The Commonwealth Fund
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September 10, 2025

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

VIA ELECTRONIC SUBMISSION

Re: CMS Calendar Year 2026 Medicare Physician Fee Schedule

Dear Administrator Oz,

Thank you for the opportunity to provide comments on the 2026 Medicare Physician Fee Schedule Proposed Rule. I appreciate your leadership on this effort to strengthen primary care.

The Commonwealth Fund is a nonprofit, nonpartisan foundation dedicated to affordable, quality health care for everyone. We support independent research on health care issues and make grants to promote better access, improved quality, and greater efficiency in health care. I lead our Improving Health Care Delivery program with a focus on strengthening primary and rural health care.

Evidence is clear that improving the capacity and quality of primary care so that it can improve the health and wellbeing of people is essential to successfully addressing the nation's most pressing health issues – from the chronic disease epidemic to the behavioral health crisis. Patients with a usual source of primary care are more likely to receive recommended preventative screenings and services and primary care has been found to improve detection, management, and outcomes for people with diabetes, cardiovascular disease, and hypertension. Critically, primary care is the only health service associated with improved life expectancy.

But in the U.S., several indicators suggest that the sustainability and future of primary care is at risk. Three in ten people report not having a usual source of care – a declining number, despite increased access to insurance. Compared to other high-income countries, U.S. patients are among the least likely to have a usual source of care or a longstanding relationship with a primary care provider. This trend is only likely to worsen as the supply of primary care providers shrinks, particularly in communities with historically few primary care clinicians, such as rural areas.

**There is growing consensus that changing *how* and *how much* we pay for primary care is a critical next step for policymakers to reverse these trends and strengthen primary care in the U.S.** The growing issues facing primary care — including workforce shortages and poor access — are in large part due to

the continued dominance of fee-for-service (FFS) payment, which discourages team-based, coordinated care, and decades-long underinvestment.

As one of the largest insurers in the U.S., Medicare plays a critical role in leading the charge by increasing our nation's investment in primary care services and changing the way we pay for them, moving towards more population-based approaches. Improvements and modernizations to the Medicare Physician Fee Schedule (MPFS) will not only influence other payers, but also improve value-based payment arrangements which are built on the FFS chassis.

We appreciate the opportunity to address steps CMS can take to modernize payment and rebalance investment to primary care in the MPFS. **Finalization of changes to improve the accuracy of service valuation as well as proposed adjustments to the Advanced Primary Care Management (APCM) codes for FY 2026 would represent a critical step towards streamlined and heightened compensation for high-value services primary care clinicians provide.**

Below we offer comment on select provisions of the proposed rule that would be most impactful for primary care.[1]

## Section II.B.5. Development of Strategies for Updates to Practice Expense Data Collection and Methodology

High-value primary care services – from diagnosing and managing chronic illness, coordinating care in a complex health system, and communicating with patients and caregivers – are often under-reimbursed, overly complex to bill, or not reimbursed at all. This is in part due to Medicare payment for services being based on flawed surveys of clinician time and work.

**CMS' proposals to obtain empirical data on physician time and work to assist in identifying and assessing potentially misvalued codes would support efforts to accurately value services and modernize physician payment.**

We offer a few additional considerations below, drawing from the evidence and expert consensus:

- **Potential data sources**: CMS has proposed several empirical data sources in the proposed rule including electronic health records, operating room logs, time-motion data and other sources which would be helpful inputs to the valuation process. Evidence has validated the feasibility of using empirical data such as that drawn from electronic health records for determining the time it takes to complete various services. A 2016 CMS commissioned study combined administrative data extracted from electronic health records for some services and direct observation of practice or physician staff to document the time needed to provide services to patients. They determined this was a feasible alternative for determining physician time and work, and ultimately RVUs. CMS could establish a rotating panel of practices to apply this approach to and source timely and objective information for determining RVUs.
- **Testing alternative fee schedules**. In addition to obtaining empirical data on physician time and work to inform RVUs, CMS could consider partnering with the Center for Medicare and Medicaid Innovation (CMMI) to develop and research alternative fee schedules. Through this mechanism,

[1] The views presented here are those of the author and not necessarily those of the Commonwealth Fund or its directors, officers, or staff.

CMS could develop and test new valuation strategies that have been suggested by experts including data collection approaches, moving from "magnitude estimation" to "building block" approaches to increase the accuracy of work estimates, and streamlining of billing codes into payment families with similar time and work valuations for related services (such as 21 different types of colonoscopies).

- **Technical Expert Panel.** Changing how RVUs are determined is a substantial and highly technical undertaking. Recent bipartisan legislation has called for the establishment of a new Technical Advisory Committee to provide guidance to CMS on modernizing the physician fee schedule and developing processes for empirically determining relative resources, consistent with current statutory authority. CMS' recently announced Healthcare Advisory Committee could also be helpful in identifying alternative data sources and processes to improve the accuracy and precision of valuation.

**Section II.E.2.b. Methodology for Establishing Work RVUs: Proposed Efficiency Adjustment**

RVU calculations do not properly account for the work and time that goes into delivering high-quality primary care services. This is due in part to the flawed survey data CMS relies on to determine physician time and work (see above section). It is also the result of the over-valuing of procedural services and tests, despite the fact that the time and work to provide these discrete services likely goes down over time as clinicians become more efficient at delivering them. RVUs are rarely updated to account for these efficiency gains which are not similarly achievable by primary care clinicians that must spend time diagnosing and managing the comprehensive needs of a patient. This has led to Medicare reimbursing procedure-based services as much as 3 to 5 times more than cognitive, time-intensive services. A recent study found per-visit revenue for primary care is one-fifth of revenue for procedure-heavy specialties.

**The proposed efficiency adjustment to intraservice time and work RVUs for non-time-based services such as procedures, diagnostic tests, and radiology, represents a meaningful first step towards improving the accuracy of valuation and rebalancing investment towards primary care.**

We offer a few additional considerations on this topic:

- **Exemption of Time-Based Codes**. CMS' proposal to exempt time-based codes which primary care clinicians disproportionately provide, such as evaluation and management visits and care management services, from the efficiency adjustment is critical to ensure the fee-schedule does not further disadvantage primary care. It is also logical to exempt these codes as time itself is the resource used in furnishing the work portion of these services, and therefore is not amenable to efficiency gains.
- **Considerations for Rural Clinicians.** CMS could consider exemptions or adjusting the efficiency adjustment for clinicians practicing in rural areas given the unique financial challenges they face and their disproportionate reliance on Medicare as a payer. Over three thousand rural medical practices closed between 2019 and 2024. With a sizable share of Medicare beneficiaries living in rural areas, ranging from 5% in Florida to 61% in Wyoming, these closures pose significant barriers to access for rural Medicare beneficiaries. Contributing to the instability of rural health care sites are their thin financial margins, caused by low volume visits and relatively higher operating costs. Narrow payer mix also contributes. Significant changes in payment, particularly from Medicare which generally pays more than Medicaid or commercial payers, can have significant impacts on practice sustainability in rural areas. It is important to balance the unique financial needs of rural clinicians with the need to streamline the efficiency adjuster.

**Section II.G. Enhanced Care Management**

**1-3. Integrating Behavioral Health into Advanced Primary Care Management.**

Evidence shows that integrated behavioral health results in better physical and behavioral health outcomes. Today, primary care clinicians are increasingly treating the behavioral health conditions of their patients, particularly those enrolled in Medicare and Medicaid, with 16% of all primary care visits being for behavioral health conditions in 2018. Primary care is capable and well positioned to treat behavioral health conditions, with ninety percent of US primary care physicians reporting they are prepared to manage their patients' behavioral health needs. Moreover, many US adults with a mental health disorder have co-occurring chronic conditions, pointing to the unique and important role primary care can play.

However, workforce shortages and financing of integration are major barriers to primary care practices looking to scale their behavioral health services. Evidence from CMMI's Primary Care First model found that over half of participating practices expanded integrated behavioral health care, however when they discontinued their integration efforts, it was owing to financial constraints, highlighting the need for payment that accounts for these services.

**The Advanced Primary Care Management (APCM) codes finalized in last year's MPFS rule represented a critical step towards streamlined and heightened compensation for high-value primary care services.** The codes removed the burdensome time-based documentation requirements associated with other care management codes and enabled primary care clinicians to bill on a monthly basis regardless of services rendered, giving them predictable revenue to manage patient care and invest in care delivery improvements and staffing.

The 2026 proposed rule builds on the APCM codes by allowing practices to bill an add-on code for behavioral health integration or Collaborative Care Model services. In doing so, as with APCM generally, these codes would not be subject to time tracking. This is particularly important as evidence has suggested that the time-based documentation requirements for the behavioral health integration codes implemented in 2017 have stymied adoption. **These add on codes would represent a critical step in ensuring access to behavioral health services integrated with primary care.**

**4. Request for Information Related to APCM and Prevention - Cost-Sharing**

Cost-sharing requirements currently associated with APCM codes pose significant barriers to uptake of services, while placing greater administrative burden on primary care clinicians themselves. Even cost-sharing of just $1 to $5 has been linked to reductions in utilization of critical preventative care services – which can result in subsequent increases in costly forms of care like emergency department visits.

**We applaud CMS' recognition that several service elements of the APCM bundle are similar to aspects of 'personalized prevention plan services', and as such APCM could be provided without beneficiary cost-sharing requirements.** While some service elements of APCM would not be considered preventative but rather are treatment services, it would be too burdensome for clinicians to apply cost sharing to specific parts of the APCM service bundle and not others. Waiving beneficiary cost-sharing for

APCM service codes would bolster uptake of critical preventative services while reducing burden on providers.

**4. Request for Information Related to APCM and Prevention – Primary Care Participation in ACOs**

Evidence has consistently found that primary care centric Accountable Care Organizations (ACOs) outperform hospital-led. Medicare Shared Savings Program (MSSP) ACOs comprised of 75% primary care clinicians or more saw $281 per capita in net savings compared to $149 for ACOs with fewer primary care clinicians. A 2019 analysis found that physician-led ACOs produce nearly seven times more Medicare savings per beneficiary than hospital-led ACOs.

Despite their promise, primary care-centric MSSP ACOs have not substantially grown over time. We applaud CMS' efforts to reverse this trend and grow primary care participation in the MSSP program while complementing and support further uptake of APCM codes.

We offer a few options for CMS to consider:

- **Year-End Reconciliation**. CMS could remove APCM services (including the BHI add-on services proposed for FY 2026) from expenditure totals that are compared to spending benchmarks as part of year-end reconciliation in MSSP. This would serve to both incentivize ACOs to partner with their primary care clinicians to adopt APCM and encourage primary care clinicians themselves to join ACOs in an effort to maximize upfront payments they are eligible to receive. For this incentive to be successful, it would need to be combined with waiver of cost-sharing as discussed above followed by waiver of APCM consent, which would be duplicative of the beneficiary notification required in MSSP. This step could greatly increase APCM uptake, which would create greater financial stability for primary care practices while increasing primary care participation in MSSP which evidence suggests could improve savings for Medicare.
- **Building on ACO Primary Care Flex Model**. CMS could learn from the first year of the ACO Primary Care Flex model and expand by accepting a new cohort of applications for FY 2027 and identifying other mechanisms for ACOs to offer prospective, capitated payments to primary care clinicians, including appropriate safeguards to ensure payments are being passed on to clinicians themselves.

For general questions about this response or inquiries for the Commonwealth Fund, please contact Christina Ramsay (cr@cmwf.org). Please contact Corinne Lewis (cl@cmwf.org) with any questions regarding our comments on the primary care.

Sincerely,

Corinne Lewis, M.S.W., Assistant Vice President, Improving Care Delivery, The Commonwealth Fund