NATIONAL HEALTH COUNCIL

September 14, 2026

Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

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 [CMS-1848-P]

Submitted electronically via regulations.gov

Dear Administrator Oz:

The National Health Council (NHC) appreciates the opportunity to comment on the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule (CMS-1848-P), which includes consequential changes across physician payment, practice expense valuation, primary and specialty care, care management, telehealth, advance care planning, the Medicare Shared Savings Program (MSSP), quality measurement, and Medicare drug policy. These policies operate through different components of the Medicare program, but their effects will intersect at the point of care. That intersection is particularly consequential for people living with chronic, disabling, rare, and complex conditions who depend on consistent access to primary and specialty clinicians, coordinated care across settings, and payment policies that recognize the resources required to provide longitudinal care.

The NHC unites nearly 200 national organizations—including leading patient groups, research institutions, providers, caregivers, and businesses across the health care sector—to drive patient-centered health policy. Representing 200+ million Americans with chronic diseases and disabilities, the NHC strengthens its members' collective influence to expand access to quality, affordable, and equitable health care. The NHC fosters collaboration to shape policies that reflect the needs of patients.

In its prior comments on the PFS, the NHC has consistently emphasized accurate and empirically grounded valuation; timely access to primary, specialty, behavioral health, and other clinically necessary services; predictable implementation of significant payment changes; continued access to telehealth and other flexible models of care where clinically appropriate; payment approaches that support coordinated management of chronic and complex conditions; sustainability for community-based

and safety-net providers; and quality and value-based payment programs that incorporate outcomes and experiences that matter to patients and caregivers. For CY 2027, the proposed rule combines substantial methodological and distributional changes with an explicit effort to reconsider the relative valuation of primary care, behavioral health, preventive services, and longitudinal care. In these areas, longstanding payment structures may not fully recognize the resources required to coordinate care for people living with chronic and complex conditions. The NHC supports reconsidering these valuations and encourages CMS to use a transparent, evidence-based process that accounts for unintended effects on access across specialties, practice settings, geographic areas, and patient populations.[1]

Accordingly, the NHC encourages CMS to evaluate the CY 2027 policies through both the aggregate expenditure and budget-neutrality analyses required under the PFS and a more granular assessment of whether the resulting distribution of payment better supports high-value primary care, behavioral health, prevention, and longitudinal management while preserving timely access to other patient-critical services. Predictability should facilitate necessary revaluation rather than preserve historical payment relationships that are no longer supported by evidence. Where CMS is undertaking substantial changes to longstanding methodologies, the agency should provide disaggregated impact analyses, reasonable transition periods where concentrated reductions could disrupt care, clearly defined access measures, and mechanisms for reassessment when real-world experience indicates that an otherwise well-supported methodology is producing unintended consequences for patients.

Summary of Recommendations

- **Payment revaluation, predictability, and cumulative impact.** Support appropriate revaluation of payments for primary care, behavioral health, preventive services, and longitudinal care where current relative values do not adequately recognize the resources required to furnish high-value care. Evaluate the combined effects of the CY 2027 conversion factors, practice-expense methodology changes, modifier 25 policy, MOD1 and MOD2, and other budget-neutral adjustments at the specialty, service, practice-setting, geographic, and patient-population levels. Publish sufficiently granular impact information to identify emerging access concerns, and use reasonable transitions where concentrated reductions could disrupt services patients rely on.

- **Practice-expense and service valuation.** Continue modernizing PFS valuation using current, empirical, and auditable data while ensuring that major methodological changes are transparent, appropriately tested, and sensitive to differences in how services are furnished across practice settings. The proposed

[1] Centers for Medicare & Medicaid Services, “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,” 91 Fed. Reg. 43842, 43936–46 (July 16, 2026).

transition away from the Indirect Practice Cost Index (IPCI) should be accompanied by access monitoring and a clear process for correcting anomalous effects before implementation.

- **Separately identifiable E/M services and longitudinal-care payment.** Reconsider a broad payment reduction for evaluation and management (E/M) services appropriately reported with modifier 25 unless CMS can demonstrate that the proposed adjustment reliably identifies duplicative resources rather than distinct clinical work. Preserve payment for medically necessary evaluation and management that is genuinely separate from a procedure furnished on the same day. Evaluate MOD1 and MOD2 for their effects on longitudinal care, specialty access, beneficiary attribution, and incentives across accountable care organization (ACO) and non-ACO settings.

- **Primary care, behavioral health, and care management.** Use the CY 2027 primary-care inquiry to strengthen the relative valuation of primary care and simplify the care-management framework around functions that patients and designated caregivers need, including accessible communication between visits, medication and treatment-plan management, coordination with specialists, navigation, and timely response to changes in condition. Finalize the proposed revaluation of psychiatric Collaborative Care Model and related behavioral health integration services. Address beneficiary cost sharing and documentation barriers that have limited uptake. Test prospective payment carefully with protections for patient choice, clinical complexity, and patients whose longitudinal care is led primarily by specialists.

- **Shared medical appointments and health coaching.** Support dedicated payment pathways for shared medical appointments and appropriately credentialed health and well-being coaching where they expand access to evidence-based chronic-disease management, self-management support, and peer or team-based care. Preserve voluntary participation, confidentiality, individualized clinical assessment, and access to individual care when group-based services do not reflect a patient's needs or preferences.

- **Clinical trial discussions.** Support development of separate payment for meaningful physician-patient clinical trial counseling so that clinicians have sufficient capacity to discuss eligibility, alternatives, risks, benefits, and practical considerations with patients. Keep documentation requirements proportionate, preserve informed choice, and make the service available through telehealth where clinically appropriate.

- **Technology-enabled care and artificial intelligence.** Develop payment approaches that allow clinically valuable technology, including artificial intelligence (AI), to strengthen primary and longitudinal care while preserving clinician accountability, transparency to patients, privacy and security, accessibility, and meaningful patient choice. Evidence of value should include patient outcomes and experience rather than utilization or efficiency alone.

- **Advance care planning and community-based palliative care.** Support payment approaches that recognize team-based advance care planning while ensuring that participation remains voluntary and informed, decisions can be revised, and services are accessible. Continue development of a sustainable pathway for community-based palliative care outside the hospice benefit with direct patient and caregiver involvement in benefit design, eligibility, quality measurement, and implementation.

- **Telehealth and virtual care.** Preserve the telehealth and audio-only flexibilities available through 2027 and implement new reporting requirements without introducing avoidable administrative barriers. Continue to permit patients and clinicians to determine the appropriate modality of care based on clinical circumstances and patient preference while monitoring quality, digital inequities, continuity, and the effects of virtual-platform arrangements on patient choice.

- **Medicare Shared Savings Program.** Support changes that make participation more sustainable, simplify quality reporting, reduce barriers to digital measurement, and expand tools that ACOs can use to engage beneficiaries. As CMS revises benchmarking, assignment, and advance-investment policies, preserve the ability of organizations serving rural, underserved, and medically complex populations to participate and succeed.

- **Digital quality measurement and patient-centered outcomes.** Provide sufficient lead time and technical support for the transition toward Fast Healthcare Interoperability Resources (FHIR)-based digital quality measurement, maintain stable reporting options during the transition, and ensure that simplification does not narrow quality measurement to what is easiest to collect electronically. Patient-reported outcomes, functional status, treatment burden, caregiver experience, and other outcomes that matter directly to patients should remain central to future quality frameworks.

- **Ambulatory Specialty Model and specialty care.** Ensure that specialty-payment models preserve individualized clinical decision-making, incorporate patient-reported outcomes, account for rural and other access challenges, and support coordination between specialty and primary care. Measures intended to reduce low-value services should include appropriate clinical exceptions and should not create incentives to delay medically necessary diagnostic or therapeutic care.

- **Drug-related reporting and program implementation**. Implement Medicare Part B and Part D inflation-rebate and 340B-related reporting requirements through standardized, reliable claims-level information that supports accurate administration, reduces the potential for duplicative discounts, and strengthens program integrity; provide clear definitions, adequate technical assistance, reasonable validation and correction processes, and alignment with existing reporting wherever possible; and ensure that the framework protects patient privacy and does not create reimbursement disputes or processing delays that interrupt access to prescribed therapies.

- **Implementation, monitoring, and patient engagement.** Sequence major changes according to operational complexity and patient risk, minimize duplicative reporting across Medicare programs, provide clear implementation guidance, and establish post-implementation monitoring that can identify and correct unintended access problems. Engage patients and caregiver throughout implementation and evaluation rather than only during notice-and-comment rulemaking.

General Comments and Patient-Centered Framework

As the NHC emphasized in its CY 2027 OPPS comments, Medicare payment policy should be assessed according to its effects on access, affordability, clinical appropriateness, continuity, and outcomes in addition to the technical consistency of the underlying methodology. In the PFS context, predictability helps clinicians, practices, and patients adapt to necessary changes, but it should not justify preserving relative payment relationships when current evidence indicates that some services have been persistently undervalued.[2]

Aggregate payment estimates can obscure substantial variation in how policies affect individual specialties, practice settings, geographic areas, and patient populations. An annual PFS update that appears modest when averaged across all clinicians can interact with code-level revaluation, practice-expense changes, geographic adjustments, participation incentives, and local market conditions. The combined effects may be far more consequential for a community-based specialty practice, a rural clinician with limited patient volume, or a service line that depends disproportionately on Medicare. For patients, those effects are experienced through appointment availability, travel requirements, movement of services across settings, changes in whether practices accept new Medicare beneficiaries, or disruption to an established clinical relationship rather than through the aggregate percentage change reported in an impact table.[3] These concerns may be particularly consequential in community-based oncology and other specialty care, where patients may require repeated treatment over an extended period and already travel significant distances to obtain specialized expertise. A payment change that reduces local capacity or shifts care to another setting can therefore increase travel and treatment burden, disrupt continuity with an established care team, or contribute to delays in clinically necessary care even when aggregate access measures appear stable.[4,5]

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[2] National Health Council, "NHC Comments on CY 2027 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule," August 31, 2026.

[3] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, chap. 4, "Physician and Other Health Professional Services" (Washington, DC: MedPAC, March 2026), https://www.medpac.gov/document/chapter-4-physician-and-other-health-professional-services-march-2026-report/.

[4] Colleen F. Longacre et al., "Evaluating Travel Distance to Radiation Facilities Among Rural and Urban Breast Cancer Patients in the Medicare Population," *The Journal of Rural Health* 36, no. 3 (2020): 334–46, https://doi.org/10.1111/jrh.12413.

Patient-access monitoring should be a routine component of significant PFS reforms and should be tailored to the policy under review rather than defined solely through changes in utilization or aggregate spending. Relevant indicators may include changes in clinician participation and practice location, appointment availability and wait times, travel distance, movement of services across settings, treatment delay or abandonment, access to specialty and behavioral health care, practice consolidation or closure, and patient- and caregiver-reported barriers. Where statistically appropriate, CMS should examine these measures by geography, specialty, practice setting, and clinically relevant beneficiary characteristics so that average national results do not conceal substantial local or population-specific effects. The agency should specify in advance how monitoring findings will inform implementation, including when it would issue technical guidance, modify coding instructions, extend a transition, refine an exception, or address the issue in subsequent rulemaking.[6]

Patient and caregiver engagement should also shape PFS reforms and help CMS interpret access data. The technical complexity and breadth of the annual PFS can make it difficult for patients and patient organizations to assess the practical implications of every valuation methodology, reporting requirement, and model-design decision within a single notice-and-comment period. Structured listening sessions on major reforms, plain-language explanations of high-impact proposals, targeted engagement with affected patient communities, and public reporting on how patient and caregiver input informed final policies would improve both policy development and implementation. Claims and expenditure data remain essential, but they cannot fully capture treatment burden, difficulties obtaining appointments, disruptions in established care relationships, caregiver constraints, or the reasons a technically available service may remain practically inaccessible to a patient.[7,8]

PFS Payment Updates, Practice Expense, and Cumulative Effects

CMS should consider the CY 2027 conversion factors alongside changes in relative valuation. Patient access depends on both the overall level of PFS payment and how payment is distributed among services. The NHC supports CMS' effort to reconsider whether primary care, behavioral health, preventive services, and longitudinal care are

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[5] Bruno T. Scodari et al., “Characterizing the Traveling Oncology Workforce and Its Influence on Patient Travel Burden: A Claims-Based Approach,” *JCO Oncology Practice* 20, no. 6 (2024): 787–96, https://doi.org/10.1200/OP.23.00690.

[6] Ge Bai et al., “Varying Trends in the Financial Viability of US Rural Hospitals, 2011–17,” *Health Affairs* 39, no. 6 (2020): 942–48, https://doi.org/10.1377/hlthaff.2019.01545.

[7] National Health Council, *The National Health Council Rubric to Capture the Patient Voice: A Guide to Incorporating the Patient Voice into the Health Ecosystem* (2019), https://nationalhealthcouncil.org/wp-content/uploads/2019/12/NHC_Patient_Engagement_Rubric.pdf.

[8] Council of Medical Specialty Societies and National Health Council, *Enhancing Patient Partnerships: How Patient Organizations and Medical Societies Can Enhance Patient Engagement in Clinical Registries and Research* (2020), 4, 7–10, https://cmss.org/wp-content/uploads/2020/04/CMSS-NHC-Patient-Primer-Pt.-Engagement-in-Registries-FINAL.pdf.

appropriately valued relative to other services, particularly where the current methodology does not fully account for care coordination, between-visit management, team-based care, and other work required to manage chronic and complex conditions. At the same time, both qualifying alternative payment model (APM) and nonqualifying APM conversion factors are expected to decline from their CY 2026 levels after expiration of the temporary 2026 payment increase. Those reductions will occur alongside practice-expense, coding, and other redistributive changes that may have materially different effects across specialties and practice settings.[9]

The NHC's central concern is whether the proposed policies, taken together, advance accurate, patient-centered valuation without creating avoidable access problems for patients who have few alternatives to affected services. Stability in this context should mean that major payment changes are transparent, empirically supported, and predictable enough for practices to adapt. It does not mean preserving historical payment differences that are unsupported by current evidence or that contribute to persistent underinvestment in primary care, behavioral health, prevention, and care coordination. The NHC encourages CMS to proceed with appropriate revaluation while using detailed impact analyses to identify where simultaneous changes concentrate reductions and provide targeted transitions when those reductions could alter where patients receive care.

The NHC encourages CMS to ensure that these impact analyses clearly demonstrate to stakeholders how changes are distributed across independent and facility-based practices, sites of service, geographic areas, and relevant service categories where the underlying data permit reliable estimation. CMS has acknowledged stakeholder interest in understanding the relationship between PFS policy and physician-practice consolidation. Reporting site-of-service and ownership-related effects would help assess whether changes intended to improve valuation are contributing to movement of services into higher-cost hospital settings or reducing the availability of community-based care. Such analyses could identify concentrated effects on a specialty or community that warrant a more measured transition, even when a policy is neutral to the PFS in aggregate.[10]

The proposed national valuation of proton beam treatment delivery provides a useful example of why this analysis should extend to services whose cost structures differ materially across sites of care. CMS proposes to establish national PFS payment rates for proton beam treatment delivery services currently priced by local Medicare contractors. The agency would use total allowed charges to establish the pool of practice-expense relative value units (RVUs) and Outpatient Prospective Payment System (OPPS) ambulatory payment classification relative weights to allocate those RVUs among the proton therapy codes. The NHC recognizes the value of replacing

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[9] CMS, “CY 2027 PFS Proposed Rule,” 43936–46; National Academies of Sciences, Engineering, and Medicine, *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule* (Washington, DC: National Academies Press, 2025), https://doi.org/10.17226/29069.

[10] National Health Council, “NHC Comments RE CY 2026 Physician Fee Schedule Proposed Rule,” September 12, 2025, https://nationalhealthcouncil.org/letters-comments/nhc-submits-comments-on-cy-2026-physician-fee-schedule-proposed-rule/.

substantial geographic variation in contractor pricing with a more consistent national methodology. However, CMS itself notes concerns that the capital outlays associated with freestanding proton therapy centers may exceed those faced by hospital systems and that freestanding centers may have less purchasing power or flexibility to amortize those costs.[11] Before finalizing the methodology, the NHC encourages CMS to examine whether the resulting payment rates adequately recognize the resources required to furnish proton therapy in freestanding settings. CMS should also assess whether material differences between PFS and hospital outpatient payment could affect the continued availability of community-based treatment, patient travel, continuity of oncology care, or movement of services into hospital outpatient settings. Where the analysis identifies substantial access effects, CMS should consider whether refinement of the methodology or an appropriate transition is warranted.

The proposed changes to practice-expense methodology warrant this form of scrutiny. CMS seeks to reduce reliance on a longstanding IPCI framework that is based substantially on older specialty-level survey information and that, in the agency's view, can constrain the influence of newer code-level inputs. The NHC supports the underlying objective of moving toward more current, empirical, and auditable valuation, which is consistent with its prior PFS comments and with the National Academies' recommendation that CMS broaden the data used in valuation and better account for the full range of resources required to furnish high-quality care. CMS should use the proposed two-year transition to identify and correct anomalous results before fully implementing the revised methodology.[12,13]

During the first year of the transition, CMS should publish service-, specialty-, and practice-setting effects with sufficient detail to identify whether the revised allocation methodology produces anomalous results or concentrated reductions in services patients rely on. The agency should also compare observed changes in utilization, practice participation, and site of service with the assumptions that supported the proposal and should be prepared to refine the methodology before full implementation if those assumptions do not hold in practice. This approach would be consistent with the NHC's broader position that valuation methodologies should increasingly rely on empirical, auditable, real-world data in valuation, while also recognizing that a methodology can be internally coherent and still require refinement if it produces effects across different care settings that modeling did not anticipate.[14]

Separately Identifiable E/M Services, MOD1, and MOD2

The proposed treatment of office and outpatient E/M services raises two related but distinct issues for the NHC. The first is whether the resources associated with a

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[11] CMS, ““CY 2027 PFS Proposed Rule,” 43884–85.

[12] CMS, “CY 2027 PFS Proposed Rule,” 43849–51.

[13] National Academies of Sciences, Engineering, and Medicine, *Improving Primary Care Valuation Processes*.

[14] National Health Council, “CY 2026 PFS Comments.”

separately identifiable E/M service furnished on the same day as a procedure can appropriately be reduced on a standardized basis without underrecognizing clinically distinct work. The second is whether the transition from G2211 to percentage-based modifiers can more accurately recognize the additional resources associated with longitudinal and accountable care without creating new distortions across specialties or delivery models. Both issues implicate longstanding NHC priorities concerning accurate valuation, continuity of care, and the risk of increasing patient burden if payment policies encourage practices to split services that could be provided in a single visit.[15]

With respect to modifier 25, the NHC recognizes CMS' interest in identifying circumstances in which resources associated with an E/M service may overlap with resources incorporated into a procedure. However, the presence of a same-day procedure does not establish that the clinical assessment, decision-making, or management represented by a separately identifiable E/M service is duplicative, particularly for Medicare beneficiaries with multiple chronic conditions, medically complex presentations, or ongoing specialty-care needs. A patient may require evaluation of an additional condition, assessment of a change in symptoms or treatment response, medication management, review of diagnostic findings, or other clinical decision-making that remains distinct from the procedural service. In such circumstances, reducing payment through a uniform methodology could inadequately recognize legitimate physician work and, depending on how practices respond, could create incentives to separate clinically appropriate services across multiple encounters, increasing travel, time, caregiver burden, and other costs borne by patients.[16]

The NHC therefore encourages CMS to establish a stronger empirical foundation for any standardized payment reduction by distinguishing resources that are demonstrably duplicative from those associated with clinically separate evaluation and management. CMS also should evaluate whether the proposed methodology produces materially different effects across specialties and patient populations before finalizing a broad adjustment. If CMS proceeds with the policy, implementation should include sufficiently granular monitoring of same-day E/M utilization, subsequent office visits, beneficiary travel and appointment burden, specialty-specific access, and other indicators that could identify whether the adjustment is changing the timing or location of care rather than more accurately valuing the resources required to provide it. The NHC also recommends that CMS establish a mechanism through which specialties and patient organizations can identify clinical circumstances in which the standardized methodology does not adequately reflect the nature of the services furnished.[17]

The transition from G2211 to MOD1 and the establishment of MOD2 warrant a different analysis. These policies concern Medicare's recognition of longitudinal complexity and participation in accountable-care arrangements rather than potential duplication of resources. The NHC has consistently supported payment approaches that recognize

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[15] CMS, “CY 2027 PFS Proposed Rule,” 43898–43903.

[16] Michael A. Kyle and Austin B. Frakt, “Patient Administrative Burden in the US Health Care System,” *Health Services Research* 56, no. 5 (2021): 755–65, https://doi.org/10.1111/1475-6773.13861.

[17] National Health Council, “CY 2026 PFS Comments.”

the additional work required to manage chronic and complex conditions over time, particularly where payment supports sustained clinician-patient relationships, coordination across multiple clinicians, and greater accountability for outcomes. A percentage-based methodology may offer advantages if it more consistently scales payment with the underlying E/M service, but CMS should evaluate whether the change produces unintended variation across specialties or disproportionately affects patients whose longitudinal care is delivered through lower-valued E/M services.[18]

The proposed MOD2 payment may also strengthen support for accountable care, but the NHC encourages CMS to clarify the patient-centered functions that the additional payment is intended to support. CMS should also evaluate whether it improves coordination, access, continuity, and patient experience rather than measuring success principally through changes in ACO participation or aggregate expenditures. This assessment is particularly important for beneficiaries whose ongoing care is led primarily by specialists. A value-based payment framework should recognize the clinical relationships through which longitudinal care is delivered. It should not create artificial distinctions between primary and specialty clinicians when both may serve as the principal coordinator for patients living with complex or serious conditions.[19]

Redesigning Primary Care and Care Management

CMS' reconsideration of primary-care and care-management payment presents an important opportunity to address persistent relative undervaluation of services that coordinate and sustain care over time, particularly for people living with multiple chronic conditions who rely on primary care to integrate specialty treatment, preventive services, behavioral health, medication management, and ongoing communication between conventional encounters. The NHC supports CMS' effort to strengthen the relative valuation of primary care and to examine payment models that better recognize longitudinal coordination, between-visit management, multidisciplinary communication, patient and caregiver outreach, and technology-enabled services. Consistent with the National Academies' recommendations on primary-care valuation, CMS should begin with the functions that patients and families need and then determine which combination of fee-for-service and prospective payment can most effectively support those functions without weakening accountability, patient choice, or access to specialty-driven longitudinal care.

The experience with chronic care management, principal care management, and Advanced Primary Care Management illustrates why creating a billing pathway does not by itself ensure that patients will receive the underlying service. Beneficiary cost sharing, documentation requirements, staffing constraints, and uncertainty regarding which services may be billed together make implementation difficult for practices and confusing for patients and caregivers. The NHC therefore encourages CMS to simplify the care-management framework around a coherent set of patient-centered functions—including accessible communication between visits; medication and treatment-plan

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[18] CMS, “CY 2027 PFS Proposed Rule,” 43898–43903.

[19] Medicare Payment Advisory Commission, *Medicare Payment Policy*, chap. 4.

management; coordination with specialists and other members of the care team; navigation of needed services; and timely response when a patient's condition changes. CMS should also clarify that clinically meaningful communication with a family caregiver or other trusted individual designated by the patient may count as care-management activity when appropriately documented and consistent with privacy and consent requirements. That communication may address symptoms, medication changes, adherence, functional status, or other aspects of the care plan. The documentation framework should recognize the practical role that designated caregivers often play in implementing and communicating the care plan rather than inadvertently placing caregiver-mediated coordination outside reimbursable workflows.[20]

Beneficiary cost sharing deserves particular attention because recurring coinsurance for services intended to prevent complications and improve chronic disease management can discourage participation among patients who already face substantial out-of-pocket costs associated with multiple conditions, medications, and specialist visits. The same financial and administrative friction can also complicate the work a family caregiver who is initiating, arranging, or sustaining a care-management service on the patient's behalf, particularly when that caregiver is already responsible for enrollment, scheduling, billing questions, and other logistical tasks. The NHC encourages CMS to reduce financial barriers to evidence-based care-management and preventive services wherever it has the authority to do so. Where statutory constraints prevent further action, CMS should identify those limits clearly for Congress. Payment reforms intended to strengthen longitudinal care will have limited effect if the beneficiary-facing cost structure makes participation unattractive or unaffordable for the patients and families most likely to benefit.[21]

Administrative simplification should proceed alongside appropriate program-integrity protections. Requirements designed to prevent fraudulent or duplicative billing should focus on evidence that a patient is receiving an ongoing care-management service, that an accountable clinical team is overseeing the care, and that clinically meaningful work is occurring between conventional visits. Minute-by-minute documentation or duplicative attestations that do not improve the agency's ability to distinguish legitimate care from inappropriate billing can reduce uptake without substantially improving program integrity. CMS should therefore evaluate the marginal value of each documentation requirement and should align data collection with existing clinical and claims workflows wherever possible.[22]

CMS should carefully test should carefully test prospective primary-care payment initially within the MSSP and potentially more broadly in Original Medicare. A predictable prospective payment could provide practices with greater flexibility to support care teams, patient outreach, navigation, and between-visit management without requiring every clinically useful activity to fit a separate fee-for-service code. The

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[20] AARP and National Alliance for Caregiving, *Caregiving in the US 2025* (Washington, DC: AARP, July 24, 2025), https://doi.org/10.26419/ppi.00373.001.

[21] AARP and National Alliance for Caregiving, *Caregiving in the US 2025*.

[22] Kyle and Frakt, “Patient Administrative Burden.”

NHC supports this direction where prospective payment is accompanied by robust risk adjustment, meaningful measures of access and outcomes, transparent beneficiary protections, and preservation of patient choice; the methodology must also recognize that some patients receive substantial longitudinal management from specialists and that a primary-care payment model should complement those relationships rather than inadvertently fragment responsibility or redirect care for administrative reasons.[23]

A phased approach within the MSSP can provide a useful environment for testing whether prospective payment improves the aspects of care that patients can observe directly, including the ability to obtain appointments when needed, responsiveness between visits, timely specialty referral, consistency of medication and treatment plans across clinicians, clarity regarding who is accountable for coordinating care, and confidence that the care plan reflects the patient's goals and circumstances. CMS should publish evaluation results that address these patient-centered outcomes alongside spending and utilization measures so that future decisions about broader implementation are informed by the experience of beneficiaries as well as the financial performance of participating organizations.[24]

Behavioral Health Integration and Psychiatric Collaborative Care

The proposed revaluation of psychiatric Collaborative Care Model (CoCM) services and related behavioral health integration services could strengthen primary care for patients living with chronic physical health conditions who frequently have co-occurring behavioral health needs that affect treatment adherence, functional status, self-management, and overall outcomes. Shortages in the specialty behavioral health workforce can make referral-based models alone insufficient to meet need. The NHC supports the proposed increases in work valuation for CoCM services and the corresponding revaluation of behavioral health care manager clinical labor, which more appropriately recognizes the contributions of the treating practitioner, psychiatric consultant, and behavioral health care manager within an evidence-based model that brings behavioral health expertise into the primary-care setting. CMS should finalize these changes and monitor whether improved payment increases adoption among smaller, rural, and safety-net practices, where staffing and infrastructure requirements may otherwise continue to limit implementation.[25]

Shared Medical Appointments and Health and Well-Being Coaching

The NHC also supports CMS' effort to create more reliable payment pathways for shared medical appointments and health and well-being coaching, both of which can

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[23] Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, chap. 1, “Reforming Physician Fee Schedule Updates and Improving the Accuracy of Relative Payment Rates” (Washington, DC: MedPAC, June 2025), https://www.medpac.gov/document/june-2025-report-to-the-congress-medicare-and-the-health-care-delivery-system/.

[24] National Academies of Sciences, Engineering, and Medicine, *Improving Primary Care Valuation Processes*.

[25] CMS, “CY 2027 PFS Proposed Rule,” 43897–98.

complement individualized care for people managing chronic conditions. Shared medical appointments can combine patient-specific clinical assessment and treatment with education, counseling, and peer interaction. This format may give patients more time to address disease-management needs and learn practical self-management strategies from peers. The NHC supports dedicated coding where participation remains voluntary, confidentiality protections are clear, the service includes meaningful individualized clinical care, and patients retain access to individual appointments when group care does not reflect their preferences or clinical needs.

Health and well-being coaching can similarly help patients translate clinical recommendations into sustainable behavior change and self-management. The NHC supports predictable national payment when services are furnished by appropriately trained personnel, connected to the broader care team, and evaluated on the basis of patient-reported outcomes, functional status, experience, utilization, and access rather than participation alone.[26]

Physician-Patient Clinical Trial Discussions

The NHC strongly supports CMS' consideration of separate payment for meaningful physician-patient discussions about clinical trial opportunities. Informed consideration of research participation may require substantial time to review eligibility, treatment alternatives, potential benefits and risks, logistical requirements, and the relationship between a trial and the patient's existing care. Without a payment pathway, it can be difficult for clinicians to devote sufficient time to these conversations within routine visits. CMS cites persistent limitations in adult cancer trial participation, evidence that eligible patients are substantially more likely to enroll when trials are actively offered, and physician time and administrative burden as important barriers to discussion. The NHC therefore encourages CMS to establish a separately payable service for substantive clinical trial counseling, with documentation requirements that confirm an appropriate discussion without becoming sufficiently burdensome to discourage use, availability through telehealth where clinically appropriate, and a design that supports informed patient choice without creating an expectation that discussion result in enrollment. The NHC further encourages CMS to consider how the service could apply beyond oncology where comparable evidence and clinical-trial opportunities exist, including rare diseases and other conditions for which trials may represent an important treatment or research option.[27]

Technology-Enabled Care and Artificial Intelligence

The increasing use of digital tools, including AI, is changing how clinicians work in primary and longitudinal care, including how they synthesize information, communicate with patients, identify gaps in care, monitor chronic conditions, and respond to information generated outside a conventional encounter. Medicare valuation should therefore account for both efficiencies and new responsibilities—including interpretating

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[26] CMS, “CY 2027 PFS Proposed Rule,” 43903–8.

[27] CMS, “CY 2027 PFS Proposed Rule,” 43912–13.

outputs, assessing whether automated recommendations are clinically appropriate, communicating results and limitations, and following up when a tool generates additional clinical work. A reduction in time spent on one task does not necessarily mean a proportional reduction in the resources required to furnish high-quality care.[28]

Evidence used to value technology-enabled care should reflect how care is delivered and include clinical outcomes, patient experience, safety, access, and treatment burden in addition to measures of clinician time or organizational efficiency. A technology that reduces documentation time but generates substantially more patient messages, alerts, follow-up decisions, or downstream diagnostic activity may alter rather than eliminate clinical work. Conversely, tools that allow earlier intervention, reduce unnecessary travel, or improve adherence may create value that is not visible through a narrow measurement of minutes spent during an encounter. CMS should not base a technology-specific payment methodology on assumptions of uniform productivity. Instead, it should use transparent criteria to determine when technology changes resource use and delivers measurable benefits to patients. .[29]

Any payment framework for AI-enabled or highly automated care should incorporate patient protections should also be incorporated into any payment framework. Patients should know when an AI-enabled tool materially contributes to information or recommendations used in their care; an accountable clinician should remain available when human judgment is necessary; tools and workflows should be accessible to people with disabilities, limited English proficiency, low digital literacy, or limited broadband and device access; and payment arrangements should not create incentives to substitute automated interactions for clinically necessary human care solely because the automated pathway is less expensive. These protections are particularly important in Medicare, where beneficiaries have wide variation in functional ability, technology access, caregiver support, and comfort with digital interaction.[30]

The same principles should inform any separate technology-enabled track for care-management services. A digital pathway may be appropriate for patients who prefer and can effectively use it, but the availability of technology should expand rather than narrow the ways in which beneficiaries can obtain clinically appropriate support. CMS should therefore preserve an equivalent pathway for patients who need telephone, in-person, caregiver-supported, or other forms of engagement and evaluate whether differential payment creates unintended incentives to steer beneficiaries toward one modality regardless of preference or clinical suitability. Patient and caregiver input should be incorporated directly into the development of any future technology-enabled care-

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[28] U.S. Food and Drug Administration, “Transparency for Machine Learning-Enabled Medical Devices: Guiding Principles,” June 2024, https://www.fda.gov/medical-devices/software-medical-device-samd/transparency-machine-learning-enabled-medical-devices-guiding-principles.

[29] National Health Council, *Rubric to Capture the Patient Voice*.

[30] U.S. Food and Drug Administration, “Transparency for Machine Learning-Enabled Medical Devices.”

management framework so that the outcomes CMS chooses to reward reflect meaningful improvements in the experience of managing illness over time.[31]

Advance Care Planning and Community-Based Palliative Care

The proposed refinements to advance care planning could more accurately recognize the team-based work involved in helping patients understand and communicate their goals, preferences, and advance directives, including circumstances in which clinical staff contribute under appropriate practitioner supervision and in which telehealth allows family members or other trusted caregivers to participate without requiring every participant to be physically present. The NHC supports payment approaches that make these conversations easier to furnish and more accessible to patients, but the design and evaluation of the services should remain centered on whether patients receive voluntary, informed, revisable, and clinically useful support rather than on completion of a particular document or achievement of a uniform participation rate.[32]

Advance care planning is highly preference sensitive, and implementation should preserve the voluntary, informed, and revisable nature of the process. A high-quality service may result in completion of an advance directive, identification of a surrogate, clarification of treatment goals, confirmation that an existing document remains accurate, or a patient's decision to defer further discussion. Payment and quality policies should recognize this range of appropriate outcomes, rather than prioritize document completion or a uniform participation rate. Clinical teams should also be able to accommodate language needs, disability-related communication requirements, supported decision-making, and participation by family members or trusted caregivers selected by the patient, particularly where these supports are necessary for meaningful participation.[33,34]

Interoperability remains important because documented preferences lose value when clinicians cannot locate or use them at the point of care. CMS should continue to work across Medicare payment and health-information policies to improve the portability of advance care planning information across settings, particularly during emergency care and transitions between facilities and clinicians.

The agency should also examine opportunities to reduce beneficiary cost sharing and to communicate clearly the circumstances under which advance care planning is available without additional out-of-pocket cost. Financial uncertainty may discourage participation

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[31] Council of Medical Specialty Societies and National Health Council, *Enhancing Patient Partnerships*, 4, 7–10.

[32] CMS, “CY 2027 PFS Proposed Rule,” 43947–50.

[33] Elizabeth Weathers et al., “Advance Care Planning: A Systematic Review of Randomised Controlled Trials Conducted with Older Adults,” *Maturitas* 91 (2016): 101–9, https://doi.org/10.1016/j.maturitas.2016.06.016.

[34] Li-Shan Ke and Hui-Chuan Cheng, “Family Caregivers’ Experiences and Perspectives Regarding the Implementation of Advance Care Planning among Older Adults: A Systematic Review and Meta-Synthesis,” *Geriatric Nursing* 69 (2026): 103800, https://doi.org/10.1016/j.gerinurse.2026.103800.

in a service that is intended to support informed decision-making before a crisis occurs.[35]

The NHC also welcomes CMS' continued exploration of community-based palliative care outside the Medicare hospice benefit. Patients living with serious illness may benefit from symptom management, communication about goals, caregiver support, and coordination of care well before they are eligible for or choose hospice. A sustainable Medicare pathway should allow palliative care to complement disease-directed treatment and should not require a patient to make a hospice election in order to receive services that support quality of life and informed decision-making. Benefit design should also recognize that palliative care may be delivered in the home, office, outpatient clinic, or other community setting and that continuity across these settings may be particularly important for patients with complex needs.[36,37]

As CMS develops this policy further, it should directly involve patients, caregivers, disability advocates, clinicians, and patient organizations in defining eligibility, covered services, quality expectations, and outcomes. Measures should address symptoms, function, care coordination, confidence in the care plan, caregiver experience, and concordance between care received and patient preferences rather than relying primarily on counts of visits or completed documents. Eligibility criteria should be sufficiently clear to support consistent administration but should avoid narrow prognostic thresholds or administrative complexity that delay access until very late in illness.[38]

Telehealth and Virtual Care

Telehealth is an established component of care for many Medicare beneficiaries who require frequent follow-ups, face mobility or transportation barriers, live far from specialists, or need behavioral health services in communities with limited local capacity. The continued availability of audiovisual and audio-only modalities through 2027 helps maintain access while Congress and CMS determine the longer-term structure of Medicare telehealth policy. The NHC supports policies that allow patients and clinicians to the modality appropriate to the clinical circumstances and patient preference, while maintaining quality and safety expectations suited to the service rather than imposing restrictions based principally on modality. Evidence syntheses and the experience of the public health emergency have shown that telehealth can improve access for selected services and populations while also reinforcing the importance of modality-appropriate quality safeguards and attention to broadband, device, and digital-literacy barriers. The NHC therefore continues to support a framework which pairs coverage flexibility with monitoring of whether beneficiaries can actually use the service

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[35] Weathers et al., “Advance Care Planning.”

[36] CMS, “CY 2027 PFS Proposed Rule,” 43949–50.

[37] National Alliance for Caregiving, *2026 Policy Agenda* (2026), 4, https://www.caregiving.org/wp-content/uploads/2026/03/NAC_2026_PolicyAgenda_FINAL.pdf.

[38] Ke and Cheng, “Family Caregivers’ Experiences and Perspectives.”

and whether virtual care complements rather than fragments longitudinal relationships.[39,40,41]

The new modifiers required for certain virtual-platform arrangements and incident-to telehealth services should be implemented with clear operational guidance, adequate lead time, and claims-processing education so that a reporting requirement intended to improve transparency does not result in avoidable denials or interrupted care. Data from these modifiers may help CMS understand how telehealth is being delivered through increasingly complex platform arrangements. The NHC encourages CMS to use those data to examine continuity with established clinicians, availability of follow-up care, referral patterns, patient access to records, and the ability to transition to in-person care when needed, thereby distinguishing models that extend clinical capacity and patient choice from arrangements that produce fragmented episodes of care.[42]

Persistent digital-access barriers should remain part of Medicare's evaluation. Coverage does not translate into meaningful access when beneficiaries lack reliable connectivity, appropriate devices, accessible technology, language support, or the skills necessary to use virtual services. CMS should continue to examine utilization and outcomes by geography and beneficiary characteristics and should coordinate with other federal and state entities on broadband, device, accessibility, and digital-literacy barriers. Telehealth policy should also preserve audio-only pathways where clinically appropriate because telephone access remains important for beneficiaries who cannot reliably use video technology and for circumstances in which requiring video would create a barrier without a corresponding clinical benefit.[43]

The NHC further encourages CMS to maintain a clear pathway for evaluating and adding services to the Medicare Telehealth Services List as evidence evolves. Annual rulemaking allows for public input, but CMS should also retain sufficient flexibility to respond to well-supported clinical developments without unnecessary delay. The agency should apply transparent evidence standards and consider patient experience, travel burden, continuity, and accessibility when determining whether telehealth is an appropriate modality for a particular service.[44]

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[39] CMS, “CY 2027 PFS Proposed Rule,” 43862–64.

[40] Annette M. Totten et al., *Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews*, Technical Brief No. 26 (Rockville, MD: Agency for Healthcare Research and Quality, 2016), https://www.ncbi.nlm.nih.gov/books/NBK379320/.

[41] Lisa M. Koonin et al., “Trends in the Use of Telehealth during the Emergence of the COVID-19 Pandemic—United States, January–March 2020,” *MMWR Morbidity and Mortality Weekly Report* 69, no. 43 (2020): 1595–99, https://doi.org/10.15585/mmwr.mm6943a3.

[42] CMS, “CY 2027 PFS Proposed Rule,” 43862–64.

[43] Sadiq Y. Patel et al., “Trends in Outpatient Care Delivery and Telemedicine during the COVID-19 Pandemic in the US,” *JAMA Internal Medicine* 181, no. 3 (2021): 388–91, https://doi.org/10.1001/jamainternmed.2020.5928.

[44] National Health Council, “CY 2026 PFS Comments.”

Vaccine Adverse Effects Management

The proposed payment pathway for clinically significant evaluation and management of suspected vaccine adverse effects addresses circumstances in which the work required to assess a patient's symptoms, evaluate alternative explanations, communicate risk, and develop an appropriate treatment plan may exceed the resources recognized in a typical E/M encounter. The NHC supports accurate recognition of clinically necessary work and agrees that individualized communication can require additional time in complex cases. This area intersects with patient concerns, clinical evidence, and established vaccine-safety systems, and coding and payment should therefore be grounded in clear clinical criteria that support appropriate evaluation without encouraging unnecessary testing or services that are not supported by the patient's presentation.[45]

CMS should align implementation with established vaccine-safety monitoring and reporting processes and should provide guidance that emphasizes evidence-based assessment, respectful communication, and documentation sufficient to establish the clinical basis for use of the add-on service. Early monitoring should examine utilization patterns, diagnoses, downstream testing, and patient outcomes to determine whether the code is being used as intended. Where patterns suggest that payment is encouraging services beyond its intended use, the agency should refine guidance in consultation with clinicians, patient organizations, and relevant public-health experts.[46]

Medicare Shared Savings Program

The CY 2027 MSSP proposals address several operational and financial issues that have become increasingly important as ACOs transition to digital quality measurement and as CMS seeks to strengthen incentives for continued participation. The NHC encourages CMS to assess whether these support coordinated, longitudinal, patient-centered care across a heterogeneous Medicare population while remaining feasible for organizations that differ substantially in size, electronic-health-record infrastructure, capital, geography, and patient mix. Changes that improve technical consistency but make participation materially more difficult for organizations serving rural, underserved, or medically complex populations could narrow rather than broaden access to accountable-care models.[47]

Several quality-reporting changes under consideration respond directly to operational difficulties that ACOs have experienced in aggregating data across multiple Taxpayer Identification Numbers (TINs) and electronic health records. Extending certain existing reporting options and flat benchmarks, establishing Medicare electronic clinical quality measures (eCQMs) as an additional collection type, and providing a phased pathway toward FHIR-based reporting are reasonable ways to support the transition without requiring every organization to move at the same pace. CMS has identified

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[45] CMS, “CY 2027 PFS Proposed Rule,” 43905–6.

[46] CMS, “CY 2027 PFS Proposed Rule,” 43905–6.

[47] CMS, “CY 2027 PFS Proposed Rule,” 44031–47.

circumstances in which uncertainty and reporting burden have affected ACO decisions about adding practices. The feasibility of quality reporting therefore matters to beneficiary access to value-based care as well as to administrative efficiency.[48]

The two-year transition CMS is considering beginning in 2028, before FHIR-based reporting becomes required for applicable measures in 2030, should be used for real-world testing, technical assistance, interoperability work, and evaluation of whether smaller, rural, and multi-EHR ACOs can meet the requirements without disproportionate cost. Existing reporting options should remain available until replacement methodologies have demonstrated reliable implementation across different organizational structures, and CMS should publish readiness indicators during the transition so that ACOs and patient organizations can understand whether the technical infrastructure is developing as expected. CMS should adjust the implementation if material portions of the delivery system remain unable to report accurately despite reasonable efforts and technical assistance.[49]

The NHC also supports greater stability in the APP Plus measure set during this period because continually adding measures while organizations are changing their data infrastructure can undermine both measurement quality and participation. Operational simplification should not, however, be interpreted as a reduced policy priority for the clinical areas represented by measures that are delayed or removed. If CMS finalizes removal of the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment and Adult Immunization Status measures because of technical or collection challenges, the agency should continue developing feasible approaches to measure performance in substance-use treatment and immunization and should explain clearly that the removal reflects implementation limitations rather than diminished importance of those outcomes.[50]

Quality measurement within accountable care should also continue moving toward outcomes and experiences that patients consider meaningful. The NHC encourages CMS to expand the use of patient-reported outcomes, functional measures, and other indicators that capture whether patients are able to manage their conditions, maintain independence, experience improvements in symptoms, and navigate care effectively; digital measurement can reduce manual reporting and make information more timely, but technical interoperability should support rather than define the content of the quality framework. Patient organizations should be involved in prioritizing measures during the transition to FHIR-based reporting so that the future measure set reflects both what can be collected electronically and what is important to the people whose care is being measured.[51]

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[48] Kyle and Frakt, “Patient Administrative Burden.”

[49] CMS, “CY 2027 PFS Proposed Rule,” 44037–40.

[50] National Health Council, “CY 2026 PFS Comments.”

[51] Danielle C. Lavallee et al., “Incorporating Patient-Reported Outcomes into Health Care to Engage Patients and Enhance Care,” *Health Affairs* 35, no. 4 (2016): 575–82, https://doi.org/10.1377/hlthaff.2015.1362.

The proposed revisions to MSSP benchmarking and financial incentives should also be assessed for their effects on access and participation. Greater predictability can make participation more sustainable, but changes in regional adjustment, historical benchmarking, and other financial parameters may have different effects depending on an ACO's market, patient population, and prior spending. CMS should therefore publish distributional analyses that identify how the changes affect organizations serving rural, underserved, and medically complex populations and should monitor whether the final methodology broadens participation or disproportionately advantages organizations with more favorable starting positions.[52]

Advance investment payments remain particularly important as a way to enable participation by organizations that lack the resources to make upfront investments in infrastructure and care management. CMS' reconsideration of the methodology used to target those payments should preserve the ability to identify organizations serving communities and beneficiaries with greater barriers to care; no single geographic index will perfectly identify individual patient need, but removing an imperfect measure without an adequate replacement can alter the distribution of support in ways that are difficult to reverse. The NHC encourages CMS to use multiple empirically supported indicators where appropriate, publish the expected distributional effect of the revised methodology, and evaluate whether organizations receiving advance payments continue to be concentrated in areas where accountable-care infrastructure and provider capacity are comparatively limited.[53]

The NHC strongly supports CMS' proposal to allow eligible Shared Savings Program ACOs, subject to applicable safeguards and approval requirements, to reduce or eliminate Part B cost sharing for selected beneficiaries and services. This flexibility gives organizations that are accountable for total cost and quality a direct tool to address out-of-pocket barriers that may otherwise impede preventive, longitudinal, behavioral health, and care-management services. CMS should finalize the proposal with clear beneficiary communications, transparent and nondiscriminatory eligibility criteria, appropriate protections for patient choice, and operational guidance that allows ACOs and participating clinicians to implement the benefit without creating billing confusion. The agency should also evaluate which services and beneficiary populations receive cost-sharing support and whether use of the flexibility improves access, adherence, patient experience, and outcomes.[54]

Ambulatory Specialty Model and Specialty Care

Specialty-focused value-based models can improve coordination for conditions in which specialist decisions have substantial influence over long-term outcomes and utilization. However, these models can also create incentives that may be difficult for patients to understand and that can affect the timing and location of diagnostic and therapeutic

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[52] Medicare Payment Advisory Commission, *Medicare Payment Policy*, chap. 4.

[53] CMS, “CY 2027 PFS Proposed Rule,” 44050–57.

[54] CMS, “CY 2027 PFS Proposed Rule,” 44115–20.

services. The NHC encourages CMS to evaluate the Ambulatory Specialty Model and additional future models based on whether they preserve individualized clinical decision-making, improve coordination across the patient's broader care team, and incorporate outcomes that patients can observe and value. Cost and utilization remain appropriate components of model evaluation, but CMS should assess reductions in spending alongside access, diagnostic timeliness, clinical outcomes, and patient and caregiver burden to ensure that apparent savings do not obscure unintended effects on care. This is particularly important where model incentives apply to services for which appropriate use depends heavily on symptoms, comorbidities, disease progression, and other patient-specific clinical factors.[55]

The proposed incentive for voluntary submission of patient-reported outcome data would capture outcomes not often visible in administrative claims such as changes in pain, function, symptoms, and quality of life. The value of these data will depend on how measures are selected, collected, and used. CMS should developed or select instruments with patient input, ensure that they are accessible to people with disabilities and limited English proficiency, and minimize repetitive survey burden. Clinicians and patients should receive information that is sufficiently timely and interpretable to support care improvement rather than contributing data solely for retrospective model evaluation.[56]

The proposed rural scoring adjustment appropriately recognizes that performance can be constrained factors such as the local workforce, referrals, transportation, and alternative capacity that are outside the control of an individual specialist. CMS should monitor whether the adjustment adequately accounts for these circumstances and should consider additional access indicators where a rural or geographically isolated practice has limited options for referral or ancillary services. Patient travel time, appointment availability, and local diagnostic capacity may provide useful context for interpreting performance measures that otherwise appear equivalent across very different markets.[57]

Measures intended to discourage low-value utilization should also preserve appropriate clinical exceptions. In low back pain and other conditions where imaging or other services are often unnecessary but occasionally essential, a model should distinguish routine use unsupported by clinical indication from testing that is warranted by symptoms, history, progression, or other patient-specific risk factors. CMS should monitor patterns in denials, delays, and downstream utilization and should avoid scoring methodologies that create a stronger incentive to withhold a service than to make the clinically appropriate decision for the individual patient.[58]

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[55] CMS, “CY 2027 PFS Proposed Rule,” 43963–76.

[56] Lavallee et al., “Incorporating Patient-Reported Outcomes.”

[57] Bai et al., “Varying Trends in the Financial Viability of US Rural Hospitals.”

[58] National Health Council, *Rubric to Capture the Patient Voice*.

Medicare Part B and Part D Drug Policies and 340B Reporting

Accurate identification of units purchased through the 340B Drug Pricing Program is increasingly important to the administration of Medicare drug-payment policies, including the statutory requirements governing Part B and Part D inflation rebates, because CMS must be able to distinguish claims subject to 340B pricing from those for which additional manufacturer rebate obligations apply. The NHC supports the development of standardized, reliable claims-level information that allows CMS to administer these requirements accurately, reduce the potential for duplicative discounts, and strengthen program integrity. Consistent with the NHC's broader principles for 340B reform, the reporting framework should be operationally workable for covered entities and manufacturers, protect patient privacy, and avoid reimbursement disputes or processing delays that interrupt access to prescribed therapies.[59,60]

The proposed Part D reporting framework can provide CMS with a more consistent mechanism for identifying 340B units. The NHC supports implementation that improves the accuracy and transparency of these determinations while accounting for the operational complexity of data that may flow across covered entities, contract pharmacies, third-party administrators, health plans, manufacturers, and other partners. CMS should provide detailed technical specifications, validation standards, and examples well in advance of implementation; establish clear procedures through which covered entities and other affected parties can identify and correct errors; and, where feasible, align required data elements with information already generated through pharmacy, claims, and 340B administration so that improved program integrity does not depend on duplicative reporting. Complete reporting may depend on information held by multiple external parties. CMS should therefore also establish reasonable processes for resolving discrepancies and distinguishing good-faith data mismatches or correctable technical errors from deficiencies that materially compromise the integrity of the rebate calculation.[61,62]

The NHC also encourages CMS to maintain clear federal stewardship of information collected through the 340B repository. Standardized claims information can benefit manufacturers, covered entities, CMS, and patients by providing a common factual basis for determining whether a particular unit is subject to 340B pricing and other Medicare payment requirements. CMS should clearly define how repository information will be validated, who may access it, the purposes for which it may be used, and the

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[59] CMS, “CY 2027 PFS Proposed Rule,” 44009–15.

[60] Medicare Payment Advisory Commission, *Report to the Congress: Overview of the 340B Drug Pricing Program* (Washington, DC: MedPAC, May 2015), https://www.medpac.gov/document/may-2015-report-to-the-congress-overview-of-the-340b-drug-pricing-program/.

[61] Biotechnology Innovation Organization, “BIO Statement to the Senate 340B Bipartisan Working Group on Safeguarding and Strengthening 340B,” April 1, 2024, 1–2, https://www.bio.org/sites/default/files/2024-04/senate_340b_rfi_final.pdf.

[62] Pharmaceutical Research and Manufacturers of America, “Comments on Senate 340B RFI,” July 28, 2023, 16–17, https://phrma.org/-/media/Project/PhRMA/PhRMA-Org/PhRMA-Refresh/Policy-Papers/PhRMA-Comments---6162023-Senate-RFI-on-340B---072823.pdf.

privacy and security protections applicable to any patient-level information. If CMS determines that the data are sufficiently reliable to inform additional program-administration decisions, it should explain the applicable methodology and provide affected stakeholders with an opportunity to identify systematic data-quality concerns before using that data to impose significant payment or compliance consequences.[63]

More broadly, the NHC continues to view the patient benefit produced by the 340B program as an important measure of program performance and has emphasized three priorities: 340B savings should demonstrably improve patient affordability, access, or services; patients should not experience delays in obtaining prescribed medications because of administrative changes; and transparency, reporting, and oversight should allow policymakers and patients to understand whether the program is achieving those objectives. The CY 2027 reporting requirements provide an opportunity to improve the reliability of the underlying data without prejudging broader questions concerning the appropriate structure of 340B pricing or the distribution of savings. CMS should continue to monitor the effects of Part B and Part D payment and reporting changes on physician-administered and specialty therapies in community settings, including treatment delays, movement of infusion services across settings, changes in community-practice participation, and beneficiary travel burden. CMS should also protect clinical decision-making so that payment or reporting changes do not create pressure to alter an established treatment when a different therapy is not clinically appropriate for the individual patient.[64]

Quality Payment Program, Digital Measurement, and Public Reporting

The CY 2027 Quality Payment Program proposals are being developed during a broader transition toward digital measurement, greater use of specialty-specific reporting frameworks, and increasing public availability of clinician performance information. The NHC supports modernization that produces more timely, comparable, and actionable information while reducing duplicative reporting. However, digital availability of information should remain a means to better measurement rather than the principal criterion for determining which aspects of quality deserve to be measured. Symptoms, function, treatment burden, confidence in care, caregiver experience, and other outcomes important to patients are not always captured reliably through administrative or electronic clinical data alone.[65]

MIPS Value Pathways and other specialty frameworks should incorporate structured patient involvement in measure development and should prioritize outcomes that patients can recognize as meaningful, including symptoms, function, ability to participate in daily life, treatment burden, and experience of care. Measures that are

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[63] Kyle and Frakt, “Patient Administrative Burden.”

[64] Arthritis Foundation and Lupus Foundation of America, *Impact of the 340B Program on Rheumatoid Arthritis and Lupus Therapies: Summary of Research* (Spring 2025), https://www.lupus.org/sites/default/files/media/documents/340BResearch%20Summary%20July2025%20FINAL%28forweb%29.pdf.

[65] CMS, “CY 2027 PFS Proposed Rule,” 44077–44125.

technically convenient to collect but weakly connected to patient outcomes may satisfy reporting requirements without improving care. Conversely, patient-reported and functional measures may require more careful design and implementation but can provide information that is not otherwise available through claims and electronic records. CMS should therefore continue investing in the infrastructure needed to collect these measures efficiently rather than allowing technical limitations to narrow the future quality framework.[66,67]

The proposed changes affecting public reporting through Care Compare also warrant direct usability testing because availability of data does not ensure that beneficiaries can interpret or use the information. Newly introduced measures may be unfamiliar to patients and clinicians, and first-year performance may reflect implementation effects in addition to underlying quality. When CMS publicly reports new measures or considers modifying star-rating methodologies, the agency should provide clear explanations of what each measure captures, the period represented by the data, and any limitations that materially affect interpretation. Patients with chronic or complex conditions may also value continuity, subspecialty expertise, accessibility, and coordination differently from beneficiaries seeking a one-time service. CMS should avoid composite presentations that imply a single ranking can identify the most appropriate clinician for every patient.[68]

The NHC encourages CMS to test proposed displays with Medicare beneficiaries and caregivers, including people with chronic conditions, disabilities, limited health literacy, and limited English proficiency, before making substantial changes to the information presented publicly. Success should be measured by whether users can accurately interpret differences in performance, identify which measures are relevant to their circumstances, and understand how quality information relates to other considerations such as geographic access and clinician availability. Public reporting should support informed choice without creating false precision or encouraging patients to change clinicians based on metrics that do not reflect the aspects of care most important to them.[69]

Administrative Burden, Implementation Sequencing, and Monitoring

The CY 2027 PFS includes multiple changes that may require practices, ACOs, safety-net providers, and other organizations to modify billing systems, electronic health records, reporting processes, contracts, clinical workflows, and patient communications on overlapping timelines. Even where each requirement has a reasonable policy rationale, cumulative implementation burden can divert resources from patient care and increase the likelihood of technical errors that result in payment disruption. CMS should

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[66] National Health Council, *Rubric to Capture the Patient Voice*.

[67] Lavallee et al., “Incorporating Patient-Reported Outcomes.”

[68] Council of Medical Specialty Societies and National Health Council, *Enhancing Patient Partnerships*, 4, 7–10.

[69] National Health Council, *Rubric to Capture the Patient Voice*.

therefore evaluate implementation timelines across the rule as a whole and sequence major changes according to operational complexity and patient risk rather than treating each provision as an independent administrative project.[70]

Policies that address immediate patient harm or correct a clearly demonstrated payment problem may warrant rapid implementation, while complex data, reporting, coding, or valuation changes may benefit from phased adoption, testing, or additional technical assistance. January 1 need not be the effective date for every new administrative process solely because it is the beginning of the payment year. Staggered implementation can improve data quality, reduce inadvertent noncompliance, and make it easier for CMS to attribute observed effects to a particular policy rather than to several changes implemented simultaneously.[71]

Alignment across Medicare programs can also reduce burden. Where the PFS, MSSP, Quality Payment Program, drug-reporting, interoperability, or other CMS requirements rely on overlapping information, the agency should use common definitions and permit reuse of data whenever possible. Digital transformation is most valuable when it eliminates duplicative documentation and manual work rather than reproducing existing administrative requirements electronically. CMS should also coordinate subregulatory guidance across program components so that clinicians and organizations do not receive inconsistent instructions from separate CMS offices or contractors concerning closely related requirements.[72]

A systematic post-implementation monitoring framework would complement these efforts by allowing CMS to identify patient-facing effects that are not apparent during rulemaking. CMS can use its existing claims, enrollment, quality, and program-participation data to track changes in where services are furnished, how many clinicians remain available, and whether utilization patterns shift unexpectedly. These data should be supplemented with targeted patient and caregiver feedback, particularly for rare diseases and other populations in which national claims volume may be too small to reveal an emerging access problem quickly. Qualitative reports should be used to identify questions for further analysis rather than treated as a substitute for quantitative evidence. CMS should maintain a structured pathway through which patient organizations can report recurring access concerns during implementation.[73]

Monitoring should ultimately be connected to action. CMS should identify in advance the types of findings that would warrant additional review and the tools available to address problems. Those tools could include technical guidance, additional transition time, changes to coding instructions, contractor education, targeted exceptions, or future rulemaking. Responsible payment policy requires the ability to correct course when real-

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[70] Kyle and Frakt, “Patient Administrative Burden.”

[71] National Health Council, “CY 2026 PFS Comments.”

[72] Kyle and Frakt, “Patient Administrative Burden.”

[73] National Health Council, “CY 2026 PFS Comments.”

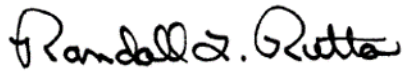
world evidence contradicts assumptions used in a proposed methodology, particularly in a system as complex and heterogeneous as the PFS.[74]

Conclusion

The CY 2027 PFS proposed rule presents important opportunities to improve the relative valuation of primary care and behavioral health, and strengthen accountable and longitudinal care/ It could also recognize additional forms of patient support—including collaborative behavioral health care, shared medical appointments, health coaching, and substantive clinical trial counseling—reduce unnecessary administrative complexity, improve digital quality measurement, and expand the ability of care teams to meet the needs of Medicare beneficiaries and the family caregivers who support them. CMS should pursue these opportunities alongside careful evaluation of the cumulative effects of conversion-factor, practice-expense, coding, and other methodological changes so that necessary revaluation toward historically underrecognized services does not inadvertently reduce access to other patient-critical care. Throughout implementation, CMS should use transparent evidence, meaningful patient and caregiver engagement, clear operational guidance, and access monitoring with mechanisms for course correction when real-world experience identifies unintended consequences.

Thank you for the opportunity to provide feedback on the CY 2027 PFS proposed rule. The NHC stands ready to work with CMS and other stakeholders to ensure that the final policies support a Medicare physician payment system that is affordable and sustainable while remaining responsive to the needs of people living with chronic diseases and disabilities and their caregivers. Please do not hesitate to contact Jennifer Dexter, Senior Vice President, Policy & External Affairs, or Shion Chang, Assistant Vice President, Policy & Regulatory Affairs, if you or your staff would like to discuss these comments in greater detail.

Sincerely,



Randall L. Rutta
Chief Executive Officer

[74] National Health Council, *Rubric to Capture the Patient Voice*.