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Policy & Advocacy Committee Meeting

Tuesday, February 17, 2026 | 3:30 – 4:30pm

agenda

Welcome & Announcements	*PCC Team*
Co-Chair Remarks & Roll Call	*Shari Erickson, ACP* *Sarah Coombs, NPWF*
MPFS and Barriers to Pediatric Care	*Margie Andreae, AAP*
Discussion on BHN's Planks: Strengthening the Primary Care Safety Net	*PCC Team* *All Participants*
2026 Primary Care Scorecard: New Report and Toolkit	*Tod Didier, PCC*

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Welcome

PCC Team

Primary Care Wins in Healthcare Package

On February 3, Congress passed H.R. 7184, the Consolidated Appropriations Act of 2026. The bipartisan legislation makes strides to protect access to primary care, especially for those in underserved and rural communities.

- $4.6 billion for the **CHC Fund** through December 31, 2026
- $350 million in funding for the **National Health Service Corps** through December 31, 2026
- An extension of **Medicare telehealth flexibilities** through December 31, 2027
- A historic, four–year funding package for the **Teaching Health Center GME** program, beginning with $225 million in FY 2026 and increasing by $25 million annually
- $1.4 billion to strengthen the **health workforce** in rural and underserved communities
- $386 million for **Certified Community Behavioral Health Clinics**.

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Co-Chair Remarks

Shari Erickson | ACP
Sarah Coombs | NPWF

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MPFS and Barriers to Pediatric Care

Margie Andreae, MD | AAP

Prevention vs. Policy: CMS Rule Making Gaps and Implications

Margie Andreae, MD, FAAP

AAP Representative the AMA RUC

February 17, 2026

Background on Preventive Medicine Service Codes

- CPT codes 99381-99397 represent age-based wellness visits
  - These services account for 30-40% of primary care pediatric visits
- In 1965 Medicare was established with a provision that the program may not pay for services that "*are not reasonable and necessary for the diagnosis or treatment of illness or injury*."
  - CPT codes 99381-99397 are considered "non-covered" services
    - Listed in Medicare Physician Fee Schedule as status "N" with RVUs published
- In recent years Congress has created exceptions for specific preventive services, such as Medicare's annual wellness visit, adding them to the Medicare program through the creation of HCPCS G codes.
    - **The G codes are included in Rule Making but codes 99381-99397 are left out**

CMS Rule Making on 2021 Office Visit E/M

In 2021 CMS accepted the RUC recommended increase in RVUs for office visits codes (99202-99215)

This resulted in increased payment for office visit E/M services.

At the same time, CMS applied similar increase in RVUs for several codes whose values are based on office visit E/M values, including transitional care management, maternity services, cognitive impairment assessments, and annual wellness visits.

▲ Age-based well visit values are based on E/M office visit values but their RVUs were not similarly adjusted by CMS.

CMS Rule Making on G2211

In 2024 CMS introduced G2211—add-on code for longitudinal care

Reported with office and other outpatient services, 99202—99215; not payable if modifier 25 is on the claim.

Changes to G2211 in 2025

Claims with modifier 25 would be payable when the service performed in addition to the office visit is an annual wellness visit, vaccine administration or other CMS covered preventive medicine service.

Age-based well visits are CMS **non-covered** preventive medicine services and hence are excluded from the change.

CMS Rule Making on Physician at Teaching Hospital (PATH) rules

The PATH rules include Primary Care Exceptions that allow teaching physicians to bill for low-to-mid-level services performed by residents without the physician's physical presence.

CMS includes Medicare Annual Wellness visits (G codes) under the Primary Care Exception but does not address the age-based preventive medicine service codes (99381-99397) in the rule.

The PATH rules state that they apply to pediatric training programs.

- Age-based well visits are not included in the primary care exception which adds unnecessary burden to teaching physicians supervising residents performing these services.

AAP Recommendation

CMS to consider “non-covered” preventive services when applying rules to Medicare covered preventive services, even though Medicare does not pay for non-covered services, with the goal of other payers (Medicaid and commercial programs) applying similar consideration.

Examples:

1. CMS can adjust RVUs for CPT codes 99381-99397 based on 2021 EM increase even though the codes are status N
2. CMS can add a provision in the G2211 guidelines that states CPT codes 99381-99397 are non-covered services that other payers may want to treat similar to the Medicare annual wellness codes
3. CMS can add a statement in the Primary Care Exception rule that CPT codes 99381-99397 may be included by payers other than Medicare.

PCC's New and Returning Members

The PCC is excited to recognize **3** new & returning organizations to the PCC's membership.

aacn American Academy of Ambulatory Care Nursing

Many settings. Multiple roles. One unifying specialty.

PBGH Purchaser Business Group on Health



American Heart Association.

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

PCC Team

All Participants

Better Health – NOW Updated Planks

1. Expand access to high-quality, comprehensive primary care by **leveraging Medicare's influence** to change how and how much we pay for primary care.
2. Protect the **primary care safety net** by ensuring state **Medicaid** programs strengthen primary care and **rural and underserved communities** are prioritized.
3. **Champion whole-person primary care** by supporting health promotion, behavioral health integration, and multidisciplinary teams.

Our Unique Focus

Objective: **Help state leaders preserve PC in the face of draconian cuts**

How Can State Officials and Advocates Accomplish This?

- **Fight back** on proposals to cut **Medicaid and the Primary Care Safety Net**
- As states retool to navigate reduced federal support, **Prioritize a Primary Care-centered Delivery System!**

What's At Stake:

- Health of our communities

Leverage PCC's State Investment Efforts

Since 2018, PCC has been backbone organization championing PC + PC Spend

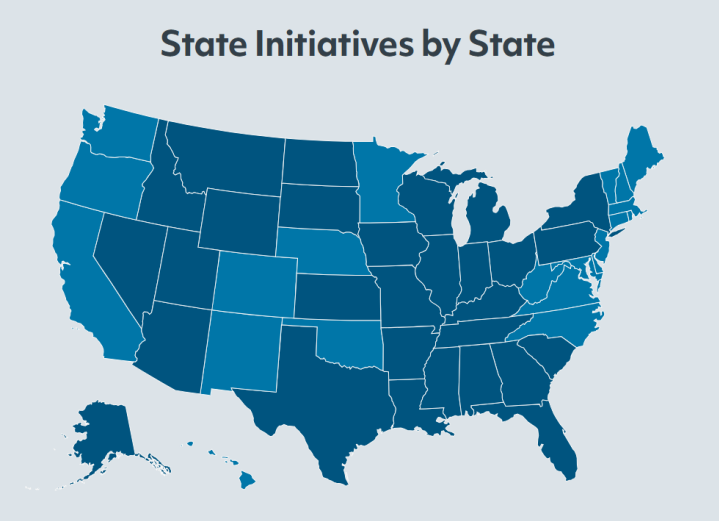
State Investment Workgroup:

- Convene 50-60 state leaders quarterly (advocates and officials)

Resource Dissemination:

- PCC features resources, exemplars, and relevant materials on State PC Investment Hub, including state legislative tracker

Reporting PC spend = 21 states; 9 set targets



State Initiative Map - PCC

Our New Approach

PCC to re-purpose + expand Workgroup, providing resources, ideas and exemplars to:

1) Pushback: defeat/mitigate anticipated cuts to primary care

2) Leverage solutions: Rural Transformation Fund, tech and value- based payment

Operationalizing Our New Approach

Track emerging threats to PC safety net including Medicaid/CHIP; and counter with PCC statements, media

Proactive PC Message and Evidence Dissemination:

- **Dissemination**: 2025 Evidence Report; Harvard Ctr for PC report, Updated PCC 50 state fact sheet;
- **Trumpeting PC-focused resources** from members and allies
- **Website Map** to reflect state Medicaid policy developments,

Feature exemplar state leaders who successfully advance PC in the current environment

Notable State Medicaid Legislation

- **New Jersey Bill A. 2150**
  - This bill mandates that Medicaid and NJ FamilyCare managed care organizations provide primary care providers with either a patient-centered medical home model or an alternative payment model that incentivizes high-quality, cost-efficient, and holistic care.

- **Oklahoma H.B. 3361**
  - This bill amends Oklahoma's Medicaid reimbursement regulations to allow the Oklahoma Health Care Authority to set discretionary minimum reimbursement rates until July 1, 2027.

HR 1: Important Federal Policy Developments for Medicaid

- NHeLP: Timeline for Advocates on Work Req. Implementation
- New CMCS Letter on Special Directed Payments
- Final Medicaid Provider Tax Rule: CMS Fact Sheet

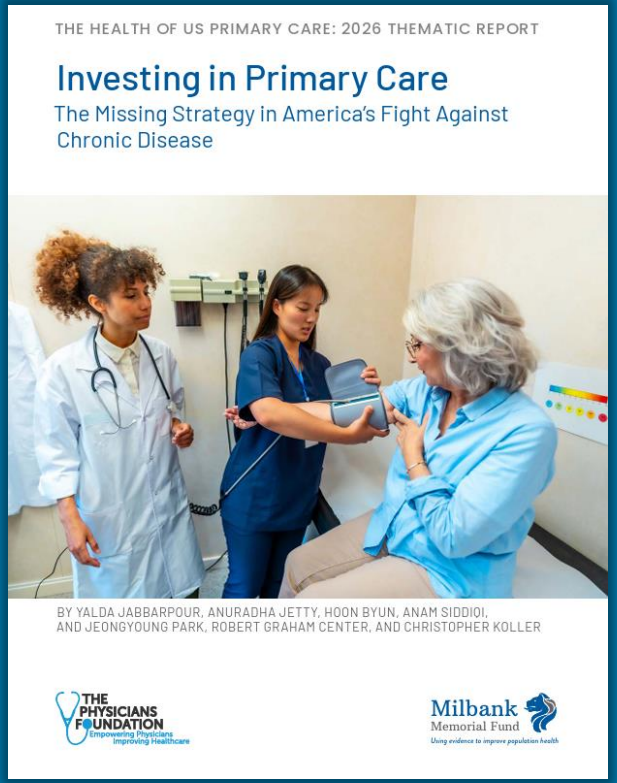
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2026 Primary Care Scorecard: New Report and Toolkit

Tod Didier | PCC

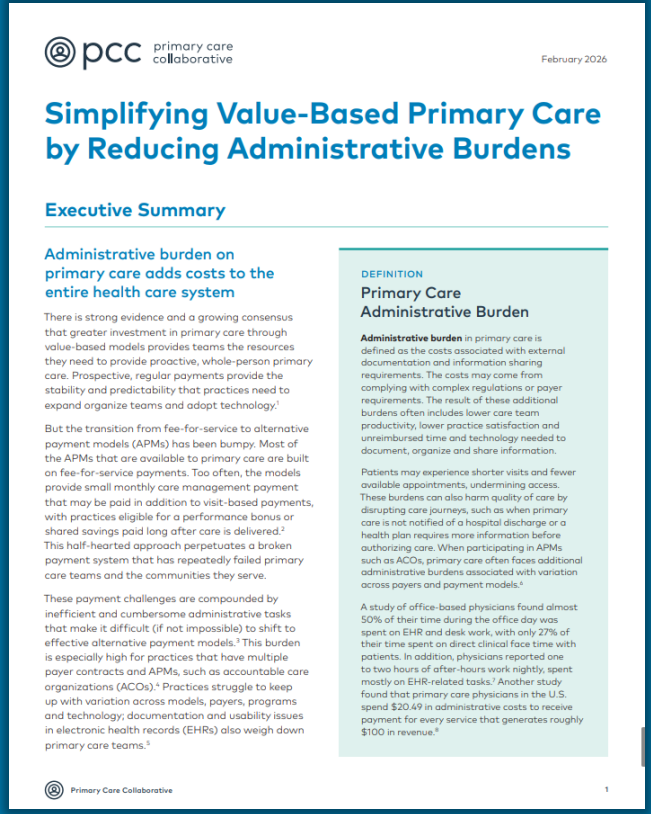
2026 PC Scorecard and Report



- **Milbank Scorecard** was released last week
- Latest report has compelling data on **chronic disease**
- Highlights **health benefits and cost savings** that come from a usual source of care
- Sharing **Milbank's toolkit** in the chat (use **PCC2026** to download)

BRIEF: Simplifying Value-Based Primary Care by Reducing Administrative Burdens

- This policy options brief explores root cause of **administrative burden** and provides **concrete recommendations** on how to **streamline primary care's participation** in value-based care
- The brief draws on **surveys of the primary care community**, **existing literature**, **case studies** and one-on-one **conversation with leading experts** (thank you to Mathematica's Ann O'Malley)
- The report will be **released next Monday**
- The PCC will be sharing a toolkit and embargoed copies of the report and executive summary with **BHN, P&A** and **Messaging Workgroup** members no later than this Friday



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February 2026

Simplifying Value-Based Primary Care by Reducing Administrative Burdens

Executive Summary

Administrative burden on primary care adds costs to the entire health care system

There is strong evidence and a growing consensus that greater investment in primary care through value-based models provides teams the resources they need to provide proactive, whole-person primary care. Prospective, regular payments provide the stability and predictability that practices need to expand organize teams and adopt technology.[1]

But the transition from fee-for-service to alternative payment models (APMs) has been bumpy. Most of the APMs that are available to primary care are built on fee-for-service payments. Too often, the models provide small monthly care management payment that may be paid in addition to visit-based payments, with practices eligible for a performance bonus or shared savings paid long after care is delivered.[2] This half-hearted approach perpetuates a broken payment system that has repeatedly failed primary care teams and the communities they serve.

These payment challenges are compounded by inefficient and cumbersome administrative tasks that make it difficult (if not impossible) to shift to effective alternative payment models.[3] This burden is especially high for practices that have multiple payer contracts and APMs, such as accountable care organizations (ACOs).[4] Practices struggle to keep up with variation across models, payers, programs and technology; documentation and usability issues in electronic health records (EHRs) also weigh down primary care teams.[5]

DEFINITION

Primary Care Administrative Burden

Administrative burden in primary care is defined as the costs associated with external documentation and information sharing requirements. The costs may come from complying with complex regulations or payer requirements. The result of these additional burdens often includes lower care team productivity, lower practice satisfaction and unreimbursed time and technology needed to document, organize and share information.

Patients may experience shorter visits and fewer available appointments, undermining access. These burdens can also harm quality of care by disrupting care journeys, such as when primary care is not notified of a hospital discharge or a health plan requires more information before authorizing care. When participating in APMs such as ACOs, primary care often faces additional administrative burdens associated with variation across payers and payment models.[6]

A study of office-based physicians found almost 50% of their time during the office day was spent on EHR and desk work, with only 27% of their time spent on direct clinical face time with patients. In addition, physicians reported one to two hours of after-hours work nightly, spent mostly on EHR-related tasks.[7] Another study found that primary care physicians in the U.S. spend $20.49 in administrative costs to receive payment for every service that generates roughly $100 in revenue.[8]

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Strengthening Primary Care Participation in ACOs

1:00 PM ET, February 24, 2026