PCC Policy and Advocacy Committee Meeting

Tuesday, August 19, 2025 | 3:30 – 4:30 PM ET

Participating Organizations

American Academy of Child and Adolescent Psychiatry, American Academy of Family Physicians, American Academy of Pediatrics, American Academy of Physican Associates, American Association of Nurse Practioners, American Board of Family Medicine, American College of Physicians, American College of Osteopathic Family Physicians, Advocates for Community Health, American College of Clinical Pharmacy, American College of Lifestyle Medine, American Psychiatric Association, American Psychological Association, Blue Cross Blue Shield of Michigan, Blue Shield of California, Community Catalyst, Converging Health, Cummins Inc, Harvard Center for PC, Humana, Mathematica, Meadows Mental Health Policy Institute, Mental Health America, Morehouse School of Medicine, NCQA, National Partnership for Women and Families, Primary Care Development Corporation, Premise Health, Society of General Internal Medicine, Socety of Teachers of Family Medicine, Upstream USA, Venn Strategies, Village MD

Speakers

- Doug Jacobs, Former CMS official
- Margaret French, Elise Tollefson & Elizabeth Lee, Venn Strategies

Welcome & Announcements

Larry McNeely (PCC), Policy Director, opened the meeting by welcoming participants and asking attendees to update their display names to include their organizational affiliations. He noted that the agenda had been slightly adjusted, with Co-Chair remarks abbreviated to allow more time for policy discussion.

Ann Greiner (PCC), President and CEO, reminded participants of PCC's advocacy efforts around the Medicare Physician Fee Schedule proposed rule. She explained that PCC had created resources — including a webinar, issue brief, and draft comment letter — to support members in preparing their own letters. Ann emphasized that CMS is likely to receive substantial opposition from stakeholders who oppose provisions favorable to primary care. Therefore, volume and visibility of supportive comments are essential. She strongly encouraged organizations to adapt PCC's materials, issue independent letters, and mobilize colleagues outside PCC membership. She noted that PCC will also release a public statement underscoring that primary care broadly supports the direction of CMS's rulemaking.

Modernizing and Improving Pay for Primary Care in Medicare

Doug Jacobs (Maryland Healthcare Commission), speaking in his personal capacity, provided an in-depth overview of the Medicare Physician Fee Schedule proposed rule and its implications for primary care. Drawing on his prior experience at CMS, Doug explained the efficiency adjustment in the proposed rule. He described how procedure codes, diagnostic tests, and radiology services often become more efficient over time, but CMS is historically slow — sometimes taking 17 years or more — to revalue these codes. As a result, procedural services are overcompensated while cognitive services like primary care and behavioral health are undervalued.

The proposed efficiency adjustment would address this by applying a 2.5% reduction to procedure-based codes, redistributing resources to undervalued services. Doug emphasized that because the Physician Fee Schedule is budget-neutral, this reform would result in increased relative payment for primary care and behavioral health services. He also described CMS's intention to rely more on empirical data instead of low-response survey data in valuing codes, which could further correct distortions.

Doug cautioned that the adjustment does not yet extend to practice expense inputs (clinical labor, equipment costs). If left unaddressed, distortions could persist. He urged stakeholders to comment in favor of expanding the adjustment to these inputs.

Doug also reviewed the Advanced Primary Care Management (APCM) codes, including proposals to simplify billing requirements and include add-on codes for behavioral health integration and collaborative care. He highlighted concerns about cost-sharing, noting that co-pays could discourage patient participation. He suggested PCC and its members advocate for elimination of co-pays for APCM and, if necessary, support including preventive services like depression screening to bolster the statutory justification.

Finally, Doug addressed opportunities to strengthen the alignment between APCM and the Medicare Shared Savings Program (MSSP). He suggested excluding APCM codes from ACO reconciliation to make practices and ACOs more willing to adopt them.

Judith Steinberg asked if the efficiency adjustment would result in higher reimbursement for primary care and behavioral health. Doug confirmed that because of budget neutrality, cognitive services not subject to the reduction would see an increase. He clarified that evaluation and management (E&M) visits and chronic care management codes are excluded from the reduction, meaning they would benefit.

Brian Outland (ACP) raised a technical question about whether inpatient E&M codes are included in the practice expense adjustments. Doug responded that he believed they were but was not certain. Larry added that there had been conflicting interpretations of the code tables, with some suggesting inpatient E&M codes were exempted. Doug recommended that stakeholders verify the methodology in the regulation and request clarification in

comments.

Mary Giliberti (Mental Health America) asked about the cumulative effect of co-pays under APCM and behavioral health add-on codes, noting that multiple co-pays could deter patient participation. She asked what the strongest argument would be for eliminating co-pays. Doug recommended framing APCM as inherently preventive and therefore eligible for zero cost-sharing. He suggested that if CMS required preventive services within the bundle, depression screening should be prioritized, while also ensuring patients are not penalized if the screening is not completed annually. He added that the annual wellness visit could also strengthen the statutory case but may be more administratively complex.

A Fall Capitol Hill Preview

Larry introduced PCC's new government relations partners from Venn Strategies, noting their role in advising PCC on federal advocacy.

Elizabeth Lee (Venn Strategies) described the current environment under the Trump administration. She identified four themes:

- cost-cutting in health systems and for patients
- deregulation through guidance rather than rules
- values-driven ideological policy
- wellness or 'health freedom' framing

She noted the administration's aggressive use of executive orders, its reliance on guidance documents, and its willingness to circumvent court rulings. Elizabeth emphasized that this creates a fluid environment where policy changes can be announced and implemented rapidly, requiring stakeholders to remain vigilant.

Margaret French (Venn Strategies) discussed congressional dynamics, emphasizing the precarious status of healthcare extenders such as the Community Health Center Fund and workforce programs. She explained that partisan tensions remain extremely high following reconciliation, leaving little room for bipartisan negotiations. Without strong advocacy, these vital programs could be sidelined.

Elise Tollefson (Venn Strategies) expanded on the Medicaid provisions in reconciliation, noting the introduction of work requirements, caps on state-directed payments, and restrictions on provider taxes. She emphasized that although these changes are law, debate will continue, with some senators already introducing bills to repeal the cuts.

Committee members asked about the prospects for Medicare payment reform in this Congress. Margaret confirmed that while bipartisan legislative vehicles are limited, there is real will among policy leaders to engage in reform conversations- en route to potential action in the future. She stressed that PCC's credibility as a convener and solution-oriented

partner would be invaluable.

Ann reinforced this point, confirming that PCC is actively positioning itself to provide pragmatic solutions and ensure policymakers view PCC as a resource.

Additional discussion touched on potential legislative vehicles, including continuing resolutions, the National Defense Authorization Act, and year-end packages. Margaret cautioned that most vehicles are unlikely to carry major reforms this year but emphasized that advocacy now can lay the groundwork for legislative opportunities in early 2026.

Closing Remarks

Larry thanked Elizabeth, Margaret, and Elise for their insights. He also expressed gratitude to committee members for their engagement, noting that the coming months would be critical for protecting primary care funding and advancing Medicare payment reform.