September 9, 2025

Chris Klomp
Deputy Administrator and Director
Center on Medicare
Centers for Medicare and Medicaid Services
400 Independence Ave., S.W.
Washington, DC 21244

Re: Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1832-P)

Dear Deputy Administrator Klomp:

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (BHN), we appreciate this opportunity to offer comment on the CY 2026 Notice of Proposed Rulemaking (NPRM).

PCC is a nonprofit, nonpartisan multi-stakeholder coalition of 70 member organizations committed to a higher value health system built on a foundation of whole-person primary care. (See PCC's Shared Principles of Primary Care — signed by nearly 400 organizations — which define our vision.) In March 2022, PCC and a diverse set of organizations launched the Better Health – NOW campaign to realize bold policy change needed to assure high-quality primary care in every American community to improve the nation's health.

Primary care is one of the few types of care where stronger investment can lead to better outcomes and lower costs over time. But for decades, Medicare's flawed payment methodology has undervalued primary care. Today Medicare spends just 3.9 cents of its health care dollar on primary care while "downstream" expenditures on more acute services continue to grow. This neglect, mirrored by many other payers, has led to a dwindling primary care workforce and access issues for millions—even as rates of chronic conditions rise and costs soar.

We therefore appreciate CMS' commitment to modernizing Medicare payment to strengthen whole person primary care as a means to drive better health outcomes for Medicare beneficiaries. Building on incremental reforms finalized in 2021, 2024 and 2025, this NPRM includes proposals that begin to address underlying flaws in Medicare payment. Whether the Administration achieves its goals of a healthier America depends, in part, on the persistence and leadership it demonstrates in successfully correcting such flaws in the final rule and future rulemaking.

In the detailed comments below, we share our perspectives and positions on specific provisions of the proposed rule and offer responses to important RFIs. The PCC's multi-stakeholder members stand ready to meet and provide additional insights on any of the comments within. In summary, PCC and our Better Health – NOW partners recommend the following:

- Finalize an efficiency adjustment.
- Finalize a site-of service differential, while carefully attending to and mitigating potential impacts on those among the primary care and behavioral health workforce that are facility-based today.
- Continue to emphasize the need for empiric data as a vital complement to currently employed survey-based data sources.
- Finalize coverage and payment for the proposed add-on Behavioral Health Integration (BHI) codes, to be billed alongside Advanced Primary Care Management (APCM) services, available in the Medicare Physician Fee Schedule (MPFS).
- Remove cost-sharing for the existing APCM codes as well as APCM-associated add-on codes.
- Provide coverage and payment for Immunization Counseling, even when not associated with the delivery of an immunization.
- Promote more primary care participation in ACOs,
    - Remove APCM billing from the expenditures compared against each ACO's benchmark, and
    - Establish primary care capitation as an option broadly available in the statutory Medicare Shared Savings Program (MSSP).
- Shift payment policies to support whole person primary care, including motivational interviewing, Health & Well-being Coaching, and other payment policy changes.
- Leverage the CMS Innovation Center to incubate further transformative payment and delivery changes, by
    - Reopening ACO Primary Care Flex to a new cohort of participants, and
    - Testing whole person care approaches like intensive lifestyle interventions and shared medical appointments.

Earlier this year, Better Health – NOW called on HHS to commit to transitioning primary care payment from a predominantly fee-for-service (FFS) approach to one based upon prospective, population-based payment (hybrid) models — including broad

availability of hybrid payment in Medicare Part B and steps to address the underinvestment in and misvaluation of primary care. We appreciate the steps proposed in this NPRM that move us closer to those objectives and believe our recommendations would strengthen the final rule.

Faced with endemic levels of chronic physical and mental disease and erosion of access to primary care, however, continued regulatory leadership from CMS must be accompanied by reform of the underlying Medicare statute as well. PCC and our Better Health – NOW Campaign partners have elsewhere called on Congress to advance Medicare payment reform with primary care at its center. We urged lawmakers to advance legislative solutions that address undervaluation of primary care and make a well-constructed primary care hybrid payment option broadly available, alongside reforms addressing budget neutrality and integration of behavioral and social care in primary care.[1] In such legislation, the zero-sum budget neutrality requirements applicable to the Physician Fee Schedule should not be allowed to undermine the scope and viability of advanced primary care hybrid payment or other substantial reforms to Part B payment. We urge CMS to work with members of Congress to advance those objectives on a bipartisan basis.

DETAILED COMMENTS ON FOUR RE-VALUATION STRATEGIES

Updates to Practice Expense (PE) Methodology – Site of Service Payment Differential

CMS Description: Indirect PE RVUs are informed by responses to the AMA's Physician Practice Information Survey (PPIS), reported as indirect practice expenses per hour (PE/HR) for each medical specialty. Due in part to limitations in this survey data, fees for procedures, imaging and tests have historically been priced too high, and fees for time spent with patients (including evaluation and management (E/M) services, behavioral health and office-based services) are priced too low, undervaluing and underpaying primary care, behavioral health and other services. As one of the strategies to correct these imbalances, CMS is proposing to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs.

PCC/BHN Response: PCC supports reducing the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. The proposed site of service differential would provide an immediate revenue boost to independent practices, making them more viable and begin to address rising health care prices associated with growing hospital ownership of

[1] Primary Care Collaborative, "Letter to Senators Whitehouse and Cassidy Regarding Primary Care Financing Reform," 2024, https://thepcc.org/wp-content/uploads/2024/07/BHN-PCC-Response-to-Whitehouse-Cassidy-RFI-FINAL-FINAL-w-sig-1.pdf.

primary care.[2] These additional resources are urgently needed in community-based practices. On the current trajectory of stagnating reimbursement and increasing administrative burdens, primary care physicians and those in small or solo practices are exiting Medicare at a higher rate than other specialties and larger groups.[3]

At the same time, it is crucial that CMS' policy achieves its objective while avoiding unintended consequences. Amidst an overall shortage of primary care clinicians and other members of the primary care team including behavioral health providers, policymakers should explore ways to mitigate impacts on clinicians currently practicing in facility-based settings.[4] We note, further, that many primary care medical residencies, PA training sites and advance nursing education and behavioral health programs currently operate in facility-affiliated clinics. Without additional policy steps to mitigate impacts, the reductions in non-facility payment could have the unintended effect of undermining the viability of these training programs and further constrict the pipeline of primary care clinicians. Going forward, the valuation of and payment for physician practice expenses could be made more accurate through more robust data collection and support. We encourage CMS to explore data sources and processes for PE valuation that allow for more regular and more precise adjustments over time.

Use of OPPS Data for PFS Rate Setting

CMS Description: CMS is proposing not to update the practice expense per hour, historically based on PPIS survey responses, due to gaps in the data. Instead, CMS plans to use auditable, routinely updated hospital (OPPS) data to set and update payment rates.

PCC/BHN Position: To ensure health care payments are truly reflective of costs, CMS should leverage a diverse set of data sources to inform PFS payment rates, including hospital data (as used in OPPS), accurate and valid survey data, and routinely collected empirical data.

In addition, CMS may also wish to examine the role of the indirect practice cost index (IPCI) by seeking stakeholder feedback on its role and potential alternatives. First, the indirect practice cost index values are derived from the 2008 PPI survey, which for reasons CMS described, are very outdated and with very low response rates. Second, the IPCI has the potential to create distortions with clear negative effects. As certain specialties, for example, psychiatrists — stop seeing Medicare patients due to historical undervaluation of their payments, the utilization of service codes by psychiatrists

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[2] Yashaswini Singh et al., "Growth of Private Equity and Hospital Consolidation in Primary Care and Price Implications," *JAMA Health Forum* 6, no. 1 (January 17, 2025): e244935, https://doi.org/10.1001/jamahealthforum.2024.4935.

[3] Hannah T. Neprash and Michael E. Chernew, "Trends in Physician Exit From Fee-for-Service Medicare," *JAMA Health Forum* 6, no. 7 (July 18, 2025): e252267, https://doi.org/10.1001/jamahealthforum.2025.2267.

[4] Alison Huffstetler et al., "Health Is Primary: Charting a Path to Equity and Sustainability," 2023, https://thepcc.org/sites/default/files/resources/pcc-evidence-report-2023.pdf?utm_source=bitly&utm_medium=link&utm_campaign=2023_evidence.

decreases, and therefore so does the IPCI, which further decreases the valuation of the services that psychiatrists bill. This creates a downward spiral, and in turn, could lead more psychiatrists to disenroll from Medicare. It also means that if certain other underpaid specialties (for example, general practitioners, with an IPCI of 0.83), start to bill a code more, the valuation of that code decreases.

Proposed Efficiency Adjustment

CMS Description: CMS proposes an efficiency adjustment applicable to work RVUs and the intraservice portion of practitioner time inputs. CMS would apply the adjustment to all codes except time-based codes, including but not limited to, E/M visits, care management services, behavioral health services, services on the CMS telehealth list, and maternity codes with a global period of MMM. The magnitude of the efficiency adjustment would be based on the productivity adjustment to the Medicare Economic Index and total 2.5% in 2026. CMS is also proposing to update and apply the proposed efficiency adjustment every 3 years.

PCC/BHN Response: PCC supports the establishment of an efficiency adjustment for procedures, tests, and radiology, applicable to both intraservice times and Work RVUs. As the NPRM suggests, this step would begin to address systematic flaws in valuation that have overvalued procedures, tests, and radiology and undervalued other services such as primary care and behavioral health. We also support exempting the time-based codes, including E/M visits, care management services, certain behavioral health services, and maternity codes with a global period of MMM.

Looking ahead to future rulemaking, CMS should move forward with corresponding updates to the direct PE inputs for clinical labor and equipment costs. Since the direct PE inputs for clinical labor and equipment costs are allocated based in part on physician time, foregoing such corresponding updates would fail to adjust for the full extent of efficiencies that are garnered over time as technology advances, workflows improve, and expertise develops.

We understand that CMS may receive comments, particularly from those who benefit from today's distorted payment, arguing against the efficiency adjustment altogether. However, as the NPRM indicates, because PFS intraservice time is higher than empirical intraservice time on average for studied non-time-based services [5] [6] applying the efficiency adjustment will enhance accuracy relative to the status quo. In fact, CMS should elaborate on why it limited the initial look-back period to five years, in light of the erosion of independent and primary practice and the reality that the average time

[5] Stephen Zuckerman et al., "Collecting Empirical Physician Time Data: Piloting an Approach for Validating Work Relative Value Units," research report, 2016, https://www.urban.org/sites/default/files/publication/87771/2001123-collecting-empirical-physician-time-data-piloting-approach-for-validating-work-relative-value-units_0.pdf.

[6] Daniel J. Crespin et al., "Variation in Estimated Surgical Procedure Times Across Patient Characteristics and Surgeon Specialty," *JAMA Surgery* 157, no. 5 (March 2, 2022): e220099, https://doi.org/10.1001/jamasurg.2022.0099.

between initial introduction and reevaluation is 17 years. The agency should consider extending the lookback period to ten years.

At the same time, we do encourage CMS to refine the proposed policy to achieve its intended objectives. Adjustments to the policy could mitigate unintended consequences, promote comprehensiveness and ultimately achieve better outcomes for beneficiaries. We recommend the following steps:

- Confirm that Inpatient E&M services are excluded from the efficiency adjustment in the final rule. The delivery of Inpatient E&M services, either by a patient's primary care team or in close coordination with them, can promote care continuity, support successful transition back to other care settings, and reduce avoidable admissions and ER visits. As the share of Medicare beneficiaries with multimorbidity and complex care needs grows, this is critical to better outcomes.
- CMS should exclude its newest proposed primary care services, the APCM BHI add-on services, from the efficiency adjustment. Under the current proposal, several new codes appear to be listed as subject to the proposed efficiency adjustment, including new care management codes *GPCM1 Initial psychiatric collaborative care management*, *GPCM2 Subsequent psychiatric collaborative care*, and *GPCM3 Care management services for behavioral health*.
- Review the list of codes to which the efficiency adjustment applies and provide exemptions for those primary care services which do not exhibit efficiency gains. We note that, while CMS plans to apply this reduction broadly to all non-time-based codes, non-time-based services do not benefit equally from efficiency gains, particularly those billed by primary care. In fact, as proposed, the efficiency adjustment would apply to a number of services that can be part of whole-person primary care. One illustrative example is Osteopathic Manipulative Therapy - a pain management treatment that can help reduce the need for addictive medications and is used by primary care to treat patients in an outpatient setting.
- As the agency cultivates improved data sources, including empiric data, CMS should consider whether and how it might tailor the efficiency adjustment to the specific circumstances of services.

Proposal to emphasize empiric data in considering misvalued code nominations

CMS Description: To further mitigate payment distortions attributable to poor survey data, CMS is proposing to emphasize "empiric" supporting information in the evaluation of codes nominated by the public via the "Potentially Misvalued Codes" process. CMS requests comment on the types of empiric data that should be considered.

PCC/BHN Response: PCC strongly supports CMS' proposal to place greater emphasis on "empiric" supporting information for the codes nominated as part of the Potentially Misvalued Codes Process. This should help mitigate the limitations of available survey data. In response to CMS' request for information on what kinds of data CMS should

consider as valid, reliable, empiric information, electronic health record (EMR) logs, operating room logs, and time-motion data are each important sources of empiric data. Health Information Exchanges, which often have access to empiric data across multiple different EMRs, may also be a source for empiric data.

DETAILED COMMENTS ON EIGHT PROPOSED PAYMENT CHANGES

Integrating Behavioral Health into Advanced Primary Care Management (APCM)

CMS Description: CMS proposes optional add-on payment codes for BHI services, delivered to beneficiaries for whom APCM services are also billed. The new add-on codes do not include the time-tracking requirements of the existing General Behavioral Health Integration (BHI) and Collaborative Care Model (CoCM) codes. These proposed optional add-on codes for APCM services would be considered a "designated care management service" and could be provided by auxiliary personnel under the general supervision of the billing practitioner.

PCC/BHN Response: We strongly support the proposal to allow for billing of BHI and CoCM services without needing to document their time spent performing the service, in conjunction with APCM. We support the designation of the proposed add-on codes as care management services and allowing the services to be performed under general supervision. We agree that with these new codes primary care practices and clinics may be more likely to offer and furnish BHI and CoCM services. This step can bolster access to the integrated behavioral health services that are essential to better outcomes across a range of chronic conditions.

This proposal is responsive to Better Health – NOW's recommendation to evolve toward hybrid payment, articulated in our prior year comments. If establishing APCM represents the first step toward hybrid payment (a mini hybrid payment), the proposed BHI add-on codes represent the next encouraging step in that evolving vision. This proposal identifies a clear methodology to align APCM with integration of behavioral health while removing existing documentation burdens related to time tracking. This should improve integration of behavioral health into advanced primary care, which is critical to better meeting patient needs. For example, practices that integrate behavioral health into primary care create a significant improvement in depression outcomes,[6] and up to 75% of primary care visits include mental or behavioral health components.[7]

Evaluation and Management (E/M) Visit Complexity Add-on

CMS Description: CMS is proposing to allow the billing of HCPCS code G2211 as an add-on code in conjunction with home or residence evaluation and management visits.

PCC/BHN Response: We appreciate CMS' responsiveness to stakeholder feedback and support the agency's proposal. As the NPRM notes, the "relationship between the patient and the practitioner is the determining factor for when the add-on code should

be billed." Whether the care occurs in the home or the office is immaterial as both locations can support the patient-clinician relationship.

Elimination of payment for Social Determinants of Health Risk Assessment Services HCPCS code G0136

CMS Description: CMS is proposing to delete code HCPCS code G0136 for CY 2026 and remove it from the Medicare Telehealth Services list.

PCC/BHN Response: PCC and our Better Health – NOW partners urge CMS not to finalize this proposal to eliminate payment for G0136. If an alternative approach is necessary, CMS should consider revising the service description and renaming G0136 'Upstream Factors Assessment Services.'

We disagree with CMS' statement that resource costs described by HCPCS code G0136 are already accounted for in existing codes, including but not limited to E/M visits. Upstream factors like food security, housing insecurity and exposure to violence/abuse should inform patient care. For example, quality clinical care for a person with type 2 diabetes on insulin varies based on their capacity to access healthy food or whether they have a refrigerator to store insulin. While the NPRM suggests that screening can be incorporated into the existing Evaluation and Management service, the reality is that 25% or more of primary care activities may already go without reimbursement.[7] Expecting upstream factors to be reliably identified using existing E&M services fails to recognize the real world costs necessary to improve outcomes in resource-constrained environments.

Add Group Behavioral Counseling for Obesity to Medicare telehealth list

CMS Description: CMS is proposing to add CPT code G0473 (Face-to-face behavioral counseling for obesity, group (2-10), 30 minutes) to the Medicare Telehealth Services List. This code includes a 30-minute group session that consists of a dietary assessment, counseling, and behavioral therapy, as well as one face-to-face visit per week for each week for the first month, one face-to-face visit every other week for months two through six, and one face-to-face visit per month for months seven through twelve (if an individual loses 3kg in the first six months).

PCC/BHN Response: We support CMS' proposal. Research has shown that group behavioral counseling yields better weight loss outcomes for patients compared to individual behavioral counseling for obesity. [8] Patients that participate in group therapy lose significantly more weight than patients who participate in individual therapy, given

[7] Howard Mark Haft and Robert Berenson, "Enhancing Primary Care Payments Without Adding Financial Risk," *Journal of General Internal Medicine* 38, no. 7 (February 22, 2023): 1747–50, https://doi.org/10.1007/s11606-023-08088-5.

[8] Virginia Paul-Ebhohimhen and Alison Avenell, "A Systematic Review of the Effectiveness of Group Versus Individual Treatments for Adult Obesity," *Obesity Facts* 2, no. 1 (January 1, 2009): 17–24, https://doi.org/10.1159/000186144.

the same treatment type and time. [9] The added benefit of group support, social learning and accountability are key elements that contribute to the success of group behavioral counseling. Patients have reported that these elements are some of the most helpful within the intervention.[10]

Community Health Integration (CHI) and Principal Illness Navigation (PIN) for Behavioral Health

CMS Description: CMS proposes to allow Psychiatric Diagnostic Evaluation and Health Behavior Assessment and Intervention codes as initiating visits for Community Health Integration and Principal Illness Navigation services. CMS further proposes to clarify that CSWs, MFTs, and MHCs can bill Medicare directly for the CHI and PIN services they personally perform.

PCC/BHN Response: We support the proposals to expand the list of initiating visits for CHI and PIN services. We agree that these professionals can connect individuals with community-based resources to address unmet social needs that affect the diagnosis and treatment of medical problems. This proposal will remove an administrative barrier now facing primary care teams that include these professionals and ensure more beneficiaries can benefit from CHI and PIN services.

Medicare DPP Expanded Model Changes

CMS Description: CMS is proposing changes to the Medicare Diabetes Prevention Program Expanded Model (MDPP) to address operational questions and barriers related to weight collection requirements as well as proposing to extend flexibilities allowed during the Public Health Emergency for COVID-19 through December 31, 2029. CMS is also proposing to test the inclusion of an asynchronous delivery modality which will allow MDPP suppliers to deliver the set of MDPP services online through 2029, clarify that MDPP suppliers are not required to maintain in-person delivery capability through 2029, and introduce a new G-code and payment for online sessions.

PCC/BHN Response: PCC and our BHN partners support finalizing the proposed asynchronous online modality and other delivery flexibilities though 2029. We agree that CMS' proposals could facilitate additional availability of and participation in DPP.

To overcome the limited participation in and availability of Medicare DPP, CMS should also set a clear goal of transitioning DPP into a permanently covered Medicare benefit. Doing so could entice more National DPP suppliers to apply to be MDPP suppliers and

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[9] David A. Renjilian et al., "Individual Versus Group Therapy for Obesity: Effects of Matching Participants to Their Treatment Preferences," *Journal of Consulting and Clinical Psychology*, vol. 69, 2001, https://www.cdrnet.org/vault/2459/web/files/Renjilian2001.pdf. 69, 2001, https://www.cdrnet.org/vault/2459/web/files/Renjilian2001.pdf. https://www.cdrnet.org/vault/2459/web/files/Renjilian2001.pdf

[10] Christie A. Befort et al., "Group Versus Individual Phone-based Obesity Treatment for Rural Women," *Eating Behaviors* 11, no. 1 (August 16, 2009): 11–17, https://doi.org/10.1016/j.eatbeh.2009.08.002.

could entice potential suppliers to create new diabetes prevention programs, seek CDC DPRP recognition, and apply to be MDPP suppliers.

Immunization Counseling (CPT codes 90XX1, 90XX2, and 90XX3)

CMS Description: In 2022, CMS created six new HCPCS codes so that Medicaid providers could bill for stand-alone vaccine counseling. The six HCPCS codes are G0310-G0315. In May 2024, the CPT Editorial Panel created three new time-based CPT codes 90XX1, 90XX2, and 90XX3 to report vaccine counseling performed where a vaccine is not administered. The RUC requested that CMS delete HCPCS codes G0310-G0313, and replace them with the new CPT codes 90XX1, 90XX2, and 90XX3. However, CMS proposes to assign status indicator ("I") to each of these three services. According to CMS, Medicare uses other coding for reporting of, and payment for immunization counseling, although CMS does not say what those other codes are apart from G0310-G0315, all of which are also status indicator "I" (i.e., not valid for Medicare purposes). CMS is not proposing any work RVUs or PE RVUs for any of the three new CPT codes.

PCC/BHN Response: Better Health – NOW is not encouraged by CMS' proposal. Lack of payment for immunization counseling would discourage Medicare practitioners from helping Medicare beneficiaries understand and weigh their own care choices. We instead urge assigning new codes 90XX1, 90XX2, and 90XX3 the status indicator "A" (i.e., active for Medicare payment) and establishing work RVU and Practice Expense inputs no less than those proposed.

CMS's rationale for assigning status "I" to new codes 90XX1, 90XX2, and 90XX3 on the basis is that Medicare uses other coding for reporting of, and payment for immunization counseling, but we are unaware of such coding. The codes that CMS references, G0310-G0315, are active for Medicaid but not Medicare. Effective vaccines for diseases ranging from flu to respiratory viruses to shingles are available and marketed to beneficiaries. Medicare's payment policy should encourage conversations between beneficiaries and their trusted source of primary care as they weigh care options.

Proposed Elimination of PCMH Accreditation from MIPS Value Pathway (MVP) tables

CMS Description: CMS proposes to no longer list *IA_PCMH Electronic submission of Patient Centered Medical Home Accreditation* in MIPS Value Pathways (MVP).

PCC/BHN Response: We recommend that CMS not finalize the proposal and instead maintain the listing of the IA_PCMH improvement activity on the MVP table. Under current regulations, MIPS eligible clinicians in a practice that are certified or recognized as a patient-centered medical home or comparable specialty practice, as determined by the Secretary, may attest to this activity and receive an improvement activities performance category score of 100 percent (81 FR 77179 through 77180). (pg. 1719) Since its inclusion, this improvement activity has simultaneously promoted the patient centered medical home model – while relieving practices of the burden of identifying

additional improvement activities. Removing IA_PCMH risks undermining the policy intent of enabling practices to leverage their accreditation status to fulfill MIPS requirements and would increase MIPS-related burdens for those practices that have attained PCMH or similar recognition or certification.

DETAILED COMMENTS ON FOUR MSSP POLICY PROPOSALS

ACO Eligibility Requirement

CMS Description: CMS proposes changes to the Shared Savings Program eligibility requirements to allow for participation by ACOs with a less than 5,000 assigned beneficiaries through their first three benchmark years, along with safeguards adjusting the shared savings payment and loss recoupment limits for such ACOs

PCC/BHN Response: PCC supports the change to allow ACOs to enter the Shared Savings Program with fewer than 5,000 assigned beneficiaries in BY1, BY2, or BY3. We believe this flexibility will encourage new ACOs to join the Medicare Shared Savings Program. We also support the corresponding methodological changes in consideration of the fact that these smaller ACOs may have greater variance in savings and losses compared to larger ACOs.

Proposal to Revise the Definition of Beneficiary Eligible for Medicare CQMs

CMS Description: CMS proposes to revise the definition of a "beneficiary eligible for Medicare CQMs" to require "at least one primary care service with a date of service during the applicable performance year from an ACO professional who is a primary care physician or who has one of the specialty designations included at § 425.402(c), or who is a physician assistant, nurse practitioner, or clinical nurse specialist." Specifically, the proposed revised definition uses "primary care services" and "performance year," instead of "claims" and "measurement period," respectively. The proposed definition in (1)(ii)(B) would continue to align with the special assignment conditions for ACOs, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs).

PCC/BHN Response: PCC supports the changes to align the definition of beneficiary-eligible for Medicare CQMs, since this should reduce burdens for ACOs and participating practices.

Proposals to remove the Health Equity Adjustment applied to ACO's Quality Score and Revise Certain Terminology

CMS Description: CMS proposes to remove the health equity adjustment applied to an ACO's quality score beginning in performance year 2025. CMS also proposes removing the phrase "health equity adjusted quality performance score" and adding in its place the phrase "quality score" and removing the phrase "health equity adjustment bonus points" and adding in its place the phrase "population and income adjustment bonus points."

PCC/BHN Response: We oppose the removal of the Health Equity Adjustment as applied to an ACO's quality score. CMS' proposal could have negative consequences for those ACOs serving hard to reach Medicare enrollee populations, including complex dually eligible beneficiaries.

When ACOs report a quality measure that is an all-payer measure, an eCQM, ACOs with a higher amount of Medicaid patients will likely perform worse. This means that the quality measurement will measure the ACOs population mix, rather than fully measuring the ACOs performance on quality, and could potentially disincentivize ACOs from forming. As CMS identified, this may become a bigger issue as newer ACOs serving increasing numbers of complex populations increases, with the "population adjustment" in place for benchmarking, and the elimination of the negative regional adjustment.

If necessary, as an alternative to the proposal outlined in the NPRM, CMS should consider retaining an adjustment for CY 2026 and future years, using CMS' proposed terminology "population and income adjustment bonus points."

Retaining an adjustment would deter ACOs from excluding clinicians that are treating a disproportionate amount of complex, dually eligible patients. As it stands, the ACO's ability to change their participation list might mean that they drop practitioners that are less "efficient" compared to their region or are serving an increasing number of Medicaid patients.

Population Adjustment – Financial Benchmarking Methodology

CMS Description: CMS proposes renaming the Health Equity Benchmark Adjustment (HEBA) to "population adjustment" to more accurately reflect the nature of the adjustment, which accounts for the proportion of the ACO's assigned beneficiaries who are enrolled in the Medicare Part D LIS or dually eligible for Medicare and Medicaid.

PCC/BHN Response: We support the retention of the renamed Health Equity Benchmark Adjustment as the Population Adjustment. As CMS indicated, "among the 33 ACOs to receive the HEBA, 13 are new ACOs participating in their agreement period and would otherwise not have received a positive regional adjustment to the benchmark (for example, ACO spending is above their region's expenditures) or a prior savings adjustment, since these ACOs are in their first agreement period. This early observation suggests that the HEBA is encouraging more participation in the Shared Savings Program, as intended, by high-cost ACOs." We agree with CMS that the population adjustment will actually increase savings. It also aligns with CMS' aims of advancing prevention, wellness, and chronic disease management, since these ACOs are more likely to be treating patients with numerous chronic conditions and managing them appropriately. We further agree that the revision to "population adjustment" more accurately reflects the population of beneficiaries that are captured by this adjustment.

REQUESTS FOR INFORMATION AND COMMENT: THREE RESPONSES

Request for Information related to APCM and Prevention

CMS Questions (Cost-sharing, preventive services and APCM):

- How should we 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?

PCC/BHN Response regarding cost-sharing, preventive services and APCM:
Eliminating cost sharing for APCM is one of the most powerful ways to support the Administration's health goals, since primary care is critical to the receipt of needed preventive services and co-pays are a financial barrier for many.

The APCM represents a bundle of both prevention and treatment services, and cost sharing should be eliminated for APCM services as a result, starting in 2026. Clinically, the blending of prevention and treatment are inseparable in a primary care setting, because primary care teams must often balance prevention and treatment in the life of the individual patient. We strongly urge CMS to waive cost-sharing for the full services covered under the APCM service codes. The APCM bundle already contains preventive elements which should be exempt from cost-sharing – and treatment elements that are not currently exempt. It would be burdensome to apply cost sharing to just one part of the service for practices, because their billing systems are built to apply 20% or 0% cost sharing for each Medicare service.

In the event that depression screening is included in the APCM bundle, CMS should ensure this service element consists of "outreach" to perform screening and is not contingent on completing the depression screening if the person refuses a screen, is currently receiving behavioral health treatment from a mental health provider, or another reason requiring flexibility documented in the record. Requiring completion without some exceptions for patient choice or for a patient that is currently in therapy or other care would add unnecessary administrative burden and reduce uptake of the APCM codes. Additionally, if depression screening is included in the APCM bundle, the valuation of the three APCM service codes should be adjusted accordingly to accommodate the added service elements.

If the AWV is included in the bundle, we would also strongly recommend that CMS make the billing of APCM contingent upon "outreach to schedule the AWV with the primary care team" and not require actual delivery of the AWV. Beneficiaries may schedule an appointment and miss the appointment due to any number of life circumstances. Prohibiting billing for APCM would be self-defeating since time and resources are going to be spent completing the APCM services. Should CMS decide to

include the AWV, the valuation of the three APCM service codes should be adjusted accordingly to accommodate the added service elements.

CMS RfI Questions regarding ACOs & Primary Care:

- 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?

PCC/BHN Response regarding ACOs and Primary Care: To achieve better outcomes and lower costs, APCM and associated reforms must align with and support care transformation in practices participating in the Medicare Shared Savings Program. Prospective payment of APCM and the proposed BHI add-on codes would be a constructive step that could help MSSP ACOs develop operational pathways for receiving prospective payment and distribute them to participating practices.

However, alone, such a policy is not sufficient. A serious effort to accelerate primary care participation must also:

- ✓ Remove spending on APCM services and BHI add-on services from the expenditures compared against spending benchmarks in MSSP.
- ✓ Offer all MSSP ACOs a primary care capitation option.
- ✓ Reopen the ACO Primary Care Flex Model to a new cohort of applicants in 2026 for a January 1, 2027 start.

To further maximize improvement in outcomes and primary care ACO participation, CMS should also remove cost-sharing for APCM services as discussed above.

Comment Solicitation on Payment Policy for Software as a Service (SaaS)

Apps, wearables and other individualized technologies show promise but are not all created equally.[11] [12] Leveraging them as a complement to a primary care relationship supported by a strong team may prove impactful as a strategy to improve health. Specifically, Medicare should focus on support for technologies that facilitate the partnership between and among a patient, their caregivers, a primary care clinician and the broader care team. It is these relationships that best facilitate care integration and coordination and improved outcomes.

[11] Sherry on Ki Chong et al., "An Umbrella Review of Effectiveness and Efficacy Trials for App-based Health Interventions," *Npj Digital Medicine* 6, no. 1 (December 16, 2023), https://doi.org/10.1038/s41746-023-00981-x.

[12] Graeme Mattison et al., "The Influence of Wearables on Health Care Outcomes in Chronic Disease: Systematic Review," *Journal of Medical Internet Research* 24, no. 7 (May 16, 2022): e36690, https://doi.org/10.2196/36690.

Request for Information: Prevention and Management of Chronic Disease

CMS RFI Questions-General:

- How could we 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?

PCC Response-General: Successful behavior change is fundamental to better health outcomes for those living with or at risk of chronic physical and/or behavioral health conditions. A trusted partnership amongst the patient, their primary care team and caregivers is a powerful stimulus to the initial commitment to change. Helping patients live out such a commitment is at the heart of primary care.

Yet today's FFS reimbursement does not support the robust care team needed to deliver whole person primary care that includes BHI, nutrition and exercise advice, and other services to help patients achieve their health and wellness goals. Primary care practices and clinics need payment options that feature an increased level of payment and more flexibility.

Scaling behavior change in Traditional Medicare therefore depends, in the first instance, on expeditiously and aggressively building on CMS' broader primary care payment reforms: improving valuation and helping primary care transition to hybrid and other population-based payment mechanisms.

CMS RFI Questions-Specific Interventions and Services:

- Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?
- Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set, and how should these interventions be prioritized? If so, what evidence has supported these services, and what do the services entail? How would additional coding and payment be substantively different from coding and payment for Intensive Behavioral Therapy?
- What has been the experience of providers and payers utilizing the codes 0591T (Health and well-being coaching: face-to-face, individual initial assessment), 0592T (Individual follow-up session, at least 30 minutes), and 0593T (Group session, two or more individuals, at least 30 minutes)? If the CPT committee were to create permanent codes with staff able to operate under the general

supervision of a billing practitioner, would this capture the time and resources to perform health coaching?

PCC/BHN Response – Specific Interventions and Services: There is no one-size-fits-all approach to integration of whole person health and behavior change. The appropriate intervention and modality depend on the patient's health goals, the primary care practice's capabilities, workforce availability and external resources in the community. Fortunately, there are a variety of proven approaches. Evidence confirms the effectiveness of diverse interventions (coaching[13], motivational interviewing[14], intensive lifestyle interventions[15], shared appointments[16]), service delivery modalities (outpatient primary care office[17], community settings[18], and telemedicine[19]) and team structure and personnel. Unfortunately, over the years, Medicare law and policy have managed to erect barriers specific to many of these approaches.

CMS should alleviate barriers to integration of nutrition, physical activity and behavior change into primary care. Better Health- NOW specifically recommends the following:

- ✓ Coverage of and reimbursement for Motivational Interviewing, under general supervision of the billing practitioner.
- ✓ Coverage of and reimbursement for Health & Well-being Coaching, under general supervision of the billing practitioner. HWC has proven effective in addressing chronic disease.[20] CMS should also explore revising CCM service codes to allow for reimbursement of HWC activities as part of CCM.
- ✓ Addition of Health & Well-being Coaching to the telehealth list on a permanent basis.

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[13] Cathy L. Melvin et al., "A Systematic Review of Lifestyle Counseling for Diverse Patients in Primary Care," *Preventive Medicine* 100 (March 23, 2017): 67–75, https://doi.org/10.1016/j.ypmed.2017.03.020.

[14] Brad Lundahl et al., "Motivational Interviewing in Medical Care Settings: A Systematic Review and Meta-analysis of Randomized Controlled Trials," *Patient Education and Counseling* 93, no. 2 (August 1, 2013): 157–68, https://doi.org/10.1016/j.pec.2013.07.012.

[15] Nan Lv et al., "Behavioral Lifestyle Interventions for Moderate and Severe Obesity: A Systematic Review," *Preventive Medicine* 100 (April 25, 2017): 180–93, https://doi.org/10.1016/j.ypmed.2017.04.022.

[16] David Edelman et al., "Shared Medical Appointments for Chronic Medical Conditions: A Systematic Review," NCBI Bookshelf, July 1, 2012, https://www.ncbi.nlm.nih.gov/books/NBK99785/.

[17] Claire D Madigan et al., "Effectiveness of Weight Management Interventions for Adults Delivered in Primary Care: Systematic Review and Meta-analysis of Randomised Controlled Trials," *BMJ*, May 30, 2022, e069719, https://doi.org/10.1136/bmj-2021-069719.

[18] Lynn Miescier et al., "Evaluation of the Health Care Innovation Awards: Community Resource Planning, Prevention, and Monitoring, Annual Report 2015," report, *Evaluation of the Health Care Innovation Awards: Community Resource Planning, Prevention, and Monitoring*, March 2016, https://www.cms.gov/priorities/innovation/Files/reports/hcia-ymcadpp-evalrpt.pdf.

[19]Laura Suhlrie et al., "The Effectiveness of Telemedicine in the Prevention of Type 2 Diabetes Mellitus: A Systematic Review and Meta-analysis of Interventions," *Diabetes & Metabolic Syndrome Clinical Research & Reviews* 19, no. 5 (May 1, 2025): 103252, https://doi.org/10.1016/j.dsx.2025.103252.

[20] Ruth Q. Wolever et al., "A Systematic Review of the Literature on Health and Wellness Coaching: Defining a Key Behavioral Intervention in Healthcare," *Global Advances in Health and Medicine* 2, no. 4 (July 1, 2013): 38–57, https://doi.org/10.7453/gahmj.2013.042.

- ✓ Coverage and reimbursement for Intensive Behavioral Therapy when delivered by a community-based organization, licensed psychologist or registered dietician (when referred by another treating practitioner).
- ✓ Waive Medicare Place of Service requirements for the delivery and reimbursement of behavior change interventions in community-based settings where people live and work.
- ✓ Limit or eliminate total beneficiary cost-sharing required for multi-touch behavior change interventions that are delivered in a series of visits.
- ✓ Work with Congress to remove the current statutory prohibition on billing medical nutrition therapy for conditions other than diabetes and kidney disease, and which limits which Medicare participating clinicians are eligible to refer patients for medical nutrition therapy.

As noted above in the discussion of Software-as-a-Service, however, it is essential the various behavior change interventions – supported by technology or not - are fully coordinated or integrated with beneficiaries' health goals and care plan.

BETTER HEALTH- NOW: TWO CMMI-RELATED RECOMMENDATIONS

PCC and Better Health – NOW applaud the ongoing partnership between the Center on Medicare and Centers for Medicare and Medicaid Innovation to bring payment and delivery innovation into permanent payment policy. As the Innovation Center develops the next generation of such innovations, we appreciate the focus on evidence-based prevention, inclusive of primary, secondary and tertiary prevention in all models, described in CMMI's Updated Innovation Strategy. Below we provide two initial recommendations to the Innovation Center.

Reopen the ACO Primary Care Flex Model to A New Cohort:

Amidst a record of payment reforms with uneven, sometimes disappointing results, the evidence clearly establishes that, with the right, appropriately financed payment model, primary care can help produce savings and outcome improvements. Two particular strategies stand out: upfront population-based payments and primary care-centric ACOs. PCC and our BHN partners were pleased to propose and provide input on the development of the ACO Primary Care Flex model. This model aims to test whether combining these already proven strategies can turbocharge results. It has enormous potential to drive savings for the taxpayer and better outcomes for Medicare beneficiaries grappling with growing rates of chronic disease.

At the primary care community's request, the Innovation Center stood up the model quickly in 2024, and we believe the model has yet to reach its full potential in participation, which may have a downstream effect on its impact. Many practices who considered the model but did not apply needed additional time to understand the model details. As just one example, the Ratebook which allowed practices to compare payment

under the model to their current revenue was not released until late summer of 2024, after many ACOs had made their plans for MSSP participation.

Additionally, shortly after the Model's announcement, PCC and our Better Health - NOW partners recommended several steps needed to realize its full potential in an April 9th, 2024 letter.

Today, CMS has the opportunity to act on those recommendations and to take the ACO PC Flex model to the next level:

- ✓ Reopen the Model to an additional participation cohort. CMS should consider a January 1, 2027 start date.
- ✓ Assess the model's spending transparency requirements related to the funds flow – with the aim of assuring added investments actually reach PC practices.
- ✓ Track beneficiary utilization and access to behavioral health services and identify opportunities to support BHI in the model.
- ✓ Enable participating ACOs and practices to remove beneficiary cost-sharing barriers.

Prevention: Testing Whole Person Primary Care

A strong patient-primary care partnership is the linchpin of successful primary, secondary and tertiary prevention, and fee-for-service reimbursement has not adequately supported this partnership over time. We are pleased to see the Administrations' commitment to strengthening this partnership reflected in the Center on Medicare's work to address valuation, build on the APCM and promote primary care participation in ACOs. Responsive to the RFIs above, we suggest specific regulatory steps to remove barriers that change interventions and support whole person primary care for all Medicare beneficiaries and primary care clinicians.

But the CMS Innovation Center has its own unique authority and opportunity to test potentially transformative preventive strategies. We specifically encourage the Innovation Center to consider the incorporation of Shared Medical Appointments (SMAs) and Intensive Lifestyle Interventions aimed at disease remission and to support such innovations with appropriately higher and more flexible payment.

Intensive Lifestyle Interventions: Properly designed intensive lifestyle interventions can support disease remission for some patients with Type II diabetes and certain cardiovascular conditions. The Innovation Center should consider approaches that are

- ✓ Integrated with primary care.
- ✓ Aim for high patient engagement with substantive behavior change.
- ✓ Employ treatment that is multifactorial and multimodal.
- ✓ Leverage a high intensity approach to clinical encounters (frequency and duration).
- ✓ Include appropriate monitoring, adjustment and, where appropriate, reduction of medications.

Shared Medical Appointments: Shared Medical Appointments are a care delivery model, shown to be effective at improving outcomes for a variety of health challenges and populations. Shared Medical Appointments enhance access to chronic disease management, and a recent study found that participants in SMA groups had lower diastolic blood pressure compared to those receiving usual care.[21] The Innovation Center should move forward with encouraging use of SMAs in future model tests.

PCC and our Better Health - NOW campaign appreciate this opportunity to provide comments on the proposed rule and look forward to working with the CMS team to further strengthen primary care in Medicare. If our team can answer any questions regarding these comments, please contact PCC's Director of Policy, Larry McNeely at lmcneely@thepcc.org.

Sincerely,

Ann Greiner
President & CEO
Primary Care Collaborative

[21]Mei Yee Tang et al., "Effectiveness of Shared Medical Appointments Delivered in Primary Care for Improving Health Outcomes in Patients With Long-term Conditions: A Systematic Review of Randomised Controlled Trials," *BMJ Open* 14, no. 3 (March 1, 2024): e067252, https://doi.org/10.1136/bmjopen-2022-067252.