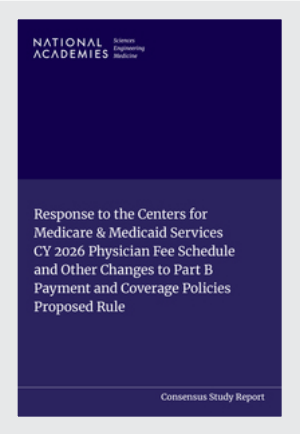

Response to the Centers for Medicare & Medicaid Services CY 2026 Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule (2025)

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Kevin Grumbach, Marc Meisnere, and Adrienne Formentos, *Editors*

Committee on the Response to the Centers for Medicare & Medicaid Services CY 2026 Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule

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Consensus Study Report

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COMMITTEE ON THE RESPONSE TO THE CENTERS FOR MEDICARE & MEDICAID SERVICES CY 2026 PHYSICIAN FEE SCHEDULE AND OTHER CHANGES TO PART B PAYMENT AND COVERAGE POLICIES PROPOSED RULE

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This Consensus Study Report was reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise. The purpose of this independent review is to provide candid and critical comments that will assist the National Academies of Sciences, Engineering, and Medicine in making each published report as sound as possible and to ensure that it meets the institutional standards for quality, objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process.

We thank the following individuals for their review of this report:

LEE A. FLEISHER, University of Pennsylvania
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BARBRA G. RABSON, Massachusetts Health Quality Partners

Although the reviewers listed above provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations of this report nor did they see the final draft before its release. The review of this report was overseen by **BETTY R. FARRELL,** City of Hope National Medical Center, and **WALTER FRONTERA,** University of Puerto Rico School of Medicine. They were responsible for making certain that an independent examination of this report was carried out in accordance with the standards of the National Academies and that all review comments were carefully considered. Responsibility for the final content rests entirely with the authoring committee and the National Academies.

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Response to the Centers for Medicare & Medicaid Services CY 2026 Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule

On July 14, 2025, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that solicits public comments on proposed policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2026.[1] The National Academies of Sciences, Engineering, and Medicine (the National Academies) appointed the Committee on the Response to the Centers for Medicare & Medicaid Services CY 2026 Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule.[2] This report responds to select requests for feedback CMS included in its proposed rule. The committee's statement of task, which details the topics from the proposed rule that the committee is responding to, is in Appendix A. Brief biographical sketches of committee members and staff are in Appendix B.

DATA SOURCES AND ASSESSMENT APPROACHES FOR THE VALUATION OF SERVICES FOR THE PHYSICIAN FEE SCHEDULE

> In its proposed rule, CMS stated:
>
> We look forward to continuing to engage with interested parties and commenters, including the RUC [the American Medical Association's Relative Value Scale Update Committee], as we prioritize our obligation to value new, revised, and potentially misvalued codes; and we will continue to welcome feedback from all interested parties regarding valuation of services for consideration throughout our rulemaking process. (CMS, 2025b, p. 142)

[1] The full text of the proposed rule is available at: https://public-inspection.federalregister.gov/2025-13271.pdf (accessed August 12, 2025).
[2] The committee members make up a subgroup of the National Academies Standing Committee on Primary Care, which was appointed in August 2023 to advise the federal government on primary care policy.

CMS also stated that "We solicit comments on what kinds of data CMS should consider as valid, reliable, empiric information for this purpose [valuation]" (CMS, 2025b, p. 152). In this section, the committee is offering responses to these requests for comments on valuation methods and processes.

Committee Response

The 2025 National Academies report *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule* briefly summarized the PFS valuation process (NASEM, 2025b). Currently, the PFS specifies payments for services provided by physicians and other clinicians participating in Medicare Part B, including professional fees and fees for diagnostic tests and radiology services. (CMS, 2024). By law, payments must be for "services furnished" and cannot be only paid to a specific specialty. Because the PFS must be budget neutral by law, if CMS decides to increase the value of a PFS service code, offsetting savings must be achieved by reducing the value of other services (NASEM, 2021, 2025b).

Currently, the Resource-Based Relative Value Scale (RBRVS) is the predominant mechanism used by CMS to translate data into recommendations for updates to the PFS. The American Medical Association's Relative Value Scale Update Committee (RUC) was established to offer annual recommendations to CMS on the RBRVS; if adopted by CMS, revisions to RBRVS values for existing CPT codes or valuation of new CPT codes ultimately lead to PFS changes. While CMS can accept recommendations from any interested stakeholders, the RUC has been uniquely influential in submitting recommendations that conform to statutory requirements for input on rulemaking. While not required to do so, CMS typically accepts between 85 and 90 percent of the RUC's recommendations each year (Laugesen et al., 2012; Moore, 2023). These recommendations greatly affect how physicians and medical providers are compensated for their work, as the PFS determines not only what CMS pays physicians through Medicare, but also what physicians are paid by the majority of state Medicaid programs and commercial payers (including Medicare Advantage plans) that model their fee schedules on the CMS PFS. Beyond influencing payment rates by government and private payers alike, relative value units (RVUs) are frequently used to monitor productivity and serve as the basis for many alternative, or value-based, payment models.

The Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO) have both raised concerns about the RUC, including whether its composition accurately reflects the proportion of primary care clinicians in the health care system and conflict of interest issues for its members (Berenson and Emanuel, 2023; GAO, 2015; MedPAC, 2018; NASEM, 2025b), as they stand to "win or lose" financially based on the recommendations this advisory body makes and what CMS ultimately decides. GAO has called the RUC surveys into question given "low response rates, low total number of responses, and large ranges in responses" (GAO, 2015, p. 26), which could lead to nonresponse bias and estimation errors (GAO, 2015). In its proposed rule, CMS notes that the low response rates for RUC surveys raise questions about their generalizability and notes that the American Medical Association's (AMA) journal—*JAMA*—requires survey studies to have response rates "generally greater than or equal to 60 percent" with "appropriate characterization of nonresponders to ensure that nonresponse bias does not threaten the validity of the findings" (JAMA, 2025).

Additionally, critics have long been concerned about the lack of transparency involving the RUC process (Berenson et al., 2022a,b; Berenson and Emanuel, 2023; Calsyn and Twomey, 2018; GAO, 2015; Laugesen, 2016; NASEM, 2025b). For example, RUC members are asked to sign nondisclosure agreements and vote by secret ballot. While meeting proceedings, survey data, and other materials are made publicly available, AMA only does so after CMS finalizes its payment rules. Furthermore, as the 2025 National Academies report details, current valuation practices do not accurately reflect the costs and care team members needed to deliver high-quality primary care (NASEM, 2025b). Frequently, the work of extended interprofessional primary care team members is not captured, nor is the amount of time required for work that is not encounter based, including managing the influx of asynchronous patient portal messages and emails, and other technologies that rapidly expanded during the COVID-19 pandemic (NASEM, 2021). Lastly, the budget neutrality requirement set forth by the Omnibus Budget Reconciliation Act of 1989 is a major constraint relative to adequate valuation of primary care services. Any proposed change to the PFS requires an offset, which can create inter-specialty conflict over payment.

Recommendation 1: When valuating physician services and activities for the Physician Fee Schedule, the Centers for Medicare & Medicaid Services should consider a range of objective data sources (e.g., electronic health record audit logs,

claims data, time-motion studies) as well as high-quality surveys (e.g. validated surveys with response rates in line with generally accepted research standards and adequate characterization of respondents and non-respondents) (Fincham, 2008; JAMA, 2025), analyzed using complementary approaches such as time-driven activity-based costing and validated large language modeling.

- The 2025 National Academies report *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule* examined alternative data sources and methodologies that would "enhance the accuracy, generalizability, and comprehensiveness of payment rate determinations" for primary care (NASEM, 2025b). Ideally, the report stated, thorough valuation of primary care would consider the full scope of work performed by primary care clinicians *and* other interprofessional team members (e.g., clinical pharmacists, behavioral health specialists, community health workers, social workers, and others) both synchronously and asynchronously. Examples of activities the report recommended should be considered in the valuation process as part of high-quality primary care include care coordination, patient navigation, specialty care referral management, results review, remote monitoring, data analytics to support population health initiatives, and more. Data used for valuation purposes should be transparent, reproducible, and not burdensome to measure. Options for more objective data sources as detailed in the 2025 report include better surveys, qualitative data, direction observation and time-motion studies, electronic health record system-event log data, artificial intelligence and large language models, time-driven activity-based costing, and simulation/modeling (NASEM, 2025b).

PROPOSED EFFICIENCY ADJUSTMENT POLICY

As part of the CY 2026 proposed Medicare Physician Fee Schedule rule (CMS, 2025b), CMS proposes including a new efficiency adjustment for non-time-based service codes to account for the efficiency gains that accrue over time in the performance of procedures and

similar services. The time spent by a clinician performing a service is a major factor for determining the work relative value unit of a service. CMS notes that very few codes are reassessed for the time factor after determination of the initial valuation score, and that there is considerable evidence that non-time-based services "become more efficient as they become more common, professionals gain more experience, technology is improved, and other operational improvements…are implemented" (CMS, 2025b, p. 145). CMS also cites evidence that studies objectively measuring physician time for diagnostic, anesthesia, and procedural services consistently find that the mean time is substantially lower than the mean time reported by physicians in surveys conducted by the RUC. CMS is therefore proposing an efficiency adjustment in CY 2026 for non-time-based procedures, radiology, and diagnostic test codes that will reduce the work RVU for these codes. The adjustment will be applied to existing codes, using a metric based on the Medicare Economic Index (MEI) productivity adjustment. The CMS Office of the Actuary uses data from the Bureau of Labor Statistics to compute the productivity adjustment. CMS proposes to use a "look-back" period of 5 years for the initial efficiency adjustment and to update the adjustment every 3 years. Application of the efficiency adjustment in CY 2026 would result in a 2.5 percent reduction in the RVU for non-time-based codes.

In its proposed rule, CMS is seeking comments on (CMS, 2025b):

- the initial look-back period and the use of the Medicare Economic Index (MEI) productivity adjustment percentage values for calculation of the efficiency adjustment for 2026,
- whether adjustments should be made in future rulemaking to also adjust the direct practice expense inputs for clinical labor and equipment time that correspond with the physician time inputs, and
- the codes expected to accrue efficiencies over time.

Committee Response

The committee considers the addition of the efficiency adjustment to the Physician Fee Schedule for non-time-based codes to be well justified by CMS and to have great merit. Accurate valuation of non-time-based services has important implications for the appropriate valuation of primary care services. As CMS notes, overvaluation of procedural codes results in "passive

devaluation of E/M [evaluation and management] services under the constraints of budget neutrality" (CMS, 2025b, p. 145).

Recommendation 2: The Centers for Medicare & Medicaid Services should implement an efficiency adjustment in CY 2026, with the initial adjustment based on the Medicare Economic Index productivity adjustment using its proposed 5-year look-back period and with adjustment incorporating practice expense inputs corresponding to physician time inputs.

Recommendation 3: The Centers for Medicare & Medicaid Services (CMS) should establish a methodology using measurement of objective data (as described in Recommendation 1) on clinician work time for determining future efficiency adjustments as part of the systematic reform of the overall CMS approach to using more valid and reliable empiric data sources and analytic methods for determining and updating relative value unit scores. Objective reevaluation of clinician time for procedure codes should be done at least every 5 years for the most common procedure codes billed to CMS (e.g., the most frequently billed codes that in the aggregate account for 50 percent of procedure claims or 50 percent of the approved payments for procedure codes).

- As Recommendation 1 states, CMS should implement alternative sources of more objective data and analytic methods for empirically based determination of valuation, including objective measures of clinician time, such as those described earlier in this report and by the National Academies (NASEM, 2025b). Recognizing that it will take time for CMS to implement such a systematic reform of its valuation data sources and methods, adoption of an efficiency adjustment based on the MEI productivity adjustment is a reasonable first step for estimating temporal trends in clinician time for procedural and related codes. This approach is consistent with options MedPAC has recommended for Physician Fee Schedule efficiency adjustment (MedPAC, 2018).

- The 5-year look-back period is a conservative window for the efficiency adjustment. As CMS notes, 17 or more years typically elapse before codes are reevaluated by RUC under current methodology (CMS, 2025b). Although the committee believes that a longer look-back period (e.g., 8–9 years, which would be half of the current average reevaluation periodicity) could be justified, the 5-year period is a reasonable start in such a rapidly changing health care landscape.
- Because clinician time almost certainly closely correlates with key elements of practice expense, such as equipment time and nonclinician labor time, the efficiency adjustment should include these practice expense factors. Objective measurement of these types of practice expense factors should be included in the future valuation methodology. In the interim, it is reasonable for CMS to incorporate practice expenses into its MEI productivity adjustment for computing the efficiency adjustment.

ADVANCED PRIMARY CARE MANAGEMENT (APCM) SERVICES

CMS' proposed rule (CMS, 2025b) asks for comments on several proposed changes for enhanced care management, including integrating behavioral health into Advanced Primary Care Management (APCM) and considering how APCM may advance the U.S. Department of Health and Human Services' priority of prevention.

Starting on January 1, 2025, clinicians (physicians and other advanced practice providers) have been able to submit per member per month APCM codes (G0556, G0557, and G0558)[3] in addition to traditional evaluation and management (E/M) service codes (CMS, 2024). These payments are intended to support work that is not captured in traditional fee-for-service payments, such as proactive care coordination, population health management, and addressing health-related social needs. These services are key primary care functions that have been shown to improve health outcomes, prevent chronic disease, and reduce long-term costs (NASEM, 2021).

[3] These codes are part of the Healthcare Common Procedure Coding System. The code requirements can be found at https://www.cms.gov/medicare/payment/fee-schedules/physician-fee-schedule/advanced-primary-care-management-services (accessed August 15, 2025).

The National Academies provided evidence-based feedback and recommendations to CMS' proposed payments and policies in its 2024 report *Response to the Centers for Medicare & Medicaid Services CY 2025 Advanced Primary Care Hybrid Payment Request for Information* (NASEM, 2024). That report identified APCM services as an effective strategy to promote the recommendations from the 2021 National Academies report, *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, and found that APCM could help (1) transition primary care payment to greater hybrid payment, (2) increase total payment to primary care, and (3) improve the quality of primary care delivered in the United States (NASEM, 2021, 2024).

To bill for APCM payments, practices are required to have the capacity to deliver 10 service elements of advanced primary care:

1. patient consent,
2. initiating visit,
3. 24/7 access,
4. comprehensive care,
5. patient-centered care plan,
6. management of transitions of care,
7. coordination of care,
8. enhanced communications,
9. population management, and
10. performance measurement (CMS, 2025a).

The APCM codes can be billed monthly regardless of whether the individual patient receives services in that time period. This reflects the ongoing practice costs of maintaining availability of these high-quality primary care services to deliver to patients as appropriate. CMS stated an intent to consider expanding the services covered in APCM in future years and the *Response to the Centers for Medicare & Medicaid Services CY 2025 Advanced Primary Care Hybrid Payment Request for Information* report (NASEM, 2024) recommended that this expansion should include such services as behavioral health and additional preventive services.

CMS outlined several guiding principles for its APCM payments and policies that the 2024 report and this committee considers essential for APCM to achieve its intended benefits. These include:

- CMS should provide stable payments to support advanced primary care.
- APCM codes are intended to be used in conjunction with existing E/M codes.
- APCM codes will not be time based or include time frame restrictions.
- Not all APCM elements must be delivered in a given month, and they should be tailored and person centered.
- APCM services will often be provided by an interprofessional team under the supervision of the billing clinician.
- Clinicians in an advanced primary care practice will be able to bill APCM services for nearly all patients for whom they assume primary care responsibility.
- Beneficiaries with social risk factors necessitate greater resource requirements.
- There will be a low-burden method for clinicians to meet APCM billing requirements.

Behavioral Health Integration Add-On Codes and Valuation

CMS is proposing the establishment of three new behavioral health integration (BHI) add-on codes for APCM: Healthcare Common Procedure Coding System (HCPCS) codes GPCM1, GPCM2, and GPCM3 (CMS, 2025b). These G-codes would be billed as add-on services when the APCM base code (HCPCS codes G0556, G0557, G0558) are reported by the same clinician in the same month. GPCM1 is for initial psychiatric collaborative care management, GPCM2 is for subsequent psychiatric collaborative care management, and GPCM3 is a monthly care management code for clinician-directed services for behavioral health conditions.

The committee is responding to CMS' request for feedback on this approach.

Committee Response

Behavioral health integration (BHI) "blends care in one setting for medical conditions and related behavioral health factors" (AHRQ, 2024). Various integrated behavioral health models have been studied including the collaborative care model, primary care behavioral health model, and others (Collins et al., 2010; Hunter et al., 2018; Reiter et al., 2018; Unutzer et al., 2002). In 2020, the Substance Abuse and Mental Health Services Administration's National Center for Excellence for Integrated Health Solutions created the Comprehensive Healthcare

Integration Framework, a structured approach that incorporates best practices, evidence-based interventions, and organizational strategies from preceding integrated behavioral health models (National Council for Mental Wellbeing, 2025). The framework emphasizes team-based care, patient-centered care, shared care plans, integrated workflows, data-driven decision making, sustainability through payment models, training and workforce development, and access and equity. This framework highlights that the specific BHI model or structure used by a practice and community may not matter as much as ensuring the collaborative concepts of BHI. Another similar conceptual framework is the Building Blocks of Behavioral Health (Gold et al., 2022). There is no one-size-fits-all model for BHI; different approaches may be appropriate based on a given practice's patient population needs and resources.

Recommendation 4: The Centers for Medicare & Medicaid Services (CMS) should implement a method to enhance Advanced Primary Care Management (APCM) payments to support primary care practices' capacity to deliver integrated behavioral health services. The committee supports the proposed APCM add-on codes GPCM1, GPCM2, and GPCM3 for integrated behavioral health services as a meritorious step towards that payment goal.

Recommendation 5: The Centers for Medicare & Medicaid Services should consider in future rulemaking an alternative payment model for behavioral health integration linked with Advanced Primary Care Management (APCM) payment that allows practices to attest to providing behavioral health integration, qualifying them for a higher APCM payment valuation for the base APCM G-codes G0556, G0557, G0558. This approach may facilitate practices' ability to build and sustain capacity for delivering integrated behavioral health services.

- This committee agrees with the 2024 National Academies report that presented evidence around BHI and recommended incorporating behavioral health services into APCM (NASEM, 2024).
- Primary care is a natural home for much of behavioral health care and currently provides about 60 percent of all behavioral health care (Park and Zarate, 2019);

however, there is a substantial national shortage of mental health clinicians with two-thirds of U.S. counties designated as mental health professional shortage areas (Hoffmann et al., 2023).

- Evidence shows that BHI in primary care can reduce costs, improve care experience and patient outcomes, build trust, promote adherence, and is more patient centered (Asarnow et al., 2015; Rapp et al., 2017).
- The proposed add-on codes GPCM1, GPCM2, and GPCM3 represent an improvement over existing codes for behavioral health integration (99484) and psychiatric collaborative care management (99494, 99493, and 99494) by not requiring time-based billing. Administrative barriers such as tracking service time have contributed to the relatively low uptake of the existing codes by primary care practices and collaborating behavioral health clinicians (Brown et al., 2021; Carlo et al., 2019). The proposed approach of linking new behavioral health integration codes with APCM codes without time-based requirements may reduce barriers to uptake and enhance delivery of behavioral health services by building this onto the platform of the APCM codes.
- While supporting the add-on codes as a worthwhile first step, the committee recognizes some limitations of the add-on code approach. The add-on codes still require tracking of individual patient services on a monthly basis to be able to appropriately bill for GPCM1 and GPCM2 in the first and second months of service, respectively, and to bill for GPCM3 in subsequent months. While it might be relatively clear to practices how to bill for GPCM1 and GPCM2 for the first and second months that a patient receives integrated behavioral health services, the number of months practices could submit GPCM3 add-ons in subsequent months might be confusing. Tracking each individual behavioral service delivered to qualify for a GPCM3 billing in a given month makes this approach have the character of traditional itemized fee-for-service billing rather than the goal of APCM to support a practice's capacity to deliver advanced primary care.
- Other successful payment models for BHI programs have used prospective monthly payments to support primary care in building interprofessional care teams and processes (Goldman et al., 2022; Malâtre-Lansac et al., 2020; McGinty and Daumit,

2020; Miller et al., 2017; O'Donnell et al., 2013; Santos et al., 2024; Virginia Center for Health Innovation, n.d.). These models have required practices to attest to the availability of behavioral health services, such as behavioral health clinicians employed or colocated at the practice or contractual relationships with decentralized behavioral health clinicians, to qualify for the additional BHI prospective payment. CMS could use an analogous approach to have practices participating in APCM attest to BHI capacity to receive a higher payment level for their core APCM codes (G0556, G0557, and G0558). Practices could demonstrate their ability to provide BHI through multiple models as described above. Small independent or rural practices may not be able to hire behavioral health clinicians and may need to create collaborative care agreements. Practices could attest to their ability to provide the critical elements of BHI rather than any specific structure or model of BHI (Gold et al., 2022).

- Having practices, including Federally Qualified Health Centers and Rural Health Centers, attest to their ability to provide BHI to qualify for increased APCM payments, rather than using add-on payments, aligns with CMS's APCM principles of stable, dependable payments; low reporting burden; avoiding time-based or time-limited requirements; and tailoring services to patient needs. Because participating practices already have to attest that they are providing the 10 service elements required for APCM, attesting to one additional *optional* service element seems like a reasonable and low burden way to add BHI to APCM.

APCM, Prevention, and CostSharing

CMS' proposed rule also considers the extent to which APCM services include preventive services, with implications for beneficiary cost sharing and what services are included in the APCM bundle, such as annual wellness visits. The committee is offering responses to the following prevention-related questions in CMS' proposed rule (CMS, 2025b):

- How should CMS consider application of cost sharing for APCM services, particularly if it were to include preventive services within the APCM bundles?

- How should CMS account for cost sharing if APCM includes both preventive services and other Part B services?
- Should CMS consider including the annual wellness visit, depression screening, or other preventative services in the APCM bundle, and if so, which services and why?
- Should CMS consider other changes to APCM or additional coding to further recognize the work of advanced primary care practices in preventing and managing chronic disease?

Committee Response

Recommendation 6: Starting in 2026, the Centers for Medicare & Medicaid Services should waive cost sharing for the Advanced Primary Care Management (APCM) services as the 10 elements of APCM are essential functions to effectively deliver recommended preventive services, including secondary and tertiary prevention (e.g., chronic care management), that are mandated to not have cost sharing by the Affordable Care Act.

- In its 2024 response to CMS' 2025 proposed rule that included the APCM model, the National Academies recommended waiving cost sharing in APCM (NASEM, 2024). As that report cited, cost sharing is a known barrier to necessary medical care. In 2017, 11 percent of Medicare beneficiaries reported delaying care because of worries about costs, with lower-income beneficiaries being twice as likely to delay care as those with higher incomes (Madden et al., 2021).
- The Affordable Care Act prohibits cost sharing for preventive services. This includes the delivery of preventive services such as colonoscopies, mammograms, lipid measurements, and vaccinations). Many of the required APCM elements, such as patient-centered care plans, coordination of care, population management, and performance measurement, are essential activities needed for primary care to coordinate and ensure the delivery of preventive services, including secondary and tertiary prevention such as care coordination for individuals with chronic conditions. Separating where these elements or care capacities are focused on prevention rather

than other aspects of care is not feasible. These coordination activities were not reimbursed under the PFS until the recent creation of the APCM G-codes (Lesser et al., 2011). Coordination and delivery of preventive services represent a substantial burden of work (Privett and Guerrier, 2021), and APCM should be viewed as paying primary care for these preventive service coordination activities.

Recommendation 7: The Centers for Medicare & Medicaid Services (CMS) should focus efforts on promoting the uptake and use of the existing Advanced Primary Care Management (APCM) codes at this time. However, it is reasonable for CMS to add an already widely adopted preventive service, such as depression screening, in APCM requirements while exercising caution in adding more codes for prevention or chronic care services that have not achieved widespread uptake (such as the annual wellness visit).

- While the 2024 National Academies report responding to CMS' 2025 proposed rule recommended that CMS consider adding "an annual wellness visit or chronic care management visit to create personalized care plans and to establish attribution" in future hybrid models (NASEM, 2024), this committee feels it is too soon to do so before there is significant uptake of APCM.
- Studies of depression screening implementation show that there have been high levels of uptake, particularly when system-level policy requires screening or it is integrated into the electronic health record workflow in primary care settings (Garcia et al., 2022; Thompson et al., 2019).
- CMS implemented the annual wellness visit in 2011 (and previously the Welcome to Medicare Visit in 2005), but widespread adoption did not occur until 2018–2022 (Gabbard et al., 2025). By 2013, only 8–23 percent of eligible beneficiaries had received an annual wellness visit, and as late as 2015, over half of practices (51.2 percent) had not adopted it at all (Ganguli et al., 2018; Jensen et al., 2015; Lind et al., 2019). Given this history, significant uptake of APCM in its first year is unlikely.
- Expanding beyond the 10 required service elements of APCM and bundling more chronic disease management and prevention services into these hybrid payments

while practices are still learning about how to operationalize APCM may result in greater hesitation for primary care practices to participate in APCM at this time (Khullar et al., 2021; Leao et al., 2023; Sandhu et al., 2023).

- If APCM payments and policies are designed to support delivery of preventive services and the annual wellness visit already requires a 10-year prevention plan, it is reasonable to expect that promoting APCM uptake would improve preventive service delivery for beneficiaries without adding new mandates or requirements to the APCM model.

APCM and Accountable Care Organizations

CMS' proposed rule also includes the following questions regarding APCM payments and accountable care organizations (ACOs) (CMS, 2025b):

- Should CMS consider new payments to Shared Savings Program ACOs for prospective monthly APCM payments to be delivered to primary care practices that satisfy the APCM billing requirements, with the payments reconciled under the ACO benchmark?
- If so, how should CMS consider consent and other features of APCM in these contexts?
- Should CMS consider other updates to APCM payments or Shared Savings Program policies that would drive increased participation of primary care practitioners in ACOs?

The committee is offering a response to these questions below.

Committee Response

Recommendation 8: The Centers for Medicare & Medicaid Services should exclude Advanced Primary Care Management (APCM) payments from reconciliation accounting for Shared Savings Program accountable care organizations (ACOs) during the initial years of evaluating the new APCM codes to prevent a disincentive for ACOs to adopt appropriate use of these codes by primary care practices in the ACO.

Recommendation 9: The Centers for Medicare & Medicaid Services should stipulate in their agreements with accountable care organizations that payments for Advanced Primary Care Management (APCM) codes flow directly to frontline practices to support interprofessional teams to deliver the required APCM elements.

- Shared savings for ACOs are based on accounting of expenditures for Medicare beneficiaries in the ACO relative to a spending target for the ACO. Although payments for APCM codes are likely to be a very small portion of total expenditure, it is not implausible that an ACO might discourage uptake of APCM codes if the ACO leadership perceived additional revenues from APCM billings as potentially jeopardizing performance on shared savings goals.
- One strategy to mitigate this potential unintended consequence of the new APCM codes would be to exclude payments for these codes from ACO shared savings reconciliations, at least for the first few years of APCM implementation while CMS is evaluating the uptake and effect of the APCM codes.
- Ensuring that APCM payments to an ACO flow to the participating primary care practices generating those codes might provide an incentive to drive increased participation of primary care practitioners in ACOs. The 2025 National Academies report *Building a Workforce to Develop and Sustain Interprofessional Primary Care Teams* recommended that through contractual agreements, payers and health care organizations such as ACOs make sure that enhanced payments for primary care are used for their intended purpose of supporting primary care practices to deliver high-quality primary care (NASEM, 2025a).

MANAGEMENT AND PREVENTION OF CHRONIC DISEASE

CMS is soliciting feedback on how the agency might better understand how to enhance and support management for prevention and management of chronic disease. The agency asks for comments on several specific aspects of this topic, including self-management, health coaching, and motivational interviewing.

The committee is offering responses to the following questions included in CMS' proposed rule (CMS, 2025b):

- How could CMS better support prevention and management, including self-management, of chronic disease?
- Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current Physician Fee Schedule code set? If so, please provide specific examples.

Committee Response

Recommendation 10: The Centers for Medicare & Medicaid Services (CMS) should focus its efforts on strengthening primary care to operationalize its strategy to better support prevention and management of chronic disease. To do this, CMS should closely monitor and promote wide uptake of Advanced Primary Care Management (APCM) codes to support comprehensive preventive and chronic care management services delivered by interprofessional primary care teams and perform ongoing empiric assessment of the time and resources required to deliver the APCM elements necessary for high-quality prevention and chronic care to ensure appropriate valuation of APCM codes.

- The 2025 National Academies report *Building a Workforce to Develop and Sustain Interprofessional Primary Care Team* documented the central role primary care practices play in delivering preventive and chronic care services. Most preventive care services, and a large proportion of chronic care services, are provided in primary care rather than specialty settings (NASEM, 2025a). As that report stated, primary care practices that include health care professionals with complementary skills, including skills in preventive and chronic care and behavior change, are key to delivering the comprehensive care patients need. Support for wellness, prevention, and self-management is often most effective when it is integrated into a relationship-based, whole-health model of primary care rather than delivered in a reductionist manner in specialty programs (NASEM, 2023).
- The traditional form and level of primary care payment has been insufficient for recruiting and sustaining the clinicians and interprofessional team staff required for

high-quality, comprehensive primary care (NASEM, 2025a). The Medicare PFS traditionally did not include codes that compensated primary care practices for the extensive non-visit-based work of coordinating and ensuring delivery of evidence-based preventive services. Reform of payment to better support primary care is therefore foundational to CMS efforts to promote prevention and management of chronic disease.

- Previous National Academies reports on the primary care workforce and CY 2025 Physician Fee Schedule rules presented evidence and endorsed CMS' implementation of a novel set of APCM codes as an important step towards enhanced payment to support comprehensive, interprofessional team-based primary care (NASEM, 2024, 2025a). The APCM codes provide a logical platform upon which to build additional support for comprehensive prevention and chronic disease management.
- It is critical that CMS evaluate the uptake and effect of the new APCM codes and intervene on an ongoing basis as necessary to ensure appropriate uptake and valuation of these codes, given their potentially pivotal role in advancing CMS goals for prevention and chronic disease management. A recent report published by the Bipartisan Policy Center recommends how CMS could do this and what it should consider (Strong et al., 2025).

HEALTH COACHING AND MOTIVATIONAL INTERVIEWING

CMS is seeking feedback specifically on motivational interviewing and health coaches for prevention and management of chronic disease.

Motivational interviewing, self-management support, and health coaching are approaches to supporting people to make healthy behavior changes (Morton et al., 2015). Motivational interviewing is a counseling method to facilitate behavior changes, such as reducing unhealthy levels of alcohol consumption and increasing physical activity (Britt et al., 2004; Cole et al., 2023; Morton et al., 2015). Self-management support is a structured method to educate patients about their chronic conditions such as diabetes, arthritis, and asthma and assist them in developing and following through on behavioral action plans based on their goals for symptom management and healthy living (Allegrante et al., 2019; Dineen-Griffin et al., 2019; Pamungkas et al., 2017). Studies on self-management interventions have demonstrated the clinical

effectiveness of mental health self-management in improving outcomes such as depression, loneliness, and/or anxiety (Lean et al., 2019; Luo et al., 2025). Health coaching incorporates elements of both methods to facilitate behavior change and self-care for a broad range of health promotion needs, including physical activity and healthy eating, management of chronic conditions, preventing unhealthy substance use, and other patient-centered priorities. Common to all these approaches is an emphasis on patient-directed goal setting and building self-efficacy.

The committee is offering responses to the following questions included in CMS' proposed rule (CMS, 2025b):

- What types of clinical staff should be able to perform motivational interviewing under the general supervision of a billing practitioner?
- CMS heard from interested parties that in many clinics, health coaches perform services under general supervision, and that there may be substantive overlap with motivational interviewing. To what extent are the services performed by health coaches encompassed by motivational interviewing?
- What training is required to effectively perform motivational interviewing? Are there agreed upon national training or certification standards for health coaches? If so, what are they? Do states have separate training or certification standards for health coaches?
- CMS welcomes feedback from stakeholders and the public on how it could better support management of chronic disease and prevention, including whether it should create separate coding and payment for motivational interviewing, along with overlap between motivational interviewing and health coaches for consideration for future rulemaking.

Committee Response

Recommendation 11: The Centers for Medicare & Medicaid Services (CMS) should prioritize payment rules that provide more financial support for evidence-based health coaching performed by clinicians and staff in integrated interprofessional primary care teams. These rules should build on existing innovative payment models such as Advanced Primary Care Management (APCM) rather than creating numerous new codes for fee-for-service billing for stand-alone health coaching and

motivational interviewing services of unproven value. Similar to Recommendation 4 in this report on APCM and behavioral health integration, CMS should consider setting a higher valuation on APCM codes for practices that attest to staff trained in health coaching.

Recommendation 12: The Centers for Medicare & Medicaid Services payment rules should support a variety of appropriately trained and supervised staff members on interprofessional primary care teams to perform health coaching. A health coaching certificate issued by a national certifying board *should not* be required for staff providing health coaching services on integrated teams under appropriate supervision but *should* be required for coaches practicing independently.

- Motivational interviewing is best understood as a counseling method that can be used for health coaching and behavioral health care and not as a distinct service. One commonly accepted definition of health coaching based on a systematic review of 214 published articles characterized its essential features as: (a) patient centered; (b) includes patient determined goals; (c) incorporates self-discovery and active learning processes; (d) encourages accountability for behavioral goals; (e) provides some education alongside coaching; and (f) a health professional who is trained in behavior change, communication, and motivational interviewing skills (Wolever et al., 2013).
- Research has found that health coaching has a small to moderate effect on behavior change and health outcomes, such as increased physical activity and better glycemic control (Racey et al., 2022). Studies have demonstrated the efficacy of health coaching performed by members of integrated primary care teams. This approach may have particular benefit for health promotion and chronic disease management for low-income patients. For example, a series of studies conducted at a county-administered clinic system found that health coaching had benefit for self-management of diabetes and chronic obstructive pulmonary disease (Sharma et al., 2016; Willard-Grace et al., 2015, 2020). The Veterans Health Administration has incorporated health coaches as a key element of its team approach to whole health,

with improved outcomes in reduced use of opiates and improved pain management (NASEM, 2023).

- Although a distinct occupation of health and wellness coaching has emerged in recent years, in practice, health coaching has been incorporated into the work of a wide variety of health professionals, including both licensed professionals such as nurses, clinicians, therapists, and social workers, and unlicensed professionals such as medical assistants and community health workers (NASEM, 2023; Wolever et al., 2013). Research has also demonstrated the contributions of peer coaches in improving care (Willard-Grace et al., 2020), and national organizations such as the National Board for Health & Wellness Coaching, the National Commission for Health Education Credentialing, and the International Coaching Federation offer formal credentialing and training program accreditation for health and wellness coaching (Abu Dabrh et al., 2025). These organizations typically require a minimum of 60 to 75 hours of training for certification eligibility. Many individuals with certification are in private practice. Most staff performing health coaching in studies in health care settings that have demonstrated coaching effectiveness were not formally certified as health coaches and had received far fewer hours of coaching training than that required for formal certification (Wolever et al., 2013).
- In 2019, the American Medical Association approved three new category III (nonbillable) CPT codes for health coaching (0591T, 0592T, and 0593T) that may only be used when the service is provided by an individual with national certification as a health and wellness coach (Abu Dabrh et al., 2025). In 2024, CMS temporarily allowed billing to Medicare for these codes as telehealth services when provided under the supervision of a physician and then proposed a systematic evaluation of this temporary policy.
- The committee urges CMS to exercise caution in adding new billable CPT codes for health coaching while carefully evaluating evidence on the potential benefit to Medicare beneficiaries of services provided by independent certified health coaches via in-person or telehealth services. Consistent with the findings and recommendations of this report and other National Academies reports responding to CMS 2025 PFS rules, primary care valuation, and building the primary care

workforce, CMS should continue to enhance the APCM code set and move to hybrid payment models that would provide payment to support evidence-based health coaching by diverse members of interprofessional primary care teams as part of comprehensive, whole-person care (NASEM, 2024, 2025a,b).

UPDATES TO PRACTICE EXPENSE METHODOLOGY

CMS is proposing to reduce the portion of the practice expense relative value units (RVU) for facility-based services relative to the portion for non-facility-based services. The total RVU in the PFS is composed of three components: clinician work, practice expenses, and malpractice liability expense. The practice expense component consists of both direct expense and indirect expense elements. Direct expenses include clinical staff, equipment, and supplies, and indirect expenses include office rent and billing and scheduling staff. The practice expense allowed by the PFS differs depending on whether a bill is submitted as an office-based bill or a facility-based bill. Facility-based billing may be used in settings such as hospital outpatient and inpatient departments and surgery centers.

A bill submitted as a facility-based, rather than office-based service, typically includes both the professional fee for the clinician service and an additional facility fee, which can be submitted under the Medicare Outpatient Prospective Payment Systems payment model. The total RVU for a professional fee for facility-based billing excludes the direct expense element, under the rationale that the facility and not the clinician is paying for the direct expenses and the facility fee reimburses these direct expenses. However, the professional fee RVU for facility-based billing does retain the indirect element of practice expenses. The total fee for a facility-based service (including both the professional and technical fees) is on average 40 percent higher than the fee for an office-based professional fee for the same code (Gillis, 2023).

Critics have noted that this discrepancy potentially unfairly overvalues facility-based services and creates incentives for health care consolidation with physicians leaving independent practice to become employees of large hospital-led health care organizations (Azar and Sebelius, 2024). Congress has considered proposals for “site neutrality” for the PFS, with the same total fee for the same code billed in an office-based or facility-based setting (Whaley et al., 2024). Both MedPAC and the RAND Corporation have conducted comprehensive analyses of this issue, questioning inclusion of the indirect cost element in both the professional fee and facility

fee for facility-based services (Burgette et al., 2018; MedPAC, 2025). CMS proposes to address this concern about including indirect practice expenses in facility fees by reducing the portion of the facility practice expense RVUs allocated based on work RVUs to half the amount allocated to nonfacility practice RVUs.

The committee is offering responses to CMS' request for feedback on the following topics:

- Is CMS' proposal to reduce the portion of the facility practice expense RVUs allocated based on work RVUs to half the amount allocated to nonfacility practice expense RVUs an appropriate reduction or should CMS consider a different percentage reduction for CY 2026 or in future years?
- Are there additional data sources that might help identify a more precise site of service difference in the allocation of indirect practice expense RVUs?

Committee Response

Recommendation 13: The Centers for Medicare & Medicaid Services should follow the Medicare Payment Advisory Commission's recommendation to intentionally target a rule change for practice expense allocation for facility-based services rather than implementing the proposed across-the-board 50 percent reduction. Such an intentional targeting should consider factors such as the wide variation in the difference in fees for office-based and facility-based codes for different categories of services and specialties.

- In its 2025 report MedPAC concluded that: "Ideally, policies to reduce or eliminate fee schedule indirect PE [practice expense] RVUs for facility services should be targeted toward clinicians who do not pay indirect PE costs because they do not maintain or finance a separate practice" (MedPAC, 2025, p. 33). The committee is concerned that CMS's proposed across-the-board reduction in indirect expense allowance for all facility-based services insufficiently targets this rule change. The facility-based disparity in fees is greatest for procedural codes, which are on average 270 percent higher for facility-based than office-based services for the same code

(Gillis, 2023). Moreover, there is large variation across service codes in the proportion that are billed as facility based, with very high proportions for services such as CT scans and emergency department visits and much lower proportions for ambulatory E/M codes (Burgette et al., 2018). Similarly, a preponderance of physicians in certain specialties such as hospitalists and interventional radiologists furnish the majority of their services in facility settings (MedPAC, 2025).

- The simulation models in the MedPAC 2025 report of different policy options for addressing indirect practice expenses provide an excellent foundation for CMS to continue to iterate a targeted policy and evaluate the likely effect (MedPAC, 2025). Future modeling could include a focus on the effect on ambulatory E/M codes to ensure that the effect is not at odds with CMS's goal of strengthening primary care.

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A
Statement of Task

A National Academies of Sciences, Engineering, and Medicine committee will develop a written response to questions for public input included in the Centers for Medicare & Medicaid Services' (CMS) “CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule." The committee will produce a report with recommendations in response to the following topics in CMS' request for feedback in its proposed rule:

1. Relative value units (RVUs)/valuation of services:
    a. Reliable, valid, and empiric data sources and assessment approaches for the purposes of valuation of services (or misvalued codes) for the physician fee schedule
    b. Proposed efficiency adjustment policy
2. Advanced Primary Care Management (APCM) services:
    a. Behavioral health integration (BHI) add-on codes and valuation
    b. Cost-sharing and adjustments to APCM to cover additional preventive services and chronic disease management
    c. Considerations for annual wellness visits (e.g., solutions to enhance uptake, improve access, impact, and usefulness)
    d. Rural Health Centers and Federally Qualified Health Centers billing for APCM BHI, care coordination, and telehealth and communication services
3. Management and prevention of chronic disease:
    a. How to best support prevention and management, including self-management, of chronic disease

   b. Specific services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set

4. Health coaching and motivational interviewing:
   a. Health coaches who provide services under general supervision and the overlap between these services and motivational interviewing
5. Updates to practice expense methodology:
   a. Reliable, valid, and empiric data sources and assessment approaches for the purposes of efficiency adjustment for practice expense

B
Committee, Fellow, and Staff Biographical Sketches

COMMITTEE

KEVIN GRUMBACH, M.D., is professor of family and community medicine at the University of California, San Francisco. He served as Chair of the University of California, San Francisco (UCSF) Department of Family and Community Medicine from 2003 to 2022. He is a founding director of the UCSF Center for Excellence in Primary Care and director of the Community Engagement Program for the UCSF Clinical and Translational Science Institute. His research and scholarship on the primary care workforce, innovations in primary care, racial and ethnic diversity in the health professions, and community health improvement and health equity have widely influenced policy and practice. Dr. Grumbach is a member of the American Academy of Family Physicians and the California Academy of Family Physicians, and cochairs the California Academy of Family Physicians Task Force on Primary Care for All to develop policy positions on primary care coverage, investment, and payment. He is also a member of Physicians for a National Health Program.

He is a gubernatorial appointee to the California Health Workforce Education and Training Council and a technical expert for the California Office of Health Care Affordability Payment and Investment Workgroup, both of which are uncompensated positions. With Tom Bodenheimer, he coauthored the best-selling textbook on health policy, *Understanding Health Policy—A Clinical Approach*, now in its 8th edition, published by McGraw Hill. He received a Generalist Physician Faculty Scholar award from the Robert Wood Johnson Foundation, the Health Resources and Services Administration Award for Health Workforce Research on Diversity, the Richard E. Cone Award for Excellence and Leadership in Cultivating Community Partnerships in Higher Education, and the UCSF Chancellor's Public Service Award.

Dr. Grumbach has been an advisor to congressional committees and government agencies on primary care and health reform and a member of the National Advisory Council for the

Agency for Healthcare Research and Quality and currently serves on the California Health Workforce Education and Training Council. He cares for patients at the family medicine practices at San Francisco General Hospital and UCSF Health. He is a member of the National Academy of Medicine.

ANDREA ANDERSON, M.D., M.Ed., FAAFP, is a family physician and an associate professor at the George Washington (GW) School of Medicine and Health Sciences. She is the immediate past chair of the American Board of Family Medicine, a board member of the Federation of State Medical Boards (FSMB), chair of the United States Medical Licensing Examination Management Committee, a past senior medical education consultant for the Association of American Medical Colleges, and a former member of the National Advisory Council of the National Health Service Corps and National Health Service Corps Scholar. At GW, she serves in several roles including as the Associate Chief of the Division of Family Medicine, the chair of the clinical curriculum subcommittee, Director of the Scholarly Concentration in Health Policy, and course director of the required Transitions to Residency internship readiness capstone course. Throughout her career, Dr. Anderson has been active in DC health policy and medical regulation as well as teaching primary care, ethics, professionalism, and physician advocacy to medical students and residents. She is the Chair of the DC Board of Medicine, licensing and determining regulatory policy for the over 15,000 DC physicians and other licensees.

She is a subject-matter expert for national advisory committees of the National Board of Medical Examiners, namely the Patient Characteristics Advisory Panel and the Legal/Ethical Task Force. She has served on multiple national advisory committees for the FSMB including chairing the 2024 Workgroup on the Regulation of Physicians in Training and the National Ethics and Professionalism Committee, which creates model practice national guidelines for state medical licensing boards. Dr. Anderson is the recipient of the 2022 GW Distinguished Service Award, the 2021 National Exemplary Teaching Award from the American Academy of Family Physicians, the 2019 Society of Teachers of Family Medicine Advocate Award, the 2016 Brown School of Medicine Young Alumnae Achievement award, and the 1997 National Health Service Corps Scholarship. She is a current fellow of the Hedwig Van Ameringen Executive Leadership in Academic Medicine program, 2023 graduate of the International Leadership Excellence in

Educating for Professionalism Faculty Scholars Program from the Academy for Professionalism in Health Care, a 2018 graduate of the Society of Teachers of Family Medicine Emerging Leaders Program, and a 2017 graduate of the GW Master Teacher Leadership Development Fellowship. Dr. Anderson is an alumna of the Program in Liberal Medical Education at Brown University and Brown University School of Medicine. She completed a Master's degree of Education at the GW School of Education and Human Development. She completed her Family Medicine residency and Academic Medicine fellowship at Harbor-UCLA Medical Center where she served as the Chief Resident. Following this, she spent 15 years in clinical practice at the Upper Cardozo Health Center, a multilingual Federally Qualified Health Center in Washington, DC.

BETH BORTZ, M.P.P., is the founding president and CEO of the Virginia Center for Health Innovation, a nonprofit, public–private partnership established to accelerate value-driven health care. Ms. Bortz has secured more than $25 million in funds for innovation initiatives, including grants from Arnold Ventures, Center for Medicare & Medicaid Innovation, Agency for Healthcare Research and Quality, the Virginia Department of Health, and the Virginia Department of Medical Assistance Services. She has served as the implementation lead for the Virginia Task Force on Primary Care, Smarter Care Virginia, Virginia Vaccinates, the State Innovation Model Design grant, and Virginia's EvidenceNow grant. She is a public member of the American Board of Medical Specialties and a registered lobbyist in the Commonwealth of Virginia. Previously, she served as Executive Director of the Medical Society of Virginia Foundation, Deputy Director of the Virginia Health Care Foundation, and Senior Associate Legislative Analyst for the Virginia General Assembly. In addition to serving on the National Task Force to Reduce Low Value Healthcare, and the boards of Rx Partnership, LEAD Virginia, Virginia Health Information, and the American Board of Family Medicine, she has received the Virginia Leader Award from LEAD Virginia, Influential Women of Virginia Award from Virginia Lawyer's Media, and the Medallion Award for Community Partnership from Mutual of America. She earned her undergraduate degree in economics and government and her Master's in public policy from the College of William and Mary.

KAREN L. FORTUNA, Ph.D., M.S.W., is an assistant professor of psychiatry at the Geisel School of Medicine at Dartmouth and Cofounder of the Collaborative Design for Recovery and Health. As an international collaborative of patients, community health workers, peer-support specialists, caregivers, policy makers and payer systems, the collaborative uses community-based participatory research to facilitate the development, evaluation, and implementation of digital tools that use mobile health to address needs identified by community members from vulnerable populations at the intersection of race and disability status, including but not limited to older adults with multiple chronic health conditions and people with disabilities, rare diseases, and psychiatric disorders. Her work spans many settings from primary care to community-based care. Dr. Fortuna has received funding from the Patient-Centered Outcomes Research Institute (PCORI), National Institute of Mental Health, American Federation of Aging, Brain and Behavior Foundation, Japan Agency for Medical Research and Development, and the New York Academy of Sciences. Overall, she has been responsible for conducting or collaborating on more than 30 research projects including topics such as health disparities, self-management, patient engagement in digital technologies, participatory human-centered design, as well as pioneering a new field of study "digital peer support." She is the 2022–2023 Chair of the Patient Engagement National Advisory Council to PCORI.

Dr. Fortuna is an invited member to the American Psychological Association's Mental Health Technology Advisory Committee, American Psychiatric Association's Smartphone App Advisory Panel, Foundation for Opioid Response Efforts Advisory Panel, and Ludwig Boltzmann Gesellschaft Research Group Die Offene Tür's Open Innovation international advisory panel. Dr. Fortuna was the recipient of the Japanese Agency for Medical Research and Development Research Proposal of the year, Ally of the Year Award from the Western Mass Peer Network, Alvin R. Tarlov & John E. Ware Jr. Award in Patient Reported Outcomes, and the Faculty Achievement Award from the National Association for Gerontology Education in Social Work. She serves as a scientific advisor for Emissary Health (a digital platform for respite care) and Skyview (a lamp designed to promote wellness).

LAUREN S. HUGHES, M.D., M.P.H., M.Sc., M.H.C.D.S., FAAFP, is a family physician working as the State Policy Director of the Farley Health Policy Center and an associate professor of family medicine at the University of Colorado. In these roles, she leads efforts to

generate and translate evidence to inform the design and implementation of evidence-based health policy at the state, national, and federal levels. She participates in the Primary Care Centers Roundtable, a volunteer collective of all of the primary care research and policy centers in the United States. Her research interests include improving rural health care delivery, strengthening primary care infrastructure, and advancing behavioral health integration. She cares for patients at a rural federally qualified health center (FQHC) north of Denver. Dr. Hughes previously served as Deputy Secretary for Health Innovation in the Pennsylvania Department of Health. In this role, she collaborated with the Center for Medicare & Medicaid Innovation to codesign and launch the Pennsylvania Rural Health Model, a new payment and delivery model that transitions rural hospitals from fee-for-service to multipayer global budgets and transforms how they deliver care to better meet community health needs. She also oversaw the creation of the Prescription Drug Monitoring Program for the Commonwealth and led the department to full accreditation through the Public Health Accreditation Board.

In 2018, Dr. Hughes was selected by Presidents Bill Clinton and George W. Bush as a Presidential Leadership Scholar. From 2022 to 2023, she served as chair of the American Board of Family Medicine Board of Directors. She also serves on the boards of directors of the Rural Health Redesign Center Organization and the American Medical Student Association Foundation. She is a member of the Primary Care Payment Reform Collaborative through the Colorado Division of Insurance and the Stakeholder Advisory Group for the Agency for Healthcare Research and Quality National Center for Excellence in Primary Care Research. Dr. Hughes is a former Robert Wood Johnson Foundation Clinical Scholar at the University of Michigan, where she earned an M.Sc. in health services research. She also holds a medical degree from the University of Iowa, an M.P.H. in health policy from The George Washington University, and a master's in health care delivery science from Dartmouth College, and she completed residency at the University of Washington. Since 2021, Dr. Hughes has been a member of the National Academies of Sciences, Engineering, and Medicine Board on Health Care Services.

ALEX H. KRIST, M.D., M.P.H., is a professor of family medicine and population health at Virginia Commonwealth University and an active clinician and teacher at the Fairfax Family Practice Residency. He is the director of the Virginia Ambulatory Care Outcomes Research

Network, director of community-engaged research at the Center for Clinical and Translational Research and is past chairperson for the U.S. Preventive Services Task Force. Dr. Krist's areas of interest include implementation of preventive recommendations, patient-centered care, shared decision making, cancer screening, and health information technology. He is the primary author of numerous peer-reviewed publications and has presented to a wide range of audiences at national and international conferences. Dr. Krist completed his doctor of medicine at the University of Virginia School of Medicine. Dr. Krist was elected to the National Academy of Medicine in 2018, was a member of the committee that produced *Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care*, and was cochair of the committee that produced *Achieving Whole Health: A New Approach for Veterans and the Nation*.

NATIONAL ACADEMY OF MEDICINE FELLOW

STEPHANIE GOLD, M.D., FAAFP, 2023–2025 Puffer/ABFM Fellow, is an associate professor in the Department of Family Medicine at the University of Colorado, a practicing family physician at a federally qualified health center in the Denver Health system, and a scholar at the Farley Health Policy Center. Her research and policy work focus on payment reform for primary care and integrating behavioral health with primary care, with the goal of system transformation to enable primary care to better and more equitably care for the whole health of individuals, families, and communities.

Dr. Gold served as president of the Colorado Academy of Family Physicians (CAFP) from 2022 to 2023. Through CAFP, Dr. Gold helped advance legislation to improve primary care investment in Colorado and has provided input on multiple state task forces and committees related to primary care payment reform. Dr. Gold coedited a book *Integrated Behavioral Health in Primary Care: Your Patients Are Waiting*, which provides guidance on practice transformation to integrate care. She led the development of the Building Blocks of Behavioral Health Integration, a framework of care delivery expectations for use in practice transformation and alternative payment models. Dr. Gold also teaches policy and advocacy skills and has developed novel curricula for residents and international learners. Dr. Gold received her M.D. from the University of Virginia School of Medicine and completed her residency at the

University of Colorado–Denver Health track. Following residency, she completed a health policy fellowship with the Farley Health Policy Center.

STAFF

MARC MEISNERE, M.H.S., is a senior program officer on the National Academies of Sciences, Engineering, and Medicine's (National Academies') Board on Health Care Services and director of the Standing Committee on Primary Care. Since 2010, Mr. Meisnere has worked on a variety of National Academies consensus studies and other activities that have focused on mental health services for service members and veterans, suicide prevention, primary care, and clinician well-being. Most recently, he was the study director for the 2021 National Academies report Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care and the 2023 report, Achieving Whole Health: A New Approach for Veterans and the Nation. Before joining the National Academies, Mr. Meisnere worked on a family planning media project in northern Nigeria with the Johns Hopkins Center for Communication Programs and on a variety of international health policy issues at the Population Reference Bureau. He is a graduate of Colorado College and the Johns Hopkins University Bloomberg School of Public Health.

ADRIENNE FORMENTOS, M.S., is an associate program officer of the Board on Health Care Services at the National Academies of Sciences, Engineering, and Medicine, where she supports the Forum on Advancing Diagnostic Excellence. Prior to this role, she was a research assistant with Knowledge Ecology International. Grounded in public and community health and health care access, she has worked with the American Red Cross as a Disaster Action Team Administrator and case manager in San Francisco County, and with RotaCare Bay Area as a patient services navigator assisting uninsured patients with follow-up care and coverage. Through a year of service with AmeriCorps at St. Vincent Medical Center, she worked as a patient advocate and community services coordinator, organizing health fairs and outreach for uninsured and underinsured populations. She holds a B.A. in political science and English with a writing emphasis from Dominican University of California, and an M.S. in global health from Georgetown University.

SHARYL J. NASS, Ph.D., serves as senior director of the Board on Health Care Services and co-director of the National Cancer Policy Forum at the National Academies of Sciences, Engineering, and Medicine (the National Academies). The National Academies provide independent, objective analysis and advice to the nation to solve complex problems and inform public policy decisions related to science, technology, and medicine. To enable the best possible care for all patients, the board undertakes scholarly analysis of the organization, financing, effectiveness, workforce, and delivery of health care, with emphasis on quality, cost, and accessibility. The forum examines policy issues pertaining to the entire continuum of cancer research and care. For more than two decades, Dr. Nass has worked on a broad range of health and science policy topics that includes the quality, safety, and equity of health care and clinical trials; developing technologies for precision medicine; and strategies to support clinician well-being. She has a Ph.D. from Georgetown University and undertook postdoctoral training at the Johns Hopkins University School of Medicine, as well as a research fellowship at the Max Planck Institute in Germany. She also holds a B.S. and an M.S. from the University of Wisconsin–Madison. She has been the recipient of the Cecil Medal for Excellence in Health Policy Research, a Distinguished Service Award from the National Academies, and the Institute of Medicine staff team achievement award (as team leader).