American College of Preventive Medicine
physicians dedicated to prevention

September 14, 2026

The Honorable Mehmet C. Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

**Re: Comments on CMS-1848-P, Calendar Year 2027 Medicare Physician Fee Schedule Proposed Rule**

Dear Administrator Oz,

The American College of Preventive Medicine (ACPM), representing approximately 2,000 board-certified Public Health and General Preventive Medicine physicians, welcomes and appreciates the opportunity to provide recommendations to further improve the delivery of preventive care in clinical practice. ACPM is grateful for the opportunity to provide feedback and recommendations to improve the practice of clinical preventive and lifestyle medicine.

Fee-for-service payment remains a dominant financing mechanism in U.S. healthcare and will continue to play an important role in supporting prevention services. ACPM urges that CMS continue to incentivize and support preventive activities through coding and payment structures, recognizing the time and resources required to reduce long-term health risk, allowing clinicians to discuss prevention-oriented options with patients and connect them to appropriate services without creating incentives for unnecessary treatment or fragmented care.

Preventive screening services are among the best-supported components of prevention within current payment systems. Coverage of recommended screening tests and immunizations has improved substantially over time and has contributed to increased use of evidence-based preventive services, earlier detection of chronic disease and improved clinical outcomes. These services represent an important foundation for prevention policy, but in the long term they are only part of the set of prevention-focused activities that must be meaningfully reimbursed.

As CMS finalizes the Medicare Physician Fee Schedule for CY 2027, ACPM hopes to partner with you to more effectively incentivize physicians to practice preventive

medicine and ensure that patients have access to services which promote wellness and reduce downstream effects of chronic disease.

**Shared Medical Appointments (HCPCS CODE GSMAS) – Section II.D, Item 54**

ACPM supports CMS's proposal to establish separate coding and payment for Shared Medical Appointments (SMAs) through HCPCS code GSMAS. CMS appropriately recognizes SMAs as a care delivery approach that can support multidisciplinary care, beneficiary engagement, sustainable lifestyle and behavior change, and peer support for beneficiaries with chronic conditions.

ACPM recommends CMS not restrict SMAs to conditions deemed lifestyle-modifiable. Systematic reviews and randomized trials demonstrate benefits across numerous chronic conditions. Hypertension, diabetes, heart failure, obesity, COPD, osteoporosis, migraine, chronic pain, depression, cancer survivorship, Parkinson's disease, rheumatoid arthritis, neuromuscular disease, prenatal care and additional chronic conditions also have evidence supporting SMA implementation. Most Medicare beneficiaries participating in SMAs have multiple chronic conditions, making diagnosis-specific restrictions impractical, inconsistent with real-world care and inconsistent with the concept of whole-person health.

CMS should clarify and permit billing existing E/M codes (99213–99215) by complexity as an alternative or supplement to GSMAS, or establish at least two complexity-based SMA code tiers analogous to 99213/99214. The E/M codes 99213-5 are universally recognized and covered by all insurances, while GSMAS may or may not be covered by certain insurances or managed care organizations. ACPM highlights that providers will be compelled by healthcare billing and compliance departments based on best practices to bill the best fitting code for the diagnosis, in which case providers may be forced to bill for a code which no longer has reimbursement from a wide range of insurers, effectively causing programs to shutter. ACPM would appreciate further clarification from CMS that 99213-5 will continue to be allowable in the event that insurer disallowance of HCPCS code GSMAS threatens interruptions to care that could cause serious downstream harm.

ACPM encourages the development of disease-agnostic SMA eligibility criteria to determine which patients would benefit from SMAs. This could be developed by the presiding medical director. ACPM also encourages CMS to permit the G2211 add-on when appropriate, with clear guidance on its use by an SMA team so it is not viewed as duplicative of a primary care team's own billing. In addition, ACPM recommends expanding the patient limit from 2-10 to 2-15 patients. Previous models commonly have used group sizes which accommodate meaningful peer interaction while preserving individualized assessment, ranging from approximately 8 to 20 participants depending on condition, practice setting and staffing.

As CMS looks to determine commensurate reimbursement for SMAs, ACPM recommends CMS ensure tiers of medical complexity, including but not limited to decisions made about medications, social determinants of health addressed, labs or tests ordered, previous labs reviewed and discussed with the patient, outside records discussed with the patient, procedures done including medication reconciliation or adjustment or counseling by physician or pharmacist, Medical Nutrition Therapy (MNT) by dietitian and individualized feedback on remote monitoring devices or patient self-tracked biometrics such as vitals and blood sugars.

Lastly, ACPM recommends a reasonable annual encounter limit of 18 sessions per year per patient. Program integrity can be optimized through documentation, audit and training standards, rather than through rigid structural limits. ACPM recommends CMS utilize individualized documentation, attendance verification, routine claims audits, documented consent, staff training, disease-agnostic eligibility criteria, documented clinical progress and periodic outcomes review. With this, ACPM hopes that CMS is able to build on this progress in the coming years as this practice grows.

**Redesigning Primary Care to Make America Healthy Again – Section II.E**

ACPM applauds CMS's efforts to shift the health care system toward disease prevention rather than reactive treatment. ACPM believes an efficient health care coverage system that maximizes reimbursement of preventive services through insurance and government-delivered programs will enable Americans to more effectively take charge of their own health. ACPM stands in support of healthcare reform efforts that maintain support for disease prevention and health promotion practices.

Preventive medicine physicians bring formal training in population health, screening guideline development, and evidence-based prevention that should directly inform how CMS defines and values "prevention-focused" primary care under this initiative. ACPM supports continued efforts to strengthen primary and preventive care.

A prevention-oriented health system requires financing mechanisms that support measurable improvement in health risk and long-term outcomes. Current payment systems are designed primarily to reimburse the diagnosis and treatment of disease.

Although preventive services such as screening and immunization are well supported, many meaningful preventive activities remain difficult to code, bill and evaluate within existing payment structures.

If preventive activities cannot be coded, they cannot be billed. If they cannot be billed, they cannot be sustained in routine clinical practice. Coding limitations also make prevention difficult to measure and evaluate, limiting the ability of policymakers and health systems to identify successful strategies and scale them effectively.

Expanding coding pathways for prevention represents one of the most important structural steps toward making prevention-first healthcare operational within existing payment systems. Many important prevention activities involve reducing disease risk or reversing disease progression rather than initiating treatment. These improvements are central to prevention-oriented care but are not consistently recognized within current coding and payment systems.

CMS should revisit RVU methodology specifically through the lens of prevention, not only "primary care" broadly defined. Any prospective payment or ACO-based prevention model that CMS considers should be designed to work for small and safety-net practices — including small FQHC care teams — not only for large, well-resourced systems that can absorb up-front investment before shared savings materialize.

ACPM also highlights the importance of incorporating documented no-show rates into FQHC PPS rate-setting methodology, so payment reflects realistic net revenue per scheduled slot rather than making overbooking the only financially viable strategy available to a clinic. Supporting a non-visit-based or population-based payment option that FQHCs could elect (for example, a per-member-per-month care management payment), so that not every physician touchpoint needs to be a completed billable encounter to sustain the clinic financially.

Lastly, ACPM recommends CMS review opportunities to fund infrastructure which reduces the frequency of no-shows — transportation assistance, reminder systems, community health workers, open-access scheduling — as its own stand-alone investment. Again, rather than leaving overbooking as the default tool for managing no-shows. Moreover, a volume-driven scheduling model is counter to some of the very prevention-forward goals CMS says it wants to advance, namely physician and care-team burnout and workforce sustainability.

**Current Procedural Terminology (CPT) – Section II.H**

ACPM commends CMS for undertaking this review as part of the broader effort to shift Medicare physician payment toward improving the focus on preventive health practice and moving away from a reactive medical system. While CMS is looking to update and improve reimbursement practices, ACPM encourages CMS to consider supporting coordination rather than fragmentation of care, which could be interrupted should there be a sweeping changes made to the Medicare program.

Currently, the AMA Relative Value Scale Update Committee (RUC) has adopted updates for preventive services which have led to increased Medicare payments for preventive medicine. This has led to improvements for preventive services such as immunization administration (90471) payment, increased from less than $4 in 2002 to $22 in 2026, as a result of physician advocacy to highlight the resource-costs required to provide immunizations. The preventive medicine office visits were also considered

under the 4th Five-Year Review of the RBRVS and CMS published the RUC recommendations to increase valuation by 15-20 percent on January 1, 2012.

The AMA CPT Editorial Panel developed codes to describe Transitional Care Management (TCM) and Chronic Care Management (CCM) services to be reported for care coordination provided over a 30-day period. After development of these codes in May 2012, RUC reviewed the physician work and practice costs associated with the provision of these services and submitted its recommendations to CMS in October. On January 1, 2013, Medicare implemented the RUC recommendations and began payment for CPT codes 99495 and 99496 for the care of transitioning patients from a hospital or skilled nursing facility to the home.

There are still key gaps, which include uneven parity for FQHCs and rural health clinics when services rely on the Physician Fee Schedule, limited reimbursement for prevention services delivered outside traditional clinic encounters and missing pathways for proven self-management interventions that do not fit existing CPT/HCPCS structures. In addition, current payment systems rarely recognize prevention success when it reduces downstream utilization — for example, when a patient's condition improves enough that medications can be safely de-intensified or discontinued. ACPM supports rewarding verified risk reduction and durable outcome improvement, while maintaining guardrails that protect against fraud and inappropriate overuse.

A clear example is medication de-intensification: today there is no standard way to code and bill for the work of safely stopping or reducing a medication because a patient's diabetes, lipid profile or hypertension or additional chronic conditions have improved. If it cannot be tracked, it is most difficult to measure savings and outcomes from prevention success. As previously mentioned, what gets measured, and adequately reimbursed, gets done. Screening tests and immunizations are essential foundations, but meaningful prevention requires sustained engagement to reduce long-term health risk. The example of medication de-intensification or discontinuation is a prime example of an outcome-based metric that improves patient health, reduces the risk of iatrogenic illness and reduces system costs over the long term, yet we lack the ability to effectively bill, reimburse, track and ultimately incentivize this activity.

Existing payment mechanisms such as chronic care management, behavioral health integration and structured lifestyle-based programs focused on whole-person health demonstrate that longitudinal prevention services can be financed within current frameworks. These models provide important examples but remain limited in scale and unevenly implemented. Current payment structures often favor brief encounters and procedure-based care over sustained prevention services. Activities such as behavior change counseling, longitudinal risk monitoring and coordination with community-based services remain difficult to sustain financially in many clinical settings.

The CPT functions as a national standard in the American healthcare system as a strong, singular nomenclature for physician and other qualified healthcare professional

services. While there are certainly flaws with the historical practices of fee-for-service healthcare impeding preventive solutions, ACPM wants to work alongside CMS to solve the problem of fragmentation across healthcare services without losing the benefits of standardized billing procedures.

ACPM nominates a preventive medicine physician to serve as one of more than 200 CPT Advisors, as well as a representative to serve on the Editorial Panel. ACPM highlights that preventive medicine, as a specialty, is underrepresented as a single voice across the many taxonomies that advise the CPT and RUC processes, which are likely to drown out calls to incentivize upstream, preventive care. ACPM and preventive medicine physicians are uniquely qualified to serve as neutral, evidence-based arbiters of clinical best practice and effective clinical outcomes. As this administration indicates, the CPT in its current state represents primarily process and not outcomes.

ACPM believes CMS should review and weigh evidence that the current arrangement imposes real costs on preventive care specifically, not only on the health system generally. ACPM would note that in order to truly incentivize prevention, CMS should further prioritize the coding and reimbursement of value-based outcomes.

Preventive care is central to modern medicine's ability to reverse the epidemic of chronic disease, and CPT codes have made strides to make these services visible, reportable, and reimbursable across the healthcare system. With more than 120 codes covering screenings, immunizations, counseling and chronic disease detection, CPT helps remove barriers to access, supports mandated coverage and enables early detection that reduces long-term costs.

ACPM urges CMS to continue to rectify the structural under-coding of prevention. The CPT preventive medicine and counseling code families (99381–99429 for preventive visits; 99401–99404 and 99406–99409 for counseling and risk-factor reduction) remain narrow, poorly differentiated by complexity and inconsistently reimbursed across payers, which the American Academy of Family Physicians and American Academy of Pediatrics coding literature has documented leads to routine underbilling and, in turn, under-delivery of evidence-based counseling (e.g. tobacco cessation, obesity, alcohol misuse, lung cancer screening shared decision-making).

ACPM notes that licensing and compliance costs fall disproportionately on smaller practices, including many prevention-focused and primary care practices least able to absorb them, relative to procedurally-oriented practices whose higher per-encounter reimbursement offsets the fixed cost of CPT licensure, EHR CPT-content licensing and coding staff. ACPM recommends CMS solicit and publish a comparative accounting of CPT licensing/compliance costs by practice size and specialty mix, and specifically study whether preventive/primary care practices face a higher cost-to-revenue ratio from CPT licensure than procedural specialties. This in turn could inform future (and perhaps reduced) burdens on smaller and preventive/primary care practices.

ACPM recommends CMS require that new and revised codes affecting preventive services be cross-walked to align with U.S. Preventive Services Task Force (USPSTF) grade A/B recommendations as a necessity anchor, similar to how Affordable Care Act Section 2713 already ties first-dollar coverage to USPSTF grades — extending that evidentiary logic from coverage into the coding and valuation process itself would help close a current gap.

The RUC's undervaluation of non-procedural, cognitive work is likely a contributing factor to the decline in physicians choosing primary care and prevention-oriented careers — a workforce consequence directly within ACPM's mission concerns. However, ACPM recognizes that a full legal standard change (replacing CPT outright) would likely require new rulemaking and possibly statutory clarification given six decades of reliance interests across payers, EHR vendors and clearinghouses.

ACPM recommends CMS increase its use of claims-based time-and-cost data (e.g., from electronic health records and claims audits) as an evidentiary check on specialty-society-submitted survey data, reducing reliance on self-reported time estimates that GAO and MedPAC have both flagged as a source of systematic overvaluation for procedural services and undervaluation for evaluation, counseling and care-management services.

ACPM sees both promise and significant limitations in an ICD-10-PCS-based approach to physician payment. Benefits include government ownership and maintenance by HHS via CMS, eliminating licensing fees and giving the federal government direct control over code development timing and content — addressing the core concerns of the administration. However, ICD-10-PCS was designed for inpatient facility procedure reporting and granularity (device, approach, body part), not for outpatient evaluation and management, cognitive care or preventive counseling — the service types most central to the clinical practice of preventive medicine. Adopting it wholesale for physician payment would require substantial new development work for non-procedural, prevention-oriented services, and could reproduce the systemic issues the RFI is trying to address if that development work is not done carefully and correctly.

ACPM recommends that any bundling or grouping model explicitly include a prevention/care-management bundle category — analogous to how MS-DRGs and APCs group by clinical episode — so that longitudinal preventive care is payable as a defined unit rather than forced into either a procedural code into which it does not fit, or a thin E/M visit code that undervalues its cognitive and counseling content. This would align with CMS's parallel RFI on redesigning primary care payment in section II.E of this rule.

**Conclusion**

ACPM underscores that a Prevention First health system requires shared accountability across providers. Clinicians who care for patients with chronic conditions should be

accountable not only for treatment decisions but also for coordination of care and efficient use of resources. Financing models should encourage providers to work collaboratively to improve outcomes and reduce unnecessary or duplicative services.

As ACPM appreciates CMS's willingness to reexamine the CPT/RUC process as part of the Department's broader prevention-oriented priorities, we urge CMS to ensure that any reforms explicitly address the systematic undervaluation of preventive, counseling and care-management services relative to procedural services, since that imbalance is the greatest opportunity to transform healthcare towards prevention.

ACPM would welcome the opportunity to provide additional data or to participate in any technical panel CMS may convene as a result of this RFI. If you have any questions, please reach out to Melissa Ferrari, Executive Director, at 202-466-2044 or mferrari@acpm.org.