Administration and Congressional Leaders Aligned on Primary Care Payment Reforms

Side-by-Side Comparison of Key Provisions in 2026 MPFS Draft Rule and the Pay PCPs Act

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Primary care is one of the few types of care where greater investment can lead to better outcomes and lower costs over time. But for decades, Medicare's flawed payment methodology has undervalued primary care. This neglect has led to a dwindling workforce and access issues for millions.

Transforming how and how much we pay for primary care is a critical step toward improving health and life outcomes for Medicare beneficiaries.[1] Recent efforts through both the CMS CY 2026 Medicare Physician Fee Schedule proposed rule and the introduction of the **Pay PCPs Act of the 118th Congress** suggest that policymakers in the Administration and on Capitol Hill are starting to take similar actions to address long-standing flaws in how Medicare values and invests in primary care. This side by side compares the proposed regulatory and legislative proposals with respect to five key issues:

- valuation of clinician time;
- practice costs;
- the transition to hybrid (part-FFS/part per beneficiary per month) payment;
- behavioral health integration;
- and cost sharing.

Valuing Time with Patients in Medicare's Physician Fee Schedule

Medicare's current method systematically undervalues primary care's comprehensive and continuous nature by devaluing time spent in dialogue with patients and their caregivers.

This has occurred, in part, because CMS has depended on survey data primarily provided by the American Medical Association's Relative Value Scale Update Committee (RUC) with average time between introduction and revaluation of 17.69 years for those services that have been revalued at all.[2] The majority of codes have never been reviewed at all. The surveys estimate key components such as practitioner time, work intensity and practice expense, all of which influence the valuation of codes paid under the Medicare Physician Fee Schedule (MPFS).[3]

This has meant that, over time, services that lend themselves to more rapid, efficient delivery (certain procedures, tests and radiological services) have captured a greater share of Medicare dollars than services that cannot be as readily economized — the time spent listening to a patient and their caregiver.

Commenters on previous years' rules raised concerns about the integrity of this process, including low survey response rates, potential conflicts of interest among respondents and the potential of inflated time assumptions.[4, 5]

Under the CY 2026 Fee Schedule	Under Pay PCPs Act
CMS is proposing a -2.5% efficiency adjustment to the work Relative Value Units (RVUs) and intraservice physician time for non-time-based services in CY 2026. This would exclude time-based services like Evaluation and Management (E/M), care management, behavioral health, telehealth and maternity global codes. This adjustment is calculated using a sum of the past five years of the Medicare Economic Index (MEI) productivity adjustment percentage. CMS also plans to prioritize empiric data, over low-response surveys, when valuing services and assessing services nominated for revaluation.	The Pay PCPs Act would establish a 13-member Technical Advisory Committee within CMS to provide expert input on the accurate determination of RVUs under the MPFS. Members would bring diverse experience in provider payment and Medicare policy. The committee's responsibilities include advising on new valuation methodologies, assessing existing codes, recommending changes, identifying opportunities for (un)bundling services and evaluating the effects of payment changes on beneficiary access, financial liabilities and quality of care.

Modernizing Payment to Reflect Today's Practice Costs

CMS's practice expense (PE) methodology currently relies on outdated data from the AMA's 2008 Physician Practice Information Survey. As a result, payment for indirect practice expense is based on data from a time when more physicians operated separate practices even when providing hospital-based care. However, clinical practice has shifted significantly, with fewer physicians in private practice and more employed by hospitals and health systems. In early 2025, the AMA submitted 2024 survey results to CMS. Due to concerns and limitations with the submitted data, CMS is not proposing to implement changes based on those results.[6]

Under the CY 2026 Fee Schedule	Under Pay PCPs Act
CMS is proposing significant updates to the practice expense (PE) methodology to better reflect current clinical practice, including • A site-of-service differential that will increase indirect practice expense payment for office-based care offset by a decrease in payment to facility-based reimbursement. • Use of routinely updated, auditable data from the Medicare Outpatient Prospective Payment System (OPPS) to inform cost assumptions for certain technical services. For CY 2026, this data would be used to set rates for radiation treatment and select remote monitoring services, improving transparency and reducing reliance on limited survey data.	The Pay PCPs Act would establish a new Technical Advisory Committee within CMS to advise the Agency on new methods to more accurately determine RVUs under the MPFS and to correct existing distortions which lead to under-reimbursement for high-value activities and services.

Hybrid Payment: Towards a Viable Alternative to Fee-for-Service

The current fee-for-service model is unequipped to support key components of advanced primary care, such as building and sustaining multidisciplinary care teams able to deliver a more comprehensive set of services and ensuring effective care coordination.[7]

The National Academies of Sciences, Engineering & Medicine (NASEM) has recommended that CMS move toward hybrid payment models within primary care. In 2025, CMS took its first steps towards hybrid payment in Traditional Medicare via the fee schedule through the CY2025 MPFS Rule with the establishment of the Advanced Primary Care Model (APCM) codes.[8] Unlike other codes, APCM codes do not include time-based thresholds, with the intention of reducing administrative burden. Instead, payments are tiered, based on the number of chronic conditions and whether the patient is a Qualified Medicare Beneficiary.

Under the CY 2026 Fee Schedule	Under Pay PCPs Act
Building on APCM services established in 2025, CMS is proposing three new optional BHI add-on codes for APCM services to support the delivery of general behavioral health integration or psychiatric Collaborative Care Model (CoCM) services. These new G-codes would be billed in the same month by the same practitioner billing for APCM. This new payment is designed to be directly comparable with existing CoCM and BHI codes but does not require minute by minute tracking of staff time. These add-on codes would also be available to Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) when providing advanced primary care.	The Pay PCPs Act would authorize the Secretary of HHS to establish hybrid payments under the MPFS available only to "primary care providers"* These hybrid payments may include both prospective, per-member-per-month (PMPM) payments and traditional fee-for-service payments. The PMPM component may support care management services, behavioral health integration services, virtual and phone-based patient communications, and office-based evaluation and management visits for new and established patients. The PMPM amount may represent 40–70% of expected annual allowed charges.

Behavioral Health Integration

Research has shown that integrating behavioral health into primary care improves health outcomes. Patients experience reduced depression severity and a better overall experience of care.[9] CMS has made progress in supporting behavioral health integration by establishing billing codes for both general behavioral health services and the Psychiatric Collaborative Care Model. In recent years, CMS has expanded these efforts by introducing additional codes for safety planning, interprofessional consultation services and the use of digital behavioral health treatment devices.[10]

** Although primary care physician societies have opposed the use "provider" terminology, in this case, the bill references a specific definition in statute. For that reason, we retain that usage here in quotes. See U.S. Congress, Senate, Pay PCP's Act of 2024. S 4338.*

Under the CY 2026 Fee Schedule	Under Pay PCPs Act
CMS is proposing three new optional BHI add-on codes for APCM services to support the delivery of behavioral health integration or Psychiatric Collaborative Care Model services. These new G-codes would be billed in the same month by the same practitioner and are designed to be directly comparable with existing CoCM and BHI codes. Additionally, CMS is proposing to expand payment policies for digital mental health treatment (DMHT) to now include treatment of Attention Deficit Hyperactivity Disorder (ADHD).	The Pay PCPs Act outlines services included in the prospective-per-member-per-month payment including behavioral health integration services.

Removing Cost Barriers to Personalized Primary Care

A growing share of Medicare beneficiaries, including dual eligibles, lack an ongoing source of primary care[11] — which is essential to health promotion and prevention, chronic disease management, and curbing hospital and emergency department utilization.[12,13] In the CY 2025 PFS final rule, commenters recommended eliminating monthly cost sharing for APCM services, noting that any cost sharing could limit the uptake of APCM services. In 2023, 32.6% of Medicare beneficiaries had incomes below 200% of the federal poverty line (FPL).[14] For seniors, particularly those living on fixed incomes, a monthly beneficiary co-pay can create significant barriers to accessing primary care and may lead to substantial financial burdens.[15]

Under the CY 2026 Fee Schedule	Under Pay PCPs Act
CMS is requesting comments on how CMS should consider cost sharing for APCM services particularly if preventative services were included within the APCM bundle. CMS asked for comments on: • How should we account for cost sharing if APCM includes both preventive services and other Part B services? • Should CMS consider including the Annual Wellness Visit, depression screening, or other preventative services in the APCM bundle, and if so, which services and why?	The Pay PCPs Act would authorize the Secretary of Health and Human Services to reduce cost sharing for beneficiaries by 50% for primary care services that are reimbursed through the established prospective, per-member-per-month payment. Cost sharing reduction would be applicable to beneficiaries visiting their designated primary care.

**Language largely adapted from the Pay PCPs Act of 2024 and the CY 2026 Medicare Physician Fee Schedule Proposed Rule Factsheet*

Sources

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About PCC

Founded in 2006, the Primary Care Collaborative (PCC) is the leading national, nonpartisan and multi-stakeholder voice advocating for better health for all Americans by strengthening primary care. The PCC unifies and engages diverse stakeholders in promoting policies and sharing best practices that encourage the growth of high-quality, comprehensive primary care.

About West Health

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