acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

September 10, 2025

VIA ELECTRONIC SUBMISSION

The Honorable Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Dear Administrator OZ:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Calendar Year (CY) 2026 Physician Fee Schedule (PFS) and Quality Payment Program Proposed Rule ("Proposed Rule").

ACOFP is the professional organization representing more than 26,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients have access to high-quality care.

We support many of the proposals in the Proposed Rule, particularly those aimed at recognizing the value of primary care. However, there are also proposals we request CMS to reconsider to better support osteopathic family physicians. Specifically, CMS should finalize a sustainable update to the proposed conversion factor that will ensure the financial viability of osteopathic family physician practices beyond CY 2026.

Our full comments are detailed on the following pages. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

Gautam J. Desai, DO, FACOFP

Gautam J. Desai, DO, FACOFP *dist.*
ACOFP, President

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

Comments on Proposed Changes to the Physician Fee Schedule

I. Physician Payment

a. Proposed CY 2026 CF

As required by statute, beginning in 2026, there will be two separate CFs: one for items and services furnished by a qualifying alternative payment model (APM) participant ("qualifying APM CF") and another for other items and services furnished by a nonqualifying APM participant ("nonqualifying APM CF"). The estimated CY 2026 qualifying APM CF is 33.5875, which represents an increase of 3.83 percent from the current CY 2025 CF of 32.3465, and the nonqualifying APM CF is 33.4209, which represents an increase of 3.62 percent from the current CY 2025 CF.

ACOFP supports the increase in the CF, but believes that there needs to be additional financial support for physicians providing care to Medicare beneficiaries because they face an increasingly challenging environment providing Medicare beneficiaries with access to care. Osteopathic family physicians are essential to the nation's public health system and play a critical role in providing care to Medicare beneficiaries. Despite their contributions to patient care and public health, osteopathic family physicians have been forced to contend with Medicare payments that do not cover the cost of providing care.

Physicians are currently facing financial difficulty given this instability in recent years. Of note, the CFs over the past few years have failed to keep up with inflation and the increasing costs of operating a practice. The failure of the PFS to keep pace with the increasing cost of providing care has created an unstable financial environment for osteopathic family physicians.

Moreover, a new analysis illustrates that primary care physicians are delivering more services since the COVID-19 pandemic, but stagnant reimbursements, inflation, and increasing labor costs are decreasing their income.[1] While net revenue per provider increased about 5 percent between Q2 2023 and Q2 2025, revenue per unit of work decreased by 7 percent.[2] This highlights the need for increased reimbursement as primary care physicians are working more, but getting paid less for their time.

Many of our solo, independent, and rural members have been struggling to remain open. These practices do not have the resources that large physician groups or hospitals have to weather an economic downturn. Also, as you know, once a primary care physician office closes in a community, it is very difficult to attract new physicians to serve that community.

Absent changes to stabilize the PFS payments for osteopathic family physicians, we are concerned with the ability of our members to continue to ensure the availability of high-quality care for Medicare beneficiaries. Payment policies must account for inflation and rising practice expense costs for physicians, which will provide much-needed financial stability. Many of our members are small-business owners, who are struggling to cope with administrative burdens, pay staff and overhead

[1] Kaufman Hall, Physician Flash Report, https://www.kaufmanhall.com/sites/default/files/2025-08/KH-PFR_Report-Q2-2025-Metrics.pdf?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiospm&stream=top.
[2] *Id.*

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

costs, and purchase essential technology. It is critical that CMS consider long-term payment reforms that account for inflation and rising costs of providing care.

Therefore, while ACOFP supports the increase in the CF, we urge CMS to support stable Medicare reimbursement based on current economic indices that better reflect the cost of providing care, so osteopathic family physicians can remain in the Medicare program and continue to provide beneficiaries with access to high-quality care.

b. Efficiency Adjustment

Beginning with CY 2026, CMS proposes a five-year lookback period to calculate the initial efficiency adjustment, which is calculated as the sum of the final productivity adjustments used in the Medicare Economic Index (MEI) over that period (2021 through 2025). As proposed, the efficiency adjustment for CY 2026 would be 2.5 percent. CMS notes that specialties that more frequently bill timed codes (e.g., family medicine) would likely see an increase in work relative value units (RVUs), while specialties that more frequently bill for procedures, diagnostic imaging, and radiology services would likely see a decrease in RVUs.

Generally, ACOFP supports the proposed efficiency adjustment given that specialties that more frequently bill timed codes, including family medicine, would likely see an increase in work RVUs. This proposal is consistent with the Administration's policy priority of promoting primary care by better recognizing these services.

However, while ACOFP supports protecting time-based codes, ACOFP is concerned with the unintended consequences of the proposal, specifically the impact on Osteopathic Manipulative Treatment (OMT) services. OMT services provided by osteopathic physicians would be subject to a 2.5 percent reduction in work RVUs, with additional cuts proposed every three years.

OMT is a high-value treatment option used by primary care providers, including osteopathic family physicians, to treat patients. It is a clinically appropriate pain management treatment that can help reduce the need for addictive medications and is a valuable tool that can be used to provide holistic care and treatment to all patients. Our osteopathic family physician members were specifically trained on delivering OMT as part of the delivery of comprehensive care to prevent and address downstream healthcare utilization.

As such, OMT is associated with cost savings given it can help avoid additional expenses related to pain management, prescriptions, surgeries, and other treatments. This underutilized service improves health outcomes and must be protected and made more available to patients. It is critical that CMS not enact policies that would decrease reimbursement for OMT services or other high-value primary care services used to better prevent and manage chronic conditions. Such policies could reduce the utilization of OMT in the primary care setting and may discourage osteopathic medical schools from providing OMT training.

Thus, while we support CMS's proposed efficiency adjustment, we urge CMS to exclude OMT from the proposed cuts as it plays an essential role in providing primary care services and must be protected to ensure patients receive the best possible care.

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

Also, we would like to highlight that physicians are the best source of information on how to value and evaluate services. Since physicians are better situated to advance appropriate valuation of the services they provide, including OMT, we urge the agency to ensure physician feedback when making adjustments to RVUs.

Further, given the current RVU adjustments offer limited potential for efficiency improvements, we are concerned about the impact that CMS's proposals will have on physician workload and productivity. Physicians are already struggling to keep up with providing care given burdensome administrative requirements that are not reflected in efficiency adjustments, meaning the approach to find efficiency does not take all factors into consideration. We therefore urge CMS to not finalize any proposal that does not account for or reflect the actual delivery of health care services.

c. Redistribution of Facility and Non-facility Practice Expense (PE) RVUs

For each service valued in the facility setting, CMS proposes to reduce the portion of the facility PE RVUs allocated based on work RVUs to half the amount allocated to non-facility PE RVUs.

ACOFP supports the redistribution of practice expense RVUs from facility to non-facility settings, where most osteopathic family medicine is appropriately delivered. This proposal plays an important role in supporting small, independent, and solo practices. The number of these types of private practices has declined in recent years, and more and more of them are being acquired by larger practices, private equity, and hospitals because of their inability to compete financially with these organizations. Other practices are closing altogether. ACOFP believes it is essential that CMS support private practices—especially small and solo osteopathic family medicine practices in rural and underserved areas—that can tailor how they provide care to best meet the needs of the communities they serve and remain a critical access point for primary care. Therefore, ACOFP supports CMS's proposal to redistribute facility and non-facility PE RVUs to help support small, independent, and solo practices that play a critical role in providing primary care to patients.

We also appreciate that CMS is considering mechanisms to better support private practices, and we encourage CMS to consider additional steps like increasing the weight of other cognitive services often performed by osteopathic family physicians (e.g., chronic care management). Further, we encourage CMS to carefully assess the impact of this proposed change to ensure there are not any unforeseen adverse impacts. Specifically, we urge CMS to ensure that osteopathic family physicians who practice in non-facility and facility settings are not disadvantaged overall as a result of this proposal.

We also urge CMS to be cautious of the potential downstream impacts of its proposal to redistribute facility and non-facility practice RVUs. For example, reductions in RVUs for Medicare may result in commercial insurers adopting lower RVUs, which could impact physician payment. In addition, in the facility setting, this could make it more difficult for employed physicians to meet productivity targets, potentially leading to increased patient loads and excessively demanding workdays. While ACOFP supports the overarching goal of protecting independent practice and more appropriately valuing primary care services, we urge CMS to avoid unintended consequences as the agency finalizes its proposal.

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

II. Payment for Medicare Telehealth Services under Section 1834(m) of the *Social Security Act* (SSA)

Beginning for the CY 2026 Medicare Telehealth Services List, CMS proposes to revise the 5-step review process for reviewing requests to the Medicare Telehealth Services List. Specifically, CMS proposes to remove Step 4 and Step 5 from its review criteria and retain Steps 1 through 3.

ACOFP supports CMS's proposals related to revising the 5-step review process. Telehealth can increase access to care, particularly for those in rural or underserved areas. Reducing the number of steps in the review process for requests to the Medicare Telehealth Services List will help expand the availability of services offered through telehealth.

While ACOFP supports the use of telehealth, we also firmly believe that in-person care is the gold standard for care and that telehealth is a tool to improve care delivery when in-person care is not possible—not a silver bullet. We believe it is critical that there are safeguards against the potential for telehealth to inadvertently disrupt existing physician-patient relationships and care coordination. Telehealth is best used for established patients, and the primary care physician should coordinate care for patients, including care furnished via telehealth. We want to avoid situations in which telehealth is used as a replacement for in-person care delivered over time, as this is an important element of chronic condition management often performed by osteopathic family physicians. Further, while telehealth is convenient and necessary at times, it also may result in large national companies providing fragmented care. Thus, ACOFP urges caution when establishing telehealth policies.

In addition, ACOFP urges CMS not to finalize its proposal to delete HCPCS code G0136 from the Medicare Telehealth Services List. Social determinants of health (SDOH) have been shown to have a major impact on patients' overall health. As osteopathic family physicians, we have been trained to treat the patient holistically and look beyond the disease. We support coding for services addressing health-related social needs and want to ensure that providers are compensated fairly for these important services.

Further, for services that are required to be performed under the direct supervision of a physician or other supervising practitioner, CMS proposes to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through audio/video real-time communications technology (excluding audio-only). Except for services that have a global surgery indicator of 010 or 090, CMS is proposing that a physician or other supervising practitioner may provide such virtual direct supervision for applicable incident-to services, and proposes to extend this flexibility to certain qualifying services that rely on the definition of direct supervision. ACOFP supports CMS's proposal to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through audio/video real-time communications technology (excluding audio-only). Allowing the physician or supervising practitioner to provide such supervision through real-time audio and/or visual interactive telecommunications, as appropriate, provides more flexibility for physicians and opportunities for teaching.

CMS is not proposing to extend its current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only when the service is furnished virtually. If finalized, this flexibility would no longer be available starting on January 1, 2026. Under this proposal, for services provided within metropolitan statistical

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

areas (MSAs), physicians would be required to maintain physical presence during critical portions of all resident-furnished services to qualify for Medicare payment, not just in-person services, ensuring consistent oversight standards. However, CMS is also proposing to maintain flexibility for services provided outside MSAs. CMS clarifies that its proposal to not extend flexibilities for virtual services would not impact teaching physicians' ability to provide virtual supervision of residents for educational purposes.

ACOFP urges CMS to continue its current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings but only when the service is furnished virtually. While ACOFP believes that in-person care is the gold standard for care, we acknowledge that telehealth can play an important role in patient care. Allowing the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications provides more flexibility for physicians and opportunities for teaching. While CMS clarifies that its proposal to not extend flexibilities for virtual services would not impact teaching physicians' ability to provide virtual supervision of residents for educational purposes, this distinction is not sufficient to meet the needs of teaching programs. Removing this flexibility would impose logistical and financial burdens on teaching physicians in MSAs and could disrupt patient care.

Moreover, as the primary care physician shortage continues, more communities lose access to care. Maintaining this flexibility is critical not only for ensuring access to care via telehealth, but also for supporting the training and supervision of osteopathic family physicians, who are essential to meeting the growing demand in underserved and rural areas. We encourage CMS to extend this provision on a permanent basis to ensure access to care for those who rely on telehealth.

III. Enhanced Care Management – Behavioral Health Integration Add-On Codes for Advanced Primary Care Management (APCM) (HCPCS codes GPCM1, GPCM2, GPCM3)

In the Proposed Rule, CMS seeks comment on how the agency should consider application of cost sharing for APCM services, particularly, if CMS was to include preventive services within the APCM bundles. The agency also seeks comment on whether it should consider new payments to Shared Savings Program ACOs for prospective monthly APCM payments to be delivered to primary care practices that satisfy the APCM billing requirements with the payments reconciled under the ACO benchmark. Further, CMS seeks comment on whether there are other updates to APCM payments or Shared Savings Program policies that would drive increased participation of primary care practitioners in ACOs.

ACOFP supports policies that increase access to primary care services. Specifically, ACOFP recommends that CMS consider including Annual Wellness Visit (AWV), depression screening, or other preventative services in the APCM bundle and that CMS consider other changes to APCM or additional coding to further recognize the work of advanced primary care practices in preventing and managing chronic disease. Osteopathic family medicine plays a critical role in the provision of primary and preventive care, contributing to improved patient outcomes and reduced healthcare costs. Many of our members are the focal point of care for their patients, especially in rural and underserved areas, and we appreciate this recognition of the role they play in coordinating and addressing all needed health care services.

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

Further, ACOFP urges CMS to create policies that ensure cost-sharing is waived for any preventive service included in APCM bundles to maintain patient access; apply a risk-adjusted monthly APCM payments based on age, chronic conditions, and social vulnerability index (SVI); allow APCM-qualified practices to receive prospective per member per month payments even outside of ACO attribution to encourage broader adoption; and include bonuses for milestone completions (e.g., full annual screenings, immunization status, and chronic care plan completion). Such policies would increase access to primary care services for patients and ensure that osteopathic family physicians are rewarded for preventing chronic illness and managing patients. We urge CMS to develop reimbursement policies that reward care provided by osteopathic family physicians who provide high-quality care and improved patient outcomes.

IV. Care Complexity Add-on Code (G2211)

Beginning in CY 2026, CMS proposes allowing HCPCS code G2211 (inherent complexity to evaluation and management (E/M) service add-on code) to be billed as an add-on code with the home or residence E/M visits code family (CPT codes 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)

ACOFP supports CMS's proposal to allow expanded use of HCPCS code G2211 in order to ensure appropriate reimbursement for primary care services. This is critical for improving the accuracy of valuation for services.

V. Policies to Improve Care for Chronic Illness and Behavioral Health Needs – Prevention and Management of Chronic Disease RFI

Given the Administration's focus on understanding and lowering chronic disease rates, CMS is seeking feedback on questions regarding how to better support the prevention and management of chronic disease. ACOFP appreciates CMS's interest in improving chronic disease outcomes and emphasizes the critical role of osteopathic family physicians in this effort. As osteopathic family physicians, we have been trained to treat patients holistically and are uniquely positioned to identify early risk factors, engage patients in preventive strategies, and manage complex chronic conditions over time. ACOFP urges CMS to recognize and support the essential role of osteopathic family physicians in addressing chronic disease by prioritizing policies that reduce administrative burden for primary care physicians and ensure fair compensation for the critical care they provide.

How could CMS better support prevention and management, including self-management, of chronic disease?

Primary care is essential to effective chronic disease management. Osteopathic family medicine plays a critical role in overall health, contributing to improved patient outcomes and reduced healthcare costs. Many ACOFP members serve as the primary point of care for their patients, especially in rural and underserved areas, where they coordinate and address a wide range of health needs, including chronic disease prevention and management.

Despite their critical role in addressing chronic disease and overall health, primary care physicians are poorly compensated relative to their peers in specialty services. A significant reimbursement

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

differential still exists between primary care and specialty care, which reflects neither the inherent complexity of providing evaluation and management services nor the significant value these services provide to patients. Medical students are financially incentivized to choose specialty training such as cardiology or pulmonary medicine over primary care because of higher reimbursement for certain specialty medicine services, such as high-cost imaging, testing, and procedures.

The Commonwealth Fund's Task Force on Payment and Delivery System Reform recently emphasized that the U.S. will only achieve its goals to create a healthier population with more consistent access to primary care through changes in how and how much primary care is paid.[3] ACOFP urges CMS to focus on primary care physician payment to address the current imbalance between primary and specialty care and better support the prevention and management of chronic diseases.

Without meaningful payment reform, the financial pressures and administrative burdens placed on primary care physicians will continue to drive the physician shortage. Many physicians, especially those in small, rural, and independent practices, are struggling to cope with rising practice expenses, staff and facility costs, and burdensome reporting requirements. As more of these practices are forced to close or relocate, more communities lose access to care. ACOFP urges CMS to recognize the critical role of primary care in addressing chronic disease and overall health outcomes, and ensure that payment policies reflect its value, support its sustainability, and improve access.

Should CMS consider creating separate coding and payment for medically-tailored meals, as an incident-to service performed under general supervision of a billing practitioner? If so, what would be the appropriate description of such a service, and under what patient circumstances (that is, after discharge from a hospital)?

ACOFP supports CMS's consideration of establishing separate coding and payment for medically-tailored meals as an incident-to service performed under general supervision of a billing practitioner. ACOFP recommends that CMS create a code for post-hospital discharge medically-tailored meal counseling, distinct from actual meal provision. This would allow primary care providers to assess a patient's nutritional needs and integrate medically-tailored meals into the patient's care plan.

ACOFP recognizes that nutrition is a foundational component of health, particularly in the prevention and management of chronic diseases such as diabetes, cardiovascular conditions, and obesity. Osteopathic family physicians are uniquely positioned to address nutritional needs as part of a holistic approach to primary care. By incorporating medically-tailored meal counseling into a patient's care plan, physicians can help patients make sustainable dietary changes that improve health outcomes and reduce hospital readmissions. Establishing a code for post-hospital discharge medically-tailored meal counseling would support CMS's goal to better support the prevention and management of chronic disease.

Please provide information on whether the agency should consider creating separate coding and payment for FDA-cleared digital therapeutics that treat or manage the symptoms of

[3] Commonwealth Fund Task Force on Payment and Delivery System Reform, *Health care delivery system reform: Six policy imperatives*, https://www.commonwealthfund.org/publications/fund-reports/2020/nov/commonwealth-fund-task-force-payment-and-delivery-system-reform.

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

chronic diseases an incident-to service performed under the general supervision of a billing practitioner.

ACOFP recommends that CMS establish separate coding and payment for FDA-cleared digital therapeutics that treat or manage chronic disease symptoms, when furnished as incident-to services under the general supervision of a billing practitioner. Digital therapeutics play an important role in care delivery, particularly for chronic conditions that require ongoing management. By creating separate coding and payment pathways for these tools, CMS can ensure that they are appropriately recognized and reimbursed, encouraging their integration into patient care plans and expanding access for patients who may benefit from them.

However, ACOFP urges CMS to limit reimbursement to digital therapeutics products that demonstrate long-term efficacy through peer-reviewed evidence and are integrated into the patient's primary care plan. Peer-reviewed evidence provides a rigorous standard for evaluating therapeutic effectiveness and is essential to ensure that only high-quality, clinically validated products receive federal support. Osteopathic family physicians are often the first point of contact for patients with chronic conditions and are uniquely positioned to guide the appropriate use of digital tools within a broader care strategy. Establishing separate coding and payment for FDA-cleared digital therapeutics will enhance their capacity to deliver high quality, personalized care and improve chronic disease outcomes.

Are there technical solutions that would enhance the uptake of the AWV, or the improving accessibility, impact, and usefulness of the AWV? How can CMS better support practitioners and beneficiaries related to the AWV? Should CMS consider moving some of the required components of the AWV to optional add-on codes of the AWV instead, with the intent of decreasing burden, improving uptake, and allowing practitioners to select additional AWV elements that may be more relevant to particular patients?

The AWV plays an important role in preventive care by enabling early detection and improved management of chronic conditions. ACOFP supports efforts to increase AWV uptake and emphasizes the need to revalue the benefit of preventive, primary care to better reflect its impact on health outcomes.

To reduce administrative burden and increase AWV uptake, ACOFP recommends that CMS allow modular billing of the AWV, in which certain AWV components would be designated as optional add-on codes. This approach would allow physicians to deliver more targeted, individualized care and increase efficiency, thereby increasing AWV utilization. It would also streamline documentation and billing processes, making it easier for practices to incorporate the AWV into care. This flexibility is particularly important for independent and rural practices, where time and resources are limited.

In addition, we urge CMS to simplify EHR documentation via Application Programming Interface (API) plug-ins. Cumbersome EHR systems are forcing physicians to spend more time on administrative tasks rather than spending time with patients. It is critical that CMS create policies that keep required documentation to a minimal to reduce the time burden that impacts patient care. EHR interoperability and standardized reporting requirements will help reduce time spent on EHRs and decrease administrative burden.

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

Reducing administrative burden is critical, as burdensome requirements contribute to the physician shortage and inhibit appropriate patient care. Many physicians, burned out by administrative requirements, retire early or leave medical practice for another profession, especially those in small, rural, and independent practices that do not have the resources to manage extensive paperwork requirements. As more of these practices are forced to close or relocate, healthcare shortages increase, and more communities lose access to care. By allowing modular billing of the AWV and simplifying EHR documentation via API plug-ins, CMS can help preserve these essential practices and support the critical role of osteopathic family physicians in providing holistic, personalized care that addresses chronic disease.

Further, ACOFP recommends that CMS consider creating a bundled bonus pool for practices achieving comprehensive preventive care thresholds per 100 beneficiaries. We also urge CMS to provide bonus payments for full completion of AWV, depression screening, and SDOH within a calendar year. These incentives would reward high-performing practices for delivering services such as AWV and encourage broader adoption of preventive care services. The goal of any healthcare system is to improve the overall health of the patients it serves, and to achieve this goal, the importance of primary care must be recognized and its greater use must be promoted.

VI. Medicare Shared Savings Program

CMS proposes updating the definition of primary care services used in the Shared Savings Program assignment methodology, effective for performance years beginning January 1, 2026 and subsequent years, to reflect updates in billing and coding under the PFS. Specifically, the revised definition would include new HCPCS codes for Enhanced Care Model Management Services (GPCM1, GPCM2, GPCM3) and remove HCPCS code G0136 (Social Determinants of Health Risk Assessment). CMS proposes that if a CPT or HCPCS code is replaced by a new code, the replacement code would automatically be included in the definition of primary care services if the assignment window (or expanded window), includes any day on or after the effective date of the replacement code under Medicare fee-for-service (FFS).

ACOFP supports updating the definition of primary care services to reflect updates in billing and coding under the PFS. We support reimbursement policies that reward care provided by osteopathic family physicians who provide high-quality care that improves patient outcomes.

However, ACOFP opposes the removal of G0136 from the list and recommends additional SDOH-related codes be added over time to reflect whole-person care. As previously noted, SDOH has been shown to have a major impact on patients' overall health. Osteopathic family physicians have been trained to treat the patient holistically and look beyond the disease. We support coding for services addressing health-related social needs and want to ensure that providers are compensated for providing these important services.

acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
advocacy • education • leadership

8501 West Higgins Road, Suite 400
Chicago, IL 60631
Phone: 847.952.5100
www.acofp.org

Comments on Proposed Changes to the Quality Payment Program (QPP)

I. Merit-based Incentive Payment System (MIPS) MIPS Performance Category Measures and Activities

CMS proposes three updates to the cost performance category for CY 2026, including adopting a 2-year informational-only feedback period for new cost measures before they affect scoring or payment.

ACOFP supports the proposed 2-year informational-only feedback period for new cost measures before they affect scoring or payment. This would provide physicians with more time to understand their impact of new cost measures.

In addition, CMS proposes several updates to the Promoting Interoperability performance category, including suppressing the Electronic Case Reporting measure for the 2025 performance period.

ACOFP supports the suppression of the Electronic Case Reporting measure for the 2025 performance period. As a general matter, ACOFP members are concerned about Medicare administrative burdens not related to patient care. Reducing reporting requirements is critical for physicians. It is essential that CMS create policies that balance reporting requirements with physicians' workload. Osteopathic family physicians are already overburdened with reporting requirements so CMS should avoid to the greatest extent possible time-consuming data reporting requirements because this type of administrative burden directly leads to burnout.

ACOFP appreciates the efforts taken by CMS to limit reporting requirements for osteopathic family physicians. Reducing administrative burden is critical to allowing physicians to focus on providing the best care possible to their patients and reducing physician burnout.