MEDPAC | Medicare Payment Advisory Commission

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September 9, 2026

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Administrator
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Department of Health and Human Services
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Attention: CMS-1848-P

Dear Dr. Oz:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare and Medicaid Programs; CY 2027 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," published in the *Federal Register,* vol. 91, no. 135, pp. 43842–44557 (July 16, 2026). We appreciate CMS's ongoing efforts to administer and improve Medicare's payment systems for physicians and other health professionals and related payment systems and programs, particularly given the many competing demands on the agency's staff.

Our comments address the following provisions in the proposed rule:

- Determination of practice expense (PE) relative value units (RVUs);
- Global surgical packages;
- National payment for non-sheet form skin substitutes;
- Evaluation and management (E&M) visit complexity add-on (Healthcare Common Procedure Coding System (HCPCS) code G2211);
- Accounting for E&M resource overlap between stand-alone visits and global periods;
- Software as a medical service (SaMS) laboratory analyses;
- Request for revaluation of physician work time based on empiric data;
- Request for information: Redesigning primary care to make America healthy again;
- Medicare Shared Savings Program (MSSP); and
- Changes to the regulations associated with the ambulance fee schedule.

Determination of PE RVUs

CMS proposes multiple changes to the way PE RVUs are determined.

First, CMS proposes to change how work RVUs and clinical labor PE RVUs are used to allocate indirect PE RVUs.[1] Because indirect practice expenses, such as rent and administrative staff, are not directly attributable to a particular service, CMS allocates indirect PE RVUs to services based on other values. For most services, one basis for allocating those indirect PE RVUs is the greater of work RVUs or clinical labor PE RVUs. However, for services that can be billed using technical, professional, and global components, sometimes referred to as "triplet services" (e.g., typically diagnostic or imaging services), CMS uses the sum (as opposed to the greater) of work RVUs and clinical labor PE RVUs. CMS states that this longstanding policy inadvertently advantages "triplet services" by allocating more indirect PE RVUs to them. The agency therefore proposes to allocate indirect PE RVUs using the sum of work RVUs and clinical labor PE RVUs for all services, except 10- and 90-day global surgical services, instead of just "triplet services."

Second, CMS proposes to eliminate over a two-year period the use of indirect practice cost indexes (IPCIs) in the calculation of indirect PE RVUs. IPCIs are specialty-specific values (e.g., in data released with the proposed rule, family practice has an IPCI of 0.998 and dermatology has an IPCI of 1.201) and are calculated using PE per hour (PE/HR) data collected in the AMA's 2007 Physician Practice Information (PPI) survey. In the current process, CMS calculates indirect PE allocators for each service based on work RVUs and/or clinical labor PE RVUs, direct PE RVUs, and other factors. CMS then multiplies those service-level allocators by a service-level IPCI, which is based on the mix of physician specialties that bill a given service. CMS states that the agency uses IPCIs to ensure that the overall allocation of PE RVUs for each specialty across the physician fee schedule (PFS) approximates those expected based on the PPI survey's PE/HR data. CMS proposes to eliminate the use of IPCIs because the PE/HR data are increasingly outdated and limited to small selective samples based on predetermined assumptions about where costs are likely to differ. CMS notes that reliance on IPCIs results in a PE methodology that privileges historic survey data over the incorporation of more recent data about specific services and produces unpredictable and counterintuitive results that are not transparent to the public.

Third, CMS proposes a PE stabilization adjustment to improve predictability and reduce volatility within PE RVUs. Specifically, CMS proposes that PE RVUs for a given service will not increase or decrease by more than 5 percent each year.[2]

Based partly on stakeholder comments on a calendar year (CY) 2026 change, CMS also seeks feedback on the extent to which the allocation of indirect PE RVUs should be altered

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[1] Clinical labor PE RVUs are calculated for the purposes of allocating indirect PE.
[2] The proposed stabilization adjustment will be applied prior to the statutory phase-in of significant RVU reductions required by Section 1848(c)(7) of the Act, which limits all codes that are not new or revised to a 19 percent decrease in total RVUs in a year. Therefore, a code may be impacted by both the PE stabilization adjustment and the statutory phase-in, meaning a code's PE RVU may ultimately differ by greater than the PE stabilization adjustment amount.

based not only on whether a service is delivered in a facility or nonfacility setting but also based on clinicians' employment models. For CY 2026, CMS reduced by 50 percent the amount of indirect PE RVUs allocated per work RVU for services furnished in a facility setting. CMS made this change based on the premise that practitioners who do not maintain practices independent of the facilities in which they provide care are less likely to incur comparable amounts of indirect PE costs as those who do. CMS notes that some stakeholders have said that the reduction has disadvantaged clinicians who practice in a facility but are not employed by a facility. More broadly, CMS states that stakeholders have suggested that the current binary model of modifying PE RVUs for facility and nonfacility settings does not account for the range of employment models associated with physician services that drive significant differences in actual practice expenses.

Comment

As outlined below, the Commission supports CMS's proposals to allocate indirect PE RVUs based on the sum of work RVUs and clinical labor PE RVUs for all services except 10- and 90-day global surgical codes, to eliminate the use of IPCIs in the calculation of indirect PE RVUs, and to create a PE stabilization adjustment. We encourage CMS to continue to update the methodology used to allocate PE RVUs to allow for the incorporation of more recent data than is currently used, much of which is two decades old.

We support equalizing the allocation of indirect PE based on the sum of work RVUs and clinical labor PE RVUs for all services except 10- and 90-day global surgical codes. We agree with CMS that this will address a longstanding inequity that disadvantages non-triplet services. In addition, CMS's proposal would be another positive step toward ensuring the appropriate valuation of E&M services, about which the Commission has expressed concern in the past.[3] We also support exempting 10- and 90-day global surgical codes from this policy. As noted in our June 2025 report to the Congress, the Commission has substantial concerns that 10- and 90-day global surgical codes are relatively overvalued because data from the Department of Health and Human Services Office of Inspector General and several years of fee-for-service (FFS) Medicare claims data indicate that very few of the assumed postoperative visits that are paid as part of these global codes actually occur.[4] Thus, if 10- and 90-day global surgical codes were included in this revised indirect PE allocation methodology, CMS would be allocating additional indirect PE RVUs based on clinical labor associated with visits that did not actually occur in the majority of cases.

The Commission supports CMS's proposal to eliminate the use of IPCIs in the calculation of indirect PE RVUs and the new PE stabilization adjustment. In our June 2025 report, we recommended improving the accuracy of Medicare's relative payment rates by using

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[3] Medicare Payment Advisory Commission. 2018. "Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun18_ch3_medpacreport_sec.pdf.

[4] Medicare Payment Advisory Commission. 2025. "Reforming physician fee schedule updates and improving the accuracy of relative payment rates," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf.

timely data that reflect the costs of delivering care, and as CMS notes, the IPCIs are calculated using data collected two decades ago that may no longer accurately reflect clinicians' practice costs.[5] We also support CMS's proposal to create a new PE stabilization adjustment because we recognize the importance of payment stability, especially when substantial changes such as eliminating the use of IPCIs are being implemented.

We also encourage CMS to seek ways to further reduce Medicare's reliance on the outdated PPI PE/HR survey data. For example, even if CMS finalizes eliminating the use of IPCIs, the outdated PE/HR data will still be used in allocating indirect PE RVUs. In the current process, direct PE RVUs are used to allocate indirect PE RVUs. However, instead of allocating indirect PE RVUs proportionately based on direct PE RVUs, the current methodology multiplies direct PE RVUs by the ratio of indirect PE costs to direct PE costs of the physician specialties that bill the service. The result is that indirect PE RVUs are adjusted up and down based on the physician specialties that bill the service (and the PE/HR data those specialties reported in the PPI survey nearly two decades ago). Forgoing the use of specialty-specific practice expense data has the potential to improve payment accuracy and make more routine updates to the practice expense data more practicable because collecting representative practice expense data from dozens of different specialties is difficult. For example, the American Medical Association (AMA) dedicated significant time, resources, and expertise in an effort to collect updated specialty-specific PE/HR data in an updated PPI survey it fielded from 2022 to 2023. However, the difficulty in obtaining responses led to the PE/HR data being based on a small number of practices for some specialties, acceptance of practices that volunteered or were recruited to report their data, and physician specialty categories being consolidated in certain circumstances (and not in others). These and other concerns led the Commission to support CMS's decision not to incorporate the new survey data into the process to calculate RVUs.[6]

Regarding CMS's request for feedback on further changes to the method used to allocate PE RVUs, we note that we generally supported CMS's 2026 change that reduced by 50 percent the amount of indirect PE RVUs allocated per work RVU for services furnished in a facility setting. That change was consistent with the Commission's recommendation in our June 2025 report to the Congress.[7] We acknowledge that the lack of up-to-date practice expense data for clinicians with different practice arrangements necessarily meant that the magnitude of the reduction of PE RVUs (and redistribution to other services) was based on CMS judgment. While we understand that all policy changes have tradeoffs, in the aggregate, the change improved payment accuracy (by recognizing that clinicians who practice in facilities are likely to incur fewer indirect practice expenses) and reduced the incentive for financially motivated vertical consolidation.

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[5] Medicare Payment Advisory Commission. 2025. "Reforming physician fee schedule updates and improving the accuracy of relative payment rates," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf.
[6] Medicare Payment Advisory Commission. 2025. Letter to CMS commenting on proposed rule for CY 2026 physician fee schedule. https://www.medpac.gov/wp-content/uploads/2025/09/09112025_MedPAC_2026_PFS_COMMENT_v3_SEC.pdf.
[7] Medicare Payment Advisory Commission. 2025. "Reforming physician fee schedule updates and improving the accuracy of relative payment rates," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf.

The Commission encourages a cautious approach as CMS considers implementing a new HCPCS modifier for employed physicians in order to reduce PE RVUs. Employment relationships between hospitals and physicians are complex, and classifying the diversity of employment relationships—including those involving joint ventures, management service organizations, foundations, contract employees, etc.— into an "employed" or "not employed" paradigm would involve uncertainty and administrative burden. Additionally, the Commission has long held that increasing or decreasing payment rates based solely on a particular financial structure (e.g., for profit vs. not for profit) is generally undesirable. In such cases, providers have an incentive to change their organizational structure to increase payments rather than focusing on improving access and efficiency.

Global surgical packages

CMS proposes to no longer collect claims data quantifying the delivery of postoperative visits following surgical procedures paid for through 10- and 90-day global surgical codes. CMS's rationale for discontinuing this data collection effort is: (1) it has now sufficiently documented the low rate of these visits being furnished, and (2) stopping this data collection would reduce provider burden. CMS also asks whether it should instead require all providers to report these postoperative visits (rather than just the current sample of practices in nine states).

CMS also asks for comments on potential global code revaluation strategies to consider in future rulemaking.

Comment

We remain troubled by CMS's findings that at least 53 percent of the postoperative visits that Medicare pays for as part of 90-day global codes are not provided, and that at least 83 percent of the postoperative visits that Medicare pays for as part of 10-day global codes are not provided.[8,9] The fact that about 4,000 codes in the PFS are 10- or 90-day global codes suggests a widespread overvaluation problem that results in the Medicare program and its beneficiaries overpaying for these services. At the same time, because RVUs are calculated on a budget-neutral basis, overpaying for global codes reduces payment rates for all other services. We have expressed concerns about the overvaluation of global codes in seven prior comment letters,[10] and in 2025 the Commission recommended that the

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[8] Crespin, D. J., A. M. Kranz, T. Ruder, 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. https://www.cms.gov/ files/document/rand-cy-2019-claims-report-2021.pdf.

[9] We report results of a sensitivity analysis by RAND that was restricted to the subset of clinicians who billed for any postoperative visits during 90-day global periods. We report these results, rather than RAND's main results, because some specialty societies contend that the reason some clinicians did not bill for any postoperative visits was that their billing system did not allow them to submit the 99024 no-pay billing code that was used by RAND to identify postoperative visits. However, we caution that it is also possible that some clinicians did not report any postoperative visits because they did not provide any. The results we report should therefore be interpreted as being conservative.

[10] Medicare Payment Advisory Commission. 2014. Letter to CMS commenting on proposed rule for CY 2015 physician fee schedule. August 28. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08282014_comment_letter_2015_pt_b_rule_final.pdf.

Congress and CMS improve the accuracy of the PFS's relative values—including for global surgical codes.[11]

Given the compelling research finding that substantially more postoperative visits are assumed in payment rates than are provided, on balance, properly valued global codes should have *materially fewer* work RVUs than they currently do. Our June 2025 recommendation discussed two options to achieve this goal, and we urge CMS to adopt one of these approaches. One option would be to convert 10- and 90-day global codes to 0-day codes. Under 0-day global codes, proceduralists would receive payment for all services provided on the day of a procedure, including preoperative and postoperative visits provided that day; visits on other days would be billed separately using E&M visit codes. Another option would be to retain 10- and 90-day global codes but revalue them using the claims data CMS has collected about the delivery of postoperative E&M visits. Under this approach, CMS would use findings from claims data to remove RVUs for postoperative visits related to surgical procedures that are not occurring. Specialty societies that believe the revised values are inappropriate could propose replacement values for CMS's consideration.

National payment for non-sheet form skin substitutes

In the final CY 2026 PFS rule, CMS established a single payment rate of $127.28 per square centimeter (effective January 2026) to pay for covered skin substitutes in a sheet form (and that are not approved by the Food and Drug Administration under Section 351 of the Public

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Medicare Payment Advisory Commission. 2016. Letter to CMS commenting on proposed rule for CY 2017 physician fee schedule. August 26. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08262016_partb_2017_medpac_comment_sec29d111adfa9c665e80adff00009edf9c.pdf.
Medicare Payment Advisory Commission. 2018. Letter to CMS commenting on proposed rule for CY 2019 physician fee schedule. September 4. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/09042018_macra_feeschedule_1693p_medpac_comment_v2_sec.pdf.
Medicare Payment Advisory Commission. 2019. Letter to CMS commenting on proposed rule for CY 2020 physician fee schedule. September 13. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/09132019_cms_1715p_physician_medpac_comment_v2_sec.pdf.
Medicare Payment Advisory Commission. 2023. Letter to CMS commenting on proposed rule for CY 2024 physician fee schedule. September 11. https://www.medpac.gov/wp-content/uploads/2023/09/09112023_MedPAC_Physician_Comment_v2_SEC.pdf.
Medicare Payment Advisory Commission. 2024. Letter to CMS commenting on proposed rule for CY 2025 physician fee schedule. September 6. https://www.medpac.gov/wp-content/uploads/2024/09/09062024_2025_PFS_MedPAC_comment_SEC.pdf.
Medicare Payment Advisory Commission. 2025. Letter to CMS commenting on proposed rule for CY 2026 physician fee schedule. September 11. https://www.medpac.gov/wp-content/uploads/2025/09/09112025_MedPAC_2026_PFS_COMMENT_v3_SEC.pdf.

[11] Medicare Payment Advisory Commission. 2025. "Reforming physician fee schedule updates and improving the accuracy of relative payment rates," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/06/Jun25_Ch1_MedPAC_Report_To_Congress_SEC.pdf.

Health Service Act (PSA) as biological products) as incident-to supplies.[12,13] However, the CY 2026 PFS final rule did not change its payment policy for skin substitutes not in sheet form. Instead, CMS continued its approach of having the Medicare administrative contractors (MACs) determine payment for these products. CMS explained that, although non-sheet-form products could potentially be paid using the same methodology as sheet-form skin substitutes, the units used in their billing codes were difficult to standardize for payment purposes.[14]

The proposed CY 2027 PFS rule would pay for non-sheet-form skin substitutes at the same national payment rate as sheet-form skin substitutes, effective January 1, 2027. The agency explains that this proposal reflects its ongoing analysis and feedback from interested parties, which led CMS to conclude that, on balance, the resource costs per square centimeter for non-sheet-form skin substitutes are comparable to those for sheet-form skin substitutes.[15] As a result, CMS proposes to apply the same national payment rate to both types of products.

Comment

CMS's proposed change to the payment of non-sheet-form skin substitutes is consistent with the Commission's long-held position that Medicare should pay similar rates for similar care.[16] The agency's proposal would protect beneficiaries and ensure good value for the Medicare program and thus taxpayers.

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[12] Prior to 2026, in the nonfacility setting, CMS paid for most skin substitutes under Section 1847A of the Social Security Act based on each product's average sales price (ASP) plus 6 percent. CMS's CY 2026 payment policy change (i.e., establishing a single payment rate of $127.28) applied to skin substitute products available in sheet form that are approved under the Food and Drug Administration's (FDA's) premarket approval (PMA) pathway; approved or cleared through the FDA's 510(k) premarket notification or De Novo pathways; or regulated as human cells, tissues, and cellular and tissue-based products (HCT/Ps) under Section 361 of the Public Health Service (PHS) Act. The policy did not apply to skin substitute products licensed as biological products under Section 351 of the PHS Act. CMS continues to pay for these biological skin substitutes based on each product's ASP plus 6 percent.

[13] "Incident-to supplies" refers to supplies that are furnished as an integral part of the physician's professional services in the course of diagnosis or treatment of an injury or illness.

[14] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026. Medicare and Medicaid programs; CY 2027 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. Proposed rule. *Federal Register* 91, no. 135: 43842–44557.

[15] Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026. Medicare and Medicaid programs; CY 2027 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. Proposed rule. *Federal Register* 91, no. 135: 43842–44557.

[16] Consistent with our long-held position of paying similar rates for similar care, the Commission recommended in June 2023 that the Congress give the Secretary the authority to establish a single ASP-based payment for groups of Part B drugs and biologics with similar health effects paid under the current ASP payment system (Medicare Payment Advisory Commission. 2023. "Addressing high prices of drugs covered under Medicare Part B," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch1_MedPAC_Report_To_Congress_SEC.pdf.).

Evaluation and management (E&M) visit complexity add-on (HCPCS code G2211)

In 2024, CMS established a separate HCPCS code to pay clinicians for the complexity and resources associated with providing longitudinal care. The code, G2211, was intended to recognize work that extends beyond the services captured in standard office and outpatient E&M visit codes. Specifically, G2211 is intended to reimburse clinicians for the additional cognitive effort required when serving as the continuing focal point for a patient's health care or providing ongoing management of a serious or complex condition.

In this proposed rule, CMS has concluded that the additional work associated with longitudinal care is more appropriately viewed as an inherent characteristic of certain E&M visits rather than a separately billable service. The agency therefore proposes replacing G2211 with two code modifiers, referred to as MOD1 and MOD2. Rather than reporting on a separate claim line, CMS proposes that clinicians would append one of these modifiers directly to qualifying office, outpatient, or home E&M services. CMS expects this approach to simplify claims processing, reduce administrative burden, and more accurately represent the fact that the additional complexity is integrated into the underlying visit rather than occurring as a distinct service. The clinical circumstances under which the modifiers would be reported remain essentially unchanged from those that currently justify use of G2211.

The proposal also revises the valuation methodology for the complexity payment. G2211 currently provides a fixed payment of about $17, regardless of the time and intensity of the associated E&M service. CMS argues that this flat payment produces inconsistent proportional increases across visit levels. For lower-level visits, G2211 represents a relatively large percentage increase in payment, whereas for higher-level visits the increase is much smaller.[17] According to CMS, a proportional adjustment would better reflect the varying intensity of work associated with different E&M visit levels while continuing to recognize the additional effort involved in longitudinal care.

CMS proposes valuing MOD1 at 16 percent of the payment for the underlying E&M service. This percentage is based on a weighted average of current G2211 payments and is expected to be budget neutral without adjusting the PFS's conversion factors. While the proposal would redistribute beneficiary cost-sharing liability across E&M visit levels, it would not increase aggregate beneficiary liability.

The proposal also introduces a second modifier, designated as MOD2, that would apply only to clinicians participating in a Medicare accountable care organization (ACO), including the Medicare Shared Savings Program (MSSP) and the forthcoming Long-term Enhanced ACO Design (LEAD) Model. CMS asserts that the care complexity payment should be higher for participants in ACOs because those providers assume broader

[17] For example, when G2211 is billed along with a lower-level E&M code (99211), the complexity payment adds about half of the payment rate of the base E&M service, whereas when billed with a high-level E&M code (99215), the G2211 payment adds about 9 percent to the base code's payment.

responsibility for managing beneficiaries' overall health, coordinating care across providers, improving quality, and controlling costs. The agency argues that these responsibilities require additional cognitive work and care coordination activities beyond the complexity recognized through MOD1 alone.

To reflect these additional resource costs and responsibilities, CMS proposes valuing MOD2 at 32 percent of the associated E&M service—twice the value of MOD1. Use of MOD2 would be voluntary and would be limited to eligible ACO participants when a visit meets the criteria for inherent complexity.

Finally, the proposal addresses operational implications for Medicare ACO programs. CMS indicates that replacing G2211 with modifiers would not fundamentally alter beneficiary assignment methodologies used in either the MSSP or the LEAD Model. Historical claims containing G2211 would continue to be incorporated into assignment and benchmarking calculations during applicable look-back periods, while future assignment would incorporate payments associated with MOD1 and MOD2 through the underlying E&M services. Expenditures associated with either modifier would be included in ACO financial calculations.

Comment

As discussed below, we support replacing the G2211 complexity add-on code with a modifier that would increase payment rates for many E&M services by 16 percent, but we oppose CMS's proposal to increase payments for E&M services by 32 percent when furnished by clinicians who participate in a Medicare ACO model.

In previous comments on the CY 2024 PFS proposed rule, the Commission expressed concerns regarding implementation of the G2211 complexity add-on code because the circumstances under which it could be billed were ambiguous and could result in underuse or overuse.[18] We also noted that ongoing care for beneficiaries with serious and complex conditions should already be reflected in the valuation of the underlying E&M services and stated that we generally preferred mechanisms outside of billing codes—such as payment adjustments or per beneficiary payments—to provide additional support for primary care.

Since the Commission first expressed its concerns about G2211, CMS has now proposed replacing the flat G2211 payment with a payment modifier, consistent with our previously stated preference that a budget-neutral payment adjuster (such as a modifier) be used to support primary care providers rather than a separate new billing code. The proposal also addresses concerns that G2211's flat payment rate means payments do not reflect differences in the relative resources needed to furnish different E&M services. The

[18] Medicare Payment Advisory Commission. 2023. Letter commenting on proposed rule for CY 2024 physician fee schedule. September 11. https://www.medpac.gov/wp-content/uploads/2023/09/09112023_MedPAC_Physician_Comment_v2_SEC.pdf.

proposed approach produces payment rates that vary with the time and intensity associated with higher- and lower-level office visits.

The Commission does not, however, support CMS's proposal to establish the higher-paying MOD2 modifier for certain clinicians participating in ACOs. CMS says MOD2's higher payment for participants in ACOs is intended to reflect the additional work and resources needed to effectively manage patients' care within an accountable care framework but offers no empirical evidence to support the need for higher payment rates.

The Commission is also concerned that MOD2 would increase aggregate cost-sharing liability for beneficiaries in ACOs for commonly furnished E&M services. Because E&M visits account for a substantial share of services furnished under the physician fee schedule, the proposal may affect a large share of the care that beneficiaries in ACOs obtain.

We also note that the proposal would also allow clinicians to report MOD2 for services furnished to beneficiaries who are not attributed to an ACO. Since the enhanced payment is based on the clinician's ACO participation rather than whether the beneficiary is included in the ACO's enhanced accountability and care management relationship, increases in cost-sharing payments for E&M visits resulting from use of MOD2 would affect beneficiaries who are not attributed to an ACO and may or may not be receiving enhanced care.

Finally, we are concerned that increasing payments to ACO participants could reduce the ability of Medicare's ACO models to generate net savings for Medicare, potentially undermining one of the central objectives of these models. We are concerned that ACOs in bonus-only tracks of models, in particular, might find that they can maximize payments by increasing their delivery of services eligible for the MOD2 modifier and might therefore focus less on efforts needed to earn shared-savings payments.

Accounting for E&M resource overlap between stand-alone visits and global periods

Payments for 0-, 10-, and 90-day global surgical services include all the necessary services normally provided by the practitioner during the global period, which includes the day of the procedure and varying amounts of time before and after the service. Medicare only makes separate payment for an office or outpatient E&M visit performed on the same day as a global surgical service if the clinician bills the E&M visit with modifier –25, indicating that the visit is significant and separately identifiable from the procedure.

CMS proposes to reduce payment rates when an office or outpatient E&M visit is furnished by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, or 90-day global surgical service. Specifically, the most expensive service (either surgical service or E&M visit) would be paid at 100 percent, and all other surgical procedures or E&M visits would be paid at 50 percent. The proposal is meant to address the likely overlap and

duplication of payment between the E&M service already paid for during the global surgical package and any additional E&M services billed using modifier –25.

Comment

The Commission supports CMS's proposal to apply a multiple procedure payment reduction (MPPR) when an office or outpatient E&M visit is billed with modifier –25 by the same physician (or a physician in the same group practice) on the same day as a 0-, 10-, and 90-day global surgical service. In general, when a standalone E&M visit occurs on the same day as a procedure, there are efficiencies (e.g., in pre-service and post-service clinician work and practice expense) that are not accounted for in the current payment system. Applying an MPPR to the procedure or visit would account for these efficiencies. In addition, the reductions stemming from this policy would be redistributed throughout the PFS, which would increase payment rates for many types of services including primary care and behavioral health services. The Commission's support of this proposal is also consistent with the Commission's support of a similar CMS proposal for CY 2019 (that was not adopted) and with the Commission's long history of recommending MPPR adjustments for multiple types of services.[19]

As CMS implements this policy, the Commission believes it is important to monitor the extent to which clinicians modify their behavior to avoid payment reductions by splitting multiple services that are typically delivered on the same day across multiple days. To the extent CMS expects or observes this behavior, the agency could consider targeted policies to address the negative effects of such behaviors, such as applying MPPRs across multiple days.

Software as a medical service (SaMS) laboratory analyses

CMS proposes changes to how Medicare classifies and pays for software-based technologies that support clinical decision-making. The use of artificial intelligence and other algorithm-driven tools (referred to by CMS as "software as a medical service" (SaMS)) has become increasingly common in physician offices and other outpatient settings.

This proposal focuses on SaMS technology that performs algorithmic analyses of data generated from laboratory testing, such as genomic sequencing. CMS notes that while the

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[19] Medicare Payment Advisory Commission. 2018. Letter to CMS commenting on proposed rule for CY 2019 physician fee schedule. September 4. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/09042018_macra_feeschedule_1693p_medpac_comment_v2_sec.pdf.
Medicare Payment Advisory Commission. 2013. "Mandated report: Improving Medicare's payment system for outpatient therapy services," in *Report to the Congress: Medicare and the Health Care Delivery System.* Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun13_ch09.pdf.
Medicare Payment Advisory Commission. 2011. "Improving payment accuracy and appropriate use of ancillary services," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Jun11_Ch02.pdf.
Medicare Payment Advisory Commission. 2005. "Issues in physician payment policy," in *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/Mar05_Ch03.pdf.

initial laboratory test must be conducted by a Clinical Laboratory Improvement Amendments of 1988 (CLIA)–certified laboratory, the resulting data can subsequently be analyzed using proprietary software to generate new diagnostic information. Because these secondary analyses do not involve the examination of patient specimens or require CLIA-certified laboratories, CMS argues that they are fundamentally different from traditional clinical diagnostic laboratory tests (CDLTs).

CMS therefore proposes that these stand-alone software analyses should no longer be paid under the clinical laboratory fee schedule (CLFS). The agency contends that existing CLFS payment methodologies are poorly suited to software-based services because vendors often provide limited information about proprietary algorithms, making it difficult to establish appropriate payment rates. In addition, the CLFS lacks beneficiary cost-sharing and budget-neutrality requirements, which CMS believes reduces pricing transparency and may expose the Medicare program to financial risk.

To promote consistent payment across care settings, CMS proposes paying for SaMS analysis of laboratory tests under the PFS rather than the CLFS. For CY 2027, the agency would transfer ten existing HCPCS codes describing software-only laboratory analyses to contractor pricing under the PFS and is considering similar treatment for future codes. CMS also seeks comment on alternative payment approaches, emphasizing that similar algorithmic technologies should receive consistent Medicare payment regardless of the clinical setting in which they are used.

Comment

We support CMS's proposed change in payment policy for post–laboratory test SaMS services. Medicare already pays for many SaMS services under the PFS, mostly using carrier pricing. Shifting payment for these services from CLFS to PFS will help align payment policies for SaMS services furnished by physicians and other clinicians.

While we support this change, the Commission urges CMS to consider evidence on clinical outcomes when determining coverage and payment for SaMS services. In our June 2024 report to the Congress, we said that developers of SaMS technologies should provide evidence that their products result in clinically meaningful improvements in outcomes for Medicare beneficiaries compared to current standards of care. Alternatively, we suggested that for a technology that lacks clear evidence that it has a positive effect on care, Medicare could use the coverage with evidence process that links a service's coverage to participation in an approved clinical study or to the collection of additional clinical data.

Request for revaluation of physician work time based on empiric data

CMS describes a letter from a commenter that provided empirical evidence from Maryland's all-payer claims database and a clinical registry that the amount of time that various billing codes assume are needed to deliver a service is higher than the amount of time physicians actually spend delivering those services. The commenter found many instances where the codes physicians use implied that the physician spent more than 8

hours delivering patient care per day (e.g., 37 hours per day). CMS states that the commenter's empirical data seems more reliable than the American Medical Association / Specialty Society Relative Value Scale Update Committee (RUC) data that these various codes are based on, and asks for comment on whether CMS should adopt the empirical time values for these codes and/or adjust the work RVUs for these codes based on these empirical data in CY 2027 or future rulemaking.[20]

Comment

We support CMS taking steps to revalue the misvalued codes identified by this commenter, who used an approach we recommended in a 2011 letter to identify misvalued codes.[21] If the commenter identified recommended work RVUs and service times for particular codes, we encourage CMS to share those values. Alternatively, CMS could ask the RUC to revalue these misvalued codes, consistent with the agency's typical process. We also encourage CMS to revalue the misvalued codes identified in other similar studies that have used time-based anesthesia claims data from surgeries, time stamp data from electronic health records, and other empirical data sources.[22] In addition to drawing on these one-time studies, we continue to recommend that CMS regularly collect data on service volume and work time from a cohort of efficient practices, which would help CMS identify and revalue a wide range of overvalued billing codes on an ongoing basis.[23]

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[20] Values and service times for most billing codes in the physician fee schedule are set using surveys approved by the American Medical Association/Specialty Society Relative Value Scale Update Committee (the RUC) that are completed by small samples of physicians and that ask them to estimate how much work and time is involved in delivering a service described by a clinical vignette included in the survey. For more information on these surveys, see: Government Accountability Office. 2015. *Medicare physician payment rates: Better data and greater transparency could improve accuracy.* Washington, DC: GAO. https://www.gao.gov/products/gao-15-434; Laugesen, M. 2016. *Fixing medical prices: How physicians are paid*. Cambridge, MA: Harvard University Press; American Medical Association. *AMA/Specialty Society RCS Update Committee: An overview of the RUC process*. Chicago, IL: AMA. https://www.ama-assn.org/system/files/ruc-update-booklet.pdf.

[21] Medicare Payment Advisory Commission. 2011. Letter to chairs and ranking members of U.S. Senate Committee on Finance, U.S. House Committee on Ways and Means, and U.S. House Committee on Energy and Commerce. October 14. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/10142011_MedPAC_SGR_letter.pdf.

[22] Zuckerman, S., K. Merrell, R. Berenson, et al. 2016. *Collecting empirical physician time data: Piloting an approach for validating work relative value units.* Washington, DC: Urban Institute, Social & Scientific Systems, Inc., and RTI International. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Collecting-Empirical-Physician-Time-Data-Urban-Report.pdf.

Chan, D., J. Huynh, and D. Studdert. 2019. Accuracy of valuations of surgical procedures in the Medicare fee schedule. *New England Journal of Medicine* 380, no. 16: 1546-1554. https://www.nejm.org/doi/10.1056/NEJMsa1807379?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed.

Burgette, L., A. Mulcahy, A. Mehrotra, et al. 2016. Estimating surgical procedure times using anesthesia billing data and operating room records. *Health Services Research* 52, no. 1 (February): 74-92. https://onlinelibrary.wiley.com/doi/abs/10.1111/1475-6773.12474.

Crespin, D., T. Ruder, A. Mulcahy, et al. 2022. Variation in estimated surgical procedure times across patient characteristics and surgeon specialty. *JAMA Surgery* 157, no. 5 (March 2): e220099. https://jamanetwork.com/journals/jamasurgery/fullarticle/2789489.

[23] Medicare Payment Advisory Commission. 2011. Letter to chairs and ranking members of U.S. Senate Committee on Finance, U.S. House Committee on Ways and Means, and U.S. House Committee on Energy and Commerce. October 14. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/10142011_MedPAC_SGR_letter.pdf.

Request for information: Redesigning primary care to make America healthy again

In this proposed rule, CMS seeks input on how to reimagine and improve the relative valuation of primary care services. The agency states that the advanced primary care management codes introduced in 2025 were a "first step" toward prospective primary care payment, and that it next plans to establish prospective primary care payment permanently within the MSSP, followed by FFS Medicare. Specific topics it seeks input on include:

- How to define and value three potential new, more granular, code sets for office/outpatient E&M visits:
    - Acute care visits (to address a discrete, one-time issue such as a sore throat).
    - Consultative visits (which would include communication of findings or recommendations back to a referring practitioner).
    - Longitudinal visits (which could bundle in payment for care management between visits).
- What changes to make to G2211 or its proposed replacement modifiers (MOD1 and MOD2) to ensure the billing clinician is serving as the focal point for a beneficiary's care, considering preventive care, reducing risk factors, and coordinating care.
- How to restructure or simplify existing care management codes to increase their use while ensuring codes are only used when clinically appropriate.
- Whether to pay different amounts for technology (e.g., artificial intelligence)–enabled care vs. "traditional" care management.
- Whether clinical AI could improve annual wellness visits.
- Whether Medicare should pay capitated amounts to some or all MSSP ACOs for primary care services for some or all of an ACO's beneficiaries. If so:
    - How these capitated payments should be defined and valued.
    - Whether some MSSP ACOs should be offered the option to receive a fully capitated payment for all care (not just primary care) furnished by their participating providers.
- How to establish prospective primary care payment in FFS Medicare while ensuring beneficiaries maintain access to care.
    - Whether payments for primary care should be fully or partially capitated.
    - Which services to pay on a capitated versus FFS basis.
    - Whether to require a certain minimum number of visits to be provided.
    - Whether to require specific clinical outcomes to be reported.
    - How to risk adjust capitated payments.

Comment

The Commission is broadly supportive of reforming payments for primary care services. In 2015, we recommended that a prospective per beneficiary payment for primary care be

added to the PFS.[24] For most of the PFS's history, its payment codes have been ill-suited to the many short, discrete activities performed by primary care providers. In some cases, the cost of documenting and billing for these types of activities can exceed the payment. We have therefore supported alternative payment approaches for these types of care coordination activities, such as flat monthly payments for managing beneficiaries' chronic conditions.[25] We have favored combining capitated payments for these types of activities with FFS payment for traditional patient-facing services (e.g., office visits), rather than shifting entirely to full capitation for all of a beneficiary's primary care services.[26]

As CMS acknowledges, capitated payments for primary care services would need to be risk adjusted to reflect beneficiaries' health status (so clinicians are not financially penalized for treating sicker beneficiaries who need more health care). The approach used to risk adjust capitated payments for primary care may need to use different beneficiary characteristics than are used in other Medicare programs (such as Medicare Advantage (MA) and ACOs), since the variables that predict beneficiaries' annual *primary care* spending may differ from the variables that predict beneficiaries' *total health care* spending. Whatever approach is ultimately used to risk adjust capitated payments for primary care, CMS should proceed cautiously and monitor how providers respond to the new coding incentives. CMS may need to modify its approach to risk adjustment over time.

Medicare Shared Savings Program

Since the creation of the MSSP in 2012, CMS has implemented a series of different benchmark, assignment, and risk-adjustment methodologies. Those methodologies have become increasingly complex as the agency balances a set of competing objectives, including growing the number of participating ACOs, rewarding the provision of efficient and high-quality care, and guarding against the gaming of program regulations.

In this rule, CMS proposes another set of refinements to those payment methodologies, including:

- Changes to the beneficiary assignment methodology to hold ACOs accountable for more of the patients served by ACO clinicians.
- Rebalancing the incentives between the BASIC track and ENHANCED track.

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[24] Medicare Payment Advisory Commission. 2015. "Chapter 4: Physician and other health professional services," in *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/march-2015-chapter-4-revised.pdf.

[25] Medicare Payment Advisory Commission. 2014. Letter commenting on proposed rule for CY 2015 physician fee schedule. August 28. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/08282014_comment_letter_2015_pt_b_rule_final.pdf.
Medicare Payment Advisory Commission. 2015. Letter commenting on proposed rule for CY 2016 physician fee schedule. September 8. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/medpac-comment-on-cms-s-proposed-rule-on-the-physician-fee-schedule-and-other-revisions-to-part-b.pdf.
Medicare Payment Advisory Commission. 2013. Letter commenting on proposed rule for CY 2014 physician fee schedule. August 30. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/comment-letters/083013_medpac_partb_comment.pdf.

[26] National Academy of Sciences, Engineering, and Medicine. 2021. *Implementing high-quality primary care: Rebuilding the foundation of health care.* Washington, DC: The National Academies Press. https://www.nationalacademies.org/projects/HMD-HCS-18-15.

- Risk adjusting the 5 percent cap on upward adjustments to an ACO's historical benchmark.
- Creating a growth adjustment to the historical benchmark to incentivize new participation.
- Reform the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor.

CMS estimates that these policies would collectively increase the number of beneficiaries assigned to MSSP ACOs by 0.5 to 1.0 million annually and reduce Medicare spending by $5.5 billion over the next 10 years.

Comment

As outlined below, we support changes to beneficiary assignment that hold ACOs accountable for a greater share of their patients. We also support modifications to the prospective trend factor in benchmarks, and we support the direction of the overall collective proposals to reduce the effect of the regional adjustment to benchmarks. However, we are concerned about adding additional upward adjustments to benchmarks to reward participation and coding. We urge CMS to take additional steps beyond their proposals to address the effects of selection and coding on MSSP benchmarks.

The Commission continues to be concerned that MSSP may not be achieving program savings because the benchmarks used for making shared-savings payments and calculating financial performance do not accurately reflect beneficiary spending in the absence of participation in an ACO. The inaccuracy in benchmarks is largely due to favorable selection and coding intensity, stemming from the influence of regional spending and diagnostic coding on benchmarks.

CMS uses an analysis of 2016 data as the rationale for using benchmarks to measure program savings. That analysis found that benchmarks were lower than what a counterfactual of spending would have been if beneficiaries were not assigned to MSSP ACOs. However, because CMS's benchmark methodology substantially changed after 2016, CMS's 2016 analysis is not a reasonable basis for using benchmarks to measure program savings in subsequent periods nor the impact of proposed policies. For example, current benchmarks include a regional adjustment and less restrictive policies on coding intensity. Because of these changes, current benchmarks result in far higher shared-savings payments per assigned beneficiary relative to benchmarks in 2016.[27] When we adjusted benchmarks to remove the approximate magnitude of the regional adjustment, we

[27] Between 2013 and 2017, shared-savings payments per assigned beneficiary in the MSSP increased by 1 percent. In comparison, between 2017 and 2020, shared-savings payments per assigned beneficiary in the MSSP increased by 148 percent. Between 2017 and 2024, shared-savings payments per assigned beneficiary increased by an average annual rate of 24 percent. Studies indicate that this increase in shared-savings payments is at least in part driven by favorable selection and coding—indicative of pricing errors when setting benchmarks (Chernew, M., J. Carichner, J. Impreson, et al. 2021. Coding-driven changes in measured risk in accountable care organizations. *Health Affairs* 40, no. 12 (December): 1823–1984. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00361. Lyu, P., M. Chernew, and J. McWilliams. 2023. Benchmarking changes and selective participation in the Medicare Shared Savings Program. *Health Affairs* 42, no. 5 (May): 605–732. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01061).

found that shared savings payments would have exceeded gross savings, implying no clear net savings from the program.[28] Since the regional adjustment is only one reason that benchmarks could exceed the true counterfactual spending of MSSP enrollees, that scenario may be a conservative estimate.

Addressing challenges in achieving annual net savings will require important changes to the way the program calculates benchmarks, attributes beneficiaries to ACOs, and addresses growth in risk scores over time. The Commission commends CMS's efforts to improve the performance of MSSP and address the effects of selection. We urge CMS to further mitigate incentives for selection and coding to help the program better achieve savings for Medicare and its beneficiaries. Beyond what the agency proposes, the Commission urges CMS to:

- Mitigate the effects of favorable selection on program spending by phasing out the regional adjustment. As we have noted in prior years, including both the prior-savings adjustment and the regional adjustment maintains undesirable incentives for ACOs to selectively include physician practices and distorts the calculation of the prior-savings adjustment.[29,30,31] Among participating ACOs in 2024, 83 percent of ACOs qualified for a positive regional adjustment to their benchmarks (including 91 percent of ACOs in the ENHANCED track).

- Address the underlying coding incentives by adopting the Commission's prior recommendations to calibrate the hierarchical condition category (HCC) model using two years of data and remove codes generated from health risk assessments (including annual wellness visits) from risk score calibration and calculation. CMS should also apply an overall adjustment that accounts for the remaining differences between ACOs and the national assignable population, as we suggested in previous comment letters.[32,33]

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[28] Using MSSP benchmarks and financial performance from 2024 (the most recent data available), the regional adjustment was about 2 percent of benchmarks. (Starting in 2024, negative regional adjustments to benchmarks were restricted to $0.) We compared shared-savings payments to gross savings estimates under a scenario where the counterfactual spending of MSSP enrollees equaled 2024 benchmarks minus 2 percent. Reducing the 2024 MSSP benchmark counterfactual by a theoretical 2 percent effectively reduces the assumed gross savings from $6.6 billion (4.7 percent) to $3.9 billion (2.8 percent). The $4.1 billion in shared-savings payments would have exceeded this hypothetical counterfactual by $0.25 billion. Under this scenario, net losses would have been further exacerbated by the participation bonuses paid to qualifying clinicians in MSSP's advanced alternative payment models (A–APMs), which CMS excludes from both benchmarks and ACO financial performance. In addition, CMS includes both shared-savings bonuses and A–APM participation bonuses in the calculation of Medicare Advantage benchmarks, which further increases Medicare spending.

[29] Medicare Payment Advisory Commission. 2022. Letter to CMS commenting on proposed rule for CY 2023 physician fee schedule. September 2. https://www.medpac.gov/wp-content/uploads/2022/09/09022022_Part_B_2023_CMS1770P_MedPAC_COMMENT_v2_SEC.pdf

[30] Medicare Payment Advisory Commission. 2023. Letter to CMS commenting on proposed rule for CY 2024 physician fee schedule. September 11. https://www.medpac.gov/wp-content/uploads/2023/09/09112023_MedPAC_Physician_Comment_v2_SEC.pdf

[31] Medicare Payment Advisory Commission. 2024. Letter to CMS commenting on proposed rule for CY 2025 physician fee schedule. September 6. https://www.medpac.gov/wp-content/uploads/2024/09/09062024_2025_PFS_MedPAC_comment_SEC.pdf.

[32] Medicare Payment Advisory Commission. 2022. Letter to CMS commenting on proposed rule for CY 2023 physician fee schedule. September 2. https://www.medpac.gov/wp-content/uploads/2022/09/09022022_Part_B_2023_CMS1770P_MedPAC_COMMENT_v2_SEC.pdf

[33] Medicare Payment Advisory Commission. 2023. Letter to CMS commenting on proposed rule for CY 2024 physician fee schedule. September 11. https://www.medpac.gov/wp-content/uploads/2023/09/09112023_MedPAC_Physician_Comment_v2_SEC.pdf

Changes to the beneficiary assignment methodology to hold ACOs accountable for more of the patients served by ACO clinicians

Beneficiaries are assigned to an ACO based on a list of taxpayer identification numbers (TINs) that an ACO annually submits to CMS; this collection of TINs represents the clinicians who will be the ACO's participants for the performance year. A single TIN can range from a sole physician in one office to a multistate integrated delivery system with many clinicians. Each clinician has a unique national provider identifier (NPI) and may bill services using a TIN inside or outside the ACO. To determine the beneficiaries assigned to an ACO, claims for each beneficiary are grouped by TINs, and if the ACO (defined as a collection of TINs) provides the plurality of allowed charges for primary care compared with any other ACO or individual TIN, the beneficiary is assigned to that ACO.

To be eligible for this claims-based assignment, a beneficiary must have had at least one primary care service with a physician and at least one month of Part A and Part B coverage while enrolled in FFS Medicare. Beneficiaries are excluded from ACO assignment if they had any months of enrollment in an MA plan or any months with Part A–only or Part B–only coverage. However, (for any months of FFS Part A and Part B coverage) these beneficiaries remain in the assignment-eligible population used to calculate benchmarks and renormalize risk scores to 1.0 within each enrollment type (end-stage renal disease (ESRD), disabled, aged/dual eligible, aged/non–dual eligible).

CMS is concerned that the existing assignment methodology includes vulnerabilities that could lead ACOs to avoid beneficiaries with relatively high spending. CMS has observed that when ACO clinicians bill non-ACO TINs, some beneficiaries are dropped from ACO assignment. CMS found that these beneficiaries tend to have relatively high spending and risk scores. To address this concern, CMS proposes to change the calculation of beneficiary assignment by excluding primary care services billed by an ACO clinician through a non-ACO TIN. By removing the allowed charges from ACO clinicians through non-ACO TINs, the remaining share of allowed charges attributed to ACO TINs would increase. Based on simulations of this approach, CMS found that MSSP assignment would increase marginally by about 1 percent, but assignment would increase by 4 percent to 12 percent for a concentrated small share of ACOs who more commonly use this billing practice.

In addition, CMS is concerned that the criteria for ACO assignment are misaligned with the criteria used for the "assignment-eligible" population when setting regional benchmarks and renormalizing risk scores. CMS has found that beneficiaries who switch from MA to FFS are disproportionately dual-eligible beneficiaries. While these beneficiaries' FFS experience is included in regional benchmarking, they are not eligible for ACO assignment because they had at least one month of MA during the assignment window. CMS proposes to address this misalignment by allowing assignment to an ACO based on the FFS experience (with both Part A and Part B coverage) during the assignment year, even if a beneficiary was enrolled in MA for part of the year. When simulating this proposal, CMS found that the overall assignment would increase by 2 percent to 3 percent (dependent on whether ACOs choose prospective assignment or concurrently reconciled assignment).

CMS seeks comment on the proposals to change the beneficiary assignment methodology by excluding ACO clinician services billed to non-ACO TINs and expanding ACO assignment to include beneficiaries with any qualifying months in FFS during the assignment window. CMS estimates that these changes will reduce spending by $4.6 billion over 10 years.

Comment

The Commission commends CMS for seeking to mitigate problems in the beneficiary assignment methodology and strongly supports CMS's proposals to hold ACOs accountable for a greater share of the patients served by their participating clinicians. The proposal to mitigate assignment changes due to billing non-ACO TINs addresses one of the concerns the Commission raised in its June 2020 report to the Congress.[34] In that report, we observed how this billing strategy can lead an ACO to have substantive changes between its historical benchmark population and its performance year population—leading to unwarranted shared-savings payments. The Commission also supports CMS's proposal to align the population used for benchmarks with the population that is eligible to be assigned to an ACO.

Rebalancing the incentives between the BASIC track and ENHANCED track

MSSP is structured into tracks that financially reward ACOs that take on higher levels of financial risk. Inexperienced ACOs (i.e., those without prior ACO experience or with less than 40 percent of participating TINs who participated in a CMS ACO in the last five years) may remain in an upside-only model in the BASIC track (i.e., Level A and B) for a full five-year agreement period. Experienced ACOs must choose to enter into a new agreement period under either BASIC track Level E (with a maximum shared-savings rate of 50 percent and a maximum shared-loss rate of 30 percent) or the ENHANCED track (with a maximum shared savings and loss rate of 70 percent).

In each five-year agreement period, CMS calculates a financial benchmark using the three years prior to an ACO's agreement period as the baseline years. CMS computes the Part A and Part B expenditures for the beneficiaries who would have been assigned to the ACO during the baseline years. ACOs are currently eligible for one of three upward adjustments to their historical baseline, and the adjustment is subject to a capped dollar amount equivalent to 5 percent of the national per capita mean expenditures for the assignable population within each enrollment type (ESRD, disabled, aged dual, aged non-dual). An ACO receives the highest of the three types of adjustments, which are calculated as follows:

- First, ACOs may receive a positive regional adjustment based on their risk-adjusted spending relative to their regional average. CMS blends an ACO's historical baseline expenditures with the risk-adjusted FFS spending for all assignable

[34] Medicare Payment Advisory Commission. 2020. "Challenges in maintaining and increasing savings from accountable care organizations," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun20_ch2_reporttocongress_sec.pdf.

beneficiaries in an ACO's region (including spending attributable to the ACO's assigned population). For ACOs with historical spending below their regional average, the regional portion of their benchmark is weighted at 35 percent in their first agreement period and 50 percent in subsequent agreement periods. For ACOs with historical spending above their regional average, they are held harmless from negative regional adjustments to their benchmarks and their regional weight is effectively 0 percent. The vast majority of MSSP ACOs receive a positive adjustment to their benchmark.

- Second, experienced ACOs that are entering at least their second agreement period are eligible for a prior-savings adjustment to their benchmark. This adjustment allows ACOs to receive 50 percent of their average shared-savings bonuses earned in the three performance years immediately preceding the start of a new agreement period. The prior-savings adjustment helps reduce the "ratcheting" effect that occurs when an ACO's prior efficiency gains lower its benchmark used in assessing future performance.

- Third, for agreement periods that start in 2025 or later, ACOs may receive a population adjustment. ACOs with a relatively small regional adjustment and prior-savings adjustment may be eligible for an upward benchmark adjustment if at least 15 percent of their assigned beneficiaries are either enrolled in the Part D low-income subsidy or are dually eligible for Medicaid. For ACOs that meet the low-income threshold, CMS calculates a scaler by taking an ACO's 5 percent adjustment cap and subtracting the maximum amount of the regional adjustment (with a floor of $0) or the prior-savings adjustment. To calculate the final population adjustment, CMS multiplies this scaler by the share of the ACO's assignable population that meets the low-income criteria.

CMS is concerned that the current high shared-savings rate in the ENHANCED track combined with the positive regional adjustment may incentivize ACOs to choose clinicians based on how the prior spending of their assigned beneficiaries compares with a regional risk-adjusted average, independent of an ACO's capacity to achieve program savings. CMS has found that the average ENHANCED track ACO is receiving relatively high shared-savings rates that correlate with the size of their regional adjustment. In addition, the average size of the positive regional adjustment has increased over time, amplifying its influence on shared-savings payments. Further, CMS has observed that ACOs in BASIC track Level E generate higher savings relative to benchmarks than ACOs in the ENHANCED track—largely due to the lower shared-savings rate in the BASIC track.

CMS proposes three changes that seek to reduce the impact of the regional adjustment in the ENHANCED track while enhancing incentives to participate in BASIC track Level E. First, CMS proposes to reduce the maximum weight of regional spending on an ACO's historical benchmark to 35 percent (down from 50 percent under current policy). Second, CMS proposes to reduce the reliance on the regional adjustment by increasing the scaling factor of the prior-savings adjustment from 50 percent to 75 percent. Because an ACO can only receive one of the three adjustments (regional, prior savings, population), increasing the scaling factor of the prior-savings adjustment combined with decreasing the weight of

the regional adjustment would make it more likely that an ACO in the ENHANCED track receives the prior-savings adjustment. Third, CMS proposes to increase the incentive for ACOs to join the BASIC track Level E by increasing the maximum shared-savings rate from 50 percent to 60 percent. CMS seeks comment on these proposals and estimates that they will reduce spending by $4.6 billion over 10 years.

Comment

The Commission supports the proposed policies attempting to partially mitigate the effects of selection and improve how ACO benchmarks are calculated. Reducing the weight of the regional adjustment and increasing the scaling factor of the prior-savings adjustment is directionally consistent with our comments in prior years. We continue to urge CMS to phase out the regional adjustment to more fully address the effects of selective participation on program benchmarks. Eliminating the regional adjustment would also remove its influence on the prior-savings adjustment and reduce program complexity. The Commission urges CMS to continue monitoring the selection effects of the regional adjustment, including their impact on the prior shared-savings adjustment. This should be part of a broader effort in understanding how MSSP affects Medicare spending prior to applying risk adjustment and the upward adjustments (e.g., regional, prior savings, population) to their historical baseline.

Risk adjusting the 5 percent cap on upward adjustments to an ACO's historical benchmark

ACOs receive the larger of three adjustments (regional adjustment with a minimum floor of $0, prior savings, population) to their historical benchmarks, and adjustments are currently capped at a dollar amount equal to 5 percent of national per capita expenditures for the assignable population within each Medicare enrollment type (ESRD, disabled, aged/dual eligible, aged/non–dual eligible) in historical baseline year 3. Thus, the 5 percent cap differs by ACO because it reflects the mix of an ACO's assignable population by enrollment type. For example, ACOs with a higher share of ESRD and dually eligible beneficiaries receive a higher cap.

ACOs with relatively high CMS-HCC risk scores within each enrollment type have expressed concern that the current 5 percent cap is too restrictive and does not reflect the medical complexity of their patients. In response to these concerns, CMS proposes to risk adjust the cap relative to an ACO's renormalized risk score within each enrollment type. CMS states that the cap would continue fulfilling its original purpose of safeguarding against extreme or outlier positive benchmark adjustments. In addition, CMS believes that this would encourage ACOs to manage patients with higher acuity.

CMS's simulation of 228 ACOs that entered into a new agreement in 2025 indicates that this proposal only increased benchmarks by 0.02 percent overall. CMS seeks comment on the proposal to risk adjust the 5 percent cap within each enrollment type.

Comment

The Commission is concerned that risk adjusting the 5 percent cap on upward adjustments to an ACO's historical benchmark would further increase incentives that ACOs have to focus their resources on efforts to increase diagnostic coding instead of delivering care more efficiently. Prior research has observed coding intensity among beneficiaries assigned to ACOs.[35,36] Currently, the effect of coding increases benchmarks in multiple ways, including increasing an ACO's regional adjustment during the historical period (baseline years 1, 2, and 3); increasing benchmarks in baseline years 1 and 2 of the historical benchmark (i.e., the risk ratio trend based on the change in risk scores relative to baseline year 3); and compounding the effect of the regional adjustment when adjusting for changes in the risk score between baseline year 3 and the performance year. The current segmentation of the cap by enrollment type already encourages greater participation from providers who serve dually eligible, disabled, and ESRD beneficiaries. Including an adjustment for an ACO's HCC risk score potentially rewards an ACO's historical coding intensity. In addition, these coding effects would not be capped as they are for increases to an ACO's risk score in its performance year.

We agree with the goal of better accounting for the medical complexity of patients when assessing an ACO's performance. As an immediate alternative to adjusting for the HCC score, CMS should consider adjusting the cap for an ACO's demographic risk score (i.e., age, sex, Medicaid status), which CMS already calculates and renormalizes to 1.0 for each enrollment type (ESRD, disabled, aged/dual eligible, aged/non-dual eligible). This would improve how the cap reflects the complexity of patients without further incentivizing coding intensity.

Growth adjustment to the historical benchmark to incentivize new participation

In 2026, the number of beneficiaries assigned to MSSP (12.6 million) is the largest in program history. CMS has observed that the quality scores of participants have increased over time and ACOs have achieved greater savings relative to benchmarks. With the goal of expanding MSSP participation, CMS proposes to establish a growth adjustment to the historical benchmark to reward ACOs for recruiting ACO clinicians who are inexperienced with ACOs in the last five years and serve beneficiaries who were not assigned to any ACO in the year before the start of the ACO's five-year agreement period (i.e., baseline year 3).

To calculate the growth adjustment, CMS would compute the share of an ACO's assignment population growth (relative to baseline year 3) that was attributed to these new beneficiaries served by inexperienced participants. This share of inexperienced growth

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[35] Chernew, M., J. Carichner, J. Impreson, et al. 2021. Coding-driven changes in measured risk in accountable care organizations. *Health Affairs* 40, no. 12 (December): 1823–1984. https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00361.
[36] Medicare Payment Advisory Commission. 2022. Letter to CMS commenting on proposed rule for CY 2023 physician fee schedule and other changes to Part B payment policies. September 2. https://www.medpac.gov/wp-content/uploads/2022/09/09022022_Part_B_2023_CMS1770P_MedPAC_COMMENT_v2_SEC.pdf

would be multiplied by 5 percent of the ACO's per capita historical benchmark (before any upward adjustments are applied such as the regional adjustment). This growth adjustment would be applied on top of the highest existing benchmark adjustments for which an ACO is eligible (either a regional adjustment, prior-savings adjustment, or population adjustment). The sum of all benchmark adjustments would be capped by the dollar amount equal to 5 percent of national per capita spending for the assignable population (adjusted for the mix of an ACO's enrollment type mix and proposed adjustment for ACO risk score).

CMS estimates that this growth-adjustment proposal would increase shared-savings payments by $5.3 billion over 10 years, but this would be partially offset by gross savings from new participants—resulting in a net increase in spending of $1.7 billion over 10 years. CMS seeks comment on the growth-adjustment proposal.

Comment

The Commission is concerned that the proposed magnitude of the growth adjustment is beyond the reasonable expectations of gross savings. The proposed growth adjustment is calculated as 5 percent of an ACO's per capita historical benchmark. If these new participants decreased an ACO's regional adjustment and prior-savings adjustment, the magnitude of the growth adjustment could exceed those offsetting effects.[37] The magnitude of the growth adjustment's benchmark increase—5 percent of an ACO's assigned historical spending—may far exceed the gross savings that new participants would achieve.[38] Recent CMS evaluations of ACOs participating in Innovation Center demonstrations from 2016 to 2023 have consistently found gross savings to be about 2 percent relative to a non-ACO counterfactual—similar to the magnitude of MSSP gross savings that MedPAC found for beneficiaries continuously enrolled in FFS from 2012 to 2016.[39,40,41]

We urge CMS to consider alternative participation incentives that do not require upward adjustments to ACO historical benchmarks. Additional upward adjustments to MSSP historical benchmarks should be particularly judicious given the numerous interactions that such a policy would have with other Medicare policies. As an alternative, CMS could begin with a modest per beneficiary per month payment for beneficiaries that would have qualified for the growth adjustment and phase out the payment as inexperienced providers gain more traction in an ACO.

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[37] CMS reduces the size of the prior-savings adjustment if the size of ACO assignment is smaller in the baseline years relative to the performance year.
[38] The average shared-savings rate in MSSP was 62 percent in 2024.
[39] NORC at the University of Chicago. 2024. *The impact of Next Generation Accountable Care Organizations on Medicare costs.* Chicago, IL: NORC. https://www.norc.org/research/library/impact-of-next-generation-accountable-care-organizations-on-medicare-costs.html.
[40] NORC at the University of Chicago. 2026. *Evaluation of the ACO REACH Model.* Report produced by NORC for the Centers for Medicare & Medicaid Services. Washington, DC: NORC. https://www.cms.gov/priorities/innovation/data-and-reports/2026/aco-reach-3rd-eval-tech-app
[41] Medicare Payment Advisory Commission. 2019. "Assessing the Medicare Shared Savings Program's effect on Medicare spending," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch6_medpac_reporttocongress_sec.pdf.

Reform the Accountable Care Prospective Trend (ACPT) component of the benchmark update factor

Starting with agreement periods that began in 2024, CMS incorporated a prospectively determined growth factor that reflected projected growth in total per capita Part A and Part B FFS spending. The growth factor, referred to by CMS as ACPT, accounts for one-third of the overall growth rate used to update benchmarks. The other two-thirds of the growth rate are composed of a weighted two-way trend of realized changes in per capita FFS spending nationally and at the regional level. The two-way blend is weighted such that the national component represents the portion of each individual ACO's share of assignable beneficiaries in its regional service area.

Relying solely on realized spending in ACO benchmark update calculations results in a phenomenon known as the "ratchet effect." Updating benchmarks based on realized spending growth means that when an ACO slows spending growth, their benchmark calculation reflects this slower growth, effectively "ratcheting" down the benchmark. The lower benchmark could make it increasingly difficult for an ACO to achieve the necessary spending level that results in shared-savings payments. Thus, the ratchet effect may reduce incentives for an ACO to reduce spending by providing care more efficiently and may even dampen incentives for providers to participate in the program.

In order to reduce the ratchet effect, the ACPT is calculated separately for each starting agreement period, and the projected growth rates remain constant over the five-year agreement period. Thus, an ACO's ACPT differs based on the start of its agreement period. Because of the potential for anomalous projection errors that are outside of an ACO's control, CMS has the discretion to reduce the one-third weight of the ACPT during these anomalous years.

For ACOs in performance year 2024, CMS recognized the unanticipated increase in Medicare spending—particularly among Part B drugs—and lowered the weight of the ACPT from one-third of trend to one-sixth of trend. Given this recent experience with the ACPT, CMS proposes changes that would simplify the ACPT and put guardrails that limit projection errors. CMS proposes to have one single ACPT for all ACOs that is updated annually and published in the summer before the start of an MSSP performance year. In addition, CMS would limit the deviation from the realized national trend such that the ACPT would be adjusted through performance year reconciliation (when the realized spending of the trend is calculated) to be no more than 1 percentage point below or no more than 1.5 percentage points above national growth.

CMS estimates that these changes would reduce spending by $350 million over 10 years. CMS seeks comment on the proposed changes to the ACPT.

Comment

The Commission commends CMS for finding a balance between reducing ratchet effects and limiting projection errors from the ACPT. We support the proposal to simplify the ACPT by creating one factor for all ACOs, and we support the projection error guardrails.

Changes to the regulations associated with the ambulance fee schedule

The Bipartisan Budget Act of 2018 (BBA of 2018) required CMS to implement a comprehensive ground ambulance data collection system that includes data on ground ambulance costs and revenues for the organizations that provide ground ambulance services. CMS has responded to the BBA of 2018 mandate by creating the Medicare Ground Ambulance Data Collection System (GADCS).

The BBA of 2018 also directed MedPAC to use the GADCS data to produce a report that assesses the GADCS, reviews Medicare payments under the Medicare ambulance fee schedule (AFS), and provides a recommendation as to whether collection of the GADCS data should continue or the data-collection system should be revised. We have completed this report and included it as a chapter in our June 2026 report to the Congress.

In this proposed rule, CMS said the agency expects to include the findings from our report when CMS addresses the ongoing data collection requirements for the GADCS in the CY 2028 PFS rulemaking.

Comment

In our June 2026 report to the Congress, we stated that the GADCS is a good first step toward a dataset that policymakers can use to effectively evaluate the adequacy of AFS payments, and we recommended that collection of the GADCS data should continue. However, we found consensus among stakeholders that the GADCS was overly burdensome on the ambulance organizations that collected and submitted the data. Therefore, we also recommended that future data collection should be streamlined to reduce the burden and suggested approaches in our June 2026 report to the Congress.[42]

Conclusion

MedPAC appreciates your consideration of these issues. The Commission values the ongoing collaboration between CMS and MedPAC staff on Medicare policy, and we look forward to continuing this relationship. If you have any questions regarding our comments, please contact Paul B. Masi, MedPAC's Executive Director, at 202-220-3700.

Sincerely,

Amol S. Navathe, M.D., Ph.D.
Chair

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[42] Medicare Payment Advisory Commission. 2026. "Mandated report: Assessment of the Medicare Ground Ambulance Data Collection System," in *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2026/06/Jun26_Ch6_MedPAC_Report_To_Congress_SEC.pdf.