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The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal lawmakers. The Panel is pleased to offer comments in response to the CY 2026 Payment Policies Under the Physician Fee Schedule Proposed Rule (CMS-1832-P).

D. Payment for Medicare Telehealth Services Under Section 1984(m).
2. Other Non-Face-to-Face Services Involving Communications Technology Under the PFS
a. Direct supervision via use of two -way audio/video communications technology
Federal Register Vol 90 No. 134: 32393-4
We endorse this proposed rule to permanently allow "immediate availability" to mean using audio/video real-time communication technology. Further, we appreciate the statement: "This flexibility has been available and widely utilized since the beginning of the PHE, and we recognized that it may enhance patient access." In the context of rural health availability and affordability, this is particularly important. We also agree with CMS that clinicians may use professional judgement to use this flexibility on a case-by-case basis.
b. Proposed changes to teaching physicians' billing for services involving residents with virtual presence
Federal Register Vol 90 No. 134: 32395
We endorse this transition to pre-PHE policy, which includes a rural exception to allow billing for services through virtual presence.

I. **Policies to Improve Care for Chronic Illness and Behavioral Health Needs**
4. Technical Refinements to Revise terminology for services related to upstream drivers of health
a. Policies to improve care for chronic illness and behavioral health needs
(1)SDOH Risk Assessment
(2)Community Health Integration Services
Federal Register Vol 90 No. 134: 32510
We appreciate CMS' rationale that the costs of collecting information needed to assess patient risk are incorporated in other payment codes. We support using the term "upstream drivers" as capturing factors impacting the health of Medicare beneficiaries. We appreciate the detailed analysis of an effective *person*-centered E/M visit, which includes "Facilitating access to community based social services to address upstream drivers." We point out, though, that meeting the objectives of *person-centered* assessment will require *community-based* actions to provide the necessary social services and to secure resources such as nutritious food and

adequate shelter. These services should be sensitive to the needs of all population groups in the community. Further, helping patients navigate the labyrinth of clinical and social services will require that members of the person-centered health team include workers focused on that need.

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

2. Payment for Care Coordination Services

b. Integrating Behavioral Health Into Advanced Primary Care Management (APCM)

Federal Register Vol 90 No. 134: 32549

We support add-on codes to facilitate billing for behavioral health and management services.

c. Payment for Communication technology-based services (CTBS) and remote evaluation services

Federal Register Vol 90 No. 134: 32552

We support this requirement as a means of assuring access to services, including in rural areas.

d. Aligning with PPS for Care Coordination Services

Federal Register Vol 90 No. 134: 32552

We support payment for care management and care coordination as separate from the all-inclusive rate and the prospective payment rate for RHCs and FQHCs, respectively. This decision will help assure services are offered and delivered, with the resulting potential for over-all cost savings.

2. Services Using Telecommunications Technology

c. Payment for Medical Visits furnished via telecom

Federal Register Vol 90 No. 134: 32557

We endorse paying for non-behavioral health visits via telecommunication technology on a temporary basis. We agree with CMS that this is a promising modality that could enhance access to services, but that we need to examine more evidence before making the payment policy permanent.

F. Medicare Shared Savings Program

2. SSP Participation Options

b. Considerations for Timing of ACOs" Progression to Performance-Based Risk in the SSP

Federal Register Vol 90 No. 134: 32650

c. Proposal to limit participation in a one-sided model to an ACO's first agreement period under the BASIC Track's Glide Path

Federal Register Vol 90 No. 134: 32655

We appreciate the analysis presented by CMS regarding actions of inexperienced ACOs. However, we differ somewhat in our interpretation of that evidence. The proposed rule text correctly concludes that most ACOs entering their first agreement and continuing into a second agreement period prefer a two-sided risk model as early as entering the first agreement or by the time they enter a second agreement. Only 4 of 25 in the first cohort and 2 of 19 in the second cohort stayed in a one-sided risk track through the first two years of the second agreement. We interpret that to be evidence that the incentive of a greater portion of shared savings, combined with resources to develop the ACO (i.e., more firms supporting new ACOs) is strong. The fact that most ACOs making the transition to two-sided risk jump to BASIC track E

supports this interpretation. However, the reality that more than a majority of new entrants into ACOs choose the BASIC track as the starting point indicates at least some trepidation about accepting downside risk. We cannot conclude from the data that absent the potential seven-year horizon to transition to full risk-sharing a high percentage would still enter the program. Furthermore, while the numbers of those staying in one-sided risk is small, it is still at least 10 percent, indicating some healthcare organizations continue to be risk averse. Our interpretation of the data is that the attraction of a higher share of shared savings is working as intended, motivating most ACOs to transition into BASIC E or ENHANCED tracks. We do not believe more than that incentive is needed. We also believe the benefits of the ACO program, in *both quality improvement and savings to the Medicare program* warrant continuing to make it attractive to new ACOs. Therefore, we recommend CMS reconsider changing existing policy regarding signing up for a second agreement. We are neutral regarding eliminating BASIC tracks C and D; the evidence is compelling that there would be little if any effect.

Respectfully submitted,

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