PCC Policy and Advocacy Committee Meeting

February 17, 2026 | 3:30 - 4:30 PM ET

Participating Organizations

Advocates for Community Health (ACH), American Academy of Child and Adolescent Psychiatry (AACAP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Academy of Physician Associates (AAPA), American College of Lifestyle Medicine (ACLM), American College of Physicians (ACP), American Psychological Association (APA), Blue Cross Blue Shield of Michigan (BCBS-MI), Blue Shield of California (BSC), Brigham and Women's Hospital Primary Care Center of Excellence, Cummins Inc., EvolvedMD, Families USA, HealthTeamWorks, Humana, Mathematica, Meadows Mental Health Policy Institute (MMHPI), Mental Health America (MHA), National Association of ACOs (NAACOS), National Association of Community Health Centers (NACHC), National Committee for Quality Assurance (NCQA), National Partnership for Women & Families (NPWF), Purchaser Business Group on Health (PBGH), Society of General Internal Medicine (SGIM), Society of Teachers of Family Medicine (STFM)

Thank you to Our Speakers

- Larry McNeely, Ann Greiner & Tod Didier, PCC
- Co-Chair: Sarah Coombs, NPWF
- Margie C. Andreae, MD, University of Michigan Medical Center

Welcome & Announcements

Larry McNeely (PCC) opened the meeting and welcomed participants to the meeting. He noted that the session would include three primary discussions: a presentation on pediatric preventive care and the Medicare Physician Fee Schedule (MPFS), a conversation on updating the Better Health Now campaign's plank on strengthening the primary care safety net, and closing updates regarding the Milbank Primary Care Scorecard and related resources.

Larry acknowledged several attendees, including PCC President and CEO Ann Greiner and PCC board member Bob Chestnut, and welcomed participants joining the discussion.

Chiyedza Mvundura (PCC) provided a brief federal policy update highlighting the Consolidated Appropriations Act of 2026 passed by Congress on February 3. The legislation included several provisions supporting primary care, particularly for rural and

underserved communities. These included funding for community health centers, the National Health Service Corps, and multi-year funding increases for the Teaching Health Center Graduate Medical Education program. The legislation also extended Medicare telehealth flexibilities through 2027 and included investments supporting rural health infrastructure, maternal and child health, workforce development, and behavioral health clinics. Members acknowledged the collective advocacy work by many organizations represented on the call that contributed to these policy outcomes.

Larry emphasized that while the package did not fully address broader challenges facing primary care, it represented meaningful bipartisan progress toward strengthening access.

Co-Chair Remarks & Roll Call

Sarah Coombs (NPWF), serving as committee co-chair, shared brief policy updates relevant to the committee's work.

Sarah noted that CMS had recently released the Notice of Benefit and Payment Parameters proposed rule for the 2027 Affordable Care Act Marketplace plan year. She highlighted concerns that the proposed rule tightens enrollment requirements while removing several protections for low-income individuals, which may increase barriers to coverage. The comment period for the rule is limited to thirty days, with comments due March 11. Sarah indicated that NPWF plans to submit comments and encouraged participants to review summaries prepared by partner organizations such as Families USA.

Sarah also noted that the comment period deadline for proposed rules restricting access to care for transgender youth was occurring that day, urging members to remain aware of these developments.

Larry thanked Sarah for the update and acknowledged that the broader policy environment includes several evolving federal discussions that PCC and member organizations are monitoring closely.

MPFS and Barriers to Pediatric Care

Ann Greiner (PCC) introduced guest speaker Dr. Margie C. Andreae of the University of Michigan Medical Center. Ann highlighted Margie's leadership as Professor of Pediatrics and Chief Medical Officer for Revenue Cycle and Billing Compliance, her active pediatric practice, and her research on immunization policy, vaccine safety, and physician payment models.

Margie presented on the relationship between the Medicare Physician Fee Schedule and pediatric preventive care, explaining how Medicare policy decisions can create unintended downstream effects for pediatric and primary care payment by other payers.

Margie explained that preventive medicine CPT codes (99381–99397) represent age-based wellness visits covering infants through young adults. In pediatric primary care practices, these visits account for approximately 30–40 percent of all encounters. Although Medicare generally does not cover pediatric preventive visits, these CPT codes are still included in the Medicare Physician Fee Schedule with a "Status N" designation, meaning they are non-covered services. However, other payers—including Medicaid programs and commercial insurers—often reference Medicare valuations when setting payment policies.

Margie described how the statutory framework governing Medicare, established in 1965, originally limited coverage to services necessary for diagnosing or treating illness or injury. Preventive services were historically excluded from coverage. While Congress has since created limited preventive benefits within Medicare—such as the Annual Wellness Visit and certain cancer screenings—these benefits are typically implemented using Medicare-specific HCPCS "G-codes" rather than the existing preventive CPT codes used broadly in primary care.

Margie provided several examples where Medicare rulemaking has inadvertently created disparities affecting pediatric preventive services. One example involved the 2021 revisions to office visit evaluation and management codes. When CMS increased the relative value units (RVUs) for office visit codes, it also adjusted several related code families whose valuation is derived from those codes. However, the age-based preventive medicine CPT codes did not receive similar adjustments, despite also being based on office visit values.

Margie also discussed the G2211 add-on code designed to support longitudinal and complex primary care. Policy updates expanded its use alongside certain Medicare preventive services, such as the Annual Wellness Visit and vaccine administration. However, because these updates reference Medicare-specific preventive codes rather than the age-based CPT preventive codes used in pediatric practice, pediatric providers and clinicians caring for younger patients remain excluded from the benefit.

A third example involved teaching physician policies under the primary care exception rule. While Medicare's Annual Wellness Visit is explicitly included in these rules, the preventive medicine CPT codes used in pediatrics are not addressed, creating administrative uncertainty for teaching physicians supervising residents in pediatric primary care settings.

Margie recommended that CMS consider the preventive medicine CPT codes when implementing rulemaking affecting preventive care, even though those services remain

non-covered by Medicare. She explained that such adjustments would not increase Medicare spending but could influence Medicaid and commercial payers to adopt more equitable valuation structures.

During the discussion, Judith Steinberg asked whether children with disabilities who qualify for Medicare could receive preventive services through these codes. Margie explained that Medicare does not recognize those CPT codes for payment, and such children typically rely on other coverage sources.

Judith also raised the broader question of whether the underlying Medicare statute is outdated given modern understanding of preventive care's value. Margie acknowledged that addressing the statutory limitation may ultimately be the most direct solution.

Katherine Gergen-Barnett commented that the issue appears underrecognized within the broader primary care community and asked how organizations could elevate it in policy discussions. Margie suggested that collaboration among major primary care organizations—such as AAP, AAFP, and ACP—could help amplify the issue.

Ann Greiner added that PCC's multi-stakeholder membership—including employers, consumer advocates, and behavioral health organizations—could bring additional voices to the conversation about the undervaluation of pediatric preventive care.

Margie concluded by thanking the group and expressing interest in continued collaboration.

Following the presentation, Nicole Beck (PCC) gave a brief shoutout to three new/returning PCC members:

1. American Academy of Ambulatory Care Nursing (AAACN)
2. American Heart Association (AHA)
3. Purchaser Business Group on Health (PBGH)

Discussion on BHN's Planks: Strengthening the Primary Care Safety Net

Larry McNeely led a discussion on proposed updates to Better Health Now's policy planks, focusing on strengthening the primary care safety net.

Larry explained that PCC staff and member organizations have been reevaluating the existing plank related to Medicaid and health equity. Based on discussions with members and evolving policy conditions, PCC is proposing to reframe the effort around protecting

and strengthening the primary care safety net—particularly in the face of potential fiscal pressures affecting Medicaid and CHIP programs.

The proposal would expand PCC's current state-focused work on primary care spending into a broader initiative supporting state leaders and advocates. The goal would be to help states preserve primary care access while navigating budget pressures and policy changes.

Larry noted that PCC has served as a backbone organization supporting state measurement of primary care spending since 2018. At that time only two states reported such spending data; today more than twenty states report primary care spending and nine have established spending targets.

Building on this work, PCC proposes expanding the existing workgroup into a broader "primary care safety net" initiative. This group would focus on tracking emerging threats to primary care access, sharing policy solutions across states, highlighting successful state strategies, and equipping advocates with resources to defend primary care investment.

Ann Greiner emphasized that PCC's role would be to provide shared resources, data, and examples rather than directly intervening in state legislative debates. She noted that PCC is also exploring opportunities to secure additional external funding to support the initiative and potentially incorporate storytelling and case studies illustrating the impact of primary care in communities.

Members expressed support for the proposal. Eric Bass (SGIM) noted the ambitious scope and asked how PCC would balance resources across priorities. Ann acknowledged the challenge but emphasized the urgency of responding to policy developments affecting Medicaid and primary care infrastructure.

Diane Rittenhouse (Mathematica) commended PCC for taking on a leadership role and highlighted the importance of cross-state learning and knowledge sharing.

Scott Barstow (APA) asked whether PCC's primary care investment tracking efforts might eventually include data on behavioral health integration spending. Larry indicated that PCC would welcome opportunities to incorporate such data as it becomes available and reaffirmed the organization's commitment to whole-person primary care, including behavioral health integration.

Larry invited members to share ideas and collaborate on the initiative as it develops.

2026 Primary Care Scorecard: New Report and Toolkit

Tod Didier (PCC) concluded the meeting with several updates.

Tod highlighted the release of the Milbank Memorial Fund's latest Primary Care Scorecard, which includes a new report examining the role of primary care in addressing chronic disease. The report presents evidence demonstrating that stronger primary care systems improve health outcomes and reduce costs over time. Tod encouraged members to review the report and share it with their networks.

Tod also previewed an upcoming PCC policy brief examining the root causes of administrative burden in primary care and strategies for streamlining participation in value-based payment models. The brief draws on survey responses from primary care clinicians, literature reviews, case studies, and expert interviews.

Read the full brief here.

Finally, Tod invited participants to register for an upcoming PCC webinar on strengthening primary care participation in accountable care organizations (ACOs). The session will feature speakers including Aisha Pittman of NAACOS and Autumn Orser, an ACO leader in Colorado, with possible participation from CMS representatives.

Watch the webinar recording here.

Closing Remarks

Ann Greiner thanked participants for their engagement and ongoing commitment to strengthening primary care across the healthcare system. She emphasized the importance of collaboration among clinicians, policymakers, employers, and community advocates in advancing policies that support primary care and improve population health.

The meeting concluded shortly before 4:30 PM ET.