Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016
Attention: CMS-1848-P

September 14, 2026

Subject: Calendar Year (CY) 2027 Medicare Physician Fee Schedule (PFS) Proposed Rule [CMS-1848-P]

To Whom It May Concern,

On behalf of the California Public Employees' Retirement System (CalPERS) and Covered California, we are writing in response to the Centers for Medicare and Medicaid Services (CMS) request for comment on the CY 2027 Medicare Physician Fee Schedule Proposed Rule.

With more than 1.5 million members, CalPERS is the largest purchaser of public employee health benefits in California and the second largest employer purchaser in the nation after the federal government. CalPERS is committed to providing access to equitable, high-quality, and affordable health care for active and retired state, local government and school employees, as well as their family members.

In 2025, CalPERS spent over $13.9 billion to purchase health benefits on behalf of the State of California (including the California State University system) and nearly 1,200 public agencies and schools. Approximately 18% of our $13.9 billion spend was for outpatient prescription drugs alone. As of 2025, CalPERS provided benefits for 190,573 Medicare Advantage enrollees and 154,911 Medicare Supplement enrollees.[1]

Covered California, the nation's largest state-based health insurance marketplace, has provided coverage to over 6.3 million Californians - about one in six residents since its launch in 2014.

With CalPERS' and Covered California's commitment to making health care more accessible, affordable, and beneficial for our members, we welcome the opportunity to

[1] *See:* Agenda Item 7a 2025 Open Enrollment Health Plan Transfers, March 2026, available at https://www.calpers.ca.gov/documents/202603-pension-agenda-item-6a-attach-1-a/download?inline

comment on proposals to address primary care challenges, promote site-neutral payments, increase access to telehealth, increase transparency in the 340B Program, and incentivize uptake of intensive lifestyle interventions to reduce the risk of Alzheimer's disease.

Determination of Practice Expense (PE) Relative Value Units (RVUs)

CalPERS and Covered California support the suite of proposals to update the PE methodology. These proposals improve payment accuracy by correcting the historic over-valuing of procedural interventions and diagnostic tests. In parallel, the changes appropriately increase the valuation of care for patients with complex needs and multiple comorbidities who may require ongoing care for extended periods of time. This rebalancing recognizes the necessary time, effort, and skill to deliver longitudinal care. In turn, it will support much needed increased investment in primary care, which should function as the cornerstone of our delivery system, and is one of the few areas of our delivery system where an increase correlates to lower costs, improved patient experience and health outcomes, and reduced hospitalizations.

Site of Service Payment Differential

CalPERS and Covered California support the proposal to equalize facility and non-facility PE RVUs for nursing facility visits (Current Procedural Terminology Codes 99304-99310 and 99315-93316). This proposed change would curtail the ability to extract higher payment rates that are based on differences in Medicare coverage rather than differences in physician resource costs.

Payment rate disparities across care settings create incentives for hospitals to acquire physician practices and then bill for the same service under the higher-paying framework. Implementing site-neutral payment policies has the potential to lower health care costs, curb vertical consolidation, and reduce beneficiary cost-sharing obligations.

Payment for Medicare Telehealth Services

CalPERS and Covered California support the proposed updates to expand member access to clinically appropriate virtual care. We believe telehealth improves access to care, reduces barriers related to geography and scheduling, and enhances continuity of care. The COVID-19 pandemic demonstrated that many services can be delivered effectively and safely via telehealth. We continue to support making permanent the telehealth flexibilities that have improved health care accessibility including removal of geographic and originating site restrictions, expansion of eligible telehealth practitioners,

and removal of the in-person visit requirement for tele-mental health services and continued coverage of certain audio-only telehealth services.

Continued access to behavioral health services through telehealth can help remove transportation barriers, reduce stigma, and enable more consistent engagement in care. CalPERS' Medicare data shows that behavioral health utilization has increased significantly since 2019, rising from approximately 17 percent of total utilization in 2020 to nearly 28 percent in 2024. Covered California data suggests a similar trend for its members, highlighting that telehealth remains an important tool for ensuring convenient and timely access to these services.

Request for Information: Redesigning Primary Care to Make America Healthy Again

Reconsidering relative primary care payment in the PFS

We appreciate CMS' efforts to address primary care challenges, promote value-based payment models in Medicare, and improve care for Medicare beneficiaries, particularly individuals with chronic diseases.

Access to high-quality primary care is critical for improving population health outcomes, reducing disparities and slowing health care cost growth. CalPERS and Covered California believe that payment for primary care should be sufficient to support the adoption and maintenance of advanced primary care attributes, including the ability to assess and address patients' behavioral health and social needs. Payment for primary care should also shift away from being solely based on volume (fee-for-service [FFS]) and move toward value (prospective, outcome-based, population-based). Multi-payer alignment on primary care investment, measurement, and value-based payment is essential to strengthening primary care, which we've recognized and acted on here in California. Covered California, CalPERS, and the California Department of Health Care Services have aligned on our health plan contracts, requiring plans to increase primary care investment and alternative payment model adoption, consistent with California's Office of Healthcare Affordability standards.

CalPERS and Covered California believe there are significant merits to the exploration of establishing a hybrid per beneficiary, per month payment model in FFS Medicare to promote access to primary care. Moving away from FFS payment and toward capitation better aligns payment incentives and supports investments, such as population health management, with the potential to improve clinical quality, patient experience, and health outcomes. We suggest providing transparency regarding primary care payment structure and methods for attributing services to providers so that incentives are clear

and there is adequate oversight of that care. We also encourage CMS to establish a mechanism for the regular review and adjustment of payment rates to reflect changes in health care costs, practice patterns, and patient needs. This could include annual or biennial reviews based on inflation, health care market changes, and feedback from primary care providers and patients.

In addition, we encourage CMS to ensure that these payment reforms support the delivery of comprehensive, coordinated, continuous, and whole-person primary care, particularly for beneficiaries with chronic conditions and complex care needs. Payment policies should give practices flexibility to build multidisciplinary care teams, including physicians, advanced practice providers, nurses, pharmacists, behavioral health clinicians, care managers, and community health workers, and partner with community-based organizations that address social needs.[2,3] Payment should support continuity of care and relationship-based care, with a primary care provider and patient relationship at the center of the multidisciplinary care team. Continuity of care has been shown to reduce total cost of care, improve health outcomes, and increase longevity.[4]

We also encourage CMS to further support integration of behavioral health into primary care. Because behavioral health and physical health conditions often co-occur, integrated care improves access to care, coordination, continuity, treatment adherence, and outcomes. The National Academies of Sciences, Engineering, and Medicine have found that integrated behavioral health is a core element of high-quality primary care and is not well supported under traditional FFS payment.[5]

Additionally, we encourage consideration of how these changes may differentially impact primary care practices with stronger administrative and billing expertise. Small, independent practices require a different level of support to adopt changes as we have seen from past introduction of new codes. We therefore support the continued reexamination of the primary care payment system and encourage the consideration of broader scale change without added reliance on specific billing codes, contracting practices, or administrative burden.

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[2] *See:* National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. *Available at:* https://www.nationalacademies.org/read/25983/chapter/15

[3] *See:* The Commonwealth Fund. Evidence-Based Strategies for Strengthening Primary Care in the U.S. *Available at:* https://www.commonwealthfund.org/blog/2022/evidence-based-strategies-strengthening-primary-care-us

[4] *See:* Center for Professionalism and Value in Health Care. Continuity of Care Bibliography. *Available at:* https://professionalismandvalue.org/wp-content/uploads/2023/05/Continuity-of-Care-Bibliography-Expansion.pdf

[5] *See:* National Academies of Sciences, Engineering, and Medicine. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. *Available at:* https://www.nationalacademies.org/read/25983/chapter/12

Understanding the payment implication of including technology in primary care
Artificial intelligence (AI) is an important tool with the potential to enhance primary care. However, it should be implemented with clear guardrails to ensure transparency, accountability, and to mitigate bias. Most importantly, AI should supplement decision making, not replace it, and clinicians must remain central to all patient care treatment decisions. CMS should consider value-based payment models for technology-enabled care to ensure that AI adoption improves patient outcomes without encouraging overuse and increasing low-value-spending.[6] Furthermore, it is critical to ensure that the costs of adopting and deploying AI and other technology tools are not passed on to patients by health systems and health insurance plans.

Medicare Part D Drug Rebates for Certain Drugs and Biologicals with Prices that Increase Faster than the Rate of Inflation

CalPERS and Covered California support the proposal to require providers and suppliers that are covered entities (CE) to submit Part D 340B data to the 340B repository beginning in 2027. Transitioning from voluntary submission to mandatory participation in the 340B repository will ensure more complete and reliable data submission, thereby improving transparency into 340B discounts for Part D drugs.

While this information will only be used for the purposes of the Part D Inflation Rebate Program, CalPERS would support broader use of the 340B claims data to ensure that the program is operating as intended. The National Alliance of Healthcare Purchaser Coalitions has found that under the 340B program, CEs "purchase medications at significant discounts and sell them to plan sponsors at the prevailing rate, a 'buy low, sell high' scheme that results in profits at the expense of working families."[7] We recommend that CMS take steps to prevent CEs from profiting off of employers and ensure that savings are applied appropriately.

Request for Information on Intensive Lifestyle Interventions (ILIs) to Slow Progression of Alzheimer's Disease

We appreciate that CMS is exploring ways to incentivize uptake of intensive lifestyle interventions to reduce the risk of Alzheimer's disease and Alzheimer's disease-related dementias. Research suggests approximately half of Alzheimer's disease cases may be related to these modifiable risk factors: type 2 diabetes, high blood pressure, midlife obesity, smoking, depression, little or no cognitive activity, and little or no physical

[6] *See:* Bipartisan Policy Center. Paying for AI in U.S. Health Care. *Available at:* *https://bipartisanpolicy.org/issue-brief/paying-for-ai-in-u-s-health-care/*
[7] *See:* National Alliance of Healthcare Purchaser Coalitions. The 340B Program's Impact on Employers. Available at: https://www.nationalalliancehealth.org/the-340b-programs-impact-on-employers/

exercise.[8] A multi-domain intensive lifestyle intervention under Medicare should address nutrition, physical activity, and cognitive activity, social engagement and cardiovascular monitoring. Because it is important to assess and track cognitive health over time, maintaining a relationship with a primary care provider is also critical.

The US POINTER Randomized Clinical Trial provides evidence supporting this approach. The study found that the structured, higher-intensity intervention produced a statistically significant greater benefit in global cognition compared with the self-guided intervention. The findings suggest that nonpharmacological strategies targeting modifiable risk factors can offer a safe, accessible, and potentially low-cost approach to supporting brain health, although further investigation is needed to assess long-term outcomes and sustainability.[9] Although global cognitive function improved for both intervention groups, greater benefit was observed with the structured multidomain intervention.

Evidence from the Finnish FINGER study published in the Lancet arrived at similar conclusions in assessing higher-intensity lifestyle interventions. Researchers concluded that comprehensive lifestyle changes improve cognition and function.[10]

CalPERS and Covered California support CMS pursuing similar evidence-based preventive interventions to address the risk of cognitive decline for older adults.[11] Providers should be required to monitor patient progress over time, including biomarker monitoring and program adherence, to ensure optimal results and to realize long term savings due to improved health outcomes and reduced hospital utilization.

We thank you for your consideration and we welcome the opportunity to work with you on our shared goals of improving health care affordability, quality, and efficiency for Medicare beneficiaries. Please do not hesitate to contact Donald Moulds, CalPERS Chief Health Director, at (916) 795-0404, Danny Brown, Chief of the CalPERS Legislative Affairs Division, at (916) 795-2565, Monica Soni, Covered California's Chief Medical Officer, at (916) 954-3225, or Kelly Green, Covered California's Director of

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[8] See: CalPERS. Boosting Brain Health & Reducing Cognitive Decline with CalPERS' Chief Medical Officer. *Available at:* https://news.calpers.ca.gov/boosting-brain-health-reducing-cognitive-decline-a-qa-with-calpers-chief-medical-officer/

[9] *See:* JAMA. Structured vs Self-Guided Multidomain Lifestyle Interventions for Global Cognitive Function: The US POINTER Randomized Clinical Trial. *Available at:* https://jamanetwork.com/journals/jama/fullarticle/2837046#250510296

[10] *See:* Ornish, D., Madison, C., Kivipelto, M. et al. Effects of intensive lifestyle changes on the progression of mild cognitive impairment or early dementia due to Alzheimer's disease: a randomized, controlled clinical trial. *Available at:* https://doi.org/10.1186/s13195-024-01482-z

[11] *Ibid.*

External Affairs and Community Engagement, at (916) 228-8309, if we can be of any assistance.

Sincerely,

Marcie Frost
Chief Executive Officer, CalPERS

Jessica Altman
Executive Director, Covered California