September 14, 2026

Dr. Mehmet Oz
Administrator, Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1848-P, P.O. Box 8016, Baltimore, MD 21244-8016.

Submitted via regulations.gov.

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 Administrator Oz,

United States of Care (USofCare) is pleased to submit comments in response to the Calendar Year (CY) 2027 Medicare Physician Fee Schedule proposed rule issued by the Centers for Medicare & Medicaid Services (CMS).

USofCare is a listening-first, nonpartisan, nonprofit organization working to ensure everyone has access to quality, affordable health care regardless of who they are, where they live, or how much money they make. We listen to people, understand how they experience the health care system in their daily lives, what they need from the system and where it is failing them. We bring the perspectives we hear into policy discussions and our advocacy, translating these community-led insights into people-first policy solutions for state and federal policymakers on both sides of the aisle.

Our response to the proposed rule centers people's perspectives identified through our years of listening work, which has shown that people, including Medicare beneficiaries, desire high-quality, affordable health care. They crave more time with providers and an approach in which their providers communicate with each other to provide them with more personalized, holistic care where the patient is at the forefront of care and decision-making. We call this "patient-first care" (or value-based care) to underscore the importance of addressing people's health care needs in care delivery by moving away from a system that incentivizes volume over quality. Promoting such a system will improve health outcomes and respond to what we know people want while also lowering costs for patients and building toward a more sustainable system overall.

We encourage CMS to continue to focus on crafting policy that can move the health care system beyond the existing fee-for-service chassis that re-aligns provider incentives, adjusts how physicians and other providers are paid, and prioritizes access to critical primary care services,

which are all key components of patient-first care. **With this in mind, USofCare's comments focus on the following areas:**

I. Redesigning Primary Care to Make America Healthy Again
II. Proposed Changes to the Ambulatory Specialty Model
III. Medicare Shared Savings Program
IV. E/M Visit Complexity Add-On (HCPCS code G2211)

Redesigning Primary Care to Make America Healthy Again

We know from our listening research that people desire a health care system in which they can spend more time with their providers, receive care that is coordinated between their providers, and are treated as a whole person rather than a series of symptoms. It is imperative that any shift towards "patient-first care" be rooted in primary care, the foundation of our health care system.

Public opinion research conducted by USofCare in 2025 illuminated public perceptions and priorities regarding primary care and patient experiences. This research concluded that people value having a regular primary care clinician. **More than eight out of 10 (83%) respondents said they highly prioritize having a regular primary care clinician**; more than half (52%) say it's a top priority. However, cost and access are the most cited barriers to accessing primary care across all demographics. Additionally, this research demonstrated that primary care is being underutilized to address chronic disease in the U.S. Among adults who have recently received primary care, **only 27% used it to manage a chronic condition**.

> *"I think it's absolutely necessary... Once or twice a year, depending on whether you're healthy or not. Obviously if you're feeling ill or whatever, you would want to see them more frequently or whatever or if you got a preexisting condition or whatever, you would see them more frequently to manage it or whatever. But generally for a healthy person, maybe once or twice a year."*
>
> ~ Young Black Man, IL, Medicare/Medicaid, Age 26-30

The evidence is clear that primary care is associated with better health outcomes and lower costs. Moreover, across demographics, people have a clear vision that primary care in the U.S. should be affordable, accessible, and convenient. However, the current health care system – and how it values primary care – does not realize that vision. As a result, patients are left with an inadequate or poor experience that fails to meet their primary care needs, or worse, unmanaged chronic conditions and lower life expectancy.

> *"If you don't have that primary care and you['re] going to the emergency room to get your care. I mean, whereas if you were having primary care*

regularly, you may have found out two years ago, oh, I have diabetes. And now you're about to lose a toe because you didn't know."

~ Rural Black Woman, SC, Private Insurance, Age 50-60

Undervaluation of Primary Care

Despite these benefits, less than five percent of all health care spending goes to primary care, and that number is declining. Nearly one-third of people nationwide don't have access to a regular primary care provider. People's access challenges – and related workforce shortages – are particularly acute in rural communities and other underserved areas, leading many to seek care in more costly emergency settings or forego care altogether. Low levels of investment also disproportionately affect people with chronic conditions who rely on consistent, coordinated primary care services to manage their health needs and avoid hospitalizations.

These realities are a symptom of the fundamentally flawed Medicare Physician Fee Schedule (PFS), which chronically undervalues primary care. As currently structured, the Medicare PFS overvalues episodic care and procedures in an increasingly fragmented, difficult to navigate sick-care environment. This comes at the expense of relationship-based, whole-person preventive and primary care designed to keep people healthy. Because private payers in states across the country largely structure their own rates around those established by Medicare, the widespread undervaluation of primary care services within Medicare often bleeds into private insurance markets, as well.

Primary care underinvestment can lead to an overutilization of low-value, high-cost services that do little to improve health outcomes and create financial instability for practices that rely on health care volume rather than improved health outcomes to keep their doors open. As a result, the number of independent physician practices across the U.S. is declining, in part due to the current system forcing physicians to consolidate with larger, corporate entities just to keep their practices afloat. In fact, the fee-for-service system is often cited as a major driver of these trends, none of which benefits primary care providers and the patients they serve.

Given the clear evidence of undervaluation of primary care in the Medicare PFS, USofCare strongly supported the efficiency adjustment that CMS finalized in the CY 2026 Medicare PFS. Ensuring that efficiencies gained over time in non-time-based procedures are accurately reflected in the code valuation will improve payment accuracy and help reduce payment discrepancies between different provider types. Additionally, we supported the establishment of the complexity add-on HCPCS code G2211, which is designed to account for the inherent complexity associated with many evaluation and management services visits (more below on G2211 changes proposed in this NPRM) and can help support proper valuation of primary care services.

The source of this undervaluation can be traced, in part, to recommendations made by the AMA/Specialty Society Relative Value Scale Update Committee (RUC), which makes recommendations on how to update the relative value units (RVUs) used to determine Medicare

physician payments. In theory, the RUC's recommendations – which are almost always adopted by CMS – should avoid incentivizing one service over another, yet given the persistent undervaluing of primary care services, it is clear these physicians, and the patients they serve, emerge at a disadvantage. We believe – and have long considered – that there are shortcomings with the RUC's survey data used in the valuation of codes, which has a particular impact on time-based services and primary care-related codes. Additionally, the RUC disproportionately relies on specialty physician input and conflicted participants who know their contributions will impact their own payments.

USofCare urges CMS to pursue additional policies to address undervaluation of primary care services in the PFS, including evaluating the role the RUC plays in code valuation.

Prospective Primary Care Payment

As CMS considers ways to improve and update primary care physician payment under the PFS, USofCare stresses the importance of shifting toward alternative payment models (APMs) that move away from the fee-for-service chassis. Prospective primary care payment or a hybrid payment model would represent an important step towards addressing primary care undervaluation and provide primary care providers with the necessary support for delivering high-quality, coordinated, whole-person care.

Hybrid payment models for primary care – which contain elements of both fee-for-service and capitated payments – have not only demonstrated improvements to quality of care for patients and long-term cost savings, but they also give providers a consistent stream of upfront payments, promoting stability. A 2021 National Academies of Science, Engineering, and Medicine (NASEM) report identified a need for hybrid models in primary care that include prospective payments for integrated team-based care, adjusted for medical and social complexity, to better deliver care.

A hybrid payment model should capture not only the cost of the underlying primary care office appointment (or evaluation and management visit) and communications with patients and their caregivers outside of the office visit, but also other services, such as care management and behavioral health integration services, that are often underutilized under the current fee-for-service system.

USofCare strongly supports the establishment of a permanent hybrid or prospective payment model for primary care services in Medicare and urges CMS to explore the inclusion of this type of model in the Medicare Shared Savings Program.

Beneficiary Cost Sharing in a Prospective Payment Model for Primary Care

By establishing a relationship with a primary care provider, patients are able to assume a greater role in their health care alongside physicians, nurses, and others that make up their care team. Despite this and other benefits associated with regular primary care access, however, an increasing number of Americans are going without a regular source of primary care. Health care costs – even as low as a dollar or two – have continued to be shown to be significant barriers to care for patients, especially for low-income people.

Our listening research on primary care underscores the barriers that cost plays in people's ability and willingness to access primary care. This is particularly true among rural Americans. Based on our research, rural adults are significantly more likely (32%) than urban (21%) and suburban (24%) adults to report not seeking out primary care because they are unable to afford it.

As CMS explores the possibility of establishing a hybrid or prospective payment system for primary care services, USofCare urges the agency to ensure that beneficiary cost sharing does not apply to these primary care services.

Technology-Enabled Primary Care

As part of this RFI on primary care, CMS contemplates a larger role for technology-enabled care in the delivery of primary care services. Artificial intelligence (AI) is rapidly growing and becoming increasingly prevalent in every aspect of today's society. Currently, AI is a major area of focus for stakeholders across the health care ecosystem – including patient groups and advocates, tech companies and innovators, large health systems and corporations, pharmaceutical and device companies, and state and federal policymakers.

USofCare observes that the end users of AI – everyday people – are absent from the critical conversations that legislators, regulators, and innovators are having, resulting in AI policy in health care without people at the center. This led USofCare to conduct listening research to better understand people's perceptions, beliefs, and attitudes that people hold regarding AI in health care to further inform ongoing policy conversations.

While we appreciate CMS's interest in leveraging AI tools to address shortcomings in the health care system, including around the Medicare Annual Wellness Visit, it is critical that any policy decisions in this area meaningfully consider people's views and comfort levels with these tools.

> *"I'm definitely someone to really want to actually connect to a human being and a doctor who wants to listen holistically to how I conduct my care."*
> ~ Voices of Real Life member

In our listening research on AI, people's feelings on AI integration in health care ranged from cautious optimism to skepticism, while emphasizing the importance of trust, transparency, and human involvement in diagnosis and treatment decisions. While some participants were open to

the use of AI in treatment recommendations, others stressed the significance of human and professional input, especially when prescribing medications.

> *"I think [AI in health care] removes a central human element from a specialty that requires human connection."*
>
> ~ Voices of Real Life member

Polling from USofCare/Morning Consult also sheds light on people's views on AI in health care. While most adults (68%) prefer their physician to use AI tools in a health care setting, the majority (59%) prefer the use of AI in a limited way (i.e. sparingly or occasionally). Only a small percentage of adults (9%) prefer their physician use AI tools extensively. And one-third of adults (33%) prefer their physician doesn't use AI tools at all.

USofCare partnered with athenahealth to examine patient and physician perspectives on AI's expanding role in care settings. Physicians generally expressed more comfort with AI use for administrative tasks and patient education, but less so for its use in clinical decision-making and direct patient interaction. In fact, 61% of physicians expressed concern about a loss of human touch in health care stemming from AI.

As CMS considers policies that would accelerate the integration of AI in care delivery and/or supplant direct clinician care delivery with AI tools, USofCare strongly urges the agency to consider beneficiaries' perspectives on AI and ensure that policies truly improve people's experiences with the health care system and address short-comings and pain points in a way that's reflective of what they want.

Proposed Changes to the Ambulatory Specialty Model

USofCare supported the establishment of the Ambulatory Specialty Model (ASM). We appreciate CMS's focus on two conditions – congestive heart failure and back pain – that have major impacts on patients' health and quality of life, in addition to being associated with high Medicare spending. We believe there is value in providing more opportunities for specialists to move into accountable care arrangements, particularly those with two-sided risk. We also support the mandatory nature of this model.

When CMS proposed this model, USofCare expressed support for the integration of patient reported outcomes data and tying that directly to provider payment. A critical component of health care delivery system reform must be ensuring that patients are active participants in their care and that their voices are heard. Establishing a mechanism for patient-reported outcome-based performance measures (PRO-PMs) on health status, physical function, symptoms, aggregate patient-reported health status, or other related outcomes as part of ASM would help advance this objective.

We appreciate that CMS is actively exploring opportunities to integrate PRO-PM reporting in ASM on a voluntary basis, and agree with CMS's assessment that establishing this reporting as

voluntary will likely require appropriate incentives in order to get ASM participants to actually report this data.

USofCare strongly supports CMS's continued consideration of the integration of PRO-PMs reporting in ASM and incentivizing participants to report this data. Moving forward, we encourage CMS to look for additional opportunities to integrate PRO-PMs into other Innovation Center models.

Medicare Shared Savings Program

CMS is proposing to discontinue the "pre-paid shared savings" participation option for Accountable Care Organizations (ACOs) due to low uptake. However, CMS is also proposing to retain an important component included in that option – providing ACOs with the ability to reduce or eliminate cost sharing for certain Part B items and services.

We know from our listening research that affordability remains a top concern and barrier to care for people across coverage types. When asked to rank the top two health care costs that have the biggest impact on them financially, over 1 in 5 Medicare beneficiaries listed copays as the most burdensome. Additionally, 42% reported at least one financial pressure (i.e. contacted by a credit agency, took out a loan, etc.) related to a medical bill in the last two years.

USofCare strongly supports retaining the ability for ACOs to reduce or eliminate cost sharing for certain Part B items and services.

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

As noted above, USofCare believes the complexity add-on HCPCS code G2211 can help support proper valuation of primary care services. CMS is proposing two changes related to the G2211 code. The first would transition HCPCS code G2211 to a modifier that can be appended to the associated E/M base code that would increase the payment of the associated E/M code by 16%, instead of a flat rate, maintaining an equal percentage increase across all levels of E/M codes. In recognition of the additional resource costs incurred by practitioners in ACOs, the second proposed change would establish another modifier for clinicians participating in a Shared Savings Program ACO or Participant Providers in a Long-term Enhanced ACO Design (LEAD) Model ACO and would increase payment of the associated E/M visit by 32%.

In recognition of people's desire to move towards a health care system that moves away from a fee-for-service structure towards one that prioritizes "patient-first care," it is critical that CMS make advanced alternative payment models (APMs) available to clinicians, but also incentivize participation and ensure payments are adequate to encompass the full range of services necessary for the delivery of coordinated, whole-person care.

In light of our strong support for improving the accuracy of code valuation and advancing patient-first care models, USofCare supports these proposed changes to the E/M complexity add-on code.

Conclusion

Thank you for the opportunity to respond to the proposed rule. Please reach out to Alyssa Penna, Director of Federal Policy, at apenna@usofcare.org with any questions.

Sincerely,

Lisa Hunter
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United States of Care