SGIM
Society of General Internal Medicine

September 14, 2026

Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies: CMS-1848-P

Submitted via Regulations.gov

Dear Administrator Oz,

On behalf of the Society of General Internal Medicine (SGIM), thank you for the opportunity to submit comments on the Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies proposed rule (CMS-1848-P).

SGIM is a member-based medical association of more than 3,000 of the country's leading general internal medicine physicians, who are dedicated to delivering high-quality clinical care for adults of all ages, especially those with multiple chronic diseases who would benefit from having a physician to coordinate a comprehensive approach to their care. Many of our members are physician-scientists committed to advancing biomedical research, as well as delivering high-quality care and ensuring patients have access to a well-trained physician workforce.

We appreciate and share the Centers for Medicare & Medicaid Services' (CMS) focus on improving the delivery of and access to high-quality primary care services. To support CMS' efforts, we encourage CMS to consider these recommendations, which are addressed in more detail in our comments, to meet our shared goal of supporting primary care:

- Recognize and define longitudinal primary care as a distinct function of care. Medicare payment should reflect first-contact access, continuity, comprehensiveness, coordination, and ongoing responsibility for patients over time—not only the work performed during individual encounters. These characteristics should be the basis of the framework that supports primary care.

- Move toward a payment architecture that supports primary-care capacity, not simply additional billable services. Appropriate fee-for-service payment should remain for discrete clinical services, but CMS should increasingly provide predictable, risk-adjusted prospective resources that support between-visit work, care coordination, team-based care, population management, and the infrastructure required for comprehensive primary care.

- Make continuity and comprehensiveness explicit goals of payment reform and measurement. Payment policy should reward sustained clinician-patient relationships and integrated care rather than inadvertently encouraging fragmentation. Measures

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such as the PCPCM are particularly important if CMS increasingly pays for longitudinal primary care because Medicare needs to know whether patients experience the care it intends to purchase.

- Ensure that payment reform works for complex patients and the settings in which comprehensive primary care is most often delivered. Risk adjustment and payment design should recognize multimorbidity, functional and social complexity, and the additional infrastructure required in safety-net and academic practices, including residency clinics, interdisciplinary teams, and teaching environments.

- Use empirical, transparent methods to define and value cognitive care. CMS should move beyond excessive reliance on legacy coding and valuation processes and use independent evidence, contemporary clinical data, and broader stakeholder input to ensure that E/M and other cognitive services reflect the actual work of modern primary care.

These recommendations are further detailed in our comments on the following topics:

- Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule: Office/Outpatient Evaluation and Management (E/M) Visits;
- Care Management Code Family & The Future of Care Management Services;
- Payment Implications of Technology Enablement of Primary Care;
- Replacing G2211 with Modifier MOD1 in non-Accountable Care Organizations (ACOs) and with Modifier MOD2 in ACOs;
- Current Procedural Terminology Request for Information;
- Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence;
- Changes to Remote Patient Monitoring (RPM) and Remote Treatment Monitoring (RTM);
- Request for Information on Intensive Lifestyle Interventions to slow progression of Alzheimer's disease;
- Updates to the Practice Expense Methodology; and
- Removal of the PCPCM Patient Reported Outcome Performance Measure.

Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule: Office/Outpatient Evaluation and Management (E/M) Visits

As discussed in the proposed rule, CMS is considering whether the outpatient E/M code set appropriately reflects the differences in the intensity and nature of care provided and if distinct categories of outpatient E/M visits should be established in future rulemaking. SGIM has long maintained that the outpatient E/M codes do not appropriately reflect the work required to deliver care to Medicare beneficiaries with a complex condition or multiple chronic conditions.

Despite the changes CMS Implemented in 2021, the outpatient E/M codes retain the same structure that was developed when the Resource Based Relative Value Scale (RBRVS) was implemented in 1992. Over three decades ago, the principal architect of the RBRVS, Dr. William Hsiao, clearly stated that the development of the E/M portion of the MPFS was not adequately supported by empiric research. At that time, he called for more refinement.

The most recent revisions of E/ M service code definitions and valuations and the addition of codes to the MPFS (e.g., G2211 and the chronic care management code family) have not remedied the original problems and fail to capture the intensity of E/M care, particularly the care provided to Medicare beneficiaries with one or more complex and/or comorbid conditions. For example, patients with diabetes, chronic kidney disease and hypertension, which are frequently present together, require a complex and precise medication regimen, with routine laboratory monitoring, home blood pressure and blood sugar monitoring, frequent dose adjustments, and regular counseling. Physicians must be able to update treatment plans and guide patients based on lab results, home readings, and medication side effects, which often occur between routine visits. Under the current E/M system, this additional time is not accounted for outside of the day of the service visit unless the physician bills a chronic care management code with its own onerous documentation requirements. The current structure remains largely focused on individual encounters and does not adequately account for the longitudinal work necessary to manage a patient's health over time.

SGIM supports formally distinguishing longitudinal primary care from acute and consultative services. Longitudinal primary care is qualitatively different from care delivered to address an isolated acute problem. It requires a sustained relationship with the patient and responsibility for managing the patient's health over an extended period. For Medicare beneficiaries with multiple chronic conditions, this often involves integrating treatment across conditions, reconciling recommendations from multiple specialists, reviewing laboratory and diagnostic results, monitoring home blood pressure, glucose, and other clinical information, adjusting medications, and communicating with patients, caregivers, and other clinicians. For particularly complex patients, these responsibilities can consume substantial physician and team time. Much of this work occurs between routine office visits and is not adequately recognized or easily billable using the existing outpatient E/M services and patchwork of non-face-to-face services, each with their own patient copay.

In defining longitudinal care, SGIM encourages CMS to consider the core functions of primary care: first-contact access, continuity, comprehensiveness, and coordination. These characteristics provide a useful framework for distinguishing longitudinal from acute care and from a consultation addressing a specific clinical question. Any distinction in outpatient E/M care should be based on the nature and function of the care delivered to Medicare beneficiaries. CMS should review and use the empiric data available to inform this delineation in the code set.

SGIM supports CMS's efforts to better recognize these differences in the nature and purpose of outpatient E/M care and encourages the agency first to accurately define the services and work associated with them rather than simply adding new codes to the MPFS. CMS should evaluate how new coding structures would interact with the existing outpatient E/M codes, G2211, and care management services, and if some or all of these codes should be removed from the MPFS.

Most importantly, any new approach should better recognize the cognitive work and ongoing responsibility inherent in longitudinal care. As Medicare increasingly moves toward hybrid and prospective approaches to paying for primary care, accurately defining longitudinal care will also be important to ensure that these payment models appropriately support the care of beneficiaries.

Care Management Code Family & The Future of Care Management Services

SGIM appreciates CMS's efforts to support comprehensive primary care through care management codes such as Chronic Care Management (CCM), Principal Care Management (PCM), Transitional Care Management (TCM), and Advanced Primary Care Management (APCM). However, significant administrative and financial barriers continue to limit their implementation, particularly in under-resourced primary care and safety-net settings. These include beneficiary cost-sharing, consent requirements, challenges identifying Qualified Medicare Beneficiary (QMB) status, burdensome care-plan requirements, staffing needs, and overall billing and administrative complexity.

For instance, one of the major obstacles to greater use of APCM is beneficiary cost-sharing. Consider a patient presenting with metastatic prostate cancer, uncontrolled diabetes, and Parkinson's disease who requires extensive coordination among his primary care physician, nurses, pharmacists, patient navigators, neurologist, and oncologist. Although APCM is designed to support this type of complex, longitudinal care, enrolling him would require an additional monthly copay for services he already receives, creating a financial barrier without providing an immediate increase in quality of care. Therefore, eliminating beneficiary cost-sharing and the associated consent requirements would substantially simplify APCM implementation and allow limited staff resources to be directed toward meaningful care planning and chronic disease management. We understand that an act of Congress is required to eliminate the copay associated with APCM and will continue to advocate for this change.

SGIM also encourages CMS to better align APCM payment with the wide variation in patient complexity and resources required to provide longitudinal care. The current APCM structure does not adequately distinguish between managing a patient with two or three chronic conditions and caring for a high-risk patient with 10+ or 20+ chronic diseases, functional limitations, frailty, and significant social needs. At least 17% of Medicare beneficiaries have 6 or more chronic conditions.[1] These patients often require hours of non-face-to-face physician and team-based care to coordinate specialists, medications, home services, caregivers, and community supports. APCM payment should more appropriately account for this complexity and intensity so that practices caring for the highest-risk Medicare beneficiaries have sufficient resources to sustain the comprehensive services that they need and help prevent avoidable hospitalizations.

The proliferation of CCM, PCM, TCM, APCM, and similar mechanisms highlights the limitations of compensating comprehensive care through increasingly complex coding requirements. If these care management codes are retained, CMS should substantially simplify their billing and administrative requirements while pursuing broader structural payment reform that reduces reliance on additional codes. Ultimately, SGIM supports moving toward more predictable, prospective payments to make it easier for practices to organize care around patient needs, strengthen continuity of care, and reduce patient burden such as additional cost-sharing requirements.

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC6407342/

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Payment Implications of Technology Enablement of Primary Care

SGIM appreciates CMS' exploration of how emerging AI-enabled technology has enhanced primary care, with many tools reducing physician burden, increasing productivity, and improving patient outcomes. However, these experiences are not uniform across all technologies or practice settings, and in many cases, usage of these tools has added new workflows and burdens. Thus, we caution against significant payment reform that relies on the assumption that new technology and AI tools only increase productivity and decrease burden.

In principle, tools such as ambient listening technology, clinical decision-support tools, form generation, and evidence review should allow physicians to spend more time operating at the top of their license and with patients managing their acute and chronic diseases, rather than performing information gathering and documentation. For example, Open Evidence can be used to examine a patient's symptoms and determine next steps such as a treatment plan or specialist referral in real time. This can help to facilitate better conversations and relationships with patients and better patient outcomes. However, because AI tools are imperfect and need to be double-checked, physicians' expertise is essential to rapidly interpret and confirm AI-generated recommendations. Therefore, AI tools do not replace expertise but rather allow physicians to complete more advanced work in the limited amount of time available for a given encounter.

In fact, the usage of some technology has *increased* physician workload, including time that is not typically compensated. For example, patients' ability to access their electronic health records (EHRs) and message their physicians have dramatically increased the number of messages received. While some EHR vendors have sought to reduce this burden by using AI to generate automated messages, these too must be reviewed by physicians for accuracy, revising prompts and modeling systems to improve the answers given to questions.

Additionally, physicians must spend time training to use new technologies. As health systems introduce new tools into their practices or as tools evolve, clinicians must take time out of an already busy schedule to learn how to implement new technologies and to troubleshoot frequent information technology (IT)-related issues.

Replacing G2211 with Modifier MOD1 in non-Accountable Care Organizations (ACOs) and with Modifier MOD2 in ACOs

CMS proposes to replace the HCPCS G2211 office visit complexity add-on code with a new modifier, MOD1, which would pay 16% of the associated E/M service while in the Medicare Shared Savings Program ACOs. Another new modifier, MOD2, would pay 32% of the associated visit. While SGIM supports CMS's goal of more appropriately valuing the added work associated with longitudinal, complex care and providing additional support for clinicians in ACO settings, we have significant concerns about the potential unintended consequences of eliminating G2211, particularly for employed physicians practicing in community health centers, safety net health systems, and academic medical centers.

Because many primary care physicians are now employed, and many community health centers and academic medical centers do not participate in ACOs, shifting from a work RVU-based payment to a percentage-based adjustment could have significant implications for many primary care physicians who are paid on an RVU basis. Unlike G2211, the proposed modifiers

would not generate separate work RVUs, potentially reducing the productivity credit and compensation that physicians receive even though the modifier results in greater Medicare reimbursement to their institution. Most SGIM members are employed physicians who face work RVU productivity targets that increased with the introduction of G2211. If the G2211 code is removed, it is unlikely that those work RVU targets would be adjusted downward, and physicians serving predominantly Medicare populations could see their work RVUs decrease by 10% or more. SGIM therefore urges CMS to consider the potential downstream effects of this change on work RVU benchmarks and physician compensation.

More broadly, SGIM views either G2211 or its proposed modifier replacements as an interim approach rather than a long-term solution for appropriately valuing primary care. Replacing an add-on code with a modifier does little by itself to reduce administrative burden and continues the reliance on a fee-for-service framework that only values individual physician services rather than the comprehensive, multidisciplinary care that primary care physicians provide. In the long term, CMS should work toward a payment reform where prospective, risk-adjusted payment provides primary care practices with predictable resources to support comprehensive, longitudinal care while maintaining appropriate recognition of physician work.

In conclusion, SGIM opposes eliminating G2211 and would only support replacing G2211 with MOD1 and MOD2 if CMS addresses the loss of work RVUs and ensures that the additional payment reaches and appropriately recognizes the clinicians providing the care.

Current Procedural Terminology (CPT) Request for Information

SGIM appreciates CMS's request for information on the CPT system. We have expressed our longstanding concerns with the CPT and RVS Update Committee (RUC) processes in previous comments on MPFS proposed rules. While CMS sees these processes as a potential contributor to the development of the United States' "sick care" system, SGIM believes these two committees are drivers of the primary care crisis we are currently facing. The inappropriate definition and undervaluation of outpatient E/M services, which fall within the purview of these committees, contributes to the ongoing shortage of primary care physicians nationwide. Both the definition and valuation of physician services should be based on the best available evidence, periodically reviewed, and publicly accountable.

The CPT Editorial Panel performs an important function in maintaining a standardized code set used throughout the health care system. Any changes that CMS makes should support the maintenance of a single code set; it would be unnecessarily confusing and administratively burdensome for general internal medicine physicians and practices already stretched thin to bill differently by payer. However, SGIM does not believe that the existing CPT and RUC processes have been sufficient to address longstanding deficiencies in the definition and valuation of E/M services. Both committees played significant roles in the revisions to the outpatient E/M services made during the first Trump administration, yet the resulting code structure continues to inadequately capture important aspects of cognitively intense care.

The challenges are particularly significant for general internal medicine and other specialties that predominantly provide cognitive rather than procedural services. CMS's request for comment on whether longitudinal, acute, and consultative outpatient E/M care needs to be coded differently is recognition of these challenges. Procedural services frequently involve discrete activities for which time, equipment, and other inputs can be identified and quantified.

Cognitive care is more difficult to capture. Its value lies in physicians' expertise in diagnosing and managing complex conditions, synthesizing information across multiple diseases and clinicians, and making treatment decisions that account for the patient's overall health and circumstances. These activities are not adequately described or measured simply by examining the time or intensity associated with an individual encounter.

Moreover, the nature of cognitive care continues to evolve without necessarily creating a discrete event that triggers the development or revision of a CPT code. SGIM members increasingly perform important work outside of face-to-face visits as discussed above. Increasing clinical complexity and the growing prevalence of multiple chronic conditions similarly increase the cognitive demands associated with outpatient E/M care. A coding system must be capable of recognizing these changes in clinical practice even when there is no new procedure or technology to prompt a coding request.

SGIM also remains concerned about the accessibility and representativeness of the existing process. We, like many other professional societies, do not have a seat in the AMA House of Delegates and therefore have limited ability to participate directly in the CPT and RUC processes that have significant implications for the services furnished by our members. Furthermore, procedural specialists dominate the membership of both panels, which likely contributes to the lack of attention to coding for cognitive services. A system that has such significant implications for Medicare payment should provide meaningful opportunities for participation by the range of clinicians and stakeholders affected by its decisions.

As discussed in previous MPFS comment letters, SGIM recommends that CMS establish a technical expert panel (TEP) dedicated to improving the definition and valuation of E/M services within the MPFS. The TEP would provide CMS with an independent, evidence-based mechanism for evaluating whether existing E/M codes continue to reflect contemporary clinical practice. Developing new outpatient E/M codes for longitudinal and acute care would be a good opportunity to prove this concept could develop codes that meet the needs of CMS, clinicians, and beneficiaries. Note that we do not suggest that the TEP develop consultation codes since CPT codes for that care already exist but are currently not payable by CMS. Should the agency pursue a TEP or other data driven approach to code definitions and values, SGIM urges CMS to examine data sources that can be used to more accurately reflect the complex care primary care physicians provide with less burden. Besides longitudinal care, CMS should assess the best ways to use available data to capture the effort required to deliver preventive care as part of population health programs and what data reflects the work involved in the coordination of care for beneficiaries with multiple chronic conditions.

The TEP, or other data driven system, should evaluate available research and data regarding E/M services; assess the methodologies used to define services; evaluate whether changes in clinical practice are adequately captured by existing codes; and recommend changes when warranted. As SGIM has previously recommended, the panel should include general practice and specialty medicine physicians; other qualified health professionals; Medicare beneficiaries; health economists and health services researchers; experts in medical coding and valuation; health information technology experts; program integrity and compliance experts; and other stakeholders with expertise in Medicare payment policy. Its findings and recommendations should be publicly available.

The 2025 National Academies of Sciences, Engineering, and Medicine report, *Improving Primary Care Valuation Processes to Inform the Physician Fee Schedule*, reinforces the need for a more empirically grounded approach and identifies promising data sources and methodologies that could inform this work. A CMS-convened TEP could apply these approaches to evaluate both existing services and potential changes to the E/M code set. Regular independent review, empirical data, broader stakeholder input, and greater transparency would provide important checks and balances and help ensure that the codes underlying the MPFS accurately reflect the work physicians perform.

Changes to Teaching Physicians' Billing for Services Involving Residents or Teaching Physicians with Virtual Presence

CMS proposes to allow teaching physicians to bill for services involving residents when either the teaching physician or resident is in the same physical location as the beneficiary. This is a modification from current policy that only allows virtual supervision if done via a three-way telehealth visit.

SGIM supported CMS' finalization of the policy to allow virtual supervision in the CY 2026 PFS. Our primary rationale was to increase access for patients who may have difficulty traveling to a clinic. However, in this proposed policy, patients would still be required to travel to the clinic, negating much of the benefit we supported. While we appreciate CMS' proposed added flexibility and your recognition that this would be useful in only rare circumstances, we urge caution to not inadvertently discourage teaching physicians from being physically present when possible. A significant portion of medical training occurs outside the exam room, including brief interactions with residents before entering and after exiting the room. We recommend that CMS specify circumstances this policy aims to address such as when a teaching physician may be unable to be physically present while treating patients in a different facility within the same health system.

Changes to Remote Patient Monitoring (RPM) and Remote Treatment Monitoring (RTM)

SGIM appreciates the need for appropriate oversight and supervision when Remote Patient Monitoring (RPM) and Remote Treatment Monitoring (RTM) services are outsourced. However, under current requirements, the significant administrative burden associated with providing these services often makes the use of third-party clinical staff or vendors a more practical option for physician practices. For certain CPT codes, RPM billing requires patient data to be collected and transmitted on a near-daily basis. Smaller and less-resourced practices, as well as many academic medical institutions where many SGIM members practice, may therefore choose to outsource these services rather than hire additional staff, change workflows, and navigate the complexities of complying with CMS's current regulatory requirements.

SGIM shares CMS's view that this reliance on third-party vendors can contribute to more complicated and fragmented care, with patients receiving services through multiple siloed vendors and programs. Another issue with third-party remote monitoring is that when monitoring identifies abnormal results, patients' primary care physicians are often responsible for addressing those findings despite not receiving RVUs for the monitoring services themselves.

However, we are concerned that prohibiting the use of third-party vendors without first addressing existing barriers to providing RPM and RTM services in-house could unintentionally increase burden on physician practices and ultimately reduce Medicare beneficiaries' access. For patients, CMS's proposed requirements for a separately reportable initiating visit and at least 20 minutes of treatment management would also create unnecessary barriers to remote monitoring. When monitoring is initiated for a known condition, patients may view an additional visit as unnecessary, face weeks or months of delay in scheduling an appointment or be reluctant to incur an additional copay. Rather than requiring a separate initiating visit, work RVUs could be offered to appropriately value staff time spent assessing a patient's understanding and needs when the patient requests additional support or when clinical staff determine that such support is necessary.

Therefore, SGIM supports efforts to reduce reliance on third-party vendors for remote monitoring to promote more coordinated, less fragmented care and supports CMS's proposal to collapse 17 RPM codes into 4 G codes. At the same time, we encourage CMS to pair these efforts with more streamlined billing requirements that meaningfully reduce the administrative burden associated with RPM and RTM and ensure that primary care physicians who provide and assume responsibility for this care are appropriately valued and recognized.

Request for Information on Intensive Lifestyle Interventions to Slow Progression of Alzheimer's Disease

SGIM appreciates CMS' request for information related to Intensive Lifestyle Interventions (ILIs) to slow the progression of Alzheimer's disease and related dementias (AD/ADRD). Our comments are consistent with the Gerontological Society of America's response to this RFI, which we full endorse. General internal medicine physicians stand at the forefront of helping patients prevent chronic diseases including AD/ADRD.

CMS notes evidence that lifestyle changes and other interventions have demonstrated the ability to slow the progression of cognitive decline. Interventions such as physical activity, nutrition, cognitive training, social engagement, and cardiovascular monitoring were included in the pivotal U.S. POINTER trial[2], which showed that more structured and intensive programs focused on multiple domains has a greater impact than self-guided programs. As such, we believe an ongoing, structured program, focused on multiple domains in a team-based approach would serve as the most valuable model for CMS to consider.

Additionally, we caution CMS against limiting eligibility to beneficiaries with confirmed diagnoses of cognitive impairment. The 2024 Lancet Commission report[3] on dementia prevention, intervention, and care emphasized that dementia prevention should begin early in life and continue throughout adulthood. While we believe all Medicare beneficiaries should be eligible for ILIs, if CMS determines the need to target these interventions, we recommend a risk stratification approach that could include factors such as genetic risk, family history, and co-occurring conditions such as hypertension, diabetes, and hearing and vision loss.

[2] Baker, et al. Structured vs Self-Guided Multidomain Lifestyle Interventions for Global Cognitive Function. July 2025. https://jamanetwork.com/journals/jama/fullarticle/2837046
[3] https://www.thelancet.com/article/S0140-6736(24)01296-0/abstract

Updates to the Practice Expense Methodology

After making changes to the indirect practice expense methodology in last year's rulemaking cycle, CMS is now proposing to eliminate the steps to calculate the indirect practice cost index (IPCI) from the physician payment calculation formula. The IPCI is used to adjust indirect practice expenses based on specialty-level survey data because indirect practice costs vary from one specialty to another.

SGIM has consistently advocated for CMS to base its reimbursement policies and rates on the best data available and supports the goal of using empiric data to inform policy whenever possible. However, CMS implemented the indirect practice expense site of service payment differential policy on January 1, 2026. This policy reduced the indirect practice costs for physician services performed in the facility setting. SGIM strongly opposed this policy and believes that the unintended consequences for general internal medicine practices, specifically the impact on primary care clinics that serve as training sites for internal medicine residencies, would be significant.

In response to the current proposal, SGIM respectfully requests that CMS not implement this change to the IPCI calculation further cutting indirect practice expense. While we agree that the IPCI relies too heavily on outdated, specialty-specific survey data, any proposal to revise the calculation should be based on empirical data on physician practice costs. Reducing reimbursement without evidence will neither improve the accuracy of physician payments nor reflect the actual resources required to furnish individual services. Furthermore, we urge CMS to first understand the impact of the indirect practice expense policy implemented this year before making further changes based on practice data.

Removal of the PCPCM Patient Reported Outcome Performance Measure (PCPCM PRO-PM, Quality #483)

CMS has proposed the removal of the PCPCM Patient Reported Outcome Performance Measure (PCPCM PRO-PM, Quality #483 from the Merit-based Incentive Payment System (MIPS) due to lack of a national benchmark. SGIM is opposed to removal of the PCPCM.

Lack of national benchmark is true for over 30% of current MIPS measures and is not unusual for a measure in the early years of implementation. Despite the lack of a benchmark, the PCPCM PRO-PM is well-aligned with the priorities of the proposed rule. In the proposed rule, CMS seeks to re-imagine primary care payment around prevention, chronic disease management, longitudinal care relationships, and movement toward outcomes-based and prospective payment. The PCPCM is an instrument for accountability that tells CMS whether beneficiaries are receiving this kind of care. It is currently used in two MIPS primary care specialty sets, the Value in Primary Care MIPS Value Pathway (MVP), and the ACO Primary Care Flex CMS Innovation Center model. Removing it at a time when federal policy interest in relational primary care is at its highest would create a measurement gap at precisely the moment the payment conversation is likely to need this measure most, increasing adoption and interest in use.

As a patient reported outcome, the PCPCM is a high priority measure and is the only one designed and validated to assess the longitudinal care relationships and broad scope functions of primary care identified as key to the “Redesigning Primary Care to Make America Healthy Again” initiative proposed in this rule. We recommend that CMS retain the PCPCM PRO-PM and apply a defined scoring floor for two performance periods, paired with retention in the Value in Primary Care MVP and the primary care specialty sets.

Thank you again for the opportunity to submit these comments. Should you require additional information or have any questions, please contact Erika Miller at emiller@dc-crd.com.

Sincerely,



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