September 14, 2026

John Brooks
Deputy Administrator & Director
Center for Medicare
200 Independence Ave., S.W.
Washington, DC 20001

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Deputy Administrator Brooks,

On behalf of the Primary Care Collaborative (PCC) and PCC's Better Health NOW campaign (BHN), we appreciate this opportunity to offer comments on the CY 2027 Medicare Physician Fee Schedule proposed rule.

The Primary Care Collaborative (PCC) is a nonprofit, nonpartisan, coalition of 66 organizational members, including clinicians, patient advocates, employer groups, and health plans. The PCC and its members are dedicated to a high-quality health care system rooted in whole-person primary care, with a focus on comprehensive, ongoing relationships and addressing underlying factors to enhance patient experience and health outcomes. In 2022, the 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 therefore thank you for several significant regulatory changes proposed for next year. The new steps to improve calculation of practice expense, a new Part B cost-sharing waiver in MSSP and improved payment for health promotion and behavioral health integration can contribute to better health outcomes for beneficiaries. And as reflected in the Redesigning Primary Care to Make America Healthy Again RfI, the agency is clearly contemplating still bolder change. **As CMS charts its path toward wider embrace of accountable care and technology-enabled care, the evidence is clear: primary care must be at the center.** Ongoing primary care relationships, characterized by trust and comprehensiveness, remain the single most

powerful lever by which health care can improve population health and long-term costs.[1] [2] [3] Rather than an incidental byproduct, continuity of primary care must be a central design principle across FFS payment, outcome-based payment and population-based or capitated payment models.

In our response to the Redesigning Primary Care RfI, we call on CMS to explicitly prioritize continuity of primary care in its work to improve PFS coding and valuation as well as its support for value-based accountable care payment. Specifically, we recommend

- Continuing CMS' work to address longstanding mispricing (valuation) of primary care.
- Establishing population-based primary care payment, available to all MSSP ACOs, with clear public reporting and payment that supports enhanced investment in front-line primary care practices and health centers.
- Removing barriers to adoption of the Advanced Primary Care Management (APCM) program by reiterating that APCM component services need not be delivered each month to beneficiaries and by removing administratively burdensome cost-sharing that is also a barrier to beneficiary adoption.

This comment letter also responds to several important CY 2027 CMS proposals and issues raised in the NPRM, as summarized here:

<u>Improved Primary Care Pricing</u>

- Move forward with practice expense proposals that reform the allocation of PE and reduce reliance on outdated indirect practice survey data.
- Expeditiously revalue overpriced global surgical practices using the best available data.
- Incorporate empiric data provided by Maryland's All-Payer Claims Database (APCD) in updated payment for misvalued services and work with the 24 other states with APCDs to inform future pricing/valuation policy.

<u>Medicare Physician Fee Schedule Payment for Whole Person Primary Care</u>

- Finalize increased CoCM reimbursement, while extending the improved behavioral health care manager valuation to other behavioral health services.
- Finalize improved payment for Smoking Cessation and SBIRT services
- Cover and pay for health coaching and clarify that the services can be provided under general supervision.
- Implement Shared Medical Appointment Services (SMAS) while assuring sufficient payment. Develop SMAS for a broader range of conditions.

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[1] Andrew Bazemore et al., "The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review," The Annals of Family Medicine 21, no. 3 (May 1, 2023): 274–79, https://doi.org/10.1370/afm.2961.

[2] Andrew Bazemore et al., "The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review," The Annals of Family Medicine 21, no. 3 (May 1, 2023): 274–79, https://doi.org/10.1370/afm.2961.

[3] Zhou Yang et al., "Physician- Versus Practice-level Primary Care Continuity and Association With Outcomes in Medicare Beneficiaries," Health Services Research 57, no. 4 (May 6, 2022): 914–29, https://doi.org/10.1111/1475-6773.13999.

- Develop coverage and payment for lifestyle interventions aimed at prevention of Alzheimer's and other dementias.

However, our comments express strong concern, broadly shared across primary care clinicians and patient organizations, that CMS' proposed restriction of RPM/RTM billing to employed staff would dramatically impact access to care for patients.

Federally Qualified Health Centers and Rural Health Clinics

- Finalize proposed payment for Diabetes Self-Management Training and Medical Nutrition Therapy in RHCs.
- To assure more accurate payment for FQHCs, undertake an assessment of the underlying Community Health Center PPS using current cost data and modernize the qualifying visit list.
- Extend to FQHCs and RHCs the ability to bill for health coaching and Shared Medical Appointments.

Medicare Shared Savings Program:

- Finalize the proposal to make Part B cost sharing waivers available across MSSP and take additional steps including eliminating cost-sharing for Advanced Primary Care Management across Part B
- Move forward with other CMS proposals to support primary care participation in MSSP, including incentives to engage patients who are new to value-based care or face complex care needs.

DETAILED COMMENTS

PRACTICE EXPENSE

Systematic overvaluation of certain services, relative to primary care, has made treatment of the complications of chronic illness lucrative while eroding payment for and access to whole-person primary care that can prevent and better mitigate chronic conditions. Better quality outcomes require rebalancing of these incentives. The PCC was encouraged by bold policy steps taken in the CY 2026 Medicare PFS final rule to address mispricing, including the introduction of an efficiency adjustment applicable to non-time-based services and prioritization of empiric data in pricing of services. We are also pleased to see additional attention paid by CMS to improving the methodologies used in the calculation of practice expense.

Practice Expense (PE) Methodology-Allocation of PE to Services

CMS Description: CMS would revise the allocation of indirect PE to account for both physician work and clinical labor for nearly all services except those with 10- and 90-day global periods. Under the current methodology, clinical labor is generally included in place of physician work when the clinical labor PE RVUs exceed the work RVUs, while both are included for services with separately billable professional and technical components. CMS states that this approach has resulted in a comparatively larger

allocation of indirect PE to services with professional and technical components, including many diagnostic and imaging services.

PCC/BHN Response: **The PCC and our Better Health NOW campaign support the proposal to revise the allocation of indirect PE.** Primary care increasingly relies on team-based models to support comprehensive whole-person care, yet the current indirect PE methodology does not fully account for both physician work and clinical labor, which are essential to delivering this care. We support counting both physician work and clinical labor in the allocator to better recognize the infrastructure and resources required to support team-based primary care.

Practice Expense Methodology-Indirect Practice Expense per Hour Data

CMS Description: CMS also proposes to phase out the Indirect Practice Cost Index (IPCI), which relies largely on specialty-level PE data collected in 2007 or earlier. The IPCI would be phased out over two years, with half of its measured variation applied in CY 2027 and no IPCI adjustment applied beginning in CY 2028. CMS states that the current methodology places too much weight on outdated specialty-level survey data and limits the effect of more recent code-level inputs and allocation methodologies.

PCC/BHN Response: **The PCC and our Better Health NOW partners support CMS' proposal to phase out the Indirect Practice Cost Index (IPCI).** In our comments on the CY 2026 Physician Fee Schedule, we noted that the IPCI relies on data that is nearly two decades old. CMS has also recognized broader concerns with survey-based practice expense data, including unreliable surveys with low response rates. Anchoring Medicare payment to outdated specialty-level spending patterns risks perpetuating longstanding distortions in the relative valuation of MPFS services.

VALUATION OF SPECIFIC CODES, INCLUDING POTENTIALLY MISVALUED CODES

Evaluation and Management (E/M) Visit Complexity Add-On (HCPCS code G2211)

CMS Description: CMS proposes replacing code G2211 with a modifier that would be appended to E/M codes (MOD1/MOD2), with some technical changes. The MOD1 descriptions would read:

> *Visit complexity inherent to new or established office/outpatient or home or residence evaluation and management service, associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.*

CMS proposes that MOD1 be valued at 16 percent of the base E/M code.

Additionally, to account for the additional resource costs associated with serving as the focal point of care for the entire beneficiary within an accountable care relationship, CMS proposes an additional modifier, MOD2. CMS proposes that MOD2 be valued at 32 percent of the base E/M code when performed by Shared Savings Program ACO participants, ACO professionals, and ACO providers/suppliers (as each is defined at § 425.20), as well as Participant Providers in the LEAD Model. The modifier would be billable for all services delivered by these clinicians, not just those delivered to beneficiaries assigned to the ACO.

PCC/BHN Response: Primary care-centric ACOs are among the most effective Medicare APM models extant today. Findings from CMS, CBO, and PCC's own published analysis confirm that primary care-centric ACOs outperform other ACOs.[4] Making MOD2 billable alongside Medicare Part B E&M visits that are part of an ongoing care relationship could provide a significant per-visit boost for ACO participating primary care clinicians. Added payment incentives may make participation in MSSP ACOs more attractive for primary care clinicians.

While we support the added investment in primary care delivery in ACOs, represented by CMS' proposal, we are concerned about an additional change that could impact payment for inherent complexity associated with an ongoing care relationship. CMS has seen a low uptake of G2211, and the additional resources may not necessarily be reaching primary care clinicians as intended.[5] [6] Over the past few years, primary care practices, plans and EMRs have made changes to support G2211, and have only recently begun to bill the G2211 code. Replacing G2211 with the proposed modifiers may be disruptive, particularly for smaller or independent practices. In the event CMS finalizes its proposal, **to assure accurate payment for the inherent complexity of ongoing primary care, CMS should consider allowing billing clinicians to either bill the newly proposed modifier or G2211.**

We are also concerned about the potential implications of moving forward with MOD1 for the growing proportion of primary clinicians in employed relationships. In particular, employed primary care clinicians whose compensation is tied to work RVUs could be negatively affected because MOD1 does not carry work RVUs. As a result, payments made through MOD1 would not count toward clinician's productivity targets, even though the organization may receive additional reimbursement.

However, the evidence does clearly call for, and we encourage, a more thorough reform. Working with the primary care community, CMS should establish a hybrid payment option within MSSP, incorporating the lessons learned from past experience with CMS

[4] Ann Greiner et al., "An Evaluation of Primary Care in Medicare Accountable Care Organizations," ed. Cristina Boccuti et al., PCC 2024 Evidence Report, November 2024, https://thepcc.org/wp-content/uploads/2025/01/Primary-Care-The-MVP-of-MSSP-2024-Evidence-Report.pdf.

[5] Joshua A. Smith et al., "A Retrospective Study Evaluating the Utilization of G2211," Annals of Internal Medicine 179, no. 5 (April 6, 2026): 761–63, https://doi.org/10.7326/annals-25-05105.

[6] Ishani Ganguli et al., "Billing of Medicare's G2211 Longitudinal Care Code Among Traditional Medicare Beneficiaries," JAMA 335, no. 11 (February 19, 2026): 1003, https://doi.org/10.1001/jama.2026.0424.

Innovation Center models. In addition, providing ACOs the option to receive APCM payments for attributed beneficiaries, first raised in the CY 2026 NPRM, would encourage enhanced participation in MSSP ACOs and strengthen primary care.

Potentially Misvalued Services Under the PFS - Request for revaluation of physician work time based on empiric data (CPT codes 15734, 19318,19380, 23472, 27130, 27447, 37227, 37229, 43281, 43644, 47120, 88305, 88307)

CMS Description: Potentially misvalued codes spanning a series of diagnostic and surgical interventions have been identified for CMS through a novel analysis of Maryland's all-payer claims database as well as previous empirical analyses from RAND and Urban Institute.[7] [8] CMS requests comment on "whether we should make these changes for CY 2027, or for future rulemaking, and whether we should consider making corresponding changes to the work RVUs for these services or if changes to the physician time would be sufficient."

PCC/BHN Response: In comments responsive to the CY 2026 MPFS, PCC and our Better Health NOW partners urged CMS to leverage a diverse set of data sources to inform PFS payment rates, including accurate and valid survey data and routinely collected empirical data. We therefore thank CMS for their attention to this and other nominated services**. We encourage CMS to move forward expeditiously to incorporate the information into its published relative values. Additionally, we call on CMS to partner with the twenty-four states with existing all-payer claims databases to identify similar overvalued services.**

Strategies for Improving Global Surgery Payment Accuracy

CMS Description: CMS proposes to pause the claims-based data collection on postoperative visits required by section 523 of MACRA while it evaluates how best to improve the accuracy of global surgical payments and reduce reporting burden. CMS states that available data indicates that many postoperative visits included in 10- and 90-day global packages are not occurring as assumed. CMS is also publishing a public-use file that displays imputed RVUs for postoperative visits included in 10- and 90-day global packages and seeks comment on additional data sources and potential future valuation strategies. CMS is not proposing to revalue global surgical packages through this component of the rule for CY 2027.

PCC/BHN Response: The PCC and our Better Health NOW partners support greater use of empiric data in the valuation of MPFS services. We agree with CMS that the postoperative visits included in the 10- and 90-day global packages are not occurring at

[7] Rachel O. Reid et al., "Surgical Procedure Time Comparisons: Comparing Physician Fee Schedule Intraservice Times With Real-World Times as Observed in National Surgical Quality Improvement Program Intraoperative Times and Anesthesia Claims," RAND, September 24, 2025, https://www.rand.org/pubs/research_reports/RRA3470-1.html.

[8] "How States' All-Payer Claims Databases Can Help CMS More Accurately Value Services," Data set, *Forefront Group*, June 5, 2026, https://doi.org/10.1377/forefront.20260601.711491.

the number of visits used to estimate packages, and we appreciate the release of the public use file. We find CMS' decision to address the issue through a separately proposed overlap policy puzzling. OIG has encouraged CMS to "update its valuation of the global surgery fees to reflect the number of postoperative visits actually being provided to Medicare patients." **We encourage CMS to move expeditiously to address the underlying core issue by revaluing global surgical packages based on the best available data.**

Remote Monitoring (CPT Codes 98975, 98976, 98977, 98978, 98980, 98981, 98984, 98985, 98986, 98979, 99091, 99453, 99454, 99457, 99458, 99473, 99474, 99445, and 99470)

CMS Description: CMS proposes changes to the coding, valuation, and billing policies for remote monitoring services. Specifically, CMS is proposing to require an initial visit with patients, requiring patients to be established to bill RPM and only allowing payment for RPM or RTM services when furnished by clinical staff employed by the practice.

PCC/BHN Response: We acknowledge CMS' legitimate interest in reducing unnecessary utilization and the need to reduce improper utilization. As CMS works to address these issues by proposing limiting reimbursement solely to those RPM /RTM services furnished by employed staff, retaining tools for RPM for appropriate use cases to maintain critical patient access continues to be of utmost concern for PCC member organizations. Primary care practices rely almost exclusively on vendors to make these services available and implementing the requirement that the services be performed by employed clinical staff would halt their delivery. Eventually, large practices may be able to bring these services in-house, but small and independent practices lack the capital to do so. As an alternative to this proposal, CMS should consider establishing a standard based on clinical control of these tools and integration into the EMR, which could provide a more appropriate framework for permitting contracted arrangements that preserve meaningful clinical oversight, coordination and management.

Shared Medical Appointment (HCPCS code GSMAS)

CMS Description: CMS proposes creating code GSMAS to establish coding and payment for shared medical appointments provided for medical conditions that are modifiable with lifestyle change. CMS defines a shared medical appointment as a voluntary, group-based medical session involving multiple patients with common medical condition(s), receiving medical care in a group setting; billed and led by a physician or qualified nonphysician practitioner and may include services provided by other qualified healthcare professionals, clinical staff or auxiliary personnel under the direction of the supervising physician or other practitioner. Sessions integrate group education, counseling, and peer support with individualized patient clinical assessment and care, 2-10 patients, billed once per patient, per 60-minute session.

PCC/BHN Response: **The PCC and our Better Health NOW partners applaud CMS for taking a step toward paying for health promotion and supporting**

whole-person primary care by expanding access to multidisciplinary, evidence-based care, including shared medical appointments (SMAs). As the agency moves forward with implementation, it will be vital to continue assessing whether the proposed payment is sufficient to fully support the model.

The PCC and our Better Health NOW partners encourage CMS to expand eligibility and flexibility for SMAs. CMS should develop and extend coverage and payment for SMAs to address a broader range of physical and behavioral health conditions, consistent with the evidence and the needs of Medicare beneficiaries and allow session duration and group size to be determined by patient needs, the condition being treated, quality of care and available clinicians. CMS should also confirm that FQHCs and Rural Health Clinics can provide and bill for SMA services.

Health Coaching (CPT codes 0591T, 0592T, and 0593T)

CMS Description: CMS proposes creating payment and codes for health and well-being coaching services and proposes qualifications for auxiliary personnel. CMS proposes valuing the services at the same level as chronic care management.

PCC/BHN Response: The PCC and our BHN partners thank CMS for this proposal. **We strongly support coverage and payment of health coaching in person and through telehealth.** Evidence clearly confirms the effectiveness of this intervention.[9] We agree that community-based organizations have an important role to play in health coaching and thank CMS for encouraging their participation through general supervision. We urge CMS to clarify that the services may also be delivered and billed under general supervision. Applying restrictive direct supervision requirements could undermine the adoption of this critical service and diminish health benefits that wider coaching could bring to the Medicare population. We further recommend that CMS enable FQHCs and RHCs to deliver these services and bill the proposed codes.

Smoking and Tobacco Use Cessation (CPT codes 99406, 99407) and Screening, Brief Intervention, and Referral to Treatment (SBIRT) (HCPCS codes G2011, G0396, G0397

CMS Description: CMS proposes applying an upward adjustment of 19.1 percent to the work RVUs for Smoking Cessation and Screening, Brief Intervention, and Referral to Treatment.

PCC/BHN Response: **The PCC and our Better Health NOW partners support the proposal to apply an upward adjustment to the work RVUs for Smoking Cessation and Screening, Brief Intervention, and Referral to Treatment (SBIRT).** The proposal appropriately recognizes both the clinical intensity of these time-based services and the important role primary care clinicians play in preventing and managing chronic disease.

[9] 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.

Successful smoking cessation is more likely with clinician intervention, including counseling, medication, or a combination of treatments.[10] Smoking cessation billing codes remain underutilized, despite evidence suggesting that cessation interventions are being delivered more frequently than reflected in CPT billing.[11] Low utilization of the codes may be due, in part, to low reimbursement rates or the administrative burden associated with billing for these services. Adequate payment for evidence-based cessation counseling can better support primary care clinicians in delivering these highly effective preventive services while reducing smoking-related disease and associated health care costs.

SBIRT is particularly valuable in primary care because it provides a structured approach for identifying unhealthy substance use early, intervening before it progresses and connecting patients with appropriate treatment when necessary. However, evidence shows persistent barriers to SBIRT utilization, including inadequate reimbursement. Current payment rates do not fully support the costs associated with treating patients. [12]

For patients with more significant needs, the referral component of SBIRT provides an important bridge between primary care and behavioral health treatment. Increasing payment for these services would better acknowledge and reflect the work required to deliver SBIRT and make it more feasible for primary care practices to incorporate evidence-based substance use prevention and treatment into comprehensive care.

Psychiatric Collaborative Care Model (CoCM) (CPT codes 99492, 99493, 99494, G2214) and APCM BHI add-on codes (HCPCS Codes G0568, G0569)

CMS Description: CMS proposes updating and increasing valuation of Psychiatric Collaborative Care Model codes by 10-46% (depending on the code). CMS also proposes increasing the rate of reimbursement for Behavioral Health Care Managers by $0.13 per minute.

PCC/BHN Response: **The PCC and our Better Health NOW partners are happy to see increased reimbursement of collaborative care and updated pricing of behavioral health care manager elements of CoCM. We encourage CMS to move forward with increased payment for these services.** Investing in behavioral health is essential to expanding access to whole-person team-based primary care. While clinician shortages continue to hinder access to behavioral health services, evidence-based models of behavioral health integration, such as collaborative care and

[10] Brenna VanFrank et al., "Adult Smoking Cessation — United States, 2022," MMWR Morbidity and Mortality Weekly Report 73, no. 29 (July 25, 2024): 633–41, https://doi.org/10.15585/mmwr.mm7329a1.
[11] Derek J Baughman et al., "Billing for Tobacco Cessation: Enhancing Data Quality and Revenue Capture," The American Journal of Managed Care 32, no. 4 (April 1, 2026): 212, https://doi.org/10.37765/ajmc.2026.89917.
[12] Rahm AK, Boggs JM, Martin C, et al. Facilitators and Barriers to Implementing Screening, Brief Intervention, and Referral to Treatment (SBIRT) in Primary Care in Integrated Health Care Settings. *Subst Abus*.36(3) (2015):281-288. doi:10.1080/08897077.2014.951140

the primary care behavioral health model, enhance primary care's capacity to address behavioral health. [13]

However, we are concerned that the proposed pricing (valuation), tied to a blend of level 3 and level 4 E/M services, may continue to undervalue these vital services. CMS should consider a higher valuation.

Additionally, CMS should consider applying the same increased pricing of Behavioral Health Care Managers to other services that rely on similar personnel (e.g., General Behavioral Health Integration).

We also encourage CMS to expand adoption of BHI by explicitly recognizing appropriately structured, evidence-based group interventions as permissible behavioral health care activities within CoCM and in General BHI. Group interventions could help address a significant barrier to BHI access and scalability: workforce capacity. Requiring therapeutic interactions that occur exclusively one-on-one can unnecessarily limit the reach of a population-based model. Appropriately structured groups can extend access to evidence-based interventions while preserving individualized oversight, assessment and measurement-based treatment-to-target as well as the ability to intensify care when clinically indicated. This approach does not replace individualized care or create a less rigorous approach. Rather, it expands the modalities through which evidence-based behavioral care can be delivered while preserving individualized clinical management.

Age-Based Preventive Services

Issue Description: Health during childhood drives outcomes and costs over the lifespan. And while Medicare provides coverage for only a small number of children, the payment policies it promulgates shape coverage, payment rates and payment modality by the state Medicaid/CHIP programs, employer-based plans and commercial insurance, all of which cover individuals under 18.

CMS has previously published values for age-based preventive medicine services (CPT codes 99381-99397) which private payers typically use to cover recommended well-child visits. CMS failed to update these valuations when it updated E/M services in 2021. Although Medicare itself is barred by statute from covering such services, it failed to update the previously published prices. Additionally, other relevant payment codes such as G2211 may be billed for analogous services such as E/M or Annual Wellness visit, but CMS has not identified age-based preventive medicine services as services with which G2211 can be billed. As a result, progress toward improved primary care reimbursement has skipped the population where improved access to primary care and prevention could have the greatest impact on long-term costs and chronic disease outcomes: children.

[13] Stacy A. Ogbeide et al., "To Go or Not Go: Patient Preference in Seeking Specialty Mental Health Versus Behavioral Consultation Within the Primary Care Behavioral Health Consultation Model.," Families Systems & Health 36, no. 4 (October 11, 2018): 513–17, https://doi.org/10.1037/fsh0000374.

PCC/BHN Response: In recognition of its unique role in shaping coverage by other public and private payers, Medicare should consider "non-covered" preventive services when it promulgates policy related to Medicare covered preventive services. In general, CMS should recognize the full scope of CPT codes for primary care services. With regard to age-based preventive medicine services, **we urge CMS to undertake the following actions:**

- **Adjust published RVUs for preventive medicine services (CPT codes 99381-99397) based on 2021 EM increase even though the services are not currently covered by Medicare.**
- **Adjust G2211 guidelines indicating preventive medicine services (CPT codes 99381-99397) are non-covered services that other payers may want to consider similar to the Medicare annual wellness codes for the purposes of G2211 or any successor codes or modifiers.**

Looking beyond these specific recommendations, Medicare's payment reform initiatives must reflect an across-the-lifespan perspective. Medicare's payment policies are commonly adopted by commercial, employer-based and Medicaid or CHIP plans. In the RfI to which we respond below, the agency itself acknowledges primary care visit CPT codes that are not covered under Medicare yet recognized by other payers (e.g., CPT codes 99381-99397). When health payment systems promote evidence-based preventive care, early detection, and disease prevention, the healthy children of today grow into the healthy American workforce and later the healthy adult Medicare beneficiaries of tomorrow.

REDESIGNING PRIMARY CARE TO MAKE AMERICA HEALTHY AGAIN RFI

The PCC and our Better Health NOW partners thank CMS for this RfI and for its efforts to shift from today's unbalanced reliance on FFS to a more optimal primary care payment system. That said, no one-size-fits-all solution – whether FFS, outcome-based or capitated – can or should be applied across all communities and every Medicare beneficiary. Rather, in the appropriate policy framework, each model could contribute to modernizing Original Medicare.

Whatever the balance Medicare strikes among the payment modalities, improved pricing of primary care in the MPFS will be crucial to its goal of strengthening primary care. As noted elsewhere in these comments, we have been encouraged by bold policy steps taken in the CY 2026 Medicare PFS final rule to address mispricing, including the introduction of an efficiency adjustment applicable to non-time-based services and prioritization of empiric data in pricing of services – as well as this year's practice expense proposals. To further build on and refine these reforms, we encourage CMS to establish a Technical Advisory Panel OR other Expert Panel charged with providing independent advice to CMS on improvement of data sources and pricing. Such a body would serve a complementary/supplementary role to other existing sources of data and recommendations.

Across all three forms of payment, continuity of care should be a central design principle rather than an incidental byproduct. Patients with continuous relationships experience lower total costs of care, fewer emergency department visits, fewer hospitalizations, lower mortality and higher patient satisfaction.[14] [15] [16] Continuous primary care relationships are the heart of high-value care.

O/O E/M Visits

CMS Description: CMS is considering establishing distinct categories of O/O E/M visits in future rulemaking, with distinctive categories such as longitudinal care, acute care or consultative visits. CMS notes that private payers, but not Medicare, pay for consultative services (CPT codes 99242-99245) and requests feedback on whether the complexity of these services is closer to the acute care services versus the longitudinal care services.

PCC/BHN Response: The PCC and our Better Health NOW partners thank CMS for its continuing interest in enhancing accuracy in payment for E/M payment, and in particular, the recognition that existing payment does not fully reflect the inputs nor the overall outcomes of primary care. We encourage CMS to continue its work to improve accurate relative pricing of existing services payment, remove barriers to adoption of the recently introduced APCM and BHI add-on services and make more comprehensive hybrid payment available.

The approach described in this section, however, raises significant issues. In real world practice, primary care does not fall neatly into the three categories. In particular, longitudinal, relationship-based primary care involves more than one category of care. For example, a primary clinician might leverage a visit prompted by an acute sore throat to address ongoing management of chronic comorbid diabetes and depression. The knowledge of the patient, the communication between the patient and the clinician and the trust built through an ongoing longitudinal relationship work together to enhance the effectiveness and the value of both services.

The approach described envisions tying certain between-visit care management functions to E/M services themselves. This approach has potential for unintended consequences. Namely, it would shift payment, currently available for non-visit-based care management such as APCM, toward payment based solely on volume and tempo of visits. This change would contradict the broader evolution of payment incentives away

[14] Andrew Bazemore et al., "The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review," The Annals of Family Medicine 21, no. 3 (May 1, 2023): 274–79, https://doi.org/10.1370/afm.2961.
[15] Andrew Bazemore et al., "The Impact of Interpersonal Continuity of Primary Care on Health Care Costs and Use: A Critical Review," The Annals of Family Medicine 21, no. 3 (May 1, 2023): 274–79, https://doi.org/10.1370/afm.2961.
[16] Zhou Yang et al., "Physician- Versus Practice-level Primary Care Continuity and Association With Outcomes in Medicare Beneficiaries," Health Services Research 57, no. 4 (May 6, 2022): 914–29, https://doi.org/10.1111/1475-6773.13999.

from payment for discrete services (like a visit) and toward health of populations (such as a patient panel).

Rather than adding further complexity to existing E/M billing and increasing administrative burdens, we encourage CMS instead to build on existing mechanisms such as G2211, care management services and in particular APCM services.

Care Management Code 'Family'

CMS Description: CMS notes the limited uptake of care management services, ranging from Chronic Care Management to APCM, and seeks feedback on whether another payment structure is needed or whether to streamline this set of codes.

PCC/BHN Response:

We appreciate CMS' interest in burden reduction. However, PCC's own examination of the issue indicates that the establishment of coverage and payment for non-visit-based care management between visits is not among the commonly noted sources of burden in primary care.[17] In fact, accurate FFS payment for team-based, non-visit-based services remains vital for two reasons. First, care management activities can prevent costly chronic disease complications and downstream costs. This is particularly important for those beneficiaries whose treating clinician is not an alternative payment model participant. Second, accurate pricing/valuation of these services furnishes building blocks for larger hybrid or capitated payment that we advocate and describe in our response to RfI regarding population-based primary care payment below.

In particular, Advanced Primary Care Management (APCM) services, launched in 2024, hold great promise in supporting primary care teams to deliver whole-person care in Medicare. APCM directs more resources to care for patients with complex chronic conditions, expanding access and outreach to the patients who we must reach to address chronic conditions in the Medicare population. APCM provides primary care in Original Medicare with bundled payments; these payments are designed to streamline the billing process, allowing clinicians to focus on building ongoing relationships with patients to manage care and support patient goals, rather than on tracking their time.

In partnership with Simple Healthcare, the PCC is currently analyzing APCM 2025 experience - to be released as part of our 2026 Evidence report. While not as widespread as we might hope, we find adoption of the code consistent with utilization of prior codes. The problem is not the code itself. Our research and engagement with primary care practices indicate that uncertainty remains about the billing and documentation requirements for APCM. We encourage CMS to reiterate and clarify that the service can

[17] Primary Care Collaborative, "Simplifying Value-Based Primary Care by Reducing Administrative Burdens - PCC," PCC, March 11, 2026, https://thepcc.org/issue_briefs/simplifying-value-based-primary-care-by-reducing-administrative-burdens/.

be billed in months when no individual components of the service (e.g., care management or communications services) are delivered.

Mandatory cost-sharing—including a 20% coinsurance for some Medicare patients—may prevent some practices from adopting APCM, due to concerns about straining patient relationships and the red tape and cost associated with putting the cost-share in place. By removing the administratively burdensome cost-sharing requirement from APCM and associated behavioral health integration codes, CMS can reduce one of the biggest hurdles to widespread adoption.

Payment Implications of Technology Enablement of Primary Care

CMS Description: CMS seeks comment on how the growing use of technology and clinical AI is changing primary care delivery and how Medicare payment should account for these changes. CMS is particularly interested in how AI affects the time, intensity, workflow and resource costs of primary care, including how clinicians use additional capacity created by productivity gains and where services are not adequately captured under existing coding and payment structures.

CMS asks whether payment should be tied more directly to demonstrated clinical outcomes and how it should evaluate the effects of technology on quality, downstream costs, clinical practice and the beneficiary experience.

PCC/BHN Response:
We support the thoughtful use of AI and other technologies to reduce administrative burden, improve care coordination, strengthen clinical decision-making and expand the capacity of primary care teams. AI and technology-enabled care generally offer important opportunities to support relationship-based whole-person primary care and many practices are already embracing them.

As indicated in the RfI, primary care practices are already deploying passive medical scribing to reduce administrative burden and, increasingly, OpenEvidence to ease the flow of information to the clinician. In the years ahead, the use cases for these particular technologies are likely to grow stronger. Other technologies, including AI-informed analytics, agentic AI personal technology and other applications also show promise and have been incorporated by participants in the CMS Innovation Center's ACCESS model.

However, CMS' approach to tech-enabled care raises important issues. Whether in the establishment of remote monitoring codes and in the Innovation Center's new ACCESS Model, Medicare has established payment mechanisms that enroll a Medicare beneficiary in an ongoing, technology-enabled service and bill for it. In each case the primary care clinician remains the person who actually manages the patient's hypertension or diabetes, who adjusts the medication when the readings come back high, orders the lab when a gap appears and sees the patient when something escalates. And in each case that work is either unpaid or paid nominally, while the organization that distributed the device and collected the data is paid in full. The technology is not

the problem. The problem is that the payment architecture treats the practice with the longitudinal relationship as an optional bystander.

It is crucial that CMS consider its next steps in the context of the effective levers available to improve population health available to primary care.
In the context of the primary care relationships built over time, the beneficiary, their caregivers and clinical team establish trust, identify goals and a care plan that spans all of the patient's medical needs and engage the patient in the care decisions and behavior change needed for optimal health. The primary care clinician is in the driver's seat as interventions are tailored to patient needs.

For the Medicare population – aging and typically facing multiple chronic conditions – this partnership amongst a patient, their caregivers and the primary care team is fundamental to integrating and delivering whole person care. An AI tool or other tech intervention that may work well for a younger or healthier patient with pre-diabetes could have an entirely different, less positive outcome for a patient with multiple chronic conditions with an ongoing, often complex care plan.

Practicing primary care clinicians have expressed concern that the promise of technology enabled care could be seriously undermined by inadequate coordination and integration with a patient's ongoing care plan and medical record. For the patient, proliferation of care options that treat one aspect of health in isolation could fragment that patients' care and undermine health improvement. As we've seen from RPM / RTM implementation, allowing tech companies to supplant primary care clinicians as the driver of the care team can have unintended and undesirable consequences. Tech enabled care must keep clinicians in the driver's seat and avoid disintermediation of primary care clinicians from the patient.

Considering bandwidth of a primary care practice, already stretched thin by administrative burdens and the needs of their patient panel, a proliferation of patient results from a variety of tech sources, such as ACCESS vendor participants, could overwhelm team capacity to make sense of patient data and advise on next steps.

We strongly urge CMS to carefully monitor the ACCESS model, attending specifically to experience of primary care clinicians and their relationships with their patients and the need to avoid further fragmentation of care particularly among Medicare beneficiaries with multiple conditions, complex care needs, or dual eligible status. Without careful analysis, scaling features of the ACCESS model in Medicare risks undermining outcomes and the success of any proposed policy.

As Medicare explores how to pay for technologically enabled care, addressing these challenges is vital. The path to successful payment for technology-enabled care must be designed and implemented with and through primary care, not pursued around it.

The PCC offers the following considerations as it considers how Medicare can best pay for technology-enabled care:

- Enrollment/Participation: **Optimally, referrals to Medicare-covered interventions should originate from an existing care relationship, rather than allowing third-party technology vendors to independently recruit and enroll patients**. This keeps chronic disease management anchored with the patient's existing care team, where evidence suggests it produces the best outcomes.[18] At a minimum, any technology-enabled or outcomes-based intervention should begin by informing and consulting with a patient's primary care clinician to verify diagnoses and determine eligibility, so that patients receive appropriate services without risk of misdiagnosis or unnecessary interventions.

- Robust Care Coordination: Given primary care's longitudinal and comprehensive nature, primary care practices and clinics are often already managing their patients' chronic conditions, including developing care plans tailored to meet each patient's unique needs and goals. **To foster improved outcomes and successful implementation, any outcome-based technology-enabled service should be required to collaborate with a patient's established source of primary care, so the technology serves as a complement and potential force multiplier to existing care plans.** CMS should require technology-enabled interventions to coordinate with the established care team and ensure that clinically relevant information is proactively incorporated into the patient's longitudinal medical record.

- Reach of Interventions: The chronic disease burden within the Medicare-enrolled population is not evenly distributed. Dually eligible beneficiaries and those with low incomes experience higher rates of individual chronic conditions and multimorbidity. To move the needle on overall prevalence of chronic physical and behavioral health conditions and ensuing costs, technology-enabled solutions, must not just reach but overperform in these communities. Yet the primary care practices may well lack the capital, team or ongoing funding needed to scale up interventions. **CMS must structure coverage for technology-enabled care and any associated payment model in a way that reaches the communities we most need to reach to successfully address the chronic disease challenge.**

- Appropriate Payment level and structure: The PCC was pleased to see that the CMS Innovation Center's ACCESS model provided quarterly payment available to primary care to review progress and eliminated Part B cost sharing for the payment. However, primary care clinicians and PCC member organizations have highlighted that the level of payment is far too low and too infrequent to successfully and effectively support the work of integrating ACCESS data into the patient's overall care plan and medical record. **CMS should consider providing a more robust add-on payment billable in conjunction with**

[18] Andrada Tomoaia-Cotisel et al., "Implementation of Care Management: An Analysis of Recent AHRQ Research," Medical Care Research and Review 75, no. 1 (October 21, 2016): 46–65, https://doi.org/10.1177/1077558716673459.https://pmc.ncbi.nlm.nih.gov/articles/PMC7177185/

the APCM or as a supplement to any future hybrid payment to account for the costs of such innovation. Primary care should be involved in co-creating AI and other tech enabled tools and remain part of the "iron triangle" that encompasses the patient/caregiver, the clinician and supporting technology to deliver on the best results in terms of cost and quality.

Technology and AI-Augmentation in Primary Care via the Medicare AWV

CMS Description: CMS asks a series of questions exploring whether technology can improve AWV effectiveness, personalization and both beneficiary and clinician experience, expressing particular interest in shifting from a point-in-time assessment to a more continuous, data-driven and beneficiary-specific preventive care function.

PCC/BHN Response: Primary care practices recognize the value of the annual wellness visit and many are open to opportunities to leverage AI to facilitate broader uptake. However, in the context of a longitudinal relationship, the AWV is an opportunity to integrate preventive recommendations with the patient's medical history, chronic conditions, behavioral health needs, personal circumstances, care preferences and long-term goals. **CMS should not permit technology vendors or other third parties to furnish substantial portions of preventive care through stand-alone encounters disconnected from the patient's established primary care relationship**.

Primary Care Capitated Payment Arrangements Considerations for the Shared Savings Program

CMS Description: In the RFI, CMS seeks comment on detailed questions about the design of potential population-based primary care payment (PPCP) available within the MSSP.

PCC/BHN Response: Working with the primary care community, CMS should establish a hybrid payment option within MSSP, incorporating the lessons learned from past experiences in MSSP, CMS Innovation Center models and the private sector. **We thank CMS for considering implementing prospective primary care payment in MSSP as a first step toward a broader shift of primary care financing.** Since 2021, the PCC, alongside our Better Health NOW partners have urged CMS to move forward with hybrid payment for primary care, yet most Medicare practices are reliant on existing fee-based payment methodologies.

Properly designed, funded and implemented, PPCP would be consistent with previous PCC and Better Health NOW advocacy. **We urge CMS to continue engaging the PCC and the primary care community in the design of this proposal and would be pleased to facilitate opportunities for the CM team to hear from clinicians, patients and ACOs.** We respond below to specific issues raised in the RfI.

- Eligibility for Participation: In order to support more primary care participation and success, hybrid or primary care capitated payment should be available to all MSSP ACOs on a permanent basis. To facilitate participation by Federally

Qualified Health Centers and Rural Health Clinics, payment guardrails are needed that would protect prospective payment system and all-inclusive rate payment levels. Moreover, CMS should permit some, but not all, ACO participants within an ACO to participate in capitated payment arrangements.

- Base Payment Design and Structure.
    - *Enhanced Payment:* Any per member per month payment must substantively increase investment in primary care above the amount available through FFS payment. The calculation and form of this added investment should be informed by the full range of experience with CMMI models, including both ACO REACH and ACO PC Flex.
    - *Services Included:* A base PC capitation should incorporate payment for care management, E&M visits and evidence-informed screening and referral for BH & social needs with sufficient reimbursement incentives to support delivery of these services; services outside the base should be payable on a fee-for-service basis without reduction (e.g. collaborative care model or general BHI, inpatient E&M, other behavioral health or health promotion services etc.).
    - *Downstream Payments*: In previous communication with CMS regarding the ACO PC Flex Model, the PCC encouraged CMS to allow for two cash flow options:
        - *Approach 1:* CMS pays prospective and per-visit payments directly to the primary care practices, with a portion paid to the ACO as the practices and ACOs mutually agree.
        - *Approach 2:* CMS makes payments directly to the ACO, which administers the capitated payments to participating primary care practices.

      Population-based payment should not be limited to the ACO entity itself. Primary care practices that participate in ACOs should have the opportunity to replace today's visit or productivity-based cash flow with downstream monthly, prospective payments at the practice level. We request that CMS consider how it might implement both approaches. We believe providing both options would increase participation in the PPCP and make MSSP more attractive to primary care, particularly those not yet participating in the program.
    - *Certainty for Participants:* Any population-based payment must provide clear, predictable cash flow and avoid retrospective payments subject to reconciliation or claw backs. Frequent adjustments made to previous CMMI models have generated uncertainty for ACOs and primary care practices, effectively pushing practices back to comparatively more stable FFS. We recommend that CMS pursue prospective payments that function like true capitation, by paying predictable amounts up front without retrospective reconciliation. At the same time, CMS should maintain FFS payment to cover complex, intensive or unpredictable services that are not well suited for inclusion in a prospective bundle.
    - *Transparent Public Reporting:* To ensure investments reach the point of care themselves, CMS should develop and apply public reporting standards for participating ACOs regarding primary care payment. In that

reporting, ACOs should ensure that clinicians, beneficiaries, and researchers should have access to practice level payment levels, the basis of payment (e.g., PMPM, RVU-based, visit or daily rates) and a description of in-kind supports such as expanded care team support, analytics and/or health IT support.

Care Delivery Requirements: Higher payment tiers should be available to those ACOs and ACO participants that deliver more expansive services, such as more robust integration of behavioral health, health promotion and social care linkages. Full integration of behavioral health services, for example, requires going beyond integration of basic care coordination by including a wider spectrum of behavioral health services critical to primary care.

Primary Care Capitated Payment Arrangements Considerations outside of the Shared Saving Program

CMS Description: While CMS is primarily focused on the development of PPCP within accountable care, it is also considering a primary care global period for traditional Medicare in the future. After an initiating visit, primary care services would be reimbursed over an interval of care consistent with the development of a longitudinal relationship between clinician and patient. Such a payment could potentially include the AWV, O/O E/M services and care management services such as APCM. Commenters are asked to consider which and how many services should be bundled, whether there should be a hybrid capitation model with a reduced FFS component and how to establish payment levels best.

PCC/BHN Response: Primary care practices not in ACOs and their patients need a viable alternative to volume-driven FFS that supports and sustains whole-person primary care relationships. The PCC has called for a broadly available hybrid payment in Part B with enhanced funding sufficient to build the teams needed to support comprehensive, whole-person primary care.

That said, establishing such a model raises a series of important design questions, including those raised in this RFI. We would recommend that CMS open a full-fledged dialogue with researchers and stakeholders on how best to develop such a model, even as it moves forward with other reforms.

We note the introduction of two pieces of bipartisan legislation that would establish such a hybrid primary care payment in Congress, H.R. 9636 Patients First Act of 2026 and S. 5269 Pay PCPs Act of 2026 and encourage CMS to continue to prioritize dialogue with and technical assistance to Congress on this issue.

SUPPORTING BENEFICIARIES PLANNING FOR FUTURE MEDICAL DECISIONS

Request for Information on Intensive Lifestyle Interventions to slow progression of Alzheimer's disease

CMS Description: CMS requests information on developing and valuing intensive, multidomain lifestyle interventions to reduce the risk of Alzheimer's disease and Alzheimer's disease-related dementias (AD/ADRD) for Medicare beneficiaries or slow cognitive decline. CMS requests information to better understand the resource costs and requirements for developing these interventions and seeks comment on:

- evidence of cost savings associated with intensive lifestyle interventions;
- the essential domains of a multidomain intervention appropriate for Medicare;
- service design, including frequency, duration, modality (in-person or virtual), eligibility and whether services should be provided one-time or on a recurring basis;
- the interdisciplinary team members and supervision requirements that should be reflected in resource costs; and how CMS's Health Technology Ecosystem could support intensive lifestyle interventions to reduce the risk of AD/ADRD.

PCC/BHN Response: The PCC and our BHN partners are appreciative of CMS' continued work to advance the prevention and management of chronic disease, specifically Alzheimer's and cognitive impairments. In 2020, 82% of primary care physicians said they [19] on the front lines of providing dementia care. Yet, they do not have the time, capacity or resources to implement effective lifestyle interventions to support these patients. There is also no existing mechanism for these clinicians to receive reimbursement for these services.

The U.S. POINTER study found that an intensive, structured lifestyle program — focusing on healthy nutrition, physical exercise, cognitive engagement and health monitoring — improved thinking and memory over two years[20]. **CMS should develop a coding and payment system to cover these evidence-based lifestyle interventions to support the growing number of Medicare beneficiaries living with Alzheimer's and properly resource the clinicians treating them.**

RURAL HEALTH CLINICS (RHCS) AND FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)

Increasing Access to Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services in RHCs

CMS Description: CMS proposes to recognize DSMT and MNT services as qualified preventive services that are covered and paid by the AIR as stand-alone billable visits under the RHC benefit. These services would need to be furnished by a certified

[19] Alzheimer's Association. "Alzheimer's Disease facts and figures." Alzheimers Dement 16–3 (2020): 391. https://www.alz.org/getmedia/809826d9-6646-4870-a9a2-4c1d8c9a7c83/alzheimers-facts-and-figures_1.pdf.
[20] Laura D. Baker et al., "Structured Vs Self-Guided Multidomain Lifestyle Interventions for Global Cognitive Function," JAMA 334, no. 8 (July 28, 2025): 681, https://doi.org/10.1001/jama.2025.12923.

provider under the direct supervision of RHC professional staff to qualify as a billable RHC visit.

PCC/BHN Response: The PCC and our Better Health NOW partners support expanding access to these services for rural populations and enhancing reimbursement to support rural clinicians. We are happy to see CMS implementing evidence-based nutrition and education services to manage chronic disease and prevent complications.

Proposed CY 2027 FQHC PPS Market Basket Update

CMS Description: CMS proposes to use an estimate of the percentage increase in the 2022-based FQHC market basket to update payments to FQHCs based on the best available data. The estimated update is 2.5 percent, based on an unexpected historical percentage increase in the FQHC market basket update.

PCC/BHN Response: **CMS should undertake a comprehensive evaluation of the CHC Prospective Payment System using current CHC cost data**, including identification of opportunities to simplify Medicare cost reporting while preserving the information necessary to accurately assess the cost of care in CHCs.

We further encourage CMS to assess the underlying PPS using current cost data, modernize the qualifying visit list and ensure that new Medicare primary care services can be appropriately reimbursed when furnished by CHCs. These changes would reduce unnecessary administrative complexity while ensuring that Medicare payment more accurately reflects the comprehensive primary care CHCs provide.

MEDICARE SHARED SAVINGS PROGRAM

Proposal to Increase the Sharing Rate under Level E of the BASIC Track

CMS Description: CMS is proposing to increase the savings rate for BASIC track Level E from 50 percent to 60 percent for agreement periods beginning on or after January 1, 2027.

PCC/BHN Response: The PCC and our Better Health NOW partners support CMS' efforts to increase participation and savings in MSSP – especially for those practicing in small and rural practices – as well as promote sustainability for long-term participation in the program.

Proposal to Risk Adjust the 5 percent Cap on Upward Adjustments to the Historical Benchmark

CMS Description: CMS proposes to risk adjust the 5 percent cap on each of the upward adjustments to the historical benchmark: the positive regional adjustment, the prior savings adjustment and the population adjustment.

PCC/BHN Response: The PCC and our BHN partners support this initial step toward ensuring that savings reflect patient complexity for ACOs with higher-risk, higher-cost populations. We encourage CMS to continue the work to align incentives that encourage ACOs with clinically complex patient populations to participate in shared savings and increase access to high-quality, comprehensive primary care for all patients.

Proposed Growth Adjustment to the Historical Benchmark

CMS Description: CMS is proposing a growth adjustment to the historical benchmark applicable to ACOs in agreement periods beginning on January 1, 2027 and in subsequent years. The proposed growth adjustment would offer a method of upwardly adjusting an ACO's historical benchmark that would be applied in addition to the existing regional adjustment, prior savings adjustment and population adjustment, up to the proposed cap of 5 percent of ACO risk-adjusted national per capita expenditures.

PCC/BHN response: We applaud this proposed incentive for ACOs to serve beneficiaries new to value-based care. Promoting ongoing care relationships is critical, particularly in ACOs, to ensure patients are receiving the longitudinal, relationship-based care we know improves outcomes.

However, CMS should remove the requirement that a beneficiary must also be assigned to a new ACO professional in order to generate the growth adjustment. ACOs should receive credit for increasing the number of beneficiaries in accountable care regardless of whether those patients are assigned through a new or existing ACO professional. The current restriction may significantly reduce the value of the incentive.

The barrier to entry for value-based care arrangements is often financial, particularly for small or rural independent practices.[21] An increase in shared savings alone is not a large enough investment to provide the stability needed for some practices, especially primary care practices, to join ACOs. As we articulate in our response to the primary care RfI, we recommend that CMS pursue prospective payments that function like true capitation, by paying predictable amounts up front without retrospective reconciliation.

Proposal to Modify Assignment Eligibility Criteria and Prospective Assignment Exclusion Criteria Based on Medicare Enrollment Status

CMS Description: CMS is proposing to expand the criteria for assignment eligibility to permit assignment of a Medicare FFS beneficiary with at least 1 month of Part A and Part B enrollment during the assignment window and no Medicare group health plan enrollment during that same month.

PCC/BHN Response: The PCC and our Better Health NOW partners support this proposal as a means of growing the MSSP program and allowing more Medicare beneficiaries in an accountable care relationship.

[21] Ann S. O'Malley et al., "Why primary care practitioners aren't joining Value-Based Payment Models: Reasons and Potential solutions," The Commonwealth Fund Website, July 3, 2024, https://doi.org/10.26099/2cxx-0z64.

Proposal to Allow ACOs To Reduce or Eliminate Part B Cost Sharing

CMS Description: CMS is proposing that eligible ACOs may, subject to certain conditions and safeguards, enter into Part B cost sharing support agreements with ACO participants, under which ACO participants reduce or eliminate cost sharing for those categories of eligible Part B items and services and eligible beneficiaries identified by the ACO. Cost-sharing support could include both Medicare FFS deductible and coinsurance amounts, or either of the two. ACOs may only reduce or eliminate Part B cost sharing for beneficiaries whose overall health is expected to be improved or maintained by receiving the associated Part B item or service. Cost sharing support is allowed for all Part B services except durable medical equipment, prosthetics, orthotics, supplies and prescription drugs.

CMS proposes to limit the ability to reduce or eliminate Part B cost sharing support to those eligible ACOs that have submitted a Part B cost sharing support application and for which CMS has approved their application to participate for that agreement period or the remainder of that agreement period.

PCC/BHN Response: **We strongly support this proposal to allow ACOs to reduce or eliminate Part B cost-sharing**. Whole-person primary care can address clinical issues upstream, mitigating the need for costly downstream services. This newly expanded waiver policy could be used by willing MSSP ACOs and practices to remove barriers to whole-person primary care. For example, an ACO might propose to waive monthly cost-sharing for APCM services or behavioral health integration services, removing a common administrative barrier to adoption of these valuable services.

Experience with ACO REACH and the private sector demonstrates that additional strategies would further strengthen relationship-based primary care in Original Medicare.

- Paper-based voluntary alignment: Voluntary alignment allows a Medicare beneficiary to choose the clinician they consider their primary source of care. But today, MSSP beneficiaries can only voluntarily align through MyMedicare.gov and roughly 1 in 400 do so. ACO REACH has tested a paper-based approach that generates 20 times the number of patient sign-ups.
- Remove administratively burdensome cost-sharing for APCM: Patient cost-sharing remains a barrier for many Medicare beneficiaries and an administrative burden for practices, slowing adoption of APCM nationwide. Eliminating cost sharing for APCM would advance the Administration's health goals by supporting access to primary care and preventive services, while reducing administrative burden.

Proposal to Modify the Methodology and Use Description for Advance Investment Payments

CMS Description: CMS proposes several changes to the methodology for calculating advance investment payments (AIPs), beginning in Performance Year 2028. These

include removing the Area Deprivation Index (ADI) from the methodology, adding rurality as a criterion and providing a flat payment amount for assigned beneficiaries who do not otherwise qualify based on rurality, low-income subsidy status, or dual eligibility.

PCC/BHN Response: The PCC and our Better Health NOW partners support providing a base payment for assigned beneficiaries as a means of reducing upfront costs and providing resources to sustain ACOs. ACOs require upfront resources to build care-management programs, data capabilities, beneficiary engagement activities and other population-health infrastructure that benefits their broader patient population.

We also appreciate CMS adding rural criterion to support often underserved and under-resourced communities. We continue to encourage CMS to take steps to ensure ACOs have the resources they need to succeed in MSSP and expand access to accountable care arrangements for Medicare beneficiaries.

Proposal To Revise Distribution Timing of Standardized Written Notices

CMS Description: CMS proposes removing the requirement to furnish a standardized written notice to beneficiaries prior to or at the first primary care service visit during the first performance year in which the beneficiary receives a primary care service from an ACO participant and proposes requiring the standardized written notice must be furnished to all of these beneficiaries by May 30, unless CMS specifies a later date during the Performance Year. CMS also proposes removing the requirement for follow-up communication.

PCC/BHN Response: The PCC and our Better Health NOW partners appreciate CMS taking steps to reduce administrative burden and complexity for ACOs. **We support allowing ACOs more flexibility in communicating with beneficiaries and streamlining workflows and processes to improve efficiency.**

The PCC and our Better Health NOW campaign appreciate this opportunity to provide comments on the CY 2027 MPFS NPRM and look forward to working with the CMS team to 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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Primary Care Collaborative