Arnold Ventures

September 10, 2026

Mehmet Oz, Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Comments on the CY 2027 Medicare Physician Fee Schedule Proposed Rule

[File code CMS- 1848-P]

Dear Administrator Oz,

Arnold Ventures (AV) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) "Calendar Year 2027 Medicare Physician Fee Schedule Proposed Rule" that was published in the Federal Register on July 14, 2026.

AV is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. As a philanthropy, we do not accept funding from industry or have a financial stake in policy outcomes. Our work on provider payment reform aims to reduce wasteful spending and re-orient the health care system toward delivering higher quality, less costly care that better addresses the high burden of chronic disease and improves outcomes for patients. A primary focus is accelerating the adoption of population-based payment models such as capitated payments for primary care and accountable care organizations (ACOs), which give clinicians greater flexibility to deliver personalized care to patients to keep them healthy while holding clinicians accountable for the total cost of care. These models are a promising alternative to fee-for-service (FFS) payment that often results in inefficient, low-value care. We also recognize the importance of improving the physician fee schedule both to ensure accurate, appropriate payment and because it is the platform for alternative payment models like ACOs.

We want to thank the agency for its important work to improve the Medicare Physician Fee Schedule (MPFS) and the Medicare Shared Savings Program (MSSP), given your many competing priorities, and for the opportunity to provide input. The table below summarizes our comments on proposed changes to the MPFS and the MSSP, and more details, including responses to the requests for information (RFIs), are below.

Provision	Comment
Updates to practice expense (PE) methodology (pg. 3)	We support the proposal to allocate indirect PE using both physician work RVUs and clinical labor RVUs for most services to improve payment accuracy, apply consistent payment across services, and continue progress toward more objective payment.
Phasing out the Indirect Practice Cost Index (IPCI) over two years (pg. 3)	We support phasing out the IPCI over two years and eliminating it in CY 2028 to enable a methodological shift towards the use of more recent, empirical data.
PE stabilization policy (pg. 3)	We support the proposed guardrails to enable implementation of the PE methodological changes; however, we do not recommend that CMS apply the stabilization adjustment to revalued codes, as this would limit any potential necessary downward revisions to PE, undermining CMS's overarching goal to improve payment accuracy.
Accounting for E/M Resource Overlap Between Stand-Alone Visits and Global Periods (pgs. 3-4)	We recommend that CMS pursue more fundamental changes, such as eliminating the 10 and 90-day global surgical packages as recommended by MedPAC.

MSSP Benchmarking Proposals (pgs. 4-5)	We encourage CMS to focus on fundamental benchmark overhauls such as an administrative benchmarking approach to strengthen MSSP and augment CMMI efforts in the LEAD model.
E/M visit complexity add on (G2211) (pg. 5)	We support this proposal and recommend that CMS include G2211 expenditures in MSSP financial reconciliation without adjustments.
MSSP Part B Cost-Sharing Waiver (pg. 5)	We support the proposal to allow ACOs to waive or reduce Part B cost-sharing as this would remove beneficiary cost barriers without shifting cost to the Medicare program.
PPCP in MSSP (pgs. 5-7)	We recommend that CMS create a permanent hybrid prospective primary care payment in MSSP. The PPCP should be limited to low revenue ACOs in BASIC tracks only. Payment should be based on average regional primary care spending, risk adjusted, and trended forward by prospective PFS spending. We do not recommend establishing a global primary care period outside of MSSP.
RUC/CPT RFI (pg. 8)	CMS should continue developing empirical alternatives to physician survey-based valuation and develop a strategy to phase in empirical data. A technical expert panel could create code groupings, or families, to extrapolate time and intensity of related codes from a subset of codes within the family. A combination of data sources, such as electronic health records, clinical registries, claims data, and other administrative datasets could be used to estimate the time, intensity, and resources associated with furnishing physician services.

I. Proposed Changes to the Medicare Physician Fee Schedule (MPFS)

A. Determination of Practice Expense (PE) Relative Value Units (RVUs)

Under the MPFS, Medicare payment rates are based in part on estimates of the resources required to furnish services to beneficiaries. These resources and associated costs are quantified through relative value units (RVUs), which are divided into three components: physician work, practice expenses (PE), and malpractice liability RVUs.

In the CY2026 rule, CMS finalized the efficiency adjustment to begin to correct the overvaluation of procedural care and ensure that physician work RVUs better reflect the true time and resources necessary to provide a service. AV strongly supported the efficiency adjustment and CMS' efforts to ground payment in empirical data. Several of the proposals in the CY2027 proposed rule build upon last year's payment accuracy focus by overhauling the methodology to determine PE RVUs, which favors payments to specialty physicians and relies heavily on outdated physician survey data. **Arnold Ventures supports the Administration's efforts to modernize the PE methodology by reducing reliance on outdated physician survey data.** These changes, which redistribute existing dollars rather than add new Medicare spending, would better reflect current clinical practice costs and continue progress on payment accuracy.

The sections below include Arnold Ventures' comments on CMS's efforts to improve the PE methodology, including its proposals to:

- Allocate indirect PE using work and clinical labor RVUs;
- Eliminate the Indirect Practice Cost Index (IPCI); and
- Establish a PE stabilization adjustment.

i. Allocate indirect PE using work and clinical labor RVUs

The current methodology to determine indirect PE (e.g., overhead costs required to operate a practice, such as rent, utilities, and administrative staff) favors services with professional and technical components, like imaging and diagnostics, which incorporate both physician work and clinical labor into the calculation. Services that involve less physician time but greater reliance on clinical staff (e.g., nurses, technicians) may be undervalued as a result (e.g., cognitive specialties, primary care). Additionally, indirect PE allocations continue to be informed by specialty-level cost assumptions based on historical physician survey data, raising concerns about whether current payment rates accurately reflect current-day resource use and practice patterns. **AV supports the proposal to allocate indirect PE using both physician work RVUs and clinical labor RVUs for most services to improve payment accuracy, apply consistent payment across services, and continue progress toward more objective payment.**

ii. Eliminate the Indirect Practice Cost Index (IPCI)

The IPCI is a tool used to adjust for geographic differences in PE costs across locations which relies heavily on specialty-level physician survey data collected nearly two decades ago. In more recent years, physician practice patterns have changed substantially, including a notable shift from independent physician practices to hospital and health system-owned settings. As a result, the IPCI may no longer accurately reflect how practice expenses are incurred today and instead distort payment by anchoring PE weights to outdated data. **Arnold Ventures supports phasing out the IPCI over two years and eliminating it in CY 2028 to enable a methodological shift towards the use of more recent, empirical data.** This will also allow the above policy to achieve its full impact, as the IPCI may otherwise dilute its effect.

iii. Establish a PE Stabilization Adjustment

Combining the proposals to change the indirect PE allocation and phase-out of IPCI could create year-to-year volatility in RVUs, necessitating guardrails. The proposed PE stabilization adjustment would generally limit annual increases or decreases in PE RVUs to 5%. **Arnold Ventures supports the proposed guardrails to enable implementation of the PE methodological changes; however, we do not recommend that CMS apply the stabilization adjustment to revalued codes, as this would limit any potential necessary downward revisions to PE, undermining CMS's overarching goal to improve payment accuracy.**

B. Global Surgical Codes

CMS proposes to reduce payment when an office/outpatient evaluation and management (E/M) visit is billed on the same day as a procedure with a 0-, 10-, or 90-day global surgical period. Global surgical packages already include payment for routine pre-operative and post-operative care, creating the potential for overlapping payment when a same-day E/M visit is billed separately. To address this potential overlap, CMS proposes paying the highest-valued service at 100 percent and reducing payment for all other same-day E/M visits or procedures furnished by the same physician (or physician group) by 50 percent.

AV appreciates the Administration's continued efforts to improve global surgical code payment accuracy. While this proposal is a good step to address duplicative payment between global surgical packages and separate E&M visits, it retains the global surgical codes, which are overvalued. **We recommend that CMS pursue more fundamental changes, such as eliminating the 10 and 90-day global surgical packages as recommended by MedPAC**. MedPAC and other experts have recommended replacing these bundled payments with separate fee-for-service billing for post-operative visits furnished after the procedure to better align payment with care delivery and reduce

the risk that Medicare pays for care that does not occur.[1] Bob Berenson and coauthors have similarly recommended eliminating the 10-day global package.[2] If CMS retains global surgical codes, the codes should be revalued using empirical data.

II. Proposed Changes to the Medicare Shared Savings Program (MSSP)

A. Benchmarking Provisions

AV shares the Administration's commitment to accelerate the adoption of population-based payment models such as ACOs. We recognize that CMS' proposed modifications to MSSP are designed to incentivize growth in accountable care while balancing costs to Medicare. We share these objectives and support many of CMS' benchmarking proposals: increasing the sharing rate in BASIC E, reducing the weight of the positive regional adjustment in ENHANCED, and Accountable Care Prospective Trend (ACPT) provisions. Raising the sharing rate in BASIC E and reducing the weight of the positive regional adjustment in the ENHANCED track may help attract more high-cost ACOs to the BASIC track, which offers greater opportunities for Medicare to share in savings.

However**, these proposals represent incremental changes to the benchmarking methodology, continuing the cycle in which CMS must adjust components of the benchmark every couple of years** to attempt to solve persistent challenges (e.g. selective participation of low-cost providers, ratcheting effects, and limited participation of high-cost providers). Despite years of incremental refinements (e.g. prior savings adjustment, regional adjustment, population adjustment, etc.), the **composition of the program has remained relatively unchanged over time**, with participation skewed towards incumbent regionally efficient groups and minimal participation of high-cost providers. While high-cost groups may enter MSSP, they rarely stay, as ACOs frequently drop after experiencing losses, limiting MSSP's potential to generate savings. While the proposed growth adjustment is well designed to attract new providers to join, it does not fundamentally alter their incentives to *remain* in the program and is projected to increase net spending by $1.67 billion over 10 years.

A new benchmark framework is needed to address 3 primary challenges:

1) protecting the Medicare program by creating a sustainable pathway for long-term savings for CMS;
2) creating stronger incentives to save by addressing ratcheting (solving the efficient ACO problem and collective success problem) without creating a secondary problem (increasing cost to Medicare); and
3) incentivizing high-cost providers to stay in MSSP.

An administrative benchmarking approach, or similar overhaul of MSSP benchmarks, **can address these challenges.** By converging both low and high-cost providers to a common regional rate set above historic spending and updating with a prospectively set trend, **CMS can solve both the low and high-cost ACO problems without relying on continued updates to benchmarking methodology**. Specifically, ACOs would not be penalized for lowering spending (either individually or collectively) under an administrative benchmarking approach, eliminating the need for a prior savings adjustment because benchmarks would not be derived from ACO historical expenditures. Similarly, high-cost providers would have an incentive to stay in the program, as benchmarks would be set above historical spending, creating achievable targets for inefficient ACOs to reduce spending. **Most importantly, the Medicare program would have a more sustainable path to savings, as more high-cost providers would stay in MSSP.**

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[1] Medicare Payment Advisory Commission. (2024). Report to Congress. Chapter 1: Approaches for updating clinician payments and incentivizing participation in alternative payment models.
[2] Berenson, R. A., Ginsburg, P. B., Hayes, K. J., et al. (2022). Public comment to the Medicare Physician Fee Schedule Proposed Rule CY 2023 (CMS-1770-P). Urban Institute.

CMS began the transition to administrative benchmarks in 2024 by blending the ACPT into the trend used to update historical benchmarks and is now proposing to: 1) establish performance year specific ACPTs that apply to all ACOs participating in a given year regardless of when their agreement started, and 2) establishing asymmetric guardrails to mitigate forecasting error. **AV supports the proposal to apply a performance year specific ACPT to mitigate arbitrage opportunities** in which ACOs start a new agreement prematurely to receive a more favorable benchmark. We recognize the need for guardrails on the ACPT but **recommend that CMS apply a symmetric guardrail**, as the proposed asymmetric guardrail raises cost to the taxpayer.

The proposed ACPT policies are a good step, but do not eliminate the need for further action towards administrative benchmarks or a similar overhaul (e.g. by beginning the convergence phase in which CMS applies different updates to ACO historical spending to gradually arrive at a common county rate). CMS can likely fully implement administrative benchmarks under existing statutory authority in 1899(i)(3). This authority was applied when introducing the ACPT and likely could be applied again to derive benchmarks from a county rate. We urge CMS to **focus on fundamental benchmark overhauls to strengthen MSSP and augment CMMI efforts in implementing administrative benchmarks in LEAD**. As part of this effort, **CMS should also explore new risk adjustment models** (e.g. the inferred risk model tested in LEAD or next generation RA models under development), **to protect against coding abuses in MSSP which may artificially inflate benchmarks and decrease Medicare's savings potential**.

B. Part B Cost-Sharing:

AV supports the proposal to allow ACOs to waive or reduce Part B cost-sharing as this would remove beneficiary cost barriers without shifting cost to the Medicare program. This proposal draws from lessons from prior CMMI models, including ACO REACH and the Next Generation ACO Model, which tested Part B cost-sharing waivers, underscoring the importance of model tests in identifying promising features to scale to MSSP.

C. E/M visit complexity add-on modifiers (G2211):

CMS proposes to offer higher care management payments for providers participating in accountable care (e.g. MSSP, ACO LEAD, and ACO PC Flex) and would allow ACO providers to bill the code for all traditional Medicare beneficiaries treated. **AV supports this proposal because it strengthens incentives to participate in accountable care**. We **recommend that CMS include G2211 expenditures in financial reconciliation without adjustments**. Carveout from expenditures used in settlement is not necessary because new codes are routinely added to the fee schedule each year and CMS rarely makes adjustments for specific codes, particularly if the value of the code is minimal relative to the benchmark, and 2) the issue will self-correct under current methodology as benchmarks are rebased and modifiers are reflected in future benchmarks.

III. Response to Requests for Information

A. Establishing Prospective Primary Care Payment in MSSP

AV commends the Administration for their interest in transformative changes to primary care payment such as prospective primary care payment (PPCP). Investment in primary care is associated with longer life expectancy, lower rates of chronic disease, and fewer hospitalizations. Yet the US continues to devote a small share of total health spending to primary care. Payment reforms that increase primary care investment, such as PPCP, can strengthen care delivery, support team-based and preventative services, and better address patients' longitudinal needs.

We recommend that CMS create a permanent PPCP in MSSP to fundamentally push primary care payment away from FFS, send a strong market signal to move towards hybrid payment for primary care, and enable practices to commit more fully to payment reform. CMS and CMMI have gained experience with prospective

primary care payment through various models testing different payment methodologies: primary care capitation predominately derived from an ACO's historical primary care spending (ACO REACH), and hybrid primary care payment largely derived from regional primary care spending (ACO PC Flex). We applaud this commitment to primary care and recognize the importance of model tests in identifying promising approaches to scale to the broader Medicare program. However, there is no permanent Medicare option available for PPCP; all current and future options (e.g. ACO LEAD) are tied to a model test, meaning that PPCP is time-limited.

Below, we recommend design features for a permanent PPCP option in MSSP which balance participation and cost to the Medicare program.

Eligibility:

AV recommends eligibility for PPCP be **limited to low revenue ACOs in BASIC A-E**, as this subset of ACOs is most likely to generate net savings to the Medicare program (or at least not increase net Medicare spending). As CMS alludes to in the proposed rule, selection of ACOs into the ENHANCED track is costly for CMS, as sharing rates are so high that shared savings payments made to ACOs in ENHANCED often exceed gross spending reductions. If CMS were to offer PPCP to all MSSP ACOs (including ENHANCED ACOs), this would decrease the likelihood of Medicare savings.

Similarly, offering PPCP to high revenue ACOs (often led by health systems) is not strongly supported by the evidence. Low revenue ACOs have historically achieved higher savings than high revenue ACOs.[3,4] CBO has reported that ACOs led by independent physician groups or a larger proportion of primary care physicians have achieved greater savings.[5] High revenue ACOs have weaker incentives to save than low revenue ACOs, as health systems must weigh whether expected shared savings payments will exceed forgone hospital revenue. Restricting PPCP eligibility to low revenue ACOs may also help mitigate incentives to consolidate (albeit weak). If CMS wants to expand PPCP to additional ACOs in the future, CMS could monitor trends in ENHANCED track savings and high revenue ACO performance to determine whether adjustments are warranted.

Payment Design:

AV recommends structuring the PPCP as a **hybrid payment**, blending prospective per beneficiary per quarter (PBBQ) payments for most primary care services with limited FFS for certain services or procedures (e.g. immunizations). The payment should be as comprehensive as possible, rather than simply offering a care management fee prospectively on top of FFS, to provide a true FFS replacement. For example, the PPCP should incorporate primary care E&Ms and care management codes such as those included in ACO PC Flex and include higher care management payments (e.g. G2211 modifier as proposed in this rule) for providers in ACOs.

PMPM rates should be derived from **regional primary care spending** using a rate book approach to divorce primary care spending from ACOs' historical primary care expenditures, which is often below the level needed for comprehensive, coordinated care delivery. Basing payment on risk standardized county average primary care spending raises primary care expenditures for ACOs whose historical primary care spending trails the county average. Conversely, ACOs with historic primary care utilization exceeding the county average would experience lower primary care rates under a rate book approach in the absence of adjustments. CMS could consider an

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[3] Medicare Shared Savings Program Saves Medicare More than $1.8 Billion in 2022 and Continues to Deliver High-quality Care. Centers for Medicare and Medicaid Services. August 2023.
[4] "Medicare Accountable Care Organizations In 2022: Renewed Growth And Improved Savings Show Small Rebound From The COVID-19 Pandemic," Health Affairs Forefront, October 19, 2023.
DOI: 10.1377/forefront.20231017.282343
[5] Medicare Accountable Care Organizations: Past Performance and Future Directions. Congressional Budget Office. April 2024.

adjustment similar to the PC Flex Enhancement to increase the attractiveness of the rate book approach for historically high primary care utilizers. CMS could also consider an adjustment similar to the PC Flex County Enhancement to boost county rates for regions with historically low primary care utilization relative to the nation.

While there are additional design considerations in using a rate book relative to the REACH PCC method, thoughtful design can mitigate concerns. Most importantly, **building hybrid payment on a rate book approach will better integrate PPCP into the framework for needed benchmark reforms discussed above (administrative benchmarks)**. By basing PPCP on a common, risk adjusted regional rate which is updated with a prospective trend, the methodology for PPCP will mirror that of administrative benchmarks, which converge an ACO's historic total cost of care to a common regional rate, updated by a prospective trend.

AV recommends **updating primary care rates with prospective PFS spending** as forecasted by OACT. Trending rates forward with projected PFS spending will increase PPCP rates, as total PFS spend has grown at a higher rate than primary care spending.[6]

Global Primary Care Period outside of MSSP:

CMS also seeks comments on design of a primary care global period outside of MSSP. AV **does not recommend establishing PPCP outside of an APM such as MSSP**. Hybrid primary care payment should be within a total cost of care framework to mitigate concerns of providers stinting care. Outside of a total cost of care model, PPCP may encourage primary care providers to increase referrals and shift care to specialists to maximize revenue. However, if a primary care provider in an ACO or similar TCOC model shifts care to specialists and this results in an increase in total cost of care, the ACO may have diminished savings to share with providers (or may sustain losses). The incentives embedded in a total cost of care construct mitigate potential stinting concerns. MIPS is too weak to provide a meaningful incentive to reduce spending (the revised POINTS system contemplated in the *Patients First Act* further weakens MIPS), meaning that strong cost containment incentives can only occur within the context of an APM. Further, the **availability of a global primary care period in the PFS weakens the incentive to join APMs**, as primary care providers may receive the benefit of flexible, prospective primary care payment, without the accountability imposed by an APM. We **recommend that CMS focus on establishing a permanent PPCP option in MSSP.**

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6 "Why Medicare Physician Fee Schedule Changes Have Not Adequately Addressed Primary Care Physician Pay," Health Affairs Forefront, March 26, 2026.
DOI: 10.1377/forefront.20260323.832870

B. Current Procedural Terminology (CPT) Coding

Arnold Ventures commends the Administration for their interest in examining the CPT process and identifying opportunities to improve how services are valued under the MPFS. As CMS considers ways to better reflect evolving clinical practice, it should also examine how the current CPT framework perpetuates Medicare's reliance on the AMA/Specialty Society Relative Value Scale Update Committee (RUC). Because the AMA both maintains CPT and convenes the RUC, the coding and valuation processes are closely intertwined, giving the AMA substantial influence over how physician services are defined and valued across the healthcare system. Specifically, AMA's CPT monopoly fuels the RUC, perpetuating its dominance in rate setting. Structural flaws with the RUC, including inherent conflicts of interest, a reliance on survey data from medical societies, and an overrepresentation of specialists, undermines the accuracy of its recommendations.[7] These structural flaws have resulted in the undervaluation of cognitive services such as primary care and overvaluation of procedural care. **Arnold Ventures recommends that CMS reduce its reliance on the RUC and develop independent, evidence-based alternatives to inform valuation decisions.**

CMS should establish an independent advisory board (e.g., a technical expert panel), create a public repository of RUC methodologies and physician work data, and use more empirical data to calculate RVUs. The technical expert panel should be made up of individuals with expertise that is not currently represented among practicing clinicians on the RUC, such as background in payment methods, economics, and insurance design. While some appointees could be clinicians, they should not be in active practice where they receive Medicare reimbursements to avoid conflicts of interest.[8] The panel could review empirical data, consider updates to nonprocedural codes, and recommend additional changes to payment amounts. They could also advise on additional information that should be collected to supplement the current survey-based approach. **At a minimum, CMS should improve transparency and better facilitate information on how the RUC reaches its valuation decisions**. The secrecy around voting within the RUC may contribute to the RUC's recommendations being biased in favor of certain specialty societies, which highlights the need for greater transparency.[9] CMS should make a public, central repository of guidelines and standards, including information on physician work data and methods, that the RUC follows to generate recommendations.[10]

Most importantly, **CMS should continue developing empirical alternatives to physician survey-based valuation and develop a strategy to phase in empirical data**. The proposed practice expense policies reflect meaningful steps towards payment accuracy and the agency should continue efforts to empirically value physician work. A **technical expert panel could create code groupings, or families, to extrapolate time and intensity of related codes from a subset of codes within the family.** A combination of data sources, such as **electronic health records, clinical registries, claims data**, and other **administrative datasets** could be used to estimate the time, intensity, and resources associated with furnishing physician services. These approaches would provide a more objective and reproducible basis for valuation than outdated, conflicted surveys. CMS should establish a glide path to gradually phase in alternative data inputs.

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

[8] Berenson, R. A., Ginsburg, P. B., Hayes, K. J., et al. (2022). Public comment to the Medicare Physician Fee Schedule Proposed Rule CY 2023 (CMS-1770-P). Urban Institute.

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

[10] Health Management Associates, Inc. (2024). Medicare Physician Fee Schedule Reform: Structural Topics and Recommendations to Strengthen the System for the Future.

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IV. Conclusion

We appreciate the Administration's commitment to improving payment accuracy in the MPFS, strengthening primary care, and accelerating adoption of accountable care. We commend CMS staff's hard work to establish prospective primary care payment in MSSP. Thank you for the opportunity to comment on the proposed rule. Please contact Josh Gordon (jgordon@arnoldventures.org), Vice President, Health Care, and Mark Miller (mmiller@arnoldventures.org), Executive Vice President, Health Care, with any questions.

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