Medicare Part B pays the list price (that is, the wholesale acquisition (WAC) cost plus 3%) for the first 6 months a new physician administered drug or biologic is on the market, manufacturers can charge Medicare any price they set during that time period. To take advantage of this, manufacturers have released more than 100 new skin substitute products since 2023 to maintain the manufacturer's inflated Medicare reimbursement under Medicare's WAC reimbursement policy.[69] As a result, Medicare payments for such products have increased from $250 million in 2019 to more than $10 billion in 2024.[70] Experts have raised that third-party wound care providers use skin substitutes excessively and fail to treat the underlying causes of a wound, leading to exorbitant expenses and poor outcomes for patients.[71] Adoption of this proposal is an important step to ensuring Medicare payment is aligned with the delivery of high value, affordable care.
- **We strongly <u>oppose</u> CMS' proposal under Section III.F to remove the health equity adjustment for quality performance in the Medicare Shared Savings Program available to ACOs who submit Electronic Clinical Quality Measures Basics (eCQMs).** Health equity adjustments are important generally because they help to ensure that Medicare payment methodology accounts for the complexity of higher-risk patient populations.[72]

Maintaining the health equity adjustment would also help CMS to retain data on providers and patient populations with risk factors that impact the delivery of care that could form the basis for future CMMI models or rulemaking.[73] As eCQM adoption becomes the standard, CMS may choose to phase out existing eCQM submission incentives that have strongly supported providers who also qualify for the health equity adjustment. At such a time, having existing health equity adjustment methodology within existing policy is ideal to ensure that the goals of risk adjustment are met.

On behalf of *Consumers First* and our undersigned partners, we thank you again for the opportunity to comment on the Medicare Physician Fee Schedule (MPFS) proposed rule for calendar year 2026, 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 Academy of Family Physicians (AAFP)
Families USA
Purchaser Business Group on Health

Partner Organizations

ACA Consumer Advocacy
American Association on Health and Disability
Colorado Consumer Health Initiative
Consumers for Affordable Healthcare, Maine
Georgia Watch
Health Care Voices
Kentucky Voices for Health
National Partnership for Women and Families
Lakeshore Foundation
Serving At Risk Families Everywhere (SAFE)
Small Business Majority
Tennessee Healthcare Campaign
Third Way
West Virginians for Affordable Healthcare

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