ADVOCATES FOR COMMUNITY HEALTH

September 14, 2026

The Honorable Mehmet Oz, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1848-P)

Dear Administrator Oz:

On behalf of Advocates for Community Health (ACH), a nonpartisan membership organization comprised of 55 community health center members in 22 states that serve over 4 million patients, thank you for the opportunity to comment on the Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule. ACH appreciates CMS's continued focus on strengthening primary care and ensuring Medicare beneficiaries, particularly those in rural and underserved communities, have access to high-quality, comprehensive care. As CMS considers changes to FQHC payment, primary care payment models, the Medicare Shared Savings Program, and remote monitoring services, we encourage the agency to ensure these policies reflect the unique needs and care delivery models of health centers. We appreciate your consideration of our recommendations and welcome the opportunity to serve as a resource as CMS finalizes these policies.

Background

Community health centers serve about 32.7 million patients nationwide, providing comprehensive primary care regardless of insurance status or ability to pay. Health centers are particularly important for Medicare beneficiaries in rural and underserved communities, providing preventive care, chronic disease management, behavioral health integration, medication management, care coordination, and enabling services. The comprehensive health center model helps patients manage complex health needs, maintain continuity of care, and avoid unnecessary emergency department visits and hospitalizations.

Federally qualified health centers (FQHCs) are reimbursed under the Medicare Prospective Payment System (PPS), which generally provides a single, bundled payment for qualifying primary care visits rather than paying separately for each individual service under the Medicare Physician Fee Schedule (PFS). Certain services, including care management and other longitudinal services, are separately payable outside the PPS. While FQHC payment is distinct from the PFS, broader Medicare payment policies directly influence health centers' ability to invest in their workforce, technology, care delivery innovation, and the infrastructure necessary to participate successfully in value-based care arrangements.

Health centers are increasingly delivering the comprehensive, longitudinal, and team-based care CMS seeks to advance through the CY 2027 PFS proposed rule. However, current Medicare payment and billing policies do not always reflect the workforce, technology, and infrastructure required to deliver this care. As CMS advances broader primary care reforms, ACH encourages the agency to modernize FQHC payment policy while preserving the stability of the PPS and ensuring health centers can meaningfully participate in new models of care.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

ACH appreciates CMS's attention to the relatively low utilization of separately payable care-management services among FQHCs and encourages the agency to consider the operational and financial barriers health centers face in delivering these services.

Simplify Care Management Requirements

Currently, Medicare separately reimburses FQHCs for care-management services, including Advanced Primary Care Management (APCM), Chronic Care Management (CCM), Community Health Integration (CHI), Principal Illness Navigation (PIN), and behavioral health integration, correctly recognizing the importance of ongoing care beyond a traditional office visit. Health centers routinely provide this type of longitudinal care through care coordination, population health management, behavioral health integration, and social-needs interventions. However, complex and sometimes unclear requirements related to consent, time tracking, documentation, initiating visits, provider involvement, and supervision can make these services difficult and costly for health centers to bill. Members also noted that health centers already billing CCM cannot simultaneously bill APCM, requiring them to consider transitioning from an established care-management

program rather than simply adding APCM. In some cases, the administrative costs associated with billing and compliance can approach or exceed reimbursement, making these services financially difficult to sustain. **ACH urges CMS to simplify care-management requirements, address billing policies that may discourage adoption, provide clear FQHC-specific guidance and ensure reimbursement reflects both the administrative and workforce costs required to deliver these services.**

Remove Beneficiary Financial Barriers to Care Management Participation

Beneficiary cost-sharing presents an additional barrier to the use of care management services. ACH members report that CCM coinsurance can discourage enrollment, particularly among patients on fixed incomes and households with multiple CCM-eligible adults. For example, one ACH member saw greater CCM participation during the COVID-19 Public Health Emergency when cost-sharing could be waived, demonstrating the impact out-of-pocket costs can have on participation. **ACH therefore encourages CMS to pursue waivers for FQHCs to waive beneficiary cost-sharing for CCM to help remove financial barriers to care-management participation.**

Expand Health Center Capacity to Deliver Comprehensive Care

FQHCs use the PPS encounter payment to support comprehensive care, but the current payment structure does not always reflect the resources required to expand the range of services available to patients. Certain specialty and procedure-based services, including infusion services, transcranial magnetic stimulation (TMS), podiatry, chiropractic care, and some ophthalmology services, can require resources that exceed what is supported through the standard encounter payment. Other services, including those provided by clinical pharmacists, physical therapists (PTs), occupational therapists (OTs), speech-language pathologists (SLPs), and registered nurses (RNs) providing wound care, may not independently generate a qualifying FQHC encounter. These limitations can affect health centers' ability to recruit specialized clinicians and sustainably provide services in-house, potentially requiring patients to seek care elsewhere. **ACH therefore encourages CMS to expand qualifying services and practitioners to trigger a PPS payment, and establish separate or add-on payment pathways for high-resource services where appropriate.**

Expanding comprehensive care also requires infrastructure investments, including Electronic Health Record (EHR) functionality, patient registries, population-health and care-management platforms, staffing, licensing, workflow redesign, and ongoing

maintenance. For health centers, making these upfront and recurring costs can make implementing and sustaining advanced care-management programs financially challenging. **ACH encourages CMS to consider temporary PPS add-on payments to help health centers build and sustain the infrastructure necessary to expand comprehensive, coordinated care.**

Redesigning Primary Care to Make America Healthy Again

ACH supports CMS's efforts to better recognize the value of comprehensive primary care and encourages the agency to ensure that payment reforms create meaningful opportunities for FQHCs to participate.

Protect the FQHC PPS While Advancing New Payment Models

As part of its Primary Care Payment Reform RFI, CMS seeks feedback on prospective and other alternative approaches to primary care payment, including their potential application more broadly in Original Medicare. ACH supports CMS's interest in exploring prospective and hybrid payment approaches that better support preventive, longitudinal, team-based, and population-based primary care. If CMS considers extending new payment approaches to FQHCs, they should not come at the expense of the existing FQHC PPS or require health centers to assume significant downside financial risk to receive adequate primary care payment. **ACH encourages CMS to preserve the FQHC PPS as the foundational Medicare payment protection for health centers and ensure new prospective, hybrid, or population-based payment opportunities are additive to, rather than replacements for or offsets to, existing PPS reimbursement.**

Ensure Payment Reflects the Full Scope and Complexity of Comprehensive Primary Care

Health centers provide comprehensive primary care to patients with complex clinical and social needs through interdisciplinary care teams, behavioral health integration, care coordination, enabling services, and population health activities. However, current payment structures do not always adequately support the full range of services and resources required to deliver this model of care, including pharmacist, therapy, nursing, specialty, and procedural services. **ACH encourages the agency to account for patient complexity and the full scope of comprehensive care and provide predictable resources that health centers can invest prospectively in the workforce and infrastructure necessary to meet these needs.**

Invest in Technology Without Assuming Automatic Cost Savings

Technology is increasingly integral to comprehensive, coordinated primary care, but adopting and maintaining these tools requires significant upfront and ongoing investment. There are significant costs associated with implementation, interoperability, cybersecurity, governance, licensing, staff training, patient engagement, and workflow redesign. While these investments may strengthen care delivery, they do not necessarily reduce the underlying cost of providing care. **ACH encourages CMS to recognize the full costs of technology adoption in future primary care payment models and avoid payment policies that assume artificial intelligence or other technologies automatically generate cost savings for health centers.**

Medicare Shared Savings Program

CMS proposes allowing certain Accountable Care Organizations (ACO) greater flexibility to reduce or eliminate Medicare Part B beneficiary cost-sharing for qualifying services furnished by ACO participants. ACH supports efforts to reduce financial barriers to high-value primary and preventive care, provided these policies do not shift the cost of waived beneficiary liability onto participating safety-net providers.

Protect FQHCs from Absorbing Waived Beneficiary Cost-Sharing

CMS proposes allowing certain Accountable Care Organizations (ACOs) greater flexibility to reduce or eliminate Medicare Part B beneficiary cost-sharing for qualifying services furnished by ACO participants. ACH supports reducing financial barriers that may discourage beneficiaries from accessing preventive care, chronic disease management, follow-up services, and other clinically appropriate care. However, ACH is concerned that beneficiary cost-sharing waivers could result in reduced reimbursement for participating FQHCs if ACOs are not required to reimburse health centers for the waived amounts. **ACH encourages CMS to require ACOs that waive beneficiary cost-sharing to fully reimburse participating FQHCs through a clear and administratively simple reimbursement or settlement process. CMS should clarify responsibility for amounts otherwise covered by supplemental insurance, establish clear beneficiary eligibility and notification requirements, and ensure waived amounts are not treated as provider bad debt or uncompensated care.**

Primary Care Exception to the Physician Presence Requirement

CMS has proposed to modernize the primary care exception (PCE) by expanding the scope of covered evaluation and management (E/M) services. While supporting your agency's

proposal, we also wish to express support for the request submitted by the American Association of Teaching Health Centers (AATHC) that CMS use the CY2027 PFS Final Rule to also address a longstanding eligibility provision that unintentionally excludes most Teaching Health Centers Graduate Medical Education (THCGME) programs from the PCE. (Section 340H Teaching Health Centers (THCs) can't avail themselves of the PCE because the PCE regulation predates the creation of the THCGME program by 15 years and didn't anticipate the concept of THCs with their different structure.)

The lack of a PCE has significant operational consequences for THCGME programs and the patients they serve. Under the standard Medicare teaching physician rule, a teaching physician must be physically present during the key portion of every billable resident encounter. Without PCE access, THCGME programs cannot staff a continuity clinic session the way hospital-affiliated programs do: one attending supervising multiple residents seeing established patients simultaneously, with the attending immediately available, reviewing each case, and stepping in when complexity warrants it. Instead, the attending must personally conduct the key portion of every billable encounter, one resident at a time.

AATHC has proposed adding new prong (iii) to the current PCE regulation: "The services must be furnished in a center that is located in (i) an outpatient department of a hospital; (ii) another ambulatory care entity in which the time spent by residents in patient care activities is included in determining intermediary payments to a hospital under §§ 413.75 through 413.83; or (iii) a site that serves as a training site for an approved graduate medical education program for which payments are made under section 340H of the Public Health Service Act (42 U.S.C. 256h)."

We understand that most THCGME programs cannot satisfy either (i) or (ii) and thus are ineligible for the PCE, regardless of how fully they satisfy the remaining five conditions of 42 C.F.R. 415.174(a). THCs are not hospital outpatient departments and therefore cannot satisfy (i) to qualify for the PCE. Similarly, THCs can't satisfy (ii) because resident salaries and fringe benefits are paid through HRSA Section 340H grants that flow directly to the sponsoring program, not to an affiliated hospital, as required by (ii). Accordingly, the AATHC proposed amendment is essential to bring parity to community-based physician training locations.

Remote Physiologic Monitoring and Remote Therapeutic Monitoring Services

ACH supports CMS's goals to leverage Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM), strengthen program integrity and simplify payment mechanisms. However, we urge CMS to ensure any changes reflect how FQHCs deliver remote monitoring and the resources necessary to operate these programs.

Allow Clinically Integrated Contracted Staff to Support Remote Monitoring

CMS proposes requiring clinical staff furnishing certain RPM and RTM services to be directly employed by the billing practitioner or practice. For FQHCs that use qualified contracted clinical staff, requiring these functions to be brought in-house could create substantial new fixed costs, including salaries, benefits, supervision, technology support, and staffing coverage. Contracted professionals who operate within an FQHC's care plan, electronic health record (EHR) workflows, escalation protocols, quality standards, and practitioner-supervision structure are significantly different from third parties providing monitoring services. **ACH encourages CMS to allow for continued use of contracted clinical staff when appropriate safeguards are in place. CMS requirements should be based on clinical integration, practitioner supervision, accountability, and interoperability rather than employment status alone.**

Ensure Remote Monitoring Payment Reflects the Full Cost of Care

CMS is considering replacing the existing RPM and RTM coding structure with four new G-codes to simplify billing and payment. While ACH supports this kind of simplification in principle, operating remote-monitoring programs requires significant resources beyond clinical labor, including devices and maintenance, software licensing, cellular and data expenses, EHR integration, patient onboarding, technical support, and multilingual and culturally appropriate patient engagement. In addition, existing billing thresholds can create barriers to reimbursement. For example, requirements related to the amount of time spent interacting with a patient or the number of days data must be collected may prevent health centers from receiving reimbursement for remote monitoring services they are already providing. **CMS should ensure that any new G-codes adequately reflect the full costs of remote monitoring, simplify billing thresholds that limit reimbursement, and provide sufficient time for health centers to implement these changes.**

Conclusion

ACH appreciates CMS's efforts to strengthen Medicare primary care and improve access to high-quality, comprehensive primary care. As CMS finalizes the CY 2027 PFS, we encourage the agency to ensure these reforms reflect the unique role of FQHCs and support health centers in sustainably expanding access to care for Medicare beneficiaries. ACH and our members welcome the opportunity to serve as a resource as CMS continues this work.

Thank you for your consideration of our comments. For additional information or to discuss these recommendations further, please contact me or Stephanie Krenrich, Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

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