Let’s Get Rural!

Key Policy, Payment, & Program Changes Shaping Rural Healthcare in 2026

January 15, 2026



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Introductions



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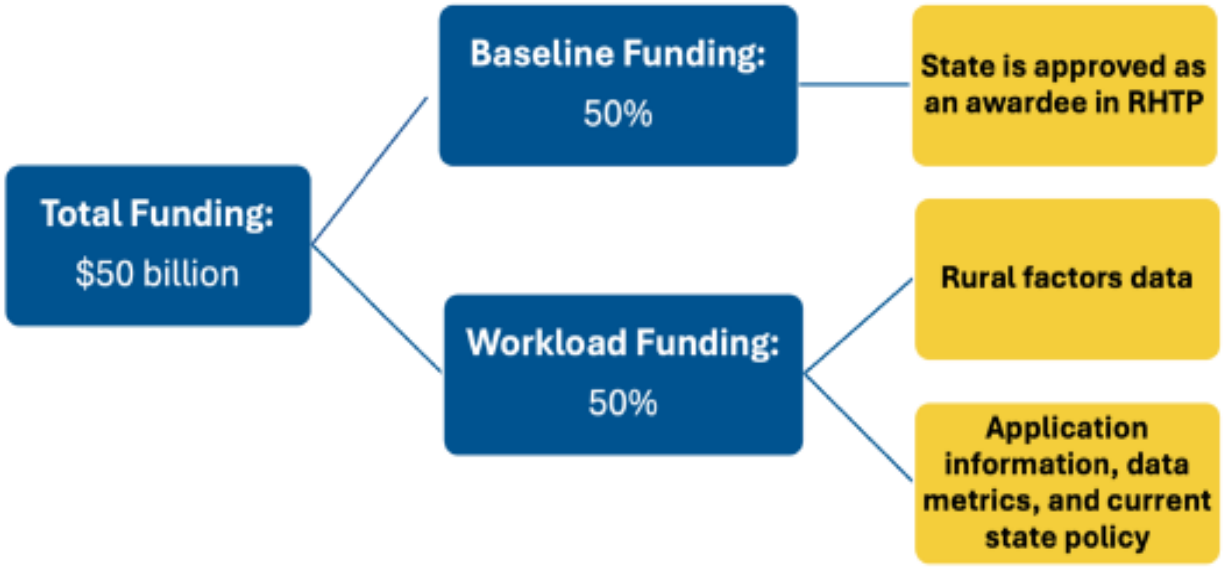
Today's Agenda

1. Rural Health Transformation Program
2. Status of Medicare Rural Extenders
3. Status of Medicare Telehealth Coverage
4. Changes to Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Billing
5. 340B Update
6. Price Transparency
7. CMS Innovation Center Alternative Payment Models
8. Medicare Advantage



1. Rural Health Transformation Program

$50 Billion Over 5 Years (FY2026-FY2030)



- $10B available each year
- Baseline funding equally distributed among states with approved applications
- Workload funding based on “content and quality of your application and rural factors”
- Baseline and workload funds subject to same requirements
- All funds must be expended in support of initiatives detailed in State’s Rural Health Transformation Plan (including up to 10% for administration)
- All funds must be expended by end of fiscal year following receipt of funds

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: December 8, 2025

FROM: Dan Brillman
Deputy Administrator, CMS
Director, Center for Medicaid and CHIP Services

SUBJECT: **Section 71119 of the "Working Families Tax Cut" Legislation, Public Law 119-21: Requirements for States to Establish Medicaid Community Engagement Requirements for Certain Individuals**

I. Introduction

On July 4, 2025, President Trump signed Public Law No. 119-21, which the Centers for Medicare & Medicaid Services (CMS) refers to as the "Working Families Tax Cut" (WFTC) legislation, into law. The WFTC legislation included changes to the Medicaid program to be implemented in the coming years, including the introduction of community engagement requirements for certain adults enrolled in Medicaid. Community engagement has potential to empower Medicaid beneficiaries through employment, education, or volunteer service so they can escape isolation and dependency, build confidence, and achieve self-sufficiency.

https://www.medicaid.gov/federal-policy-guidance/downloads/cib12082025.pdf

Factor Scoring

- Workload funding based on State's score across 23 factors relative to other states
  - Rural facility and population score factors
  - State policy factors
  - Initiative-based factors
- Each factor assigned 100 total points
- State's total point score for each budget period = weighted sum of score for each factor
  - Rural facility and population score factor points assessed once during Q4 2025
  - Other factors assessed annually based on State's progress on State policy and initiative-based factors

Rural Facility and Population Score Factors

- 7 data-driven factors = 50% total score
  1. Absolute size of rural population in a State = 10%
  2. Proportion of rural health facilities in a State = 10%
  3. Uncompensated care in a State = 10%
  4. % of State population located in rural areas = 6%
  5. Metrics that define a State as being frontier = 6%
  6. Area of a State in total square miles = 5%
  7. % of hospitals in a State that receive Medicaid DSH payments = 3%
- CMS will calculate States' scores
  - States to submit data on number of hospitals receiving Medicaid DSH payments

Source: NOFO, Table 3

8 State Policy Factors

1. Health and lifestyle (not counted in 2026) (25 points; other 75 points assigned to initiative-based factor) (0.9375%)
   - State requires schools to re-establish Presidential Fitness Test per Executive Order 14327
2. SNAP waivers (3.75%)
   - State has USDA-approved waiver prohibiting purchase of non-nutritious items with SNAP
3. Nutrition Continuing Medical Education (not counted in 2026) (1.75%)
   - State requires nutrition to be included in mandatory CME
4. Certificate of Need (1.75%)
   - State score on Cicero report

8 State Policy Factors (*cont.*)

5. Licensure compacts (1.75%)
   - Average of physician, nurse, EMS, psychology, and physician assistant score
6. Scope of practice (1.75%)
   - Average of physician assistant, nurse practitioner, pharmacist, and dental hygienist score
7. Short-term limited-duration insurance (1.75%)
   - State does not restrict such insurance beyond latest federal guidance
8. Remote care services (50 points; other 50 points assigned to initiative-based) (1.875%)
   - Average of score based on Medicaid reimbursement for live video, store and forward, RPM, exceptions to in-state licensing, telehealth license/registration process

State Policy Factors

- CMS to access 3rd party resources to determine current state policy
  - State must include attestation regarding current policy in application
- State may receive partial credit by committing to specific policy changes
  - State must follow through on meeting policy commitments by 12.31.2027 (12.31.2028 for Presidential Fitness Test and nutrition requirement for physician CME)
  - Failure to meet policy commitment = claw-back of funds awarded based on commitment

10 Initiative-Based Factors

1. Population health clinical infrastructure (3.75%)
   - Enhancement of and/or creation of community-based initiatives
   - Strengthen rural health ecosystem through tech innovation, focus on primary care and behavioral health, expanded scope of practice
   - Coordination among providers, CBOs, and other stakeholders to improve access to care and social services
2. Health and lifestyle (2.8125%) (25 points assigned to State policy factor)
   - Evidence-based novel prevention-focused models on lifestyle changes, nutrition, exercise
   - Engagement of multiple stakeholders and community resources
3. Rural provider strategic partnerships (3.75%)
   - Exchange of best practices and care coordination partially facilitated through remote care services
   - Expand access to specialty services
   - Centralize/streamline back-office functions
   - Improve financial viability of rural providers, keep care local where appropriate
   - Converting (right-sizing) hospitals

10 Initiative-Based Factors (*cont.*)

4. EMS (3.75%)
   - State policy/infrastructure supporting coordination between EMS and other provider types (e.g., community paramedicine)
   - Infrastructure to support alternative site of care treatment ("in place" as part of emergency call)
   - Other investments to improve speed and access and reduce cost to deliver services
5. Talent recruitment (3.75%)
   - Career education infrastructure in rural communities (career pathways)
   - New residency training programs, fellowships tied to 5 years of service
   - Relocation grants tied to 5 years of service
   - IHS recruitment, as appropriate
   - Pathways for non-physician healthcare providers
6. Medicaid provider payment incentives (3.75%)
   - Payment mechanism incentivizing providers/ACOs to reduce costs, improve quality, shift to lower cost of care settings
   - Value-based programs with pathway to two-sided risk models supported by evidence suggesting will change patient/provider behavior

10 Initiative-Based Factors (*cont.*)

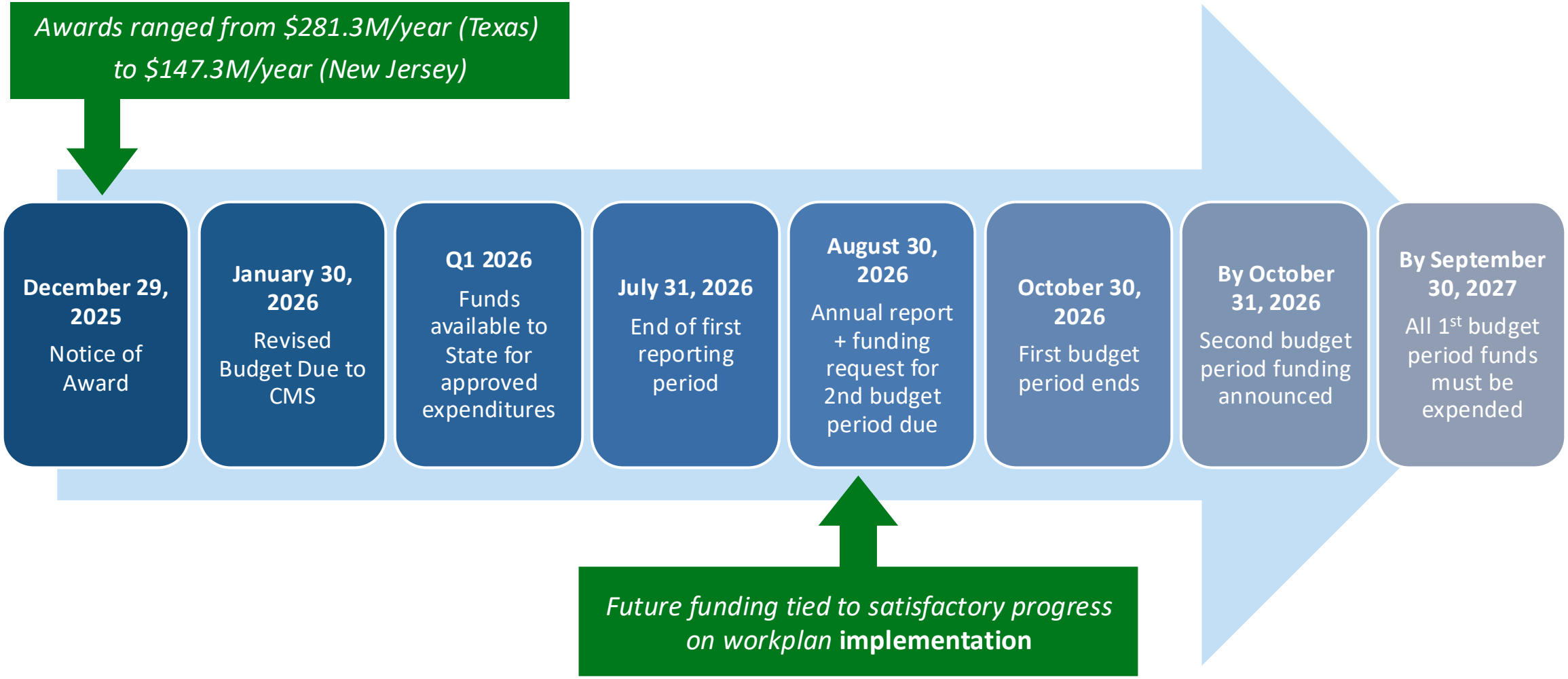
7. Dual eligible enrollment in integrated plans (3.75%)
   - Investments to promote enrollment, e.g., data integration, technical assistance to improve duals support and resources, enrollment support
8. Remote care services (50 points assigned to State policy factor) (1.875%)
   - Enhancement of State's remote care services infrastructure
9. Data infrastructure (3.75%)
   - Investments in EHR, clinical support, and operational software infrastructure upgrades that enable participation in data exchange and interoperability (aligned with CMS' Health Technology Ecosystem criteria and ASTP/ONC criteria, as applicable
10. Consumer-facing technology (3.75%)
    - Support development and appropriate usage/deployment of tools for prevention/management of chronic disease
    - Align with CMS' Health Technology Ecosystem criteria for patient-face apps, as applicable

Funding Restrictions

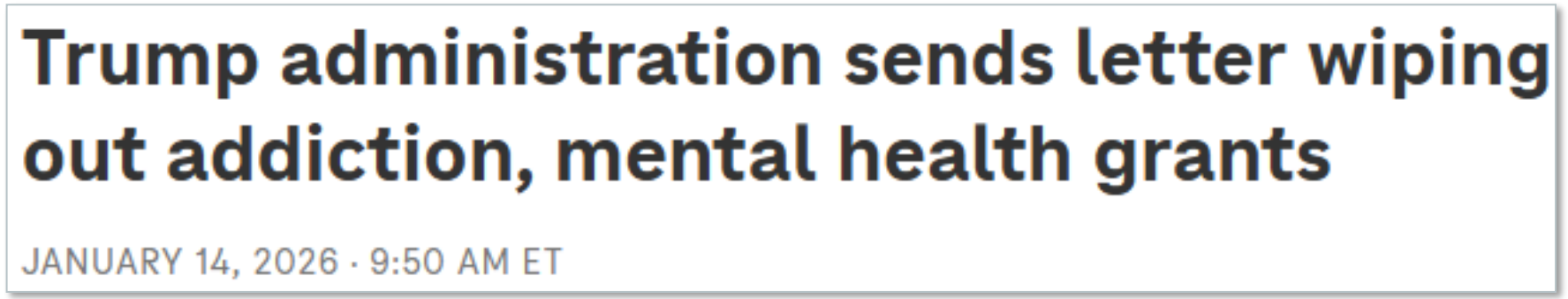
1. Administrative expenses capped at 10% of total funding in given budget period
2. Cannot use funds for new construction
3. Capital expenditures and infrastructure capped at 20% of total funding in given budget period
4. Cannot pay for clinical services presently reimbursable by insurance
5. Payments for non-reimbursable clinical service capped at 15% of total funding in given budget period
6. Cannot change payment amounts on existing fee schedules
7. Cannot pay specialist located in urban area to provide telehealth services for rural residents
8. Cannot purchase food
9. EHR replacement capped at 5% of total funding in given budget period
10. Cannot back-fill programs that have lost funding
11. All funded positions subject to federal salary rate limitation (currently $225,750)
12. Cannot use funds to pay clinician salaries or wage supports for facilities that subject clinicians to non-competes
13. “Start-up” initiative funding capped at lesser of 10% of total funding or $20M for any given budget period
14. Cannot use funds as expenditure that is attributable to intergovernmental transfer, certified public expenditure, or otherwise finance non-Federal share of expenditures required by law
15. Other standard limits on grant expenditures apply

1st Budget Period Timeline

Awards ranged from $281.3M/year (Texas) to $147.3M/year (New Jersey)



Cause for Concern?



Trump administration sends letter wiping out addiction, mental health grants

JANUARY 14, 2026 · 9:50 AM ET

https://www.npr.org/2026/01/14/nx-s1-5677104/trump-administration-letter-terminating-addiction-mental-health-grants



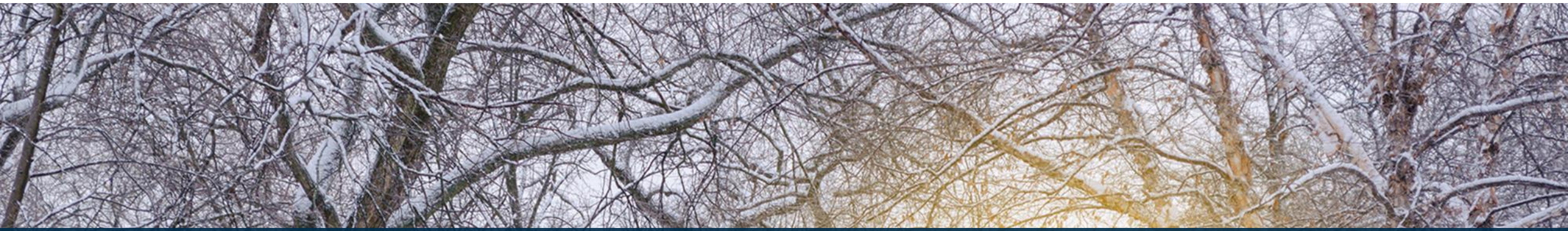
'People will die': Trump administration cancels up to $1.9bn for substance use and mental health

Funding to end immediately for up to 2,800 grantees of US agency that serves thousands seeking help and in recovery

https://www.theguardian.com/us-news/2026/jan/14/trump-cuts-substance-use-mental-health

Polling Question 1





2. Status of Medicare Rural Extenders



Funding Deadline Approaches

- Provisions of current Continuing Resolution
  - Extended telehealth flexibilities, community health center funding, GPCI floor, rural ambulance add-on payment, payment adjustments for low volume and Medicare dependent hospitals through January 30, 2026
    - Includes $14 million for No Surprises Act implementation
    - Delays Medicaid DSH cuts and lab cuts under Protecting Access to Medicare Act
  - Included full backpay for all federal workers; re-instatement of workers laid off since October 1, 2025; no additional layoffs through January 30, 2026
- Ongoing negotiations between Senate and House appropriations leaders
  - In addition to healthcare funding, also needs to address budgets for Defense, Labor, Health and Human Services, Education, Commerce, Transportation/Housing, and Interior Departments
- Final legislation requires majority vote in the House and 60 votes in the Senate



3. Status of Medicare Telehealth Coverage

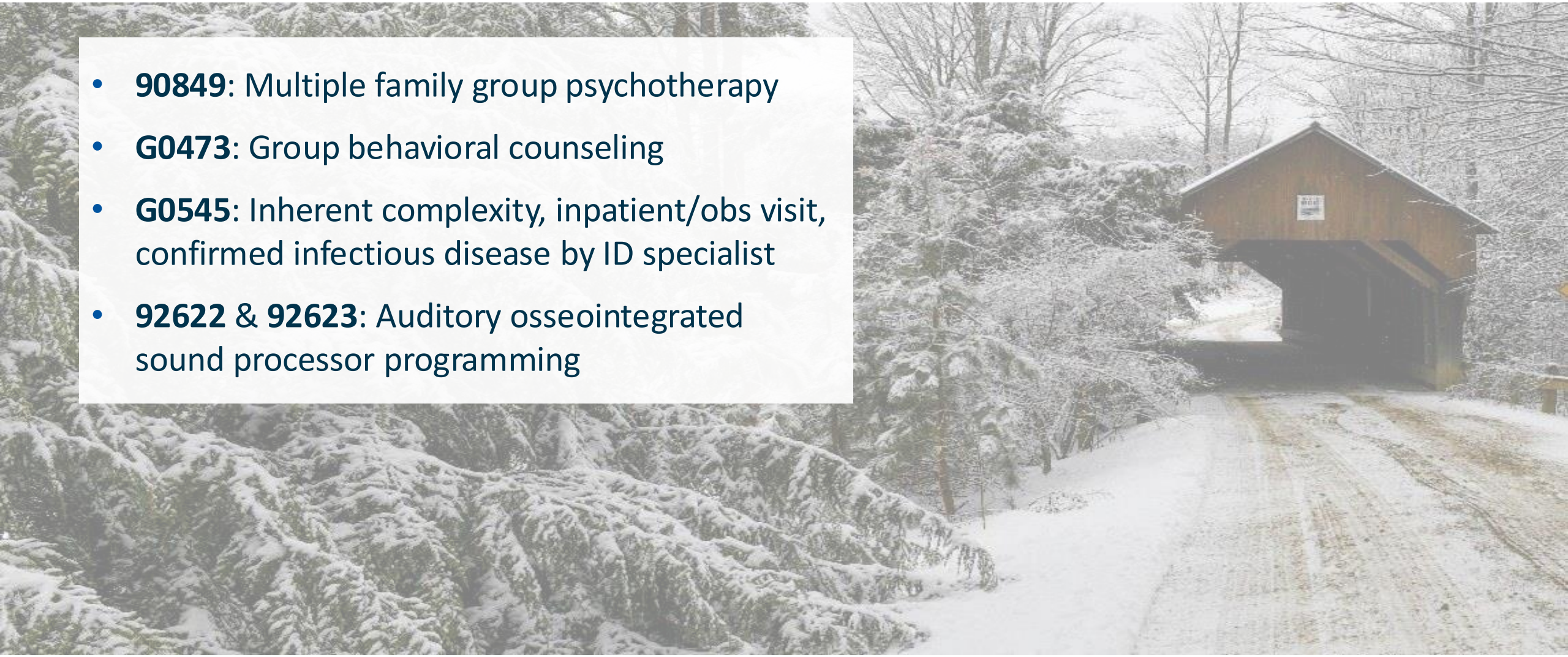
Medicare Telehealth Coverage: January 30 Cliff

- Medicare covers tele-behavioral health services furnished to beneficiary at home on permanent basis
  - May be billed by physicians, practitioners, RHCs, and FQHCs
  - Effective 1/31/2026 must have:
    - Face-to-face visit within 6 months of initiating telehealth services, and (2); ***and***
    - Face-to-face visit once every 12 months following initiation of tele-behavioral health services (with certain exceptions).
- Effective 1/31/2026:
  - Medical telehealth services covered only if patient physically present at facility in rural area at time of service
  - PTs, OTs, and SPLs cannot bill Medicare for telehealth services furnished in any setting
- Through 1/30/2026:
  - 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:
  - Beneficiary is at home when service provided;
  - Practitioner is capable of audio-video connection; ***and***
  - Beneficiary cannot or does not want to connect by video.

Streamlined Review Process for Telehealth Services

- 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 under PFS?
    - Is the service subject to 1834(m)?
      - Meets the definition of telehealth; a substitute for an in-person encounter as opposed to a remote service
      - Involves the services of the physician or APP
    - Are one or more 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.**

Additions to List of Covered Telehealth Services



- **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

Permanent Removal of Frequency Limitations

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

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

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

Expansion of Virtual Direct Supervision

- **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)
- **Includes:**
  - Incident-to services (§ 410.26)
  - Diagnostic tests (§ 410.32)
  - Pulmonary rehabilitation services (§ 410.47)
  - Cardiac rehabilitation and intensive cardiac rehabilitation services (§ 410.49)
  - Certain hospital outpatient services as provided at § 410.27(a)(1)(iv)
- **Excludes** services with global surgery indicators 010 and 090

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.
  - Future changes will align with federal waivers, currently effective through January 30, 2026.
- **One-year extension** to bill for **non-behavioral health visits (or medical visit services)** via telehealth (including audio-only).
  - Continue using **G2025** through **December 31, 2026**.
  - CMS solicited feedback on paying at PPS/AIR rates.
  - However, it will maintain the use of the G2025 paid at the weighted average of all services on the telehealth list.

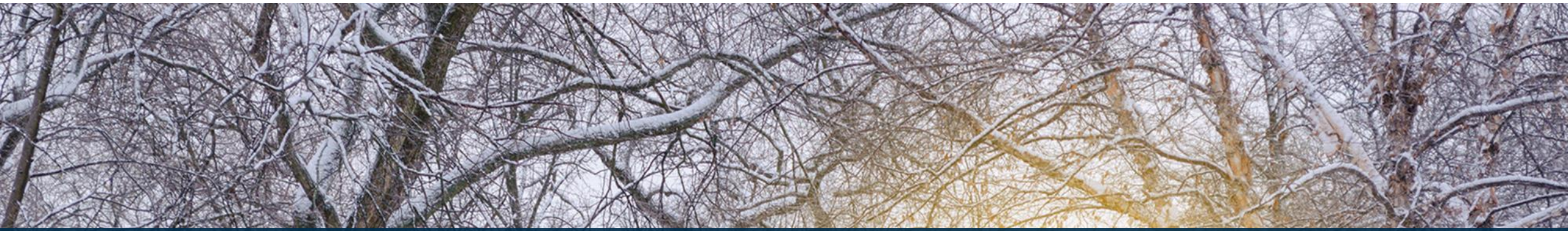
Telehealth: Enrollment

- **No extension** for allowing distant site providers to use their enrolled practice address instead of home address when providing services from their home.
  - See FAQ for suppression of street address details:
    - *"A doctor or clinician may need to enroll their home address as a practice location but prefer their personal contact information not be publicly reported. Doctors and clinicians can either mark the address as a "Home office for administrative/telehealth use only" location in the Provider Enrollment, Chain, and Ownership System (PECOS), which will suppress street address details, or email the QPP Service Center to suppress the street address and/or phone number. In such cases, CMS maintains city, state, and zip code information so that doctors and clinicians can still be included in searches and have their performance information reported.*
    - *CMS may also suppress street addresses when there's a safety concern related to a clinician's practice location information being publicly available."*

https://www.cms.gov/medicare/quality/physician-compare-initiative

Polling Question 2





4. Changes to RHC and FQHC Billing



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 QMBs
- 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)
- Neither APCM nor add-on codes have minimum time requirements
- Services can be delivered by FQHC/RHC practitioner or clinical staff under practitioner's general supervision
- Separate consent is required for APCM and for BHI services

BHI Add-On Codes for APCM

HCPCS Code	CPT Code (time required)	Description	Primary Care Team	Service Components
GPCM1	99492 (*70 min*) 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 • BH Care Manager • Patient • Psychiatric Consultant	• Initial assessment • Joint care planning • Ongoing follow-up • Weekly systemic case review
GPCM2	99493 (*60 min*) 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	Non-Facility Total RVUs	Facility Total RVU	2026 National MPFS Non-Facility Price	2026 National MPFS Facility Price
GPCM1	99492	2.81	2.02	$93.85 / $94.33	$67.47 /$ 67.81
GPCM2	99493	2.06	1.49	$68.80 / $69.15	$49.77 / $50.02
GPCM3	99484	2.81	2.02	$93.85 / $94.33	$67.47 / $67.81

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
99445 (NEW)	Data transmission – remote monitoring of physiologic parameters; **2-15 days in a 30-day period**	CY2026 OPPS GMC for 99454 divided by CY 2026 PFS conversion factor (non-qualifying) 1.42 RVUs (currently 1.33)
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
99470 (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
98984 (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
98985 (NEW)	Data transmission – RTM of musculoskeletal system; **2-15 days in a 30-day period**	CY2026 OPPS GMC for 99454 divided by CY 2026 MPFS conversion factor (non-qualifying) 1.2 RVUs (currently 1.33)
98977	Data transmission – RTM of musculoskeletal system; **16-30 days in a 30-day period**	
98986 (NEW)	Data transmission – RTM of cognitive behavioral therapy; **2-15 days in a 30-day period**	Contractor priced
98978	Data transmission – RTM of cognitive behavioral therapy; **16-30 days in a 30-day period**	Contractor priced

RTM (*cont.*)

CPT Code	Short Description	Proposed Payment Structure
98979 (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

FQHC/RHC Billing for Other Care Management Services

- Effective 1/1/2026, FQHCs and RHCs no longer bill G0512 for CoCM services; bill individual CPT codes that comprise G0512
  - **99492**: Initial psychiatric CoCM (first month, 70 minutes)
  - **99493**: Subsequent psychiatric CoCM (60 minutes)
  - **99494**: Add-on code for additional 30 minutes
- Effective 1/1/2026, FQHCs and RHCs no longer bill G0071 for communication technology-based services; bill individual CPT codes that comprise G0071
  - **G2010/G2250**: Remote evaluation of recorded video and/or images submitted by established patient (store-and-forward), including interpretation with follow-up within 24 business hours
  - **98016**: Brief, patient-initiated audio-only communication (5–10 minutes) between qualified healthcare provider and established patient

Social Determinants of Health (SDOH) Screenings

- Use term **upstream drivers** of health in place of SDOH
  - Upstream drivers, e.g., smoking, low physical activity, substance misuse, in addition to environmental drivers
- Revise HCPCS code G0136 from administration of a standardized, evidence-based ***social determinants of health risk assessment tool*** to administration of a standardized, evidence-based ***assessment of physical activity and nutrition***
  - Time remains 5-15 minutes, not more often than every 6 months
  - CMS had proposed deleting code because resource costs already accounted for in existing codes
  - "[R]eturn to more clinically salient areas of risk assessment"
  - Evidence-based tools
    - Nutrition: Mini-EAT tool, Starting the Conversation: Diet tool, Short Dietary Assessment Instruments,
    - Physical activity: Physical Activity Vital Sign tool, CHAMPS Physician Activity Questionnaire for Older Adults, Rapid Assessment of Physical Activity (RAPA), Telephone Assessment of Physical Activity (TAPA)
- **RHC/FQHC CANNOT bill for G0136**



5. 340B Update

340B Rebate Model Pilot Program

- Program was intended to modify the 340B rebate program by shifting from an upfront rebate to a post-purchase rebate
  - Had been expected to begin January 1, 2026
- Judge in Maine issued a preliminary injunction blocking the program while litigation continues
  - Order applies nationwide and applies to all 340B covered entities
  - Court found that HRSA failed to adequately consider the long-standing reliance of 340B covered entities on upfront discounts
    - Also did not address financial and administrative burdens of the new program, particularly on safety-net and rural providers

Medicare OPPS Drug Acquisition Cost Survey (ODACS)

- April 15 Executive Order “Lowering Drug Prices by Once Again Putting Americans First”
- CMS to survey acquisition costs for each separately payable drug acquired by all hospitals **paid under OPPS**
  - Provider registration between December 9 and December 31
    - Point of contact (POC) and submitter (can be the same person)
  - Submission window opening January 1 – March 31, 2026 (11:59 pm EST)
  - Data period covered: July 1, 2024 – June 30, 2025
- CMS wants to use the data for CY 2027 OPPS NPRM

Medicare OPPS Drug Acquisition Cost Survey

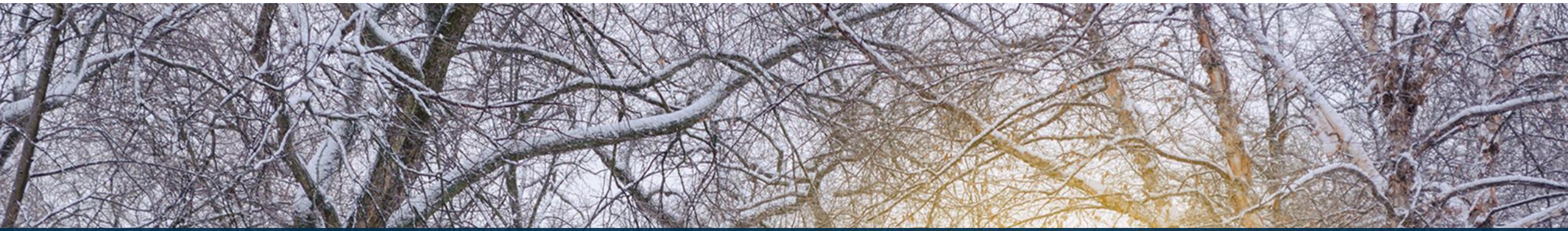
- Providers should report net acquisition costs for required NDCs purchased (leave blank for drugs not acquired during applicable period)
  - Should be inclusive of all discounts and rebates at NDC level
  - Also need to report rebates (in price concessions tab) through group purchasing organizations or other buying group (likely not at the NDC level)
  - For each NDC, in an 11-digit format, hospitals should provide:
    - Total units purchased – non-340B
    - Total units purchased – 340B
    - Total net acquisition cost – non-340B
    - Total net acquisition cost – 340B

Medicare OPPS Drug Acquisition Cost Survey

- Cannot force hospitals to complete the survey; may consider non-responses in future rate reductions
  - FAQ: *"CMS is considering the assumptions it would be reasonable to make in the event a hospital does not adhere to the statute, including how those assumptions might be reflected **in that hospital's** future payment rates."*
- Final Rule: May impute values for non-responsive hospitals as equal to the lowest reported acquisition costs among similar hospitals, prices under the Federal Supply Schedule, 340B ceiling prices, or average sales price benchmarks. They also address packaging drug costs into APC payments for non-responders, **essentially not paying those providers separately for the 340B-acquired drugs on which they did not report.**

Polling Question 3





6. Price Transparency



Hospital Price Transparency: Machine-Readable File

- New requirements effective January 1, 2026; enforcement delayed to April 1, 2026:
  - Requires reporting of actual payment amounts when standard “charges” are based on percentages or algorithms
    - Report real dollar “costs”
    - Requires disclosure of 10th percentile, median, and 90th percentile allowed amounts in MRF
    - Also requires hospital to calculate and encode count of allowed amounts used to calculate encoded amounts
    - Requires that hospitals use EDI 835 ERA or an alternative, equivalent source of remittance data
    - Defines look-back period as no less than 12 months and no longer than 15 months prior to posting MRF
  - Requires encoding of name of CEO, president, or senior hospital official designated to oversee reporting of true, accurate, and complete data
  - Requires encoding of active organizational (Type 2) National Provider Identifiers associated with primary taxonomy code starting with -28 (hospital) or 27 (hospital unit)
  - Modified attestation also required

Transparency in Coverage Proposed Rule

- NPRM issued December 19; comments due February 21
- Goal is to improve data usability while enhancing accuracy and standardization
- Key provisions:
  - Exclude in-network data for those services a provider is unlikely to perform
  - Revises reporting timeframes from monthly to each quarter
  - Files would be organized by provider network rather than plan or policy
  - Adds change logs and utilization files
  - Revises how insurers would report information on out-of-network pricing
  - Insurers would be required to make the same level of detail available online, in print or by phone

Polling Question 4





7. CMS Innovation Center Alternative Payment Models

WISeR, GENEROUS, GUARD, GLOBE, BALANCE, MAHA ELEVATE, ACCESS, LEAD, TEAM, and ASM

- Enhancing traditional Medicare program integrity: **WIsER** model
- Reducing drug costs: **GENEROUS**, **GUARD**, **GLOBE**, and **BALANCE** models
- Testing lifestyle and functional medicine interventions: **MAHA ELEVATE**
- Providing outcome-based payments for chronic disease management: **ACCESS** model
- Replacing ACO REACH with model designed to accommodate rural providers: **LEAD** model
- Engaging specialists though mandatory alternative payment models: **TEAM** and **ASM** models

Advancing Chronic Care with Effective, Scalable Solutions

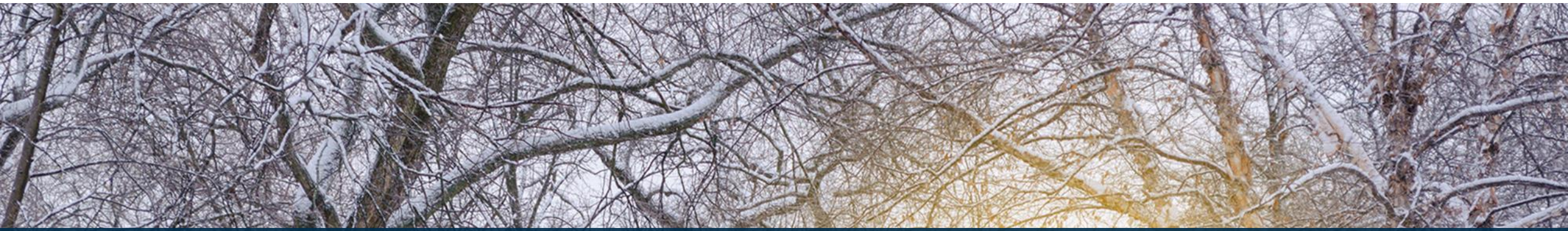
- RFA released December 19; apply by April 1 for July 1 start date
- Tests Outcome-Aligned Payments (OAPs), recurring payments made to Part B-enrolled entity for managing patients' qualifying conditions, with full payment tied to achieving measurable health outcomes + avoiding duplication of services
  - ACCESS participants must enroll traditional Medicare beneficiaries
  - Clinicians who co-manage ACCESS beneficiaries with ACCESS participant may bill new ACCESS Model Co-Management service for documented review of ACCESS updates and care coordination activities
  - Participant payment reduced if beneficiaries receive substitute services from other providers for same condition
  - Waivers of co-payments and deductibles
- Four tracks:
  1. Hypertension, dyslipidemia, obesity or overweight with marker of central obesity, and prediabetes
  2. Diabetes, chronic kidney disease, and atherosclerotic cardiovascular disease (including heart disease)
  3. Musculoskeletal conditions: chronic musculoskeletal pain
  4. Behavioral health conditions: depression and anxiety

Long-Term Enhanced ACO Design

- Replaces ACO REACH in 2027 and continues through 2036
- Key enhancements:
  - Improved benchmarking to overcome obstacles to broader participation in ACO models
  - Capitated population-based payments to support team-based care
  - Episode-based risk arrangements (EBRAs) between ACOs and Preferred Providers
  - Optional beneficiary engagement incentives and benefit enhancements

Traditional Medicare Mandatory APMs: TEAM and ASM

- TEAM: Mandatory 5-year episodic payment model launched 01/01/2026 making selected PPS hospitals financially accountable for total cost of defined episode of care
  - Episode of care = anchor event (specified inpatient stay/outpatient procedure) + 30 days post-discharge/post-procedure
  - Total cost = all non-exempt Part A & B payments (prorated if service staddles episode)
  - Accountable = owe money if total cost > target price, receive additional payment if total cost < target price
  - Focus on reducing post-acute care costs (e.g., swing bed vs. SNF)
- ASM: Mandatory 5-year MIPS-like model launching 01/01/2027 for cardiologists (heart failure) and orthopedists, neurosurgeons, and pain specialists (lower back pain)
  - Specialists ranked by score across 4 MIPS categories (limited measures for quality, improvement activities, promoting interoperability, and cost) with corresponding payment adjustments
    - Initially -9 to +9, increasing to -12 to +12



8. Medicare Advantage



2027 Technical Changes Proposed Rule

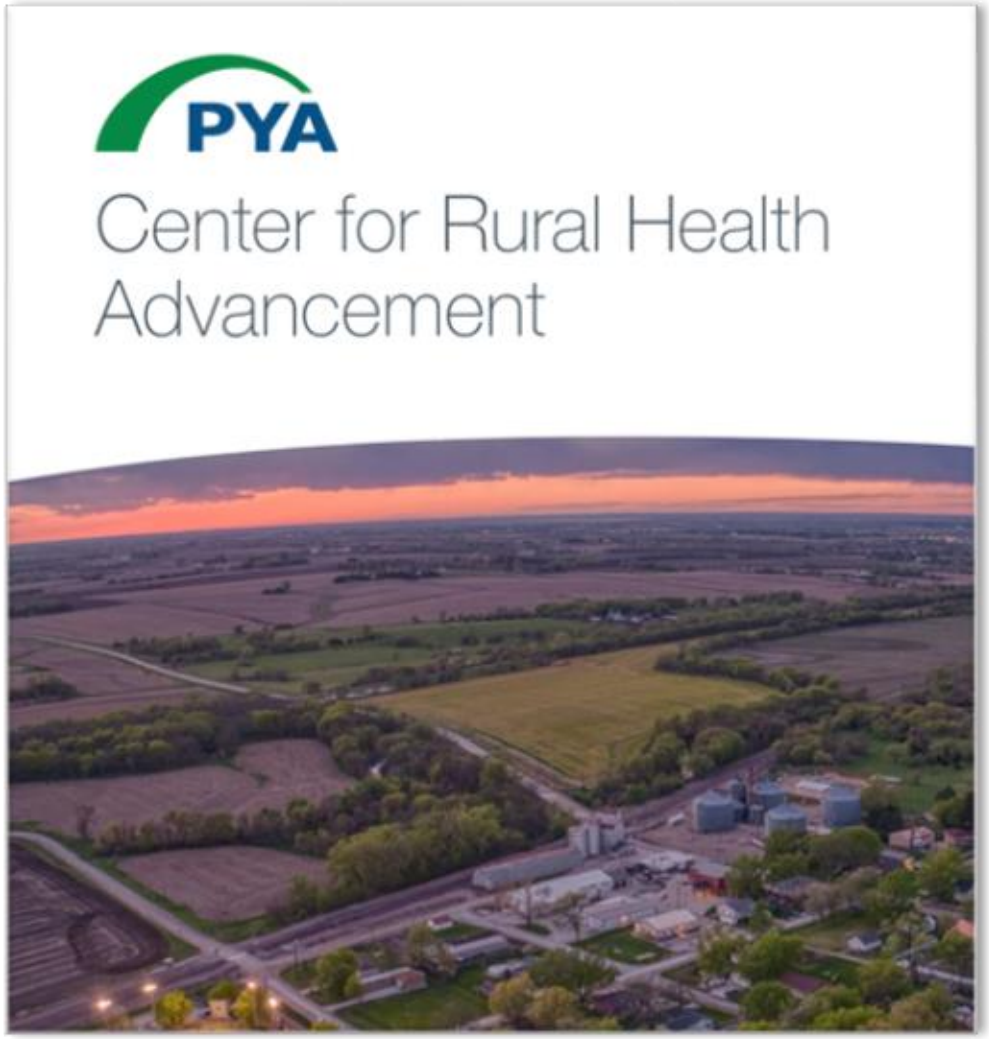
- Proposed rule issued November 25; comments due January 26
- Proposes to reform Stars Quality Measures
  - Removes 12 process-heavy or administrative measures, shifting focus to outcomes
  - Includes removing appeals timeliness, call center support (TTY/foreign language), health plan complaints, Plan Finder accuracy, Maximua concurrence rate, eye exams for diabetes, and statin therapy, plus patient experience measures like "Members Choosing to Leave the Plan"

Medicare Advantage Complaints Tracking Module

- New online complaint tool to capture basic information about the complainant, beneficiary, provider, and Medicare Advantage plan, a complaint summary, and optional fields for date(s) of service and claim number
- Provider complaints will be placed into a queue in the CTM, where CMS will review and triage prior to assigning a contract number
- Available at https://www.cms.gov/medicare/health-drug-plans/provider-complaints-form

Polling Question 5





The PYA Center for Rural Health Advancement helps rural providers transform their operations by delivering a full range of practical, rural-specific solutions focused on the four foundations of long-term sustainability.

Community Engagement – Understanding and prioritizing community needs, aligning with community organizations, building and maintaining trust with local residents, enhancing access to affordable primary care services, maintaining a strong governance and leadership team.

Clinical Excellence – Engaging in service line planning and execution, pursuing collaborative relationships and provider alignment, securing an adequate workforce.

Financial Stability – Gaining access to needed capital, optimizing revenue cycle operations, making purposeful IT investments, positioning for value-based contracting.

Regulatory Compliance – Understanding and implementing new regulatory requirements, ensuring IT security, preparing for and responding to survey findings.

There’s a lot going on in D.C. right now.
What do the policy changes mean for the healthcare industry?

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