September 9, 2025

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 2026 Medicare Physician Fee Schedule Proposed Rule

[File code CMS-1832-P]

Dear Administrator Oz:

Arnold Ventures (AV) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) "Calendar Year 2026 Physician Fee Schedule Proposed Rule" that was published in the Federal Register on July 16, 2025.

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 are below.

Provision	Comment
Addition of an Efficiency Adjustment (pg. 4)	We support the addition of an automatic efficiency adjustment to the fee schedule, rather than relying on ineffective ad hoc review under the misvalued codes initiative. This change is long-overdue and will increase payments for time-based codes, like those used by primary care clinicians.
Updates to Indirect Practice Expense Payments (pg. 4)	We support the proposed change to indirect practice expense (PE) payments and commend CMS's efforts to address potentially duplicative payments. CMS should proceed with the proposed approach but work to develop a more precise process for adjusting valuations and PE payments over time.

Strategies for Improving Global Surgery Payment Accuracy (pg. 5)	We support efforts to accurately pay for global surgical codes and CMS's preferred approach to adjust procedure shares, and thus payment, based on empirical data (e.g. claims data).
Changes to Payment for Skin Substitutes (pg. 7)	We support this proposal and CMS's efforts to modify Medicare payment policy to discourage unnecessary spending on skin substitutes.
Request for Information on Advanced Primary Care Management (APCM) & Prevention (pg. 7)	We support recent progress like the introduction of APCM codes but encourage CMS to focus on more transformative changes for primary care payment, such as implementing a hybrid capitated payment model for primary care. If nested in an ACO framework, hybrid, capitated payments could attract more primary care clinicians to participate in ACOs.
Average Sales Price: Bundled Arrangements and Bona Fide Service Fees (pg. 9)	We support the proposed definition of a bundled arrangement and propose allocating discounts proportionally across arrangements. We support the proposal to ensure that the fair market value of a bona fide service fee is correctly calculated.
Average Sales Price: Units Sold at Maximum Fair Price (pg. 10)	We support the clarification that units sold at MFP should be included in the ASP. We also recommend that CMS collect disaggregated data from manufacturers that shows the number of units sold at the MFP as well as the revenues earned from sales to Medicare beneficiaries that fall within the ASP calculation for a given quarter.
Proposal to Limit Participation in a One-Sided Model to an ACO's First Agreement Period (pg. 10)	We support the move to downside risk to ensure ACOs have greater incentives to generate savings for the Medicare program, but the increased risk should be balanced against sufficient participation incentives and strong program design given that the MSSP is a voluntary program. CMS should watch for greater than anticipated program attrition and selective participation, where only successful ACOs remain in the program.

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

We appreciate CMS's interest in improving the MPFS. The MPFS has substantial influence on our nation's health care system, determining not just Medicare payments but also influencing other payors' reimbursements and in turn the quantity and type of services that are delivered to patients. Furthermore, most alternative payment models, the MSSP included, are built on a FFS chassis, so improving the MPFS is critical for increasing value in our health care system and ensuring the incentives in FFS are aligned with the objectives of supporting more efficient care delivery.

A. Tackling Misvaluation & Charting a Path Towards Payment Accuracy

Several of the proposals in the CY2026 proposed rule reflect concerns about the valuation of services and the limitations of current data sources and processes used to determine physician payment rates. **Arnold Ventures is supportive of the Administration's efforts to improve payment accuracy in the MPFS, reduce potentially duplicative payments, and the acknowledgement of structural flaws in the current valuation process.** The valuation of services in the fee schedule is based on recommendations to CMS from the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC), an expert panel with

substantial influence on value determinations, the rate-setting process, and, subsequently, physician payment. Structural flaws with the RUC, including inherent conflicts of interest, a reliance on survey data from medical societies, and an overrepresentation of specialists, undermine the accuracy of its recommendations and point to an urgent need for reforms.[1] As a result of the current approach, valuation decisions are biased by specialty societies, payment is not well aligned with the value of services, and reimbursement levels do not always reflect the actual time and resources needed to deliver a service. This has led to systematically undervaluing primary care and cognitive services and overvaluing procedural care. **Arnold Ventures commends the Administration for acknowledging the challenges with the current approach for valuing codes and beginning efforts to improve payment accuracy.**

While this rule represents important, long-overdue work to address misvaluation and improve payment accuracy, it does not negate the need for CMS to develop a long-term strategy to overhaul the current valuation process and begin moving to objective and empirical data collection. Given the issues with the data that the RUC uses to determine valuation, **Arnold Ventures recommends that CMS implement accurate and ongoing data collection so that it has information to independently validate relative value units (RVUs) and supplement the existing survey information with empirical information on time and intensity associated with services**. As the proposed rule points out, the RUC relies on surveys of specialty medical society members to assess the time and intensity of a specific service and to produce a recommendation for the service's total work RVU.[2] These surveys tend to lead to inaccurate, distorted RVUs because they are subjective and may not accurately account for the time and effort of most physicians performing the service.[3] Physician respondents also have an inherent conflict of interest to inflate work values. One study comparing data from operative logs with RUC survey data found that the RUC survey data overestimated procedural times by an average of 31 minutes across 60 procedures.[4] We recognize that using more accurate, ongoing data collection to validate RVUs will take time to implement, but CMS could start putting in place the building blocks for a more robust data collection infrastructure and shift away from its overreliance on the RUC.

Specifically, CMS should establish an advisory body within CMS (e.g., a technical expert panel) to balance the RUC process. This aligns with recommendations from experts as well as a proposal in the bipartisan *Pay PCPs Act*.[5, 6] Such a committee 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 in the current structure.[7] 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 around 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.[8] CMS should

[1] U.S. Government Accountability Office. (2015). Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy (GAO-15-434).
[2] Ibid.
[3] Calsyn, M., & Twomey, M. (2018). Rethinking the RUC: Reforming How Medicare Pays for Doctors' Services. Center for American Progress.
[4] Sinsky, C., & Dugdale, D. (2013). Medicare payment for cognitive vs procedural care: Minding the gap. *JAMA*, 310(18), 1936–1937.
[5] Pay PCPs Act, S.4338, 118th Congress. (2024). Introduced May 15, 2024.
[6] Berenson, B. (2025). Modernizing The Medicare Physician Fee Schedule, Part 1: The Role Of A Technical Expert Panel. Health Affairs Forefront. Berenson, B. (2022). Comment Letter on CY 2023 Medicare Physician Fee Schedule Proposed Rule.
[7] Ibid.
[8] U.S. Government Accountability Office. (2015). Medicare Physician Payment Rates: Better Data and Greater Transparency Could Improve Accuracy (GAO-15-434).

make a public, central repository of guidelines and standards, including information on physician work data and methods, that the RUC follows to generate recommendations.[9]

The sections below include our comments on CMS's efforts to improve the fee schedule, including proposals related to:

- The proposed Efficiency Adjustment,
- Updates to Practice Expense Methodology,
- Strategies for Improving Global Surgery Payment Accuracy, and
- Payment for Skin Substitutes.

i. Addition of an Efficiency Adjustment

In this rule, CMS proposes to decrease the valuation of non-time-based codes (e.g. procedure-based services, diagnostic tests) to reflect reduced costs that occur as a service becomes more efficient over time. Services often become more efficient the longer they are on the fee schedule because clinicians gain experience with the service or technology is improved, reducing the intensity or time involved in delivering a service. **Arnold Ventures supports the addition of an automatic efficiency adjustment to the fee schedule, rather than relying on ineffective ad hoc review under the misvalued codes initiative**. This change is long-overdue and will increase payments for time-based codes, like those used by primary care and behavioral health care clinicians, which have been passively devalued over time as those services remain consistently time-intensive. **Arnold Ventures supports focusing the efficiency adjustment on non-time-based codes as these are the services most likely to see gains in efficiency.**

Specifically, CMS proposes to decrease the work RVUs and intraservice time (clinician time spent during a service) for non-time-based codes every three years by a factor equal to the productivity adjustment used in the Medicare Economic Index (MEI). For CY2026, CMS will use a 5-year lookback period which equates to a 2.5% reduction. Stakeholders will be able to use the existing public nomination process for misvalued codes if they believe the efficiency adjustment will lead to an inaccurate valuation. **Arnold Ventures supports CMS's proposal to place a greater emphasis on empirical data rather than survey data in this review process.**

Currently the fee schedule does not have an automatic, regular adjustment to account for efficiency gains over time. While codes can be recommended for revaluation through the CMS misvalued codes initiative, there is significant variability in how often codes are reviewed by the RUC. As CMS estimates in the rule, there are on average 18 - 25 years between code revaluations.[10] This proposal is a good first step to improving payment accuracy and addressing misvaluation that has grown over time, but it does not eliminate the need for more robust, empirical data collection in the future to inform more nuanced valuation decisions. **To enable more precise efficiency adjustments and support accurate code valuations in the future, CMS needs additional data and infrastructure to enhance and complement the work of the RUC.**

ii. Updates to Indirect Practice Expense Payments

In this rule, CMS proposes to reduce payments for indirect practice expenses (PE) by half for services performed in facility settings compared to non-facility settings. **Arnold Ventures supports this proposed change and commends CMS's efforts to address potentially duplicative payments for PE, which may contribute to misaligned incentives through site-of-service payment differentials.** Indirect practice expenses include

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

[10] Centers for Medicare & Medicaid Services (2025). 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. *Federal Register*, 90(145), 44404–44690.

administrative costs, rent, office supplies, and information technology costs that are associated with operating a practice but are not directly connected to an individual service.[11] For services delivered in a facility, physicians can be paid for indirect costs under the MPFS and through the Outpatient Prospective Payment System (OPPS). The current arrangement assumes that all clinicians who deliver services at a facility need to be compensated for the indirect costs of operating an independent, freestanding office outside of a facility, which is reflective of historic patterns of care and ownership.[12] As clinicians are increasingly employed by facilities or choose not to maintain separate offices, MPFS payments for indirect PE costs are potentially duplicative of other OPPS payments for indirect costs.[13]

This proposal addresses an important area of potential overpayment and because the PE RVUs are budget-neutral, reducing potentially unnecessary PE payments for facility-based services will increase payments to non-facility-based services, providing an immediate boost in revenue to independent practices that deliver services in a non-facility setting, like independent primary care physicians. Reducing facility payments and increasing non-facility payments can also reduce financial incentives for vertical integration between clinician practices and hospitals.[14] **Arnold Ventures has long supported reforms that work against such consolidation and the resulting commercial market dynamics that follow, including price increases without evidence of increased quality.[15]** As discussed, Arnold Ventures also urges the Administration to continue exploring alternative data sources and processes for PE valuation that do not rely on the flawed AMA survey data and could allow for more precise adjustments over time. The valuation of and payment for physician practice expenses could be made more accurate through more robust data collection and support from outside experts, such as a technical expert panel, discussed above. CMS should proceed with the across-the-board approach proposed in the rule but could work to develop a more precise process for adjusting valuations and payments over time.

There also remains a need to look at broader Medicare reforms to reduce differential payments across different sites of service. We are encouraged by CMS's move to site neutrality in an attempt to address the increase in the volume of specific drug administration services in off-campus hospital outpatient departments in the CY 2026 Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule. This step will reduce Medicare spending by more than $5 billion and reduce beneficiary cost sharing by nearly $1 billion over a decade.[16] **Arnold Ventures urges CMS to continue to use their authorities to address services with increased volume in higher-priced settings. Congress should also look at more comprehensive site-neutral reforms that could save around $150 billion for taxpayers and $80 billion for beneficiaries.[17]**

iii. Strategies for Improving Global Surgery Payment Accuracy

In this rule, CMS is seeking feedback on the best approach to ensure accurate payment for surgeons who perform a procedure under a global surgical code, but do not deliver the associated post-operative care. Specifically, CMS discusses three potential approaches to adjust the surgical and post-operative "procedure shares," which determine the payment for surgeons under a global surgical code when they use a transfer of care modifier, indicating they are not delivering post-operative care. **We recognize longstanding inaccuracies with global surgical code payments and support efforts to eliminate potentially duplicative or wasteful spending for post-operative visits that are**

[11] Medicare Payment Advisory Commission. (2025). June 2025 report to the Congress: Medicare and the health care delivery system.
[12] Ibid.
[13] Ibid.
[14] Ibid.
[15] Liu, J. L., Levinson, Z. M., Zhou, A., Zhao, X., Nguyen, P., & Qureshi, N. (2022). Environmental scan on consolidation trends and impacts in health care markets. RAND Corporation.
[16] Bulat, T., & Brake, R. (2024). Sizing Medicare Off-Campus Hospital Outpatient Department site neutrality Proposals. Actuarial Research Corporation.
[17] Arnold Ventures (2025). New Research Brief Finds Billions in Savings for Seniors.

delivered by other clinicians or do not occur at all. Global surgical codes – which include a 0-day, 10-day, and 90-day code – provide a single payment for all services associated with a surgical procedure, including pre- and post-operative care within the global period. A well-established body of evidence suggests that the 10- and 90-day global packages are overvalued – while services included in the package reflected clinical practice at the time of their introduction decades ago, it is now common for practitioners to provide less follow-up care or for clinicians other than the surgeon to furnish the care.[18, 19, 20]

In this rule, CMS expresses a preference for one of the three discussed approaches that would base adjusted payments on actual, observed claims data which indicates the split in work between a surgeon and the clinician delivering post-operative care, rather than long-standing assumptions. CMS seeks to ensure that the procedure shares, and thus payments, are better aligned with actual clinical practice. **Arnold Ventures supports CMS's preferred approach to use empirical data to inform valuation decisions (e.g. claims data) for adjusting the procedure shares and thus payment.** Where possible, CMS should move towards using empirical evidence like claims data for more valuation decisions. Under current policy, procedure shares are not based on any sort of empirical data on the actual distribution of work between surgery and post-operative care.

In addition to improving the accuracy of procedure shares, Arnold Ventures supports further work to ensure accurate payment for global surgical codes. MedPAC and other experts have long recommended strategies to improve payment accuracy:

- **Evaluate whether global surgical codes are an appropriate bundle given the evidence on low post-operative care delivery.** Evidence suggests a substantial discrepancy between the number of post-operative visits assumed under the global surgical packages and the number of post-operative visits that are typically provided. MedPAC has recommended that CMS convert the 10- and 90-day global codes into 0-day codes and bill pre- and post-operative visits that occur on other days via FFS.[21] While surgeons have raised concerns with MedPAC's recommendations, the benefits of addressing overvaluation by eliminating the bundles likely outweighs the risks. **If global surgical codes remain as a bundle in the fee schedule, CMS should consider evaluating the codes as potentially misvalued.** CMS's work to date has focused on adjusting payments based on services delivered by different clinicians, but as practice patterns have changed, there may be payment for post-operative care that is never delivered, neither from the surgeon nor another clinician. Greater use of empirical data and expertise from a technical expert panel could help improve valuation of global surgical codes.
- **Consider more aggressive steps to address overvalued 10-day codes**. CMS's work to date has focused on improving the accuracy of payment for 90-day codes, but evidence suggests that even less of the assumed post-operative care is being delivered in the 10-day code. Researchers at RAND found that just 17 percent of post-operative visits assumed in the 10-day global package were actually provided.[22] Bob Berenson and coauthors have recommended that CMS eliminate the 10-day global package.[23] At a minimum, CMS should consider how to address overvaluation of the 10-day codes if they remain on the fee schedule.

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[18] Kramer, R., et al. (2024). Medicare physician fee schedule reform: Structural topics and recommendations to strengthen the system for the future. Health Management Associates.
[19] Crespin, D. J., Kranz, A. M., Ruder, T., et al. (2021). Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using calendar year 2019 data. Santa Monica, CA: RAND Corporation.
[20] Medicare Payment Advisory Commission. (2024). MedPAC comment on CMS's proposed rule on CY 2025 revisions to payment policies under the physician fee schedule and other changes to Part B payment policies.
[21] Medicare Payment Advisory Commission. (2024). Report to Congress. Chapter 1: Approaches for updating clinician payments and incentivizing participation in alternative payment models.
[22] Crespin, D. J., Kranz, A. M., Ruder, T., et al. (2021). Claims-based reporting of post-operative visits for procedures with 10- or 90-day global periods: Updated results using calendar year 2019 data. Santa Monica, CA: RAND Corporation.
[23] 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.

- **Ensure strong enforcement and oversight of any newly implemented policies**. Any policies intended to improve the accuracy of the global surgery codes through expanded modifiers should have a robust enforcement mechanism to ensure billing practitioners are adhering to the modifier requirements that result in an adjusted payment. CMS could consider other changes to remind clinicians of their responsibility to accurately indicate when a portion of care is shared with another clinician to avoid inaccurate or fraudulent billing, such as a False Claims Act acknowledgement when submitting claims.

iv. Changes to Payment for Skin Substitutes

Arnold Ventures supports CMS's efforts to modify Medicare payment policy to discourage unnecessary spending on skin substitutes and further site neutral payment reform. The proposed policies would result in lower spending for patients and taxpayers. Under current law, Medicare reimburses each skin substitute provided in a non-facility setting as a biologic drug, at WAC+3% for new products and ASP + 6% for established products and reimburses each skin substitute provided in a hospital outpatient setting as part of a bundled payment with the procedure. Payment using these methodologies incentivizes manufacturers to launch at high prices[24] and providers to opt to furnish high-cost products[25] in non-facility settings. As noted by CMS, there has been significant growth in launch prices for skin substitutes, which could be attributed to the current payment methodology.[26] Part B spending for skin substitutes rose from $252 million in 2019 to over $10 billion in 2024, a nearly 40-fold increase.[27] The New York Times recently reported that Medicare now pays more for skin substitutes than on ambulance rides, anesthesia, or CT scans.[28]

B. Request for Information on Advanced Primary Care Management (APCM) & Prevention

The status quo FFS payment system undervalues primary care and does not support the type of comprehensive primary care needed to drive better health outcomes and create a more efficient health care system. A reliance on FFS codes for reimbursement limits the delivery of flexible, personalized care and points to the need for a long-term solution that moves primary care away from FFS. **Arnold Ventures supports recent progress like the introduction of APCM codes but encourages CMS to focus on more transformative changes for primary care payment beyond adding or amending fee schedule codes.** While an important step, primary care experts have argued that adding more and more billing codes, even if well-intentioned, can add administrative complexity and still fail to adequately reimburse primary care physicians.[29]

More holistic primary care reform should include several policy aims, including:

- **Implementing a hybrid capitated payment model for primary care.** This would enable predictable, prospective payments to primary care clinicians and give them greater flexibility to deliver the services that

[24] The New York Times (2025). Medicare Bleeds Billions on Pricey Bandages, and Doctors Get a Cut.
[25] Arnold Ventures (2023). Medicare Prescription Drug Coverage. Improving Medicare Parts B and D to lower spending for patients and tax payers.
[26] The New York Times (2025). Medicare Bleeds Billions on Pricey Bandages, and Doctors Get a Cut.
[27] Centers for Medicare & Medicaid Services. (2025). 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.
[28] The New York Times (2025). Medicare Bleeds Billions on Pricey Bandages, and Doctors Get a Cut.
[29] U.S. Senate Committee on Finance Hearing on "Bolstering Chronic Care through Medicare Physician Payment." (2024); Testimony of Amol Navathe; United States Senate Committee on the Budget Hearing on "Achieving Health Efficiency through Primary Care." (2024). Testimony of Amol Navathe.

improve efficiency and are essential to keeping patients healthy such as preventive care and chronic disease management (see more below).[30]

- **Rebalancing the fee schedule so that payments better reflect the value of services**. The proposed efficiency adjustment and PE payment change take important steps to address the current specialty bias in the fee schedule and to better support independent clinicians. Arnold Ventures supports these proposals and encourages future work to further advance rebalancing as appropriate.
- **Improving and addressing structural flaws with the process for valuing services.** Shifting to an empirical basis for determining code valuations and developing a process to independently validate value determinations can support more accurate valuations for all services, including primary care.[31, 32, 33, 34] As discussed above, initial steps like creating a technical expert panel could support this aim.

i. Integrating Advanced Primary Care Payments and Accountable Care

Arnold Ventures supports CMS's interest in considering the integration of flexible payments for advanced primary care and ACOs. **At a high level, Arnold Ventures encourages the development of new opportunities to "nest" hybrid capitated payment for primary care within an accountable care framework.** For context, in a landmark 2021 report on implementing high-quality primary care, the National Academy for Science Engineering and Medicine (NASEM) highlighted the shortcomings of FFS and recommended that a hybrid capitated, per-patient per-month payment, rather than FFS, be the default for primary care.[35] In a hybrid capitated payment model, clinicians receive two kinds of payments: (1) a per-member, per-month population-based payment for a core set of services and care management and (2) FFS payments for select additional services provided at visits. This payment structure can result in more comprehensive, patient-centered care, greater use of emerging technology like telehealth when appropriate and cost-effective, and stronger team-based staffing that enables high-quality primary care.[36]

Nesting these payments within an ACO framework can also help contain total costs of care and ensure greater efficiency in care delivery. Without the ACO framework, clinicians who receive a capitated payment could shift services to other FFS service lines to maximize revenue from a capitated payment – this would increase overall spending and costs of care.[37] If the physician was in an ACO, the ACO would be held accountable for that increased spending and the risk of increased costs or cost-shifting would be mitigated.[38] The flexibilities provided by capitated payments also align with the goals and ethos of successful ACOs, which typically leverage primary care to limit unnecessary or higher-cost care. One opportunity to advance hybrid capitated payments for primary care could be through the recently launched ACO Primary Care Flex Model, which is testing hybrid, capitated payments for primary care in select, low-revenue ACOs.[39] As the Agency considers expanding and scaling hybrid capitated payment, CMS could consider expanding participation in ACO PC Flex with a second cohort of low-revenue ACOs.

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[30] National Academies of Sciences, Engineering, and Medicine. (2021). Implementing high-quality primary care: Rebuilding the foundation of health care. The National Academies Press.
[31] Urban Institute. (2022). RE: Comment on NPRM Calendar Year 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Requirements, etc.
[32] National Academies of Sciences, Engineering, and Medicine. (2021). High-quality primary care policy brief 1: Payment.
[33] Calsyn, M., Twomey, M. (2018). Rethinking the RUC: Reforming how Medicare pays for doctors' services. Center for American Progress.
[34] Arnold Ventures. (2023). AV responds to annual Medicare Physician fee schedule proposed rule. Arnold Ventures.
[35] National Academies of Sciences, Engineering, and Medicine. (2021). Implementing high-quality primary care: Rebuilding the foundation of health care. The National Academies Press.
[36] Ibid.
[37] McWilliams, J. M. (2024). Physician payment reform in Medicare: Putting the pieces together. Health Affairs Forefront.
[38] Ibid.
[39] Centers for Medicare & Medicaid Services. (2025). ACO Primary Care Flex Model.

ii. Increasing Participation of Primary Care Clinicians in ACOs

Arnold Ventures applauds CMS's interest in increasing participation of primary care physicians in ACOs and recommends using hybrid, capitated payments to primary care clinicians in ACOs as a tool to help make ACOs more attractive than FFS. Evidence suggests that physician-led and "primary-care centric" ACOs are associated with greater savings because physicians, primary care physicians in particular, have more clearcut financial incentives to reduce costs, are better suited to redirect or transform patient care to avoid low-value services, and can more effectively manage chronic conditions that could lead to higher future spending. The Congressional Budget Office reported that ACOs led by independent physicians and those with a larger proportion of primary care clinicians are associated with greater savings.[40] Similarly, the Primary Care Collaborative found that primary care-centric ACOs were more likely to earn back savings through MSSP, generating 2.4 times as many savings under their benchmarks other ACOs, although this does not equate to Medicare program savings compared to a counterfactual.[41]

Increased primary care reimbursement in the form of hybrid payments could act as an incentive to drive greater primary care participation in ACOs, acting similarly to a bonus payment. CMS must navigate the tension between applying more flexible, higher reimbursement for primary care broadly across FFS and creating incentives for physicians to participate in accountable care relationships. The introduction of APCM codes or of hybrid payments across the fee schedule could affect the overarching incentives physicians face to participate in ACOs and other APMs because increased or flexible payment, typically a benefit of joining an APM, would be accessible while remaining in FFS. To incent greater ACO participation among primary care physicians, CMS could provide more generous hybrid payments for primary care physicians in ACOs than in FFS or explore ways to increase flexibility and reduce associated administrative burden for participating primary care physicians (e.g. streamlining FFS billing requirements, beneficiary consent requirements, etc.).

C. Changes to the Average Sales Price Used for Medicare Part B Drugs

Several proposals in this proposed rule relate to the calculation of the Average Sales Price (ASP), which is used in payment for Part B drugs. Arnold Ventures is supportive of CMS's work to clarify the calculation of the ASP and to improve its accuracy.

i. Average Sales Price: Bundled Arrangements and Bona Fide Service Fees

A bundled arrangement can occur when a discount is either tied to the purchase of multiple products or is made contingent upon certain performance standards such as achievement of market share. In this rule, CMS proposes defining the term "bundled arrangement" and proposes allocating the discounts associated with the bundled sale proportionally across all products. **Arnold Ventures supports this definition of a bundled arrangement, which is consistent with the Medicaid definition. Arnold Ventures also supports the proposal to allocate discounts under a bundled sale proportionally across all products in the bundled arrangement.** This allocation has been suggested by MedPAC.[42]

Bona fide service fees (BFSFs) are payments from the drug manufacturer to another entity for a service that the manufacturer would otherwise perform, such as drug distribution, patient support or data collection. The fee must reflect the fair market value (FMV) of the service and must not be passed on to a client or customer of the service

[40] Congressional Budget Office. (2024). Medicare Accountable Care Organizations: Past Performance and Future Directions.
[41] Primary Care Collaborative. (2024). Primary care: the MVP of MSSP (2024 Evidence Report). PCC.
[42] Medicare Payment Advisory Commission. (2007). Report to Congress: Impact of changes in Medicare payments for Part B drugs.

provider. If a price concession is improperly classified as a BFSF, or if the BFSF exceeds the FMV for the service, this will increase the ASP resulting in Medicare overpayments. **Arnold Ventures supports CMS's proposed steps to help assure that the FMV is correctly calculated.** These steps include the requirement that manufacturers submit information on the assumptions they utilize for ASP calculations, such as the methodology used to determine FMV to CMS. **Arnold Ventures also supports the requirement that manufacturers submit to CMS a certification from the recipient of the BFSF that the fee was not passed on to an affiliate or client.** These requirements will help to assure that BFSFs are correctly classified and calculated so that the ASPs are more accurate.

ii. Average Sales Price: Units Sold at Maximum Fair Price

In this rule, CMS clarifies that units sold at the Maximum Fair Price (MFP) should be included in the calculation of the ASP. **Arnold Ventures supports this clarification that units sold at the MFP will be included in the calculation of the ASP.** This clarification is consistent with the definition of the average sales price as a market-wide price net of nearly all discounts and rebates (except for example rebates and discounts under Medicaid and 340B).

Arnold Ventures also recommends that CMS collect disaggregated data from manufacturers that shows the number of units sold at the MFP as well as the revenues earned on sales to Medicare beneficiaries that fall within the ASP calculation for a given quarter. Manufacturers currently include the total number of units sold and total sales that fall within the ASP calculation when reporting the ASP to CMS. This additional, disaggregated data on the number of units sold and total revenues earned on sales to Medicare beneficiaries for selected drugs with an MFP would allow CMS to estimate the amount earned by manufacturers per unit on sales to the non-Medicare market. That price to the non-Medicare market would approximate what the ASP would be, if sales at the MFP were not included. That price better reflects what providers pay for drugs than the reported ASP for selected drugs that incorporate MFPs, since MFPs are below acquisition sales for many providers. These additional data would help CMS monitor whether manufacturers are setting appropriate payment amounts when reimbursing providers for the difference between their acquisition costs and the MFP. The disaggregated data on sales revenues would clarify for CMS how payments from manufacturers to providers that effectuate the MFP could be affecting the ASP.

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

The MSSP has demonstrated the ability to generate modest net savings while maintaining or improving quality.[43] **Arnold Ventures supports the Administration's interest in maintaining and improving the MSSP as it is a promising alternative to FFS**. The MSSP is also an important avenue for innovation as it is Medicare's only permanent ACO program and allows new approaches to payment to transition into permanence beyond CMMI's certification of models. In this section, we provide comments on the proposal to limit the length of time that an ACO can participate in a one-sided model.

[43] Bond, A. M., Civelek, Y., Schpero, W. L., et al. (2025). Long-term spending of accountable care organizations in the Medicare Shared Savings Program. JAMA.

A. Proposal to Limit Participation in a One-Sided Model to an ACO's First Agreement Period

In this rule, CMS proposes to reduce the maximum length of time that an ACO inexperienced with performance-based risk can participate in an upside-only model from seven to five performance years. Beginning in 2027, all ACOs entering their second agreement period must enter a program track with downside risk (BASIC E track or ENHANCED track). **Arnold Ventures supports the move to downside risk to ensure ACOs have greater incentives to generate savings for the Medicare program, but the increased risk should be balanced against sufficient participation incentives and strong program design given that the MSSP is a voluntary program**, such as reformed benchmarks, discussed below**.** While early evaluations showed that physician-led ACOs in upside-only agreements can generate net savings for Medicare, downside risk has the potential to increase incentives for greater savings in the long-run.[44]

i. Balanced Approach, Need for Additional Evaluation

As the MSSP is a voluntary program, ACOs have the choice to enter into a new agreement period or to leave the program depending on potential success at meeting their spending benchmark and weighing potential revenue in FFS versus the MSSP. **The proposed 5-year limit reflects a middle ground between recent policy changes and likely strikes a reasonable balance between increasing participation in the MSSP, creating an on-ramp for new ACOs, and strengthening incentives for ACOs to generate Medicare program savings by moving to risk after an appropriate time.** The limit on maximum length of participation in an upside-only risk agreement has fluctuated from six years (pre-2019) to two or three years based on revenue level (2019 – 2023) to seven years (2023 – present). The proposed approach appears balanced in comparison but likely still requires ongoing evaluation and monitoring.

In response to similar proposals in the CY2019 fee schedule rule, which would have moved to downside risk faster than this proposal, MedPAC and other experts acknowledged potential drawbacks and the need for additional monitoring to see how changes would affect ACO participation trends.[45] Experts agree that downside risk plays a role in generating greater savings to Medicare, but that it can also reduce overall participation and thus the aggregate savings that the Medicare program realizes – this dynamic and tradeoff is also reflected in this proposals' regulatory impact analysis, which states that CMS projects more ACOs will leave the program, potentially outweighing the efficiencies that could be gained. Given this risk, **CMS should monitor participation trends to watch for greater than anticipated program attrition and exacerbated selective participation, which could lead to less savings for the Medicare program.** Moving to downside risk faster will cause some ACOs to leave the program and ACOs that currently have spending above their regional average are more likely to leave as they would face greater downward pressure on spending, and risk losing money when moving to two-sided risk.[46] For the MSSP to generate savings for the Medicare program, higher-cost hospitals and clinicians must participate as these are the entities driving high spending in the program. CMS must navigate the balance between maintaining ACO participation, incentivizing higher-cost clinicians to join the MSSP, and creating opportunities for net program savings.[47]

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[44] McWilliams, J. M., Hatfield, L. A., Landon, B. E., Hamed, P., & Chernew, M. E. (2018). Medicare Spending after 3 Years of the Medicare Shared Savings Program. New England Journal of Medicine.
[45] Fiedler, M. (2018). Comments on CMS's Proposed Rule, "Medicare Shared Savings Program; Accountable Care Organizations–Pathways to Success". Brookings.; Medicare Payment Advisory Commission. (2018). Re: File code CMS-1701-P
[46] Ibid.
[47] Lyu, P. F., Chernew, M. E., & McWilliams, J. M. (2023). Benchmarking changes and selective participation in the Medicare Shared Savings program. Health Affairs

ii. Ensuring Strong Incentives for Participation & Benchmarking Reform

Recognizing the need for robust incentives to ensure ACO participation in the MSSP, **Arnold Ventures urges the Administration to develop a long-term vision for MSSP benchmarking policy such as an approach that relies on an administrative benchmark**. How ACO benchmarks are developed impacts an ACO's ability to succeed in the program, the chances that they will face shared losses or receive shared savings, and thus the potential difference in payment between FFS and accountable care. To increase the long-term effectiveness of the MSSP, CMS will need to address structural issues with the current benchmarks, such as the reliance on an ACO's historical spending which becomes increasingly stale over time and the ratchet effects created when ACOs successfully reduce spending. Restricting the length of time in upside-only risk will not lead to long-term increased savings or program success in isolation – other program updates, like benchmarking reform, are needed to realize the MSSP's full potential. A transition to an approach like administrative benchmarks, where benchmark updates are tied to exogenous factors such as inflation or the growth in gross domestic product, could increase participation and strengthen incentives for ACOs to save money relative to their benchmarks.[48]

CMS began the transition to administrative benchmarks in 2024 by adjusting the formula used to develop ACO benchmarks to be based on a "three-way blend" – assigning two-thirds weight to the existing national-regional trend and one-third weight to a new accountable care prospective trend (ACPT), which is a fixed growth rate based on CMS's estimate of future Medicare spending growth per beneficiary.[49] One risk with administrative benchmarks is that they may be set too far above or below actual spending. For 2024, actual national spending grew much faster than forecasted, meaning the ACPT used to develop benchmarks was much lower than the actual growth rate, which would make benchmarks more difficult to meet. Recognizing this challenge, CMS chose to reduce the weight of the ACPT in the overall benchmark blend.[50] While Arnold Ventures acknowledges adjustments were needed to mitigate the large gap between forecasts and actual spending, **AV recommends CMS continue to develop and use the ACPT as designed in the CY2023 rule, while exploring alternative guardrails to ensure continued progress towards administrative benchmarks.**[51] While it is unfortunate that the misestimate occurred during the first year the ACPT was used, CMS should not abandon the effort to use alternative benchmarking approaches like an administrative benchmarks. Accurate, predictable, and sustainable benchmarks are critical for an effective program that balances opportunities for savings for Medicare and ongoing program participation.

III. Conclusion

We appreciate the Administration's commitment to improving payment accuracy in the MPFS, taking on conflicts of interest and structural challenges within the valuation process, and bolstering primary care. We commend efforts to strengthen the MSSP and ensure greater participation of primary care-centric and physician-led ACOs. Thank you for the opportunity to comment on the proposed rule. Please contact Erica Socker (esocker@arnoldventures.org) or Andrea Noda (anoda@arnoldventures.org), Vice Presidents of Health Care at Arnold Ventures, with any questions.

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[48] Chernew, M. E., & McWilliams, J. M. (2025). The ACPT: Why we have it and four ways to improve it. Health Affairs Forefront.
[49] Mechanic, R. (2024). Implementing administrative benchmarks in the Medicare Shared Savings Program: Opportunities and challenges. Health Affairs Forefront.
[50] Centers for Medicare & Medicaid Services. (2025). Medicare Shared Savings Program, Shared Savings and Losses, Assignment and Quality Performance Standard Methodology, Specifications of the ACPT and Three-Way Blended Benchmark Update Factor.
[51] Chernew, M. E., & McWilliams, J. M. (2025). The ACPT: Why we have it and four ways to improve it. Health Affairs Forefront.