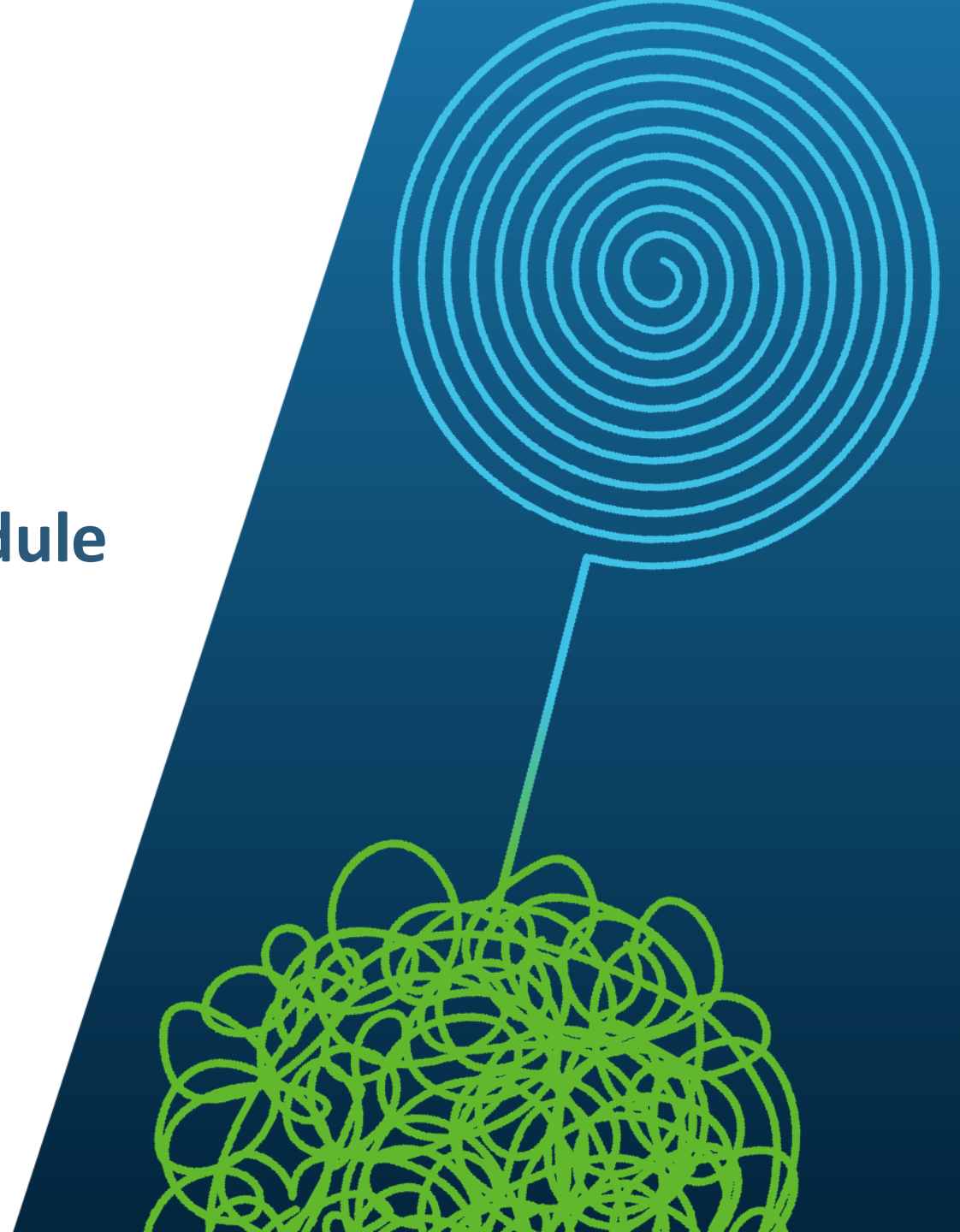
## Healthcare Regulatory Roundup #99

# 2026 Medicare Physician Fee Schedule Proposed Rule – *Part 2*

## August 13, 2025



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- Slides, handouts, and forms available in **Resources Panel**
- Enter questions in **Q&A Panel**
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# Introductions


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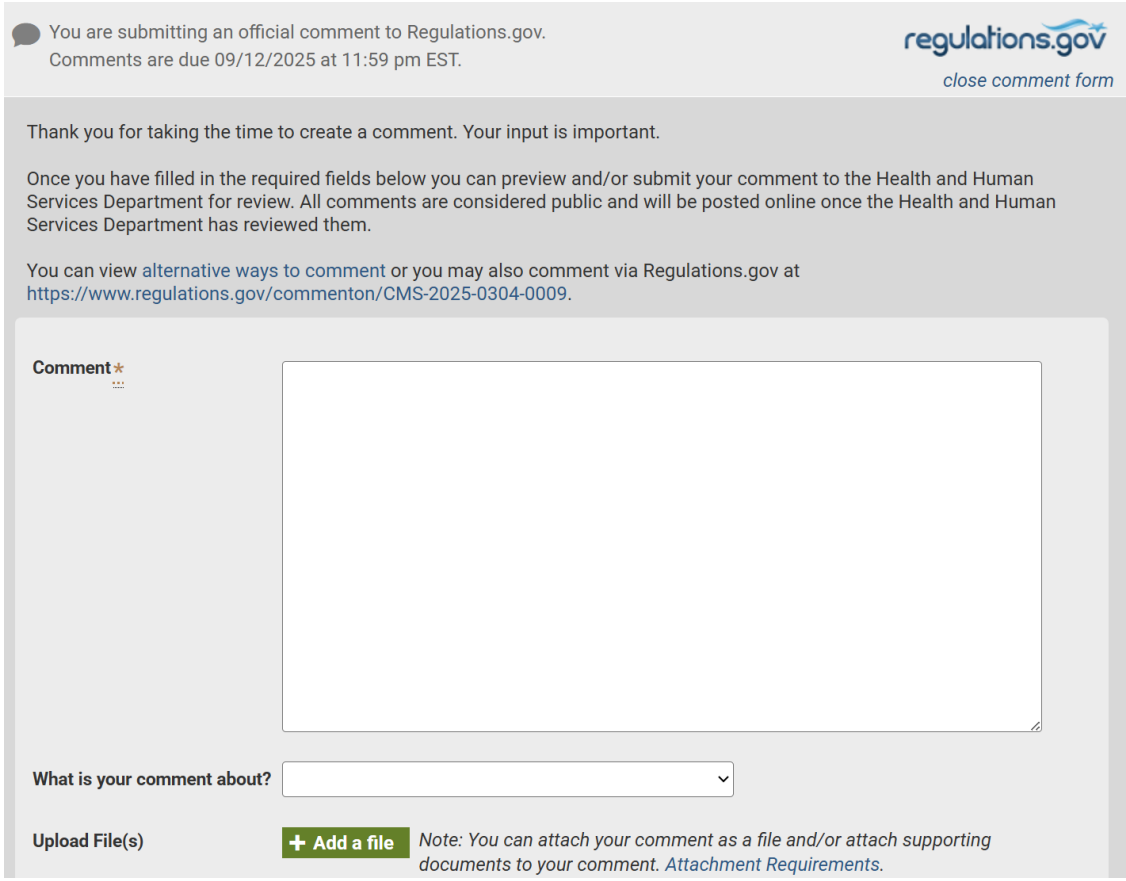
# Comments Due September 12


https://www.federalregister.gov/documents/2025/07/16/2025-13271/medicare-and-medicaid-programs-cy-2026-payment-policies-under-the-physician-fee-schedule-and-other

# Agenda

## 2026 Medicare Physician Fee Schedule Proposed Rule
## Parts 1 and 2

### Today – Part 2

1. Telehealth Changes
2. Global Payments Reforms
3. Skin Substitutes
4. Care Management
5. Prevention and Wellness

### Part 1 (July 30)

*On-demand at pyapc.com*

1. 2026 Payment Rate/Conversion Factor
2. Efficiency Adjustment
3. Practice Expense Methodology
4. Merit-Based Incentive Payment System (MIPS)
5. Ambulatory Specialty Model
6. Medicare Shared Savings Program (MSSP)

# 1. Telehealth Changes

# Medicare Telehealth Coverage – September 30 Cliff

- Medicare covers tele-behavioral health services furnished to beneficiary at home on permanent basis
  - May be billed by physicians, practitioners, and Rural Health Clinics (RHCs)/Federally Qualified Health Centers (FQHCs)
  - **Effective 10/1/2025** (1/1/2026 for RHCs/FQHCs) must have:
    1. Face-to-face visit within 6 months of initiating telehealth services, and (2); and
    2. Face-to-face visit once every 12 months following initiation of tele-behavioral health services (with certain exceptions)
- **Effective 10/1/2025:**
  - Medical telehealth services covered only if beneficiary physically present at a facility in rural area at time of service
  - PTs, OTs, and speech language pathologists cannot bill Medicare for telehealth services furnished in any setting
- **Through 12/31/2025**, RHCs/FQHCs can be distant site providers for medical telehealth services, billing under HCPCS G2025 (~$97)
- **Through 9/30/2025**, those medical telehealth services CMS previously identified as covered when using audio-only platform will be covered (except CPT 99441-99443)
- Going forward, any telehealth service will be covered when furnished audio-only if:
  1. Beneficiary is at home when service provided;
  2. Practitioner is capable of audio-video connection; and
  3. Beneficiary cannot or does not want to connect by video

# Streamlined Review Process for Telehealth Services

- CMS proposes simplifying the process for adding services to the **Medicare Telehealth Services List**:
  - Reduces the evaluation from 5 steps to 3 and focuses on whether services are separately payable, subject to telehealth provisions, and feasible via interactive technology.
    - Is the service separately payable when furnished in person under PFS?
    - Is the service subject to 1834(m)?
    - Are each of the elements of the HCPCS code descriptions capable of being provided via interactive telecommunication per 42 CFR § 410.78(a)(3)?
  - Eliminates the "provisional" status—approved codes will be considered **permanent**, though CMS retains removal authority.
  - Submit codes for consideration for 2027 by February 10, 2026.

# Proposed Code Changes

- **Added** to Telehealth List:
  - 90849 (Multiple family group psychotherapy)
  - G0473 (Group behavioral counseling)
  - G0545 (Inherent complexity, inpatient/obs visit, confirmed infectious disease by ID specialist)
  - 92622 & 92623 (Auditory osseointegrated sound processor programming)

- **Not Added**:
  - Dialysis codes (90935–90947), INR monitoring code G0248, AMA's Telemedicine E/M codes (98000–98015) due to the code's clinical feasibility of providing the entire service via telehealth, is a technical code, or is not covered, respectively.
  - CMS is proposing the deletion of HCPCS code G0136 (SDOH risk assessment) thereby removing it from the list; considers the services accounted for in current codes.

# Removal of Frequency Limitations

- CMS proposes **permanently removing frequency limits** for:

Subsequent inpatient visits (**99231–99233**)

Subsequent nursing facility visits (**99307–99310**)

Critical care consults (**G0508 & G0509**)

# Expansion of Virtual Direct Supervision

- CMS proposes **permanent allowance** of real-time audio-video supervision for incident to services, adopting the definition of "immediate availability" to include using A/V real-time communication (audio-only is excluded).
- **Excluding** those with global surgery indicators **010** and **090**.
- **Includes:**
  - Incident-to services (§ 410.26)
  - Diagnostic tests (§ 410.32)
  - Pulmonary rehabilitation services (§ 410.47)
  - Cardiac rehabilitation and intensive cardiac rehabilitation services (§ 410.49)
- Seeking information regarding potential concerns about patient safety and quality of care for 000-day global surgical services per revised definition of ***immediate availability***.

# Teaching Physician Virtual Supervision Limited

- CMS proposals:
  - No longer allow teaching physicians to have a virtual presence for purposes of billing for virtual services furnished involving residents in all teaching settings after December 31, 2025.
  - Within MSAs, teaching physicians must maintain physical presence during key or critical portions of services rendered by a resident, in telehealth and in-person services, to qualify for Medicare payment.
  - **Maintain the rural exception** established in the CY 2021 PFS final rule.
    - **Only for telehealth services**, such as 3-way visits – patient, resident, and teaching physician in different locations
    - Rural settings may fulfill the presence requirement through **active, real-time observation and participating in the service via AV real-time communication technology.**
    - Document whether the teaching physician was physically present or present via AV technology for the telehealth service; include which portion of the visit.

# Telehealth: FQHCs and RHCs

- **Reminder**: CMS permanently allows FQHCs/RHCs to provide mental health visits via telehealth (2022 PFS).
  - Telehealth eligibility requires prior and subsequent in-person visits.
  - 2025 PFS delayed in-person visit requirements through end of 2025.
  - CMS plans to update policy in 2026 PFS.
  - Future changes will align with federal waivers, currently effective through September 30, 2025.
- **One-year extension** to bill for **non-behavioral health medical visits** via telehealth (including audio-only).
  - Continue using **G2025** through **December 31, 2026**.
  - CMS is soliciting feedback on making this permanent and paying at PPS/AIR rates.
- Communication Technology-Based Services (CTBS)
  - CMS proposes **unbundling G0071** and requiring reporting of individual codes (e.g., G2010, G2250, 98016) for FQHCs/RHCs.

# Telehealth – Other Notables

- CMS continues to explore **payment parity** between telehealth and in-person services, with some services possibly reimbursed differently depending on modality and setting.
- **No extension** proposed for allowing distant site providers to use their enrolled practice address instead of home address when providing services from their home.
- **Digital Mental Health Treatment (DMHT)** and **Remote Monitoring** codes clarified and expanded.
- **MDPP virtual delivery** extended through **December 31, 2029**.[1]

1. https://www.cms.gov/innovation-insight-proposed-changes-expand-reach-medicare-diabetes-prevention-program-achieve-maha

# 2. Global Payments Reforms

# Global Surgical Package

- No immediate changes:
  - CMS does not propose changes to the valuation of global surgical packages for CY 2026
- **Request for public input:**
  - What next steps can CMS take to improve the accuracy of payment for global surgical packages?
  - Should or how should CMS revise the portion of the global surgery package relative value unit (RVU) attributed to the surgical procedure?
  - What should the procedure shares be based on when the transfer of care modifier(s) are applied for the 90-day global packages?
  - What are the current practice standards related to the division of work between surgeons and providers of post-operative care?

# Reminder: 2025 Changes

- **Modifier -54** (surgical care only) reporting expanded in **CY 2025 PFS Final Rule**.
  - Now required whenever surgeon does not intend to provide post-op care, formal and informal agreements.
- **New add-on code G0559** finalized for CY 2025.
  - Used when post-op care is provided by a different practitioner/group.
  - Added to the E/M code performed and billed.
- **Improving global package valuation**
  - CMS views expanded use of **transfer of care modifiers** as a first step in refining global surgical payment accuracy.
  - Exploring ways to **allocate payment shares** when care is split between providers.

# Three Proposed Approaches

## Approach 1

**Subtract Assumed Post-Op Work RVUs**

- Uses Physician Time File to subtract wRVUs for assumed post-op visits from total global package RVUs.

## Approach 2

**Claims-Based Post-Op Visit Counts**

- Uses **actual post-op visits** reported via CPT code **99024**.
- Multiplies median visit count by average valuation per visit.
- **CMS prefers this approach** for its accuracy and transparency.

## Approach 3

**Time-Based Ratio**

- Calculates procedure RVUs using **physician time** data.
- Uses ratio of time spent in post-operative visits to total physician time.

# Current Procedure Share Assumptions

- Modifier -54 assigns surgeons a **fixed share** of global package valuation:
  - ~79–81% for about half of the 90-day globals
  - ~90% for most of the 10-day globals
- Key findings from 2023 data:
  - Current assumptions **underestimate** surgeon workload:
    - Only **28% of 90-day** and **2% of 10-day** assumed post-op visits were actually provided.
  - **Claims-based approach (Approach 2)** yields higher, more accurate procedure shares:
    - Average share would rise from **82% to 91%**.
    - 85% of procedures would see increased shares.
- Findings support revising procedure shares to reflect **real-world care patterns**.

# CMS Seeks Public Input

Best approach to adopt
(prefers Approach 2)

How to assign shares for codes
**missing pre/intra/post-op percentages**

Whether some codes are **misclassified**
as 90-day global packages

# 3. Skin Substitutes

# Skin Substitutes Overview

- Skin substitutes are commonly used in outpatient settings.
- Primarily for treating **diabetic foot ulcers** and **venous leg ulcers**.
- Procedures involving skin substitutes require multiple **HCPCS codes**:
  - **Wound preparation**
  - **Product usage**
  - **Application technique** (e.g., suturing)
- **CPT Codes 15271–15278**:
  - Describe application based on **wound size** and **anatomical location**.
  - Normally supplies in the non-facility setting are bundled; however, these products have been paid separately under the ASP plus 6% payment methodology, historically.

# Proposed Local Coverage Determination (LCD)

- Released April 25, 2024
- Collaboratively developed by the MACs
- L36377, titled: Skin Substitute Grafts/Cellular and Tissue-Based Products for the Treatment of Diabetic Foot Ulcers and Venous Leg Ulcers[1]
- All MACs have delayed implementation to January 1, 2026

1. https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=36377&ver=19

# Skin Substitute Payment Overhaul

- CMS proposes a national standardized payment methodology for skin substitutes, replacing the current product-specific approach.
  - CMS cites explosive growth in spending—from **$250 million to over $10 billion** in five years—while the number of patients only doubled.
  - Skin substitutes are already on the OIG Work Plan.
- Single Rate Across Settings: **A uniform rate of approximately $125.38 per $cm^2$ will apply to all associated HCPCS supply codes paid across physician offices and outpatient departments.**
  - Estimated savings: $9.4 billion
  - Rates to be based on ASP reporting and hospital outpatient rates and utilization patterns.
  - Proposed fee is a weighted average of the three FDA categories represented.

# Proposed Change:
## Skin Substitutes to Be Paid as Incident-To Supplies

- Certain skin substitutes would no longer be paid under section 1847A.
- ASP reporting for skin substitute manufacturers would become **voluntary**.
- CPT codes 15271 through 15278 would be billed with the current HCPCS supply code and paid as incident-to supplies in the non-facility setting.

# FDA-Based Grouping

- Products will be grouped into three categories based on FDA regulatory pathways:
  - Premarket-approved (PMA)
  - 510(k)-cleared or De Novo pathway devices
  - 361 HCT/Ps (Human Cell, Tissue, and Cellular/Tissue-Based Products)
- Products (biologicals) licensed under **Section 351** will continue to be reimbursed under the **ASP methodology**.
- CMS is considering this grouping for the purpose of prospective payment setting.
- CMS highlighted that FDA determinations of a products safety is not associated or authoritative to CMS' decision that a product is reasonable and necessary.
  - CMS dictates coverage policy alone.

# Action Steps

1. Assess the products utilized and their FDA category.
2. Evaluate supplier contracts, financial impact, and adjust clinical protocols.
3. Review charges to determine if any changes need to be made.
4. Educate staff on documentation requirements for coverage and billing changes.
5. Participate in the **public comment process** (deadline: **September 12, 2025**).

# 4. Care Management

# Advanced Primary Care Management Services (APCM)

- APCM includes current codes:
  - **G0556** – APCM for patients with one or no chronic conditions
  - **G0557** – APCM for patients with two or more chronic conditions
  - **G0558** – APCM for patients with two or more chronic conditions and who are Qualified Medicare Beneficiaries
- Behavioral Health Integration (BHI) add-on codes for APCM
  - **GPCM1** – Initial psychiatric collaborative care management (CoCM)
  - **GPCM2** – Subsequent psychiatric collaborative care management (CoCM)
  - **GPCM3** – Care management for behavioral health conditions (BHI)
- APCM and now the add-on codes do not have minimum time requirements
- Services can be delivered by professional and auxiliary personnel under general supervision of billing practitioner
- **Consent is required for APCM and for the BHI services**

# BHI Add-On Codes for APCM

| HCPCS Code | CPT Code (time required) | Description | Primary Care Team | Service Components |
|---|---|---|---|---|
| GPCM1 | 99492 (*70 min*)<br>99494 (*30 add'l min*) | Initial Psychiatric CoCM, in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional | • Treating provider<br>• BH Care Manager<br>• Patient<br>• Psychiatric Consultant | • Initial assessment<br>• Joint care planning<br>• Ongoing follow-up<br>• Weekly systemic case review |
| GPCM2 | 99493 (*60 min*)<br>99494 (*30 add'l min*) | Subsequent Psychiatric CoCM, in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional | | |
| GPCM3 | 99484 (*at least 20 min*) | Care management services for behavioral health conditions, directed by a physician or other qualified health care professional, per calendar month | Same as above but **excludes** the psychiatric consultant | same as above but **excludes** weekly systemic case review |

# Valuation of BHI Add-On Codes

| BHI Add-on Code | CoCM/BHI CPT Code | Work RVU | PE Non-Facility RVU | PE Facility RVU | 2025 National MPFS Non-Facility Price | Facility Price |
|---|---|---|---|---|---|---|
| GPCM1 | 99492 | 1.88 | 2.48 | 0.80 | 145.24 | 90.89 |
| GPCM2 | 99493 | 2.05 | 1.93 | 0.86 | 133.59 | 98.98 |
| GPCM3 | 99484 | 0.93 | 0.66 | 0.30 | 53.05 | 41.40 |

# FQHC/RHC – CoCM Code Change Proposed

- Starting **January 1, 2026**, **FQHCs and RHCs would no longer bill G0512** – composite code to bill for **CoCM** services –behavioral health integration (BHI) care delivered in primary care settings.
- Instead, they would bill using the **individual CPT codes** that make up G0512:
  - **99492** – Initial psychiatric CoCM (first month, 70 minutes)
  - **99493** – Subsequent psychiatric CoCM (60 minutes)
  - **99494** – Add-on code for additional 30 minutes
- This change aligns behavioral health billing with broader APCM reforms.
  - It may allow for **more accurate tracking and reimbursement** of time and services provided.
  - CMS is seeking public comment on this proposal before finalizing it.
- **Communication Technology-Based Services (CTBS)**
  - CMS proposes **unbundling G0071** and requiring reporting of individual codes (e.g., G2010, G2250, 98016) for FQHCs/RHCs.

# Remote Physiological Monitoring (RPM)

| CPT Code | Short Description | Proposed Fee Structure |
|---|---|---|
| **99453** | Patient education and device set-up | No changes in work or PE RVU for CY 2026 |
| **99XX4 (NEW)** | Data transmission – remote monitoring of physiologic parameters; **2-15 days in a 30-day period** | Using hospital claims data, total geometric mean cost published in the CY 2025 OPPS final rule/CY 2026 PFS conversion factor |
| **99454** | Data transmission – remote monitoring of physiologic parameters; **16-30 days in a 30-day period** | |
| **99091** | Collection and interpretation of physiologic data by the physician and/or other QHP, minimum of 30 minutes each 30 days | No changes in work or PE RVU for CY 2026 |
| **99XX5 (NEW)** | RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **first 10 minutes** | 50% of 99457 RVU |
| **99457** | RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **first 20 minutes** | No changes in work or PE RVU for CY 2026 |
| **99458** | RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **each additional 20 minutes** | No changes in work or PE RVU for CY 2026 |

# Remote Therapeutic Monitoring (RTM)

| CPT Code | Short Description | Proposed Payment Structure |
|---|---|---|
| **98975** | Patient education and device set-up | No changes for CY 2026 |
| **98XX4 (NEW)** | Data transmission – RTM of respiratory system; **2-15 days in a 30-day period** | Contractor priced – an approach used for 98978 in 2025 |
| **98976** | Data transmission – RTM of respiratory system; **16-30 days in a 30-day period** | Contractor priced – an approach used for 98978 in 2025 |
| **98XX5 (NEW)** | Data transmission – RTM of musculoskeletal system; **2-15 days in a 30-day period** | Using hospital claims data, total geometric mean cost published in the CY 2025 OPPS final rule/CY 2026 PFS conversion factor |
| **98977** | Data transmission – RTM of musculoskeletal system; **16-30 days in a 30-day period** | |
| **98XX6 (NEW)** | Data transmission – RTM of cognitive behavioral therapy; **2-15 days in a 30-day period** | Contractor priced – an approach used for 98978 in 2025 |
| **98978** | Data transmission – RTM of cognitive behavioral therapy; **16-30 days in a 30-day period** | Contractor priced – an approach used for 98978 in 2025 |

# RTM (cont.)

| CPT Code | Short Description | Proposed Payment Structure |
|---|---|---|
| **98XX7 (NEW)** | RTM treatment services, physician or other qualified healthcare professional time in a calendar month requiring at least one real-time interactive communication with the patient or caregiver during the calendar month; **first 10 minutes** | 50% of 98980 RVU |
| **98980** | RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **first 20 minutes** | No changes for CY 2026 |
| **98981** | RPM treatment management services by clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; **each additional 20 minutes** | No changes for CY 2026 |

# Social Determinants of Health (SDOH)

- CMS proposes to change the name of SDOH to **upstream drivers** of health
  - Upstream drivers – such as smoking, low physical activity, substance misuse, in addition to environmental drivers
  - CMS proposes to delete HCPCS code G0136 (Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5-15 minutes) and remove from the telehealth list
    - CMS states resource costs are already accounted for in existing codes including E/M visits and Community Health Integration (CHI).

# 5. Prevention and Wellness

# Medicare Diabetes Prevention Program (MDPP)

- Eligibility limited to beneficiaries at risk of developing Type 2 diabetes
  - One of the following within 12 months before attending first core session
    - Hemoglobin A1c test result between 5.7% and 6.4%
    - Fasting plasma glucose of 110-125mg/dL
    - 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerant test)
  - BMI of 25 or more (BMI of 23 or more for Asian beneficiares).
  - Never been diagnosed with ESRD or type 1 or type 2 diabetes
  - No prior MDPP participation
- MDPP suppliers must separately enroll in Medicare, have CDC preliminary or full recognition
- One-hour group sessions furnished by trained lifestyle coach using CDC-approved DPP curriculum
  - 16 weekly core sessions
  - 6 monthly follow-up sessions

https://www.cdc.gov/diabetes-prevention/php/program-provider/program-requirements.html

# MDPP Limited Participation

- As of March 2025, only 331 Medicare-enrolled MDPP suppliers
- Over 8 years, only 9,000 participants (split evenly between traditional Medicare and MA)
  - Per AMA, about 50% of all Medicare beneficiaries have prediabetes (in addition to about 27% having diabetes)
- Recent efforts to expand participation:
  - During COVID-19, permit live, virtual delivery in compliance with CDC requirements for *distance learning* sessions
    - Now extended through 2027
    - May use remote monitoring or date-stamped photo(s) showing weight on digital scale + beneficiary present in home to meet baseline and performance achievement weight measurement requirements
    - Supplier must maintain capability to deliver in-person services
  - In 2024, simplified payment structure
    - Fee-for-service reimbursement for beneficiary attendance at sessions
    - Performance-based payments tied to beneficiary weight loss

# MDPP Current Reimbursement

| HCPCS G-Code | Payment Description | Payment |
|---|---|---|
| G9886* | Behavioral counseling for diabetes prevention, in-person, group, 60 minutes | $26 |
| G9887* | Behavioral counseling for diabetes prevention, distance learning, 60 minutes | $26 |
| | **Subtotal Maximum Attendance-Based Payment (22 Sessions)** | **$572** |
| G9880 | 5 percent weight loss (WL) achieved from baseline weight | $149 |
| G9881 | 9 percent WL achieved from baseline weight | $26 |
| G9888** | Maintenance 5 percent WL from baseline in months 7-12 | $8 |
| | **Total Maximum Payment** | **$755** |

- MDPP supplier may offer in-kind incentives with reasonable connection to approved curriculum during MDPP services period
- Cost of incentives cannot be shifted to beneficiary or another Federal health care program
- Must maintain documentation of incentives that individually exceed $25 in retail value; incentives involving technology may not, in aggregate, exceed $1,000 in retail value for any one beneficiary

# MDPP Proposed Changes

- Extend virtual option through 2029
  - Eliminate requirement that supplier must have capacity to deliver in-person services
- Add asynchronous delivery modality (online sessions) through 2029
  - MDPP supplier requirements
    - Obtain online organization code from CDC prior to delivering online sessions
    - Adhere to CDC standards regarding program format, coach interaction, program intensity and duration
      - Live (not AI) coach-beneficiary interaction for each session (includes bi-directional emails and texts)
    - Ensure beneficiaries engage with content (documented completion of sessions, knowledge checks, contribution to discussion boards)
  - New code, G9871, pays $18/session (vs. $26 for in-person and virtual); same performance achievement payments
  - Cannot combine asynchronous with live sessions (virtual or in-person)
- Expand options for recording weight measurements
  - Permit photos from locations other than beneficiary's home (maintain date-stamp requirement)
  - As alternative to photos, submit medical record documentation of weight taken within 2 days of session

# Digital Mental Health Treatment (DMHT)

- New reimbursement in 2025 for physicians + practitioners authorized to deliver services for diagnosis and treatment of mental illness
  - **G0552** – supply of DMHT device + onboarding and education to augment behavioral health treatment plan (contractor priced)
  - **G0553** – first 20 minutes of monthly treatment management services directly related to use of device, requiring at least one interactive communication with beneficiary/caregiver
  - **G0554** – additional 20 minutes
- Current conditions of payment
  - Furnished incident to billing practitioner's plan of care for behavioral health treatment
  - Billing practitioner must incur cost of device furnished to beneficiary
  - Device must have been cleared under FD&C Act section 510(k) or granted De Novo authorization by FDA + classified at 882.5801 (psychiatric disorders)
- CMS proposes to expand coverage to include devices classified at 882.5803 (ADHD)
  - Seeks comment on expanding to devices for gastrointestinal conditions, sleep disturbances, fibromyalgia

# Comment Solicitation on Digital Health Reimbursement

- Separate coding and payment for digital tools used by practitioners intended for maintaining or encouraging healthy lifestyle, as part of mental health treatment plan of care.
- Coding and payment similar to DMHT codes for FDA-cleared digital therapeutics that treat or manage symptoms of chronic diseases
- Other digital device reimbursement policies including new add-on G code to track use of FDA-authorized eye-tracking technology for diagnosing Autism Spectrum Disorder in children

# Comment Solicitation – SaaS and AI Payment Policy

- Software-based technologies to support clinical decision-making in outpatient setting not well accounted for in current practice expense methodology
  - Software and licensing fees treated as indirect cost associated with computer hardware
- Seeking comments to assist with payment policy development
  - What factors should be considered in making payment for SaaS?
  - Experience of APM participants in use of SaaS?
  - Should CMS crosswalk values from OPPS payment amounts for technical components of services incorporating SaaS? Integrate OPPS geometric mean costs into rate setting methodology (as proposed for RTM and RPM)? Set payment rates relative to OPPS rates (as proposed for radiation oncology services)? Alternative data sources that accurately reflect SaaS costs?
  - How should CMS value physician work associated with utilizing clinical outputs from SaaS?
  - How are SaaS and AI used in treatment of chronic conditions
  - How can CMS evaluate quality and efficacy of SaaS and AI?

# RFI on Prevention and Management of Chronic Disease

***What options are available to CMS, and how should the agency prioritize opportunities?***

- How to better promote chronic disease prevention and management, including self-management?
- Opportunities to address root causes of chronic disease?
- Encourage programs to reduce loneliness and social isolation?
- Reimbursement for programs to enhance physical activity?
- Reimbursement for intensive lifestyle interventions?
- Reimbursement for medically-tailored meals?
- Methods to increase utilization of annual wellness visits?
- Encourage participation in evidence-based programs to prevent chronic disease?
- Create additional coding and payment for motivational interviewing?
- Overcome obstacles to securing existing reimbursement for chronic disease management?

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## August 27, 2025; 11 am – 12 pm ET

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