Statement for the Record
by the
Primary Care Collaborative
for the
House Committee on Ways & Means Health Subcommittee
on
"Modernizing Care Coordination to Prevent and Treat Chronic Disease"

November 19, 2025

Thank you for the opportunity to submit this statement on behalf of the Primary Care Collaborative (PCC).

PCC is a nonprofit, nonpartisan coalition of more than 70 organizational members, including clinician organizations, patient and consumer advocates, employer groups, and health plans. We share a commitment to a high-value health care system with a strong foundation of primary care that is comprehensive, continuous, team-based, and focused on the upstream drivers of health.

Simply stated, we believe that modernizing care coordination for chronic disease starts with strengthening primary care payment and infrastructure, especially in rural and high-need communities.

Chronic Disease & Care Gaps: Why Primary Care Led Coordination Matters

Chronic diseases drive most morbidity, mortality, and health care costs in the U.S. The burden is especially heavy in rural and underserved communities, where rates of chronic illness and behavioral health needs are higher, and access to care is more limited.

Rural communities have fewer primary care clinicians per capita than urban and suburban areas. But rural primary care clinicians often deliver more comprehensive care, addressing physical health, behavioral health, and social needs across multiple settings (office, hospital, nursing facility, home). However, primary care's share of total health spending is declining, even though stronger primary care is associated with better outcomes and lower overall costs.

Indeed, recent data[1] suggests that each additional in-person primary care visit is associated with a total cost reduction of $721 (per patient per year). Even further, the higher the patient severity of illness, the larger the cost reduction: Among the top 10% of high-risk patients, the first PC in-person visit was associated with a reduction of $16 406 or 19%.

And yet, primary care continues to be underfunded. 90% of healthcare spending in the U.S. was directed toward treating patients with one or more chronic conditions, but primary care

[1] https://pmc.ncbi.nlm.nih.gov/articles/PMC9793026/

accounted for only 4.6% of total U.S. healthcare spending and the share of spending on primary care in Medicare was even lower, at just 3.4%.[2]

In short, the clinicians best positioned to coordinate chronic disease care, those in primary care, are being asked to do more with less. Any serious effort to modernize care coordination must reinforce primary care's role as the front door and hub for patients living with chronic conditions.

Rural Health Considerations

For rural America, payment policy is not an abstract issue, it is the difference between having a local care team and having to travel hours for basic services.

Rural practices often serve as de facto care coordinators for everything: specialty referrals, post-hospital transitions, behavioral health, social services, and pharmacy access. They survive financially through a fragile mix of Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) payment structures, 340B revenue, small grants, and innovative membership or cash-pay models. Recent federal Medicaid changes and ongoing hospital closures amplify the importance of strong, community-based primary care as the central coordinating entity for chronic disease.

About 66 million people or roughly 1 in 5 Americans live in rural areas, where Medicaid covers about 1 in 4 adults and is a key source of financing for health care. The Congressional Budget Office estimates that H.R. 1 would reduce federal Medicaid spending by about $911 billion over 10 years and increase the number of uninsured by roughly 10 million, with a disproportionate impact on rural communities.

New initiatives like the Rural Health Transformation Program (RHTP) seek to offset some of these Medicaid losses in rural and underserved communities and create an opportunity to build rural systems around comprehensive primary care and care coordination, not just hospital infrastructure. But this program will only be successful if primary care is funded and structured to play that central role.

A Step Toward Better-Funded, Coordinated Primary Care

Medicare payment policy has long undervalued time-intensive, relationship-based care and overvalued procedures and tests. That imbalance undermines care coordination for chronic disease.

Fortunately, the Calendar Year (CY) 2026 Medicare Physician Fee Schedule Final Rule (CMS-1832-F) is a meaningful step forward as it seeks to rebalance value toward time and relationships, support community-based practices, advance care management and integration, and strengthen prevention and patient self-management

[2] https://thepcc.org/wp-content/uploads/2025/03/Make-Medicare-Beneficiaries-Healthier-Issue-Brief.pdf

These changes move the system closer to what patients with chronic conditions need: a primary care team that knows them, coordinates across settings, and helps them manage their health over time.

Recommendations: Modernizing Care Coordination Through Primary Care

PCC recommends the Subcommittee focus on four core areas to modernize care coordination for chronic disease:

1. **Increase and Track Primary Care Investment.** Direct the Centers for Medicare & Medicaid Services (CMS) to measure primary care spending by geography and payer, including rural vs. urban breakdowns. Set expectations for raising primary care's share of Medicare spending over time, moving above the current very low level. Encourage states and Medicaid managed care plans to protect or enhance primary care investment, particularly in rural and high-need communities.
2. **Build on the 2026 Medicare PFS to Support Coordinated, Team-Based Care.** Sustain and refine the efficiency adjustment so that time-intensive, relationship-based services, especially for complex chronic disease, are appropriately valued. Monitor and adjust the site-of-service differential to stabilize independent and community-based primary care, which is where most chronic care coordination occurs. Encourage CMS to address beneficiary cost-sharing and administrative barriers for Advanced Primary Care Management (APCM) and behavioral health integration (BHI) so patients and practices can fully use these tools.
3. **Make Rural Transformation Primary Care Centric**. Ensure the RHTP and related Rural Health policies prioritize primary care-led models that integrate behavioral health and social needs, rather than focusing solely on hospital preservation. Support and align programs that sustain the rural primary care workforce (e.g. RHCs, FQHCs, Teaching Health Center GME, and the National Health Service Corps).
4. **Align ACOs and Prevention Policy With Care Coordination Goals.** Encourage CMS to align APCM and BHI policy with Medicare Shared Savings Program (MSSP) benchmarks so that practices are not penalized for investing in better care coordination. Support payment reforms that make it easier for primary care teams to deliver prevention, health coaching, and intensive lifestyle support for patients with or at risk for chronic disease.

Conclusion

Modernizing our nation's health care system to better prevent and treat chronic disease will not be achieved by technology alone or by adding more siloed programs. It requires a strong, well-funded primary care foundation, especially in rural and underserved communities, where patients have a trusted team that can coordinate across settings and over time.

CMS makes important progress in this year's payment rule by better valuing primary care and care coordination. Congress now has an opportunity to lock in and build on those gains: raising

primary care investment, removing barriers to care management and behavioral health integration, and ensuring that rural transformation is organized around comprehensive primary care.

PCC and our multi-stakeholder members stand ready to work with the Subcommittee to ensure that Medicare payment policy truly supports modern, coordinated care for the millions of Americans living with chronic disease.

Thank you for including our perspective in the record. Any questions may be directed to PCC Director of Policy Larry McNeely at LMcNeely@thepcc.org.