January 16, 2026

The Honorable Gregory F. Murphy, MD
United States House of Representatives
Washington, DC 20515

The Honorable Kim Schrier, MD
United States House of Representatives
Washington, DC 20515

The Honorable John Joyce, MD
United States House of Representatives
Washington, DC 20515

Dear Representatives Murphy, Joyce and Schrier,

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health – NOW campaign (BHN), we are pleased to respond to your bipartisan request for information (RfI).

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 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.

We offer our responses to the bipartisan RFI below. The PCC and its Better Health-NOW partners greatly appreciate the leadership of the GOP Doctors Caucus and Congressional Doctors Caucus to drive meaningful reforms to improve our nation's health. Ensuring primary care clinicians are encouraged to participate in new payment models is foundational to achieving that goal and should be central to your legislative work.

1. **What legislative reforms are most needed to ensure future CMMI models deliver real improvements in cost and quality, while also ensuring successful scaling of innovations?**

To ensure that patients and taxpayers realize the full promise of the CMS Innovation Center, and to create viable pathways away from fee-for-service (FFS), CMS' Innovation Center should be pursuing more advanced payment and delivery innovation.

Continued testing of approaches that have been found effective (including primary care-centric Accountable Care Organizations) does not meet the moment. To truly advance innovation, Congress should act, bringing to scale successful approaches across an array of programs and pursuing complementary reforms that lay the foundation for future innovation. This would free up the CMS Innovation Center to pursue bolder model tests.

Specifically, we urge lawmakers to:

- Establish a hybrid primary care payment alternative in traditional Medicare;
- Encourage primary care participation in ACO models through monetary and non-monetary incentives;
- Provide support for small, independent primary care practices to pursue advanced primary care and Alternative Payment Model (APM) participation;
- Remove barriers to whole person primary care;
- Improve data informing CMS decisions, and enhance transparency;
- Modernize Medicare Physician Fee Schedule (MPFS) budget neutrality requirements.

Establish a hybrid primary care payment alternative in traditional Medicare

Congress should direct CMS to work with the primary care community to establish a voluntary hybrid primary care payment option in Traditional Medicare for Part B primary care practices, including those reimbursed under the MPFS, as well as community health centers (CHCs) and rural health clinics (RHCs). CMS has taken helpful steps through the ACO Primary Care Flex model and a monthly Advanced Primary Care Management (APCM) code established during CY2025 rulemaking, but Congress should provide explicit leadership by setting up a permanent pathway.

The design and implementation of hybrid payment should invest in primary care capacity, support personalized, team-based care, and pay for services tailored to the needs of the patient and the community. Key design elements should include:

- Tiered hybrid primary care payment: Medicare would provide a tiered monthly prospective payment for a defined set of primary care services delivered by primary care clinicians and teams in primary care settings. Levels of payment should be based on the scope of services furnished, including care management, patient and caregiver communications (email, phone, portals), behavioral health

integration, office-based evaluation and management visits for new and established patients, regardless of modality, and other services the Secretary deems necessary and appropriate.
- Risk adjustment: Payments would be adjusted for clinical risk and community-level risk.
- Cost-sharing policy: Beneficiary cost sharing for the monthly prospective population-based payment would be waived. Additional cost-sharing waivers for other primary care services delivered through a participating practice or clinic to applicable beneficiaries would be available. Both would encourage "upstream" utilization to keep beneficiaries healthy and reduce downstream costs.
- Coordination with fee-for-service: Participating practices and clinics would continue billing under the fee schedule for services not included in the monthly payment (for example, inpatient E/M), care for beneficiaries not attributed to the practice, and other services Medicare wishes to incentivize.
- Permanent Part B option outside MPFS: The hybrid payment should be available as a permanent Medicare Part B payment option. The budget neutrality requirements applicable to the Physician Fee Schedule should not be allowed to limit the scope and viability of advanced primary care hybrid payment.

In tandem with establishment of a broadly available hybrid payment option, Congress should pursue complementary near-term reforms that support value-based care and create the necessary foundation for future model development and testing at the CMS Innovation Center.

- Support and encourage primary care participation in ACO models: We urge lawmakers to develop and advance legislation directing CMS to further encourage primary care participation in Accountable Care Organization (ACO) models. An April 2024 CBO report found **two times the savings** among primary care-centric Medicare Shared Savings Program (MSSP) ACOs, compared to high-revenue ACOs.[1] PCC's 2024 Evidence Report, *Primary Care: The MVP of MSSP*, reached similar conclusions and highlighted "bright spot" innovators from across across our nation's Heartland and in our largest cities alike.[2] To support increased participation in primary care-centric ACOs and help connect more individuals to a usual source of primary care, Congress should
    - Offer all MSSP ACOs a primary care capitation option,
    - Exclude spending on APCM and related Behavioral Health Integration (BHI) add-on services from the expenditures used to assess performance against MSSP spending benchmarks,
    - Eliminate beneficiary cost sharing for APCM and associated BHI add-on services, and
    - Enable primary care to receive hybrid and capitated payments directly instead of paying ACOs for primary care services and having them pay

[1] Congressional Budget Office, "Medicare Accountable Care Organizations: Past Performance and Future Directions," 4/2024 https://www.cbo.gov/publication/60213
[2] Huffstetler, et al, "Primary Care: The MVP of MSSP: An Evaluation of Primary Care in Medicare ACOs," 11/2024 https:// thepcc.org/reports/primary-care-the-mvp-of-mssp-2024- evidence-report

practices. Providing this option has the potential to encourage increased ACO participation by small, rural and independent practices.

- Ready small, independent primary care practices for advanced primary care and Alternative Payment Model (APM) participation: Congress must do more to support adoption of advanced primary care delivery models among small, independent, and rural primary care practices which have exhibited lower rates of adoption. They can do so by pairing targeted technical assistance with predictable revenue and upfront investment resources for small, independent and rural practices. Specifically, Congress should
    - instruct CMS to make payment for APCM and the associated BHI add-on codes available prospectively so practices have reliable cash flow to add care team capacity, invest in basic infrastructure, and standardize care management and behavioral health integration;
    - fund technical assistance that helps practices adopt the required workflows, document services, and implement and bill APCM and related codes correctly. (Reintroduction and enactment of the Small, Underserved and Rural Support program (SURS) Extension Act of 2023 would represent an initial step in this direction.); and
    - work with CMS to implement advance payments for infrastructure to facilitate APM participation by small independent, rural and safety net primary care practices, drawing on lessons from CMS Innovation Center.

- Remove barriers to whole person primary care: Congress should provide CMS with clear direction to cover services that primary care teams rely on but often cannot bill for under current payment rules. Congress should instruct CMS to reimburse for health and wellbeing counseling under general supervision and to make this service available through telehealth so practices can reach patients who face access barriers to receiving preventive, lifestyle-focused care. To support integrated, team-based care for patients with behavioral health needs, Congress should also strengthen behavioral health integration by including the COMPLETE Care Act (H.R. 2509) in future health legislation.

- Promote Transparency: Congress should require that CMS track and publish primary care spending, payment mechanisms and chronic disease outcomes across its programs, including traditional Medicare, MSSP, and Medicare Part C.

- Optimize data informing CMS decisions: To strengthen the data that informs CMS payment policy, Congress should work with the agency to ensure CMS continues to incorporate new data sources, including empirical sources, that more accurately value time-based services in the MPFS.

- Modernize MPFS Budget Neutrality Requirements: Updating the MPFS budget neutrality threshold to reflect inflation is critical. This threshold has been set at

$20 million and has not been adjusted since its establishment in the 1990s. We urge lawmakers to require that this threshold be adjusted automatically going forward. Congress should also address persistent overestimation issues by instructing CMS to revisit assumptions used in calculating budget neutrality adjustments retroactively. Additionally, to meet its oversight responsibilities, Congress should direct the Government Accountability Office to compare CMS utilization estimates for new Medicare codes with actual utilization and payments after implementation, and to report its findings to Congress by a specified deadline.

2. **QUESTION: If MIPs were to be reformed or replaced entirely, what would a new physician-led quality program look like? How can we ensure a new program reduces administrative burdens and is applicable to all types of clinicians in all settings, while focusing meaningfully on real outcomes?**

PCC and our Better Health-NOW partners have previously urged HHS to pursue an accountability framework that stresses the Barbara Starfield framework for high quality primary care -- comprehensiveness, first contact access, coordination, continuity of care -- and tracks utilization of services (e.g., in-person evaluation and management visits, behavioral health integration services, screening and referral, etc.).[3] To be effective, however, the federal government and payers must act rapidly to streamline metrics, avoid duplication or unnecessary measurement burden, and incorporate new measures that better reflect the value of primary care.

Overwhelming evidence indicates that an ongoing primary care relationship is core to improved population health outcomes.[4] Transitioning toward payment and delivery models that support advanced primary care, like hybrid payment or primary care-centric ACOs, can help sustain those primary care relationships and achieve better health. Unfortunately, the still dominant fee-for-service payment and burdensome quality framework have negatively impacted the primary care workforce - thereby negatively impacting patients' access to a usual source of care. Today almost 1/3 of Americans lack access to a usual source of care.[5]

To date, the transition from FFS to new models has been two steps forward and one step back – driven in part by the growing administrative burden on primary care practices

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[3] 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.

[4] National Academies of Sciences, Engineering, and Medicine National Academies of Sciences, Engineering, and Medicine, "Implementing High-Quality Primary Care," *National Academies Press eBooks*, May 4, 2021, https://doi.org/10.17226/25983.

[5] National Association of Community Health Centers, Health Landscape, and American Academy of Family Physicians, "Closing the Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis," 2023, https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf.

and clinicians. Administrative burden related to quality measurement is especially high for practices that have multiple payer contracts and care models supported by APMs, such as ACOs.[6] Variation across models, payers, programs and technology also adds administrative burden, complexity and additional financial costs to primary care practices.

Outsized administrative and cost burdens borne by primary care must be alleviated. There are *systemwide* benefits when quality and population health measures are evidence-based, standardized, collected and publicly reported. In fact, the work primary care does to support measurement and information exchange amounts to a common good. Common measure sets – which further transparency and enable comparability -- can inform purchaser and patient decisions and raise the level of quality systemwide. Health information exchanges (HIE) also produce systemwide benefits from improved care coordination, enhanced patient safety and less duplication of services. To all patients, including those of small, independent and rural practices, the cost of HIE should be spread broadly and based on the practice's ability to pay. Even when widely shared, HIE costs should be identified in system costs and managed responsibly.

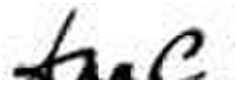
[6] Ann S. O'Malley et al., "Administrative Burden in Primary Care: Causes and Potential Solutions," *The Commonwealth Fund Website*, September 26, 2025, https://doi.org/10.26099/86n1-4m81.

When participating in APMs, primary care practices should receive both more resources and more flexibility to innovate on behalf of patients. By taking accountability for quality and cost outcomes in APMs, practices should enjoy non-financial upsides in addition to financial incentives. Specifically, when primary care practices participate in APMs with accountability for population outcomes and costs, they should be provided relief from documentation demands and regulatory "safe harbors," such as waivers of audits or other oversight. Until key stakeholders prioritize primary care administrative burden reduction, payment models to support whole-person primary care will not scale, nor will the patient-centered, systemwide benefits such models generate.

Consider greater standardization and alignment as a solution. Working with the private sector, government can help set expectations and leverage its roles as a convener and purchaser - helping align industry players around common electronic formats and processes. Recent federal leadership on a broad set of priorities for a "patient-centric healthcare ecosystem" has potential to build voluntary alignment to reduce some of the biggest pain points in primary care administrative burden. However, to reduce unnecessary measurement burden, policymakers must align and harmonize measurement across programs (e.g. traditional Medicare, Medicare Advantage, and Medicaid) while assuring appropriateness for the reporting entities and populations served. Further for some sources of administration burden, such as failure to support data exchange, stronger regulatory action may be needed to achieve true interoperability – where appropriate information can be exchanged without burdensome effort or financial expense for the patient or their primary care team.

PCC and our Better Health - NOW campaign partners appreciate the opportunity to work with you on concrete legislative steps to reform MACRA and strengthen primary care. If our team can answer any questions regarding these comments, please contact PCC's Director of Policy, Larry McNeely at lmcneely@thepcc.org.

Sincerely,



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