Milbank Memorial Fund
Using evidence to improve population health

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Feedback

Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule
(CMS-1832-P)
Centers for Medicare and Medicaid Services
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The Milbank Memorial Fund welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) "Calendar Year 2026 Physician Fee Schedule Proposed Rule" that was published in the Federal Register on July 16, 2025.

The Milbank Memorial Fund is an endowed operating foundation whose mission is to improve population health and health equity by connecting leaders and decision makers with evidence and sound experience. Given the importance of primary care to a high-performing health system in general, and effective treatment of chronic conditions in particular as well as the weak state of U.S. primary care — we at Milbank have worked on initiatives to strengthen primary care for the last 14 years.

We want to thank the agency for its important work to improve the effectiveness of the Medicare Physician Fee Schedule (MPFS), given your many competing priorities, and for the opportunity to provide input.

An effective and efficient Medicare program is one that promotes a healthcare delivery system that improves the health of Medicare beneficiaries. Evidence clearly shows that strong primary care is foundational to such a health system. Critically, primary care is the only health service associated with improved life expectancy.

Improving the capacity and quality of primary care so that it can improve the health and wellbeing of people is essential to making America healthy and 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 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.

But in the U.S., several indicators suggest that the sustainability and future of primary care is at risk. In 2022, three in ten people reported not having a usual source of care — an increasing share of the population over the last decade, despite increased access to insurance in the same period. 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 likely to only worsen as the supply of primary care clinicians shrinks, particularly in communities with few primary care clinicians historically, such as those in 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 number of challenges facing primary care — including workforce shortages and poor access — are in large part due to the continued dominance of inadequate and largely fee-for-service (FFS) payments, which discourage team-based, coordinated care, and decades-long underinvestment.

As one of the largest insurers in the U.S., Medicare has helped create these delivery system trends, and it plays a critical role in reversing them.

We thus appreciate this opportunity to identify steps CMS can take to **modernize payment, rebalance investment to primary care, and improve the efficiency and effectiveness of the Medicare Physician Fee Schedule (MPFS).**

Below we comment on select provisions of the proposed rule that would achieve these goals:

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 inadequately 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 from the NASEM report:

- **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 that would be helpful inputs to the valuation process. Evidence has validated the feasibility of using empirical data to determine the time it takes to complete various services. A 2016 CMS commissioned study, for example, combined administrative data extracted from electronic health records for some services and direct observation of practice or physician staff. The study determined this approach was a feasible alternative for determining physician time and work, and ultimately RVUs. CMS could apply this approach to a rotating panel of practices 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, CMS could develop and test new valuation strategies that have been suggested by experts, including data collection approaches, changes to over- and under-valued services, and the streamlining of billing codes with similar time and work valuations for related services into payment families (such as 21 different types of colonoscopies).

- **Technical Expert Panel.** Changing how RVUs are determined is a substantial and highly technical undertaking. Recent 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.

2. Methodology for establishing Work RVUs

B. 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, even as clinicians become more efficient at delivering them over time. RVUs are rarely updated to account for these efficiency gains, which are not similarly achievable by primary care clinicians who 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.

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 some additional considerations on this topic:

- **Exemption of Time-Based Codes**. CMS' proposal to exempt time-based codes, 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. We would not expect great efficiencies over time from such cognitive and time-intensive services delivered by primary care clinicians, which require diagnosing and managing multiple chronic conditions, coordinating care across settings, and regularly communicating with patients and caregivers.
- **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 3,000 rural medical practices closed between 2019 and 2024. With a sizable share of Medicare enrollees living in rural areas, ranging from 5% in Florida to 61% in Wyoming, these closures pose significant barriers to access for rural Medicare enrollees. Contributing to the instability of rural health care sites are their thin financial margins, caused by a low volume of visits and relatively higher operating costs. Narrow payer mix also contributes to practice vulnerability. 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.

5.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 well-positioned to treat behavioral health conditions, with 90% of U.S. primary care physicians reporting they are prepared to manage their patients' behavioral health needs. Moreover, many U.S. 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 for 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, some discontinued their integration efforts due 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 higher 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 toward 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 are treatment rather than preventative services, since all services are being provided in the same visit, 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. It would also create further economic and behavioral incentives for beneficiaries to maintain a relationship with a usual source of care, which has been shown to result in better treatment of chronic conditions and lower use of inpatient and emergency room care.

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 ACOs. Medicare Shared Savings Program (MSSP) ACOs composed 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 grown substantially over time. We applaud CMS' efforts to reverse this trend and encourage primary care participation in the MSSP program while complementing and support further uptake of APCM codes:

- **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, creating 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.

5.C. Updates to Practice Expense Methodology—Site of Service Payment Differential

We strongly support the proposal to reduce the portion of the facility Practice Expense (PE) Relative Value Units (RVUs) allocated based on work RVUs to half the amount allocated to non-facility PE RVUs beginning in CY 2026. However, CMS should **increase the reduction of the facility PE RVUs to two-thirds**, up from one half, in 2026 and in subsequent years. In other words, the facility PE RVUs should be only one-third of what they are today, allocated off of the work RVU. In 2024, only 35.4% of physicians owned their own practice, which is closer to one-third than one half. Furthermore, even in 1988, approximately 72% of physicians were full or part owners of their practice, but CMS overpaid as if 100% fully owned their practice. So, while a 50% reduction in facility indirect PE would be an important change, it would still represent an overpayment in facility-based settings. We would recommend further decreasing the facility-based indirect PE as described.

Payment for services in Urgent Care Centers

CMS should not consider an additional code related to the "visit complexity inherent to evaluation and management associated with medical care services that serve as the immediate

focal point for all needed urgent, non-emergent health care services." An additional place of service code is not necessary.

An effective Medicare Fee Schedule should encourage and reward care that is effective and efficient, i.e., care that is comprehensive and promotes long-term relationships. Urgent care settings do not promote either of these attributes. They do not focus on a patient's myriad of chronic problems, but rather on the immediate symptom at hand. When patients receive care at multiple urgent care centers, they receive disjointed care by definition, which oftentimes does not address underlying root causes of disease — health-related behaviors such as smoking, alcohol use, drug use, physical exercise, nutrition, medication adherence, and more.

The 2024 Physician Fee Schedule stated why it is the longitudinal nature of patient care that creates additional complexity, in particular. For reference, it stated: "There is previously unrecognized but important cognitive effort of utilizing the longitudinal relationship itself in the diagnosis and treatment plan and weighing the factors that affect a longitudinal doctor patient relationship….Weighing these various factors, even for a seemingly simple condition like sinus congestion, makes the entire interaction inherently complex, and it is this complexity in the relationship between the doctor and patient that this code captures."

Creating a visit complexity code would also encourage the establishment of additional urgent care centers, which could lead to further erosion of comprehensive primary care in this country. More primary care clinicians could be hired by urgent care centers, and patients could visit urgent care centers more frequently.

Finally, many primary care practices have extended hours on certain days (indeed, this is part of the discussion of the APCM services). Site neutrality is important and creating incentives to perform services in urgent care centers, as opposed to physician offices, would be problematic. CMS should ensure that primary care clinics, urgent care centers, and emergency department services are treated identically.

Again, we thank you for this important work to make Medicare more efficient and effective and our country healthier. We appreciate this chance to comment on the proposed rule changes. Please contact me with any questions you may have.

Sincerely

Christopher F. Koller