AUGUST 19, 2026

Dear Representatives Joyce, Murphy, and Schrier,

Arnold Ventures welcomes the opportunity to respond to your recent Request for Information (RFI) related to your introduced legislation H.R. 9693, *The Patients First Act*, posted on July 20, 2026.

Arnold Ventures is a philanthropy dedicated to investing in evidence-based policy solutions that maximize opportunity and minimize injustice. Our work on provider payment reform aims to reorient the health care system toward delivering higher quality, less costly care that improves health outcomes. A primary focus is improving Medicare physician payment by strengthening incentives to join advanced alternative payment models (AAPMs) and promoting primary care.

We acknowledge the need for meaningful reforms to MACRA and the desire among physicians for more long-term stability in payment policy. We also applaud the bipartisan work that has been done to draft *The Patients First Act* as a starting point for discussion of those reforms.

However, as the RFI rightly points out, durable reform will only be accomplished if done in a fiscally responsible manner. That is why below we outline opportunities to improve the policy framework within *Patients First* to more efficiently strengthen Medicare physician payment and promote alternative payment models. We then suggest additional offsets from within the broader health care policy landscape to responsibly pay for the bill's increases in physician payments.

Physician Payment and Conversion Factor Indexing

It is apparent that the nearly annual ritual where Congress acts at the last minute to provide ad-hoc bonuses to physician payments is inefficient and problematic for physician practice operation and planning. We commend the Doctors Caucuses for taking MedPAC's recommendation to tie payment updates to just a portion of growth in the Medical Economic Index (MEI). This choice of MEI - 1 is superior to full indexing since it balances beneficiary access, clinician participation, and taxpayer and beneficiary liability.

Overall, this new indexing will be expensive, likely costing at least $25 billion over the next decade according to the Committee for a Responsible Federal Budget. Removing a separate draft provision that guarantees a payment increase of at least .25% of MEI, which would potentially allow for increases to physician payments above the inflation rate, would be one way to slightly reduce the cost of indexing over the long term.

Budget Neutrality

The budget neutrality threshold in the physician fee schedule is essential for protecting taxpayers and Medicare beneficiaries from even faster growth in spending and premiums. Budget neutrality is even more important in the payment system contemplated in the *Patients First Act,* where physician payment growth will be on autopilot given the tie to medical inflation.

Unfortunately, the Act abandons the discipline imposed by budget neutrality by indexing the threshold to the MEI (which, along with related provisions, will have a reported cost of $5 billion over the next decade). This gives physicians two bites at the apple for payment increases. While a one-time adjustment to the current decades-old threshold might be warranted, further increases to the budget neutrality threshold should be avoided, otherwise redistributions among services become another vehicle to increase aggregate spending. Changing the legislation to prevent this double counting is essential to developing fiscally responsible physician payment reform.

Additionally, the legislation provides for retrospective correction to the conversion factor in instances where projected utilization misaligns with actual utilization. While the concept makes sense, the legislation should be changed to *require* (not just "permit") CMS to apply adjustments up *or down* when projections differ from actual spending. Allowing adjustments to be applied selectively will contribute to higher PFS spending over time.

Alternative Payment Models and Primary Care

We appreciate the Doctors Caucuses' interest in supporting AAPM participation through the draft legislation's split conversion factor tied to a portion of MEI. However, extending and restructuring the current-law AAPM bonus may provide a more effective incentive for provider participation. That would especially be the case if the bonus was based on a fixed amount per beneficiary attributed to an AAPM.

This improves on the approach taken to date which incentivizes fee-for-service (FFS) billing by basing AAPM bonuses on a percentage of Part B revenue. Using a new flat amount per beneficiary would remove the incentive to increase utilization to receive a higher bonus, thus encouraging movement of more beneficiaries into AAPMs, and further delinking physician reimbursement from FFS.

The efforts to advance hybrid primary care payment models are also appreciated. However, the provision to waive beneficiary cost sharing when combined with the implementation of budget neutrality could be counterproductive. As currently drafted, Medicare's new responsibility for cost sharing may require CMS to decrease per-member per-month (PMPM) rates below current levels to maintain budget neutrality. This decrease in prospective payments to providers would incentivize an increase provider FFS billing, undermining the goal of the model and increasing costs.

Budget neutrality is the right goal, so the model should be altered by either removing the provision eliminating beneficiary cost-sharing, or instead allowing providers to waive cost-sharing but absorb the cost and not pass the costs on to the Medicare program. Such a system has been utilized in the form of Part B cost-sharing waivers in current and prior CMMI models, including the ACO REACH and Next Generation ACO models.

Finally, the provisions that aim to restrict model entry to independent practices while excluding practices either owned by, or "de facto" controlled by, non-physician entities will likely be very challenging for CMS to implement given ownership data is not robust and "de facto" control is inherently not quantifiable.

The Center for Medicare and Medicaid Innovation (CMMI)

AV supports targeted policy reforms to strengthen the effectiveness, transparency, and scalability of value-based payment models in Medicare. However, the CMMI model requirements in the draft legislation undermine CMMI's statutory authority by requiring rulemaking for any model modifications or terminations -- not just for models implemented via rulemaking.

This provision would effectively neuter CMMI, contradicting the entire purpose of CMS' innovation hub and making it indistinguishable from the rest of CMS. It would also allow stakeholders with a vested interest in a model's continuation to successfully challenge or prevent termination of models that increase taxpayer costs and/or fail to reach their other goals (e.g., the MA Value-Based Insurance Design Model).

It is imperative that CMMI remain nimble to innovate, as CMMI's ability to operate outside of rulemaking has enabled it to test, identify, and scale innovations into the Medicare program. For example, the Medicare Shared Savings Program (MSSP) incorporated CMMI's Pioneer ACO Model and ACO Investment Model (AIM) into the program following evaluations demonstrating the models' net savings. MSSP has also incorporated features of models, such as benefit enhancements like the 3-day SNF waiver, following evidence of its value. The Medicare

Diabetes Prevention Program was incorporated as a permanent Part B benefit following model evaluation. These would not have happened if CMMI were required to implement all tests via rulemaking. CMS relies on CMMI's ability to innovate to identify policy solutions to reduce spending and improve quality, meaning that efforts to weaken CMMI are fiscally irresponsible and ultimately weaken CMS and the Medicare program.

Merit Based Incentive Payment System (MIPS)/Patient Outcome Improvement National Tabulation System (POINTS)

Given evidence that MIPS (POINTS) has fundamental design flaws, AV recommends eliminating it. MIPS has not achieved its initial purpose of improving quality, decreasing spending, or reducing low-value care. In addition to its design flaws, MIPS weakens incentives to participate in an AAPM.

However, if policymakers are committed to salvaging MIPS, AV recommends modifying the program to be cost saving (not budget neutral). This would permit negative payment adjustments to exceed positive payment adjustments in aggregate, decreasing Medicare spending and reducing the attractiveness of MIPS which would encourage movement into AAPMs.

Offsets Outside of the Draft Legislation

We want to thank the Doctors Caucuses for their important work to improve Medicare physician payment policy and for the opportunity to provide input. In addition to the above recommendations to reduce costs within the legislation, below we include explanations summarizing important policy reforms that should be considered to offset the costs associated with the *Patients First Act.*

Advance Comprehensive Site-Neutral Payment Reforms

Problem: Paying higher prices for the same services depending on the site of care increases health care costs for taxpayers and Medicare beneficiaries, as well as the privately insured. This payment differential also creates a financial incentive for further consolidation as hospitals buy physician practices to charge higher prices for the same services. Increased hospital consolidation stifles competition, reduces choice, and drives up prices including in the commercial insurance market. Over time, care has shifted from lower-cost independent physician offices to higher-cost hospital outpatient departments, even for routine services like office visits or MRIs.

Solutions and Savings: Site-neutral reforms would be a natural companion to physician payment reform since they are part of the same payment mechanism. Stabilizing independent physician payments higher and making their growth more predictable makes the resulting payments to hospital-owned locations after site-neutrality higher and more predictable than would be the case for reforms under the current system. Furthermore, both reforms would work together to counter incentives for consolidation.

In **Medicare**, enact comprehensive site-neutral payment reform by:

- Equalizing payments for a specific set of low-complexity, routine services based on the lowest-cost setting where they are most commonly performed, whether a hospital outpatient department, ambulatory surgical center, or physician's office. This would save **$157 billion** (CBO) over ten years. Site-neutral payment reforms would also reduce out-of-pocket costs for Medicare beneficiaries, with comprehensive reform reducing cost-sharing and premiums for Medicare beneficiaries by $80-$90 billion over ten years (ARC, CRFB). President Trump included similar policies in his FY21 budget, and Senators Cassidy and Hassan developed a bipartisan legislative framework for comprehensive reform in late 2024 that also includes some hospital reinvestment in rural and safety-net providers. The savings achieved by this policy can be dialed by paying for a more or less expansive set of services on a site-neutral basis.

In **Medicare**, pursue less comprehensive, but impactful reforms by:

- Eliminating the Medicare grandfathering exemption for off-campus hospital-owned outpatient departments created prior to the 2015 BBA. The 118th Congress' *SITE Act* serves as a blueprint for the less comprehensive solution of eliminating the Medicare grandfathering exemption for off-campus hospital-owned outpatient departments. This would save about **$30 billion** (ARC).
- Alternatively, enacting site-neutral payments for small sets of services that can be safely and routinely provided in any care setting could save **a few billion** if enacted on a one-off basis (ARC).

In the **commercial market**:

- Ban facility fees that are tacked on for care received in hospital-owned outpatient offices and clinics for certain routine services, such as office-based clinic visits, behavioral health services, and telehealth services, among others. These fees raise premiums and out-of-pocket costs for the privately insured. This is a more limited and incremental solution that would save the federal government around **$2.3 billion** over 10 years (CBO), with much larger savings accruing in the commercial market and for employers.

Modify Risk Adjustment Payments to Medicare Advantage Insurers

Problem: While the MA program was created with the intention of delivering efficiencies and cost-savings to the Medicare program, it has never produced savings relative to traditional Medicare (TM) and in fact costs the program substantially more per enrollee than TM (114% more, according to MedPAC), contributing to Medicare's fiscal challenges and threatening its solvency. Upcoding is a major driver of overpayments to MA insurers.

MedPAC estimates that upcoding will result in about $22 billion in excess payments to MA insurers in 2026 alone. Numerous lawsuits, audits, and investigations have documented widespread, abusive and in some cases fraudulent billing practices by MA insurers. In some cases, insurers are coding diagnoses for which a beneficiary receives no treatment.

The billions in overpayments to MA insurers each year due to upcoding increase Medicare spending and threaten the solvency of the Medicare trust fund. They also increase Medicare premiums for all beneficiaries including beneficiaries in TM who are not even enrolled in MA plans.

Solutions and Savings:

- Fully account for upcoding in MA by increasing the statutory minimum coding intensity adjustment that reduces payments to MA plans based on the coding differential between MA and TM. This policy should be implemented in a way that accounts for coding differences across MA plans, as some MA insurers code much more aggressively than others. This could reduce Medicare spending by around **$500B** (CRFB) over 10 years. This would also save Medicare beneficiaries $100B in lower premiums. The coding intensity adjustment can be dialed to achieve a specific level of savings.
- A more limited reform could exclude health risk assessments (HRAs) and all chart reviews (the administration recently excluded some, but not all reviews) as sources of diagnoses and use two years of diagnostic data for MA risk adjustment, as specified in the *No UPCODE Act*, would save **$124B** (CBO) over 10 years.

Reform the Medicare Advantage Quality Bonus Program

Problem: The Medicare Advantage (MA) Quality Bonus Program (QBP) increases payment benchmarks and rebates to MA plans that receive quality ratings of 4 stars or higher. Most plans receive these quality bonuses, with the likelihood that nearly three-quarters of MA enrollees will be in plans with 4+ stars in 2027. MedPAC and other experts have argued that the QBP provides little meaningful quality information, cannot demonstrate an impact on quality, and does not help beneficiaries select a plan. Unlike quality programs in TM that are either penalty-only or redistribute both bonuses and penalties to be budget-neutral, the QBP is financed with additional program dollars and does not impose penalties on poor performing plans. And the problem has been getting worse – bonus payments to insurers have increased dramatically over the last decade, from $3 billion in 2015 to more than $16 billion in 2026 (MedPAC). Furthermore, a recent court decision has injected major uncertainly into how CMS will calculate star ratings, but that uncertainly is leading to even higher spending on bonuses as CMS figures out how to respond and the arguments work their way through the courts.

Solutions and Savings:

- Eliminate the additive financing of the QBP and make it budget-neutral by redistributing quality bonuses and penalties among MA plans. This would save between **$115-170 billion** (CRFB) over 10 years.
- A more limited reform could reduce quality bonus payments to MA plans by eliminating double bonuses from MA benchmarks, saving over **$20 billion** (CRFB) over 10 years.

Reform the No Surprises Act

Problem: In 2020, Congress passed the bipartisan *No Surprises Act* (NSA) to protect patients from receiving costly surprise medical bills when they obtained care from out-of-network providers through no fault of their own. Congress also intended for the NSA to lower health care premiums for consumers, employers, and taxpayers by disincentivizing out-of-network care and rebalancing market negotiations over in-network rates. The law did this by establishing the Independent Dispute Resolution (IDR) arbitration process for determining providers' payments for out-of-network care, intending to limit excessively high payments for out-of-network care that drive up insurance premiums.

While patients remain protected from surprise bills, the NSA's IDR process has seen litigation, misuse, and outright abuse, resulting in a flood of out-of-network claims and egregiously high awards for out-of-network care. Recent data shows that providers – many often backed by private equity or other corporate entities – overwhelmingly prevail in IDR, receiving awards that are significantly higher than the median in-network amount. These challenges have ultimately resulted providers receiving nearly $15B (as of 2025) in awards from the IDR process per recent research from the *Wall Street Journal*, with employers and health plans also reporting increases in premium costs.

Solution and Savings:

- The NSA should be reformed to establish a benchmark payment rate for out-of-network awards, set at a percentage of Medicare or median commercial market rates based on publicly available data (e.g., the Transparency in Coverage files or other available data sets). During the NSA debate in 2019, CBO scored a benchmark set at median in-network rates as saving approximately **$25B** over 10 years. We believe a newly imposed benchmark policy could save at least that amount, if not substantially more.
- Other policies – such as reforming the IDR process and penalizing arbitrators for egregious awards – would also likely save, though at a much lower amount.

Ban Anticompetitive Contracting Practices in the Commercial Insurance Market

Problem: Over the last several decades, large, consolidated hospitals and health systems have used their market power to demand certain contract provisions in their commercial market contract negotiations with health plans with the aim of limiting competition and increasing their ability to charge high prices. Frequently used anticompetitive contracting terms include: "all-or-nothing" terms in which health systems require a health plan to contract with all facilities in the system if they want to contract with any of them; "most-favored nation" clauses that require a provider to offer a health plan the lowest rate it offers to any plan with which it contracts, which ultimately incentivizes providers to raise rates overall; and **"**anti-tiering"/"anti-steering" clauses that prevent insurers from using incentives or tools (such as tiering providers in the plan's benefit design) to steer patients to higher-value, lower cost providers.

Solution and Savings:

- Ban anticompetitive terms (e.g., anti-steering, anti-tiering provisions) in provider-health plan contracts that limit insurers' ability to contract with and steer enrollees toward lower-priced providers. The *Healthy Competition for Better Care Act* would save **$4.9 billion** over 10 years (CBO).

Lower Drug Prices by Mitigating Anticompetitive Behaviors

Problem: Brand and biologic manufacturers engage in anticompetitive behaviors to prevent generic and biosimilar entry, ensuring their ability to maintain elevated drug prices and increasing costs to taxpayers, patients, and the government. They do this through a variety of tactics, such as creating patent thickets, negotiating pay-for-delay deals, product hopping, and filing sham citizen petitions.

Solution and Savings:

- Restrict patent thickets and further limit pay-for-delay deals. There are a number of bills being considered by Congress to address this including: The *Eliminating Thickets to Increase Competition (ETHIC) Act*, which would limit the number of patents that brand manufacturers can assert to one patent per family when suing for infringement; the *Medication Affordability and Patent Integrity Act (MAPIA)*, which addresses incomplete coordination between the FDA and U.S. Patent and Trademark Office that can also be exploited to hinder generic competition; and the *Preserve Access to Affordable Generics and Biosimilars Act*, which would restrict agreements that limit generic or biosimilar entry and require that manufacturers prove an agreement is not anticompetitive before it can be effectuated. That bill would save **$1.7 billion** over 10 years (according to a CBO score from 2024, with an updated score forthcoming).
- Prohibit product hopping. In anticipation of generic competition, a brand manufacturer can make small patent-protected changes to their product, move consumers over to the new product, and take the original product off the market. The *Drug Competition Enhancement Act* would ban this practice (CBO score forthcoming).
- Disincentivize manufacturers from filing baseless citizen petitions. The citizen petition process enables ordinary people to voice concerns about the safety and efficacy of drug being considered for approval. However, manufacturers have been using it to hold off competition, filing petitions close to the expected generic approval date. This practice is addressed in the *Stop the Overuse of Petitions and Get Affordable Medicines to Enter Soon Act of 2026 (STOP GAMES Act),* the *Stop Significant and Time-wasting Abuse Limiting Legitimate Innovation of New Generics Act (Stop STALLING Act),* and the *Ensuring Timely Access to Generics Act*. The *Stop STALLING Act* would save **$400 million** over 10 years (according to a CBO score from 2024, with an updated score forthcoming).

Boost the Biosimilar Market

Problem: The potential for savings from biosimilars is significant and has not been fully realized. Biologics, the higher cost, branded reference products of biosimilars, make up only about 3 percent of prescriptions in the U.S. but more than half the spending. The average biosimilar uptake after three years on the market is around 60 percent, with significant variation depending on product. Meanwhile, for generic drugs, uptake is on average above 80 percent in year two.

Solution and Savings:

- Eliminating biosimilar switching studies would allow biosimilars to be more quickly approved as interchangeable as put forward in the *Biosimilar Red Tape Elimination Act* (CBO score forthcoming).
- The prescription drug provisions above on mitigating anticompetitive behaviors would also bring more competition to the biosimilar market, lowering drug prices and saving money for taxpayers.

Arnold Ventures is prepared to assist with any additional information needed. Please contact Josh Gordon at jgordon@arnoldventures.org, Andrea Noda at anoda@arnoldventures.org, or Alexandra Spratt at aspratt@arnoldventures.org. Thank you for the opportunity to comment and your consideration of the above.

Mark E. Miller, Ph.D.
Executive Vice President, Health Care
Arnold Ventures