American Academy of Ambulatory Care Nursing

Shaping Care Where Life Happens

AAACN Comments on Medicare and Medicaid Programs

CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program; and Medicare Overpayments - Proposed Rule

The American Academy of Ambulatory Care Nurses (AAACN) is pleased to offer comments on the proposed rule related to the CY 26 Physician Fee Schedule, Part B Payment and coverage policies, Medicare Shared Savings program requirements as well as Basic Health Program rules. AAACN is the only specialty nursing association that focuses on excellence in ambulatory care and represents more than 1 million of the 4.7 million registered nurses across the US. Our members practice in settings such as hospital-based outpatient clinics/centers; solo, group and system ambulatory primary care and specialty care practices; ambulatory surgery and diagnostic procedure centers; telehealth service environments; university and community hospital clinics; military and Veterans Administration settings; nurse-managed clinics; managed care organizations; colleges and educational institutions; as well as organizations supporting care coordination, nurse coaching, and care management services (AAACN, 2017).

GENERAL COMMENTS

The mission of AAACN is Shaping Care Where Life Happens with a vision of A healthier world through nursing excellence, leadership, and innovation, revolutionizing healthcare. To that end, we have promulgated standards of practice in ambulatory care nursing to support high quality nursing practice. Review of these standards and scope of practice demonstrate to CMS the important range of services provided by Registered Nurses (RNs) in ambulatory care settings that create high quality patient care.

First, we would like to again highlight to CMS the need to recognize the services provided to patients by RNs in ambulatory care environments. Registered Nurses are categorized as “auxiliary personnel”, an overall designation that includes a variety of licensed and non-licensed staff. However, unlike Licensed Practical Nurses, Medical Assistants and Certified Nursing Assistants, ***RNs are licensed to independently provide nursing services within their licensed scope of practice.*** The current designation of RNs as “support staff” fails to acknowledge the professional education, experience, training and demonstrated competencies of RNs in the care for patients with chronic conditions and in health promotion. Our practice is heavily based on the RNs’ role in supporting health promotion and self- management of chronic disease. RNs hold broad competencies in provision of effective education of patients and caregivers, with strong skills in coordination of care across settings, specialties, and populations. These capabilities are recognized by the independent licensure of RNs by states to conduct nursing practice, which includes assessment, planning, nursing interventions and evaluation of the patient response to health and illness. Care management activities fall within the licensed scope of nursing practice.

Evidence is mounting that connects the contributions of RNs in primary and specialty care to high quality outcomes, safety, and service at a lower overall cost to the organization. RNs practicing at the full scope of their education and experience have the capacity to improve outcomes and access, support implementation of the medical care plan, and more importantly, improve care connections across the health care continuum and settings. The current CMS policy of not recognizing RNs as qualified professionals capable of delivering services fails to recognize the contributions of RNs in providing pre-visit planning, care management services for chronic, behavioral, and social conditions, transition care management services, as well as conducting annual wellness visits and advanced care planning services. RNs who are delivering these services should be acknowledged as qualified providers who can provide these services. In addition to the services mentioned above, contributions of RNs on care management teams through managed care Medicaid demonstration projects and through the Shared Savings program are also undervalued and often unrecognized.

It is AAACN's position that RNs should be considered to be acknowledged as providers of service delivery as opposed to being considered auxiliary staff or "clinical labor," as is the current practice under the Physician Fee Schedule. The registered nurse (RN) in primary care and ambulatory settings is uniquely positioned to help address the growing health demands of today's changing healthcare landscape. Practicing at the top of their scope, RNs bring a holistic and comprehensive lens that is central to the nursing discipline. Their role centers on partnering with patients to meet health goals through advocacy, assessment, education, care management, and preventive care. These functions can be carried out independently or in collaboration with other members of the care team.

The National Academy of Medicine (NAM) and other organizations have called for full role optimization of all care team members as a strategy to meet increasing health demands. RNs are well-suited to deliver care either independently or collaboratively under general supervision, such as hypertension management clinics, education and behavioral interventions, and telephone triage. These services currently receive little to no reimbursement despite their demonstrated value. Additionally, they are able to provide protocol-based care in collaboration with their provider partners, which can serve to enhance overall efficiency. Expanding billing and payment models to support these contributions would strengthen primary care capacity and other ambulatory care services.

A number of provisions within the proposed rule include allowing certain services to be provided under general or virtual supervision. As certain services fall within the licensed scope of practice for RNs, these services should all be moved to general and/or virtual supervision when conducted by an RN. Furthermore, RNs should be recognized through the addition of the term Registered Nurse (RN) as qualified healthcare providers for certain services, such as Annual Wellness Visits (G0438/G0439), Advance Care Planning (99497, 99498) All Care Management Services (CCM (99490/99439/99487/99489), BHI (99484), CoCM (G2214/99492/99493/99494), PCM (99426/99427) CHI (G0019/G0022), PIN (G0023/G0024/G0140/G0146)), Health Coaching (0591T/0592T0593T), Care Giver Education and Training (97550/97551/97552/G0541/G0542/G0543/G0539/G0540/96202/96203, Social Determinant risk assessments (G0136), Atherosclerotic Cardiovascular Disease Risk Assessment and ASCVD Care Management (G0537/G0538).

AAACN recognizes that CMS has certain limitations within the statutory language of the Social Security Act as it relates to reimbursement for services under Medicare. Additional information on the scope and standards of ambulatory care nursing practice,

care coordination and transition management along with information on nurse sensitive indicators in ambulatory care settings can be found on our website at https://www.aaacn.org. Any information requests can be directed to Cynthia Murray, BN-RN, AMB-BC, LNC, President of AAACN, at cynthiamurraylnc@gmail.com.

DIRECT RESPONSE TO THE CY 2026 PHYSICIAN FEE SCHEDULE PROPOSED RULE

AAACN is pleased that CMS is recognizing the importance of Care Coordination and Care Management Services as well as other prevention-focused services such as the Annual Wellness Visit. The reality is that it is incredibly difficult to care for patients with complex and multiple chronic conditions in an E/M visit alone. As Chronic Care Management services could technically be considered secondary or tertiary prevention activities, CMS should consider these services as preventative services, to provide flexibility in elimination of the copayment requirements for these services. Because RNs are often providing these services (incident to the physician or other licensed medical provider), the bulk of our comments relate to the proposed actions under this proposed rule. Below we highlight our response to specific sections within the proposed rulemaking.

Section	Proposed Language	Written Response
II. Provisions of the Proposed Rule for the PFS **D.** Payment for Medicare Telehealth Services Under Section 1834(m) of the Act **b.** Proposal To Modify the Medicare Telehealth Services List and Review Process	Under this proposal, services on the Medicare Telehealth Services List would no longer be designated "permanent" or "provisional". All services listed or added on the Medicare Telehealth Services List would be considered included on a permanent basis	We applaud CMS for acknowledging that providers of services are in the best position to decide whether use of a telehealth service will meet the unique needs of each patient. We further support attempts to streamline the process by which CMS determines the list of services that can be reimbursed when delivered through an interactive telecommunications system. We also agree that once a service has been listed, it should be considered permanent to allow practices to move forward with implementation of various services.These services are especially important for certain populations who may have transportation or other limitations that may prevent them from receiving in- person services. This is also an important consideration in supporting CMS's acknowledgement of the importance of care coordination and care management services, which are often provided using various telecommunication systems. For example, use of video enabled devices can help the care manager to conduct an environmental assessment of the home, which could provide certain information which may not be self-reported by the patient using a questionnaire.

Section	Proposed Language	Written Response
II. Provisions of the Proposed Rule for the PFS **D.** Payment for Medicare Telehealth Services Under Section 1834(m) of the Act **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	We are proposing to continue to build on this incremental approach to allow certain services to be furnished under direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only). We are proposing to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications technology (excluding audio-only), for all services described under § 410.26, except for services that have a global surgery indicator of 010 or 090. We are proposing to revise the regulations at § 410.32(b)(3)(ii) to state that the presence of the physician (or other practitioner) may include virtual presence through audio/video real-time communications technology (excluding audio-only) for services without a 010 or 090 global surgery indicator.	AAACN supports the move to adopt a broader definition for "direct supervision" as well as proposals throughout the rulemaking to increase the use of virtual supervision when services are being provided by a qualified healthcare professional. Activities involving nursing assessment, provision of patient and caregiver education, and disease management counseling are within the independent scope of practice of the RN. Thus, RNs should be listed as qualified professionals to perform these services.
II. Provisions of the Proposed Rule for the PFS **E.** Valuation of Specific Codes **2.** Methodology for Establishing Work RVUs and Direct PE Inputs to Develop PE RVUs	Our longstanding adjustments have reflected a broad assumption that at least one-third of the work time in both the preservice evaluation and post-service period is duplicative of work furnished during the E/M visit. Section 1848(c)(2)(B)(ii)(I) of the Act provides that the Secretary shall, to the extent he determines to be necessary, adjust the number of RVUs to take into account changes in medical practice. (p 147) Our proposal is based on our assumption that both the intraservice portion of physician time and the work intensity (including mental effort, technical effort, physical effort, and risk of patient complications) would decrease as the practitioner develops expertise in performing the specific service. (p 147) The MEI is a measure of inflation faced by physicians with respect to their practice costs and general wage levels, and includes inputs used in furnishing physicians' services such as physician's own time, non-physician employees' compensation, rents, medical equipment, and more. Every year, the CMS Office of the Actuary (OACT) subtracts the MEI productivity adjustment from the MEI percent change moving average to calculate the final MEI update.	Given the move to team-based care delivery, the methodologies used to calculate RVUs, which are based on time spent by the physician (or other indirect or direct costs) is not really a great model to encourage the correct skill mix of members of the healthcare team. This model incentivizes physicians and practices to minimize clinical labor costs to maximize revenue. For example, practices have realized improved efficiencies when RNs engage in pre-visit planning, which can result in more care gaps being identified and less time spent by the medical provider, thus increasing capacity to provide additional services. The desire to improve efficiencies is laudable, however this current methodology fails to support implementation of cost-effective team based care models. MEI as a measure to only address impact of inflation again does not incentivize the practice to identify the best skill mix needed to support patient care needs. For example, a practice with a high number of patients with multiple chronic diseases may need a skilled RN to support these patients with complex needs.

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	We solicit comments on the initial look-back period and the use of the MEI productivity adjustment percentage values for calculation of the efficiency adjustment for 2026. (p152). We seek comments on whether and how we should consider additional efficiencies for services that require less time to perform.(p 153 section II.B. of this proposed rule, Determination of Practice Expense Relative Value Units (PE RVUs).	Addressing inflation alone, without any acknowledgement of the skill mix needed to care for patients and generate positive outcomes, provides a disincentive for the practice to benefit from the clinical expertise of an RN. CMS might consider including incorporation of the RN in conducting activities such as pre-visit planning, advanced care planning and Annual Wellness visits, as an efficiency measure included in the MEI and Direct PE Practice Expense Relative Value Units (PE RVUs), calculations.
	Remote physiologic monitoring (RPM) represents the remote monitoring of parameters such as weight, blood pressure, and pulse oximetry to monitor a patient's condition and inform their management. The remote physiologic monitoring code set currently includes CPT codes 99453, 99454, 99091, 99457, 99458, 99473, and 99474 (code descriptors can be found in Table 17). For CY 2026, the CPT Editorial Panel created two new RPM codes to describe RPM services that describe less than 16 days of data transmission per 30-day period and less than 20 minutes of interactive communication per month: CPT codes 99XX4 and 99XX5. The CPT Editorial Panel also made edits to specify the minimum days of data transmission per 30-day period for CPT code 99454 (new code descriptors and revised code descriptors can be found in Table 18). None of the RPM codes (CPT codes 99091, 99474, 99XX5, 99457, and 99458) met the minimum survey requirements established by the RUC for the January 2025 RUC meeting. As a result, the RUC-recommended that CPT codes 99091, 99474, 99XX5, 99457, and 99458 be resurveyed after 1 year of utilization data is available for this CPT 2026 code structure. All RPM codes are expected to be reviewed at the January 2028 RUC meeting.	
F. Evaluation and Management (E/M) Visits		

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II. Provisions of the Proposed Rule for the PFS ***G.*** *Enhanced Care Management* ***1.*** *Integrating Behavioral Health Into Advanced Primary Care Management (APCM) and* **2.** Behavioral Health Integration Add-On Codes for APCM (HCPCS Codes GPCM1, GPCM2, GPCM3)	1. Integrating Behavioral Health Into Advanced Primary Care Management (APCM)1. Integrating Behavioral Health into Advanced Primary Care Management (APCM) In the CY 2025 PFS final rule (89 FR 97859 through 97902), we finalized separate coding and payment for Advanced Primary Care Management (APCM) services (HCPCS codes G0556, G0557, and G0558). Patients with chronic health conditions are "more likely to have related behavioral health concerns and find it easier to improve chronic conditions when these concerns are also addressed."[54] Integrating behavioral health with primary care has been shown to improve outcomes like reduced depression severity and enhancing patient's experience of care.[55] For CY 2026, we are proposing to create optional add-on codes for APCM services that would facilitate providing complementary BHI services by removing the time-based requirements of the existing BHI and CoCM codes. We believe that removing the time-based requirements will reduce burden on practitioners by reducing the documentation requirements for billing. By reducing the documentation requirements, we also believe primary care practitioners may be more likely to offer and furnish BHI and CoCM services, which would improve access to BHI and CoCM for primary care patients.	Although we agree that providing whole person care is essential, combining chronic care and behavioral health care into one service and simply using an add on code without the documentation of time spent delivering behavioral health would not necessarily ensure that the patient receives needed services.There is value in ensuring that both services are provided and documented to ensure the focus of chronic and behavioral health needs are met. We suggest that until APCM has been widely used, BHI and CoCM remain separately billable under the current rules. Reducing documentation is not the greatest barrier to integration of behavioral health services. In many areas, especially rural and underserved locations, there simply are not enough behavioral health providers to offer these services and most primary care providers are not qualified to provide behavioral health services without additional training.
II. Provisions of the Proposed Rule for the PFS **G.** *Enhanced Care Management* **2.** Behavioral Health Integration Add-On Codes for APCM (HCPCS Codes GPCM1, GPCM2, GPCM3)	We are proposing the establishment of three new G-codes to be billed as add-on services when the APCM base code (HCPCS codes G0556, G0557, and G0558) is reported by the same practitioner in the same month. HCPCS code GPCM1, an add-on code based on CPT code 99492, HCPCS code GPCM2, an add-on code based on CPT code 99493 for CoCM services delivered to patients also receiving APCM services, and HCPCS code GPCM3, an add-on code for general behavioral health integration services based on CPT code 99484. We are not proposing to create an add-on code for CPT code 99494, as that code describes additional time, and these codes do not require the counting of minutes.	AAACN posits that the BHI should remain a separate service and not be included in the APCM bundle. Providing care management for patients with behavioral health needs takes time and using the existing time based codes as a guide without the use of additional time will not provide the needed time to care for these patients and therefore, until the current APCM codes have been widely implemented and researched, we suggest the BHI and CoCM services not be integrated into APCM and continue to be allowed in addition to APCM as time based codes.

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II. Provisions of the Proposed Rule for the PFS **G.** Enhanced Care Management **4.** Request for Information Related to APCM and Prevention	Given these factors, we are seeking comments on how CMS should consider application of cost sharing for APCM services, particularly, if we were to include preventive services within the APCM bundles. How should we account for cost sharing if APCM includes both preventive services and other Part B services? Should CMS consider including the Annual Wellness Visit, depression screening, or other preventative services in the APCM bundle, and if so, which services and why?	It is our position that all care management activities should be considered preventative in nature, including CCM and APCM services. Care management seeks to promote healthy behaviors and support self-care management of chronic diseases and should thus be considered a preventative service. Additionally, the incorporation of add-on treatment focused codes (as proposed earlier in regard to Behavioral Health Services for APCM) presents a challenge for cost-sharing requirements, unless all care management services are deemed preventative in nature. AAACN posits that the AWV should remain a separate service and not be included in the APCM bundle. When performed correctly, AWV is a valuable visit to ensure development of a comprehensive health promotion plan. When conducted by a highly qualified professional, such as an RN, the comprehensive nature of assessment during the AWV can identify patients who would potentially benefit from care management services. Furthermore, as a service well within the scope of an RN, we believe this visit should be conducted under general supervision and remove the additional administrative barrier of direct or even virtual supervision for this service, including services provided through Rural Health Clinics and Federally Qualified Health Centers.
Policies to Improve Care for Chronic Illness and Behavioral Health Needs	We are seeking comments on the possibility of establishing for CY 2026 additional separate coding and payment for a broader based set of services describing digital tools used by practitioners intended for maintaining or encouraging a healthy lifestyle, as part of a mental health treatment plan of care.	Technology to support promotion or maintenance of a healthy lifestyle can be helpful, and can support care management services, but does not replace the skills needed to support client care coordination and care management. Technology: Expanding billing to cover oversight of technology-driven interventions could be helpful as care delivery evolves and AI creates new opportunities for more tailored approaches. However, these tools cannot replace the care provided by the care team. There are concerns about availability, digital literacy, discerning the difference between

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		targeting and tailoring strategies, and how much providers need to be involved. Billing in this area should be considered, but only with clear monitoring, outcome measures, and strong health care professional involvement to ensure technology supports quality care.
II. Provisions of the Proposed Rule for the PFS **I.** Policies To Improve Care for Chronic Illness and Behavioral Health Needs **b.** Comment Solicitation on Payment Policy for Software as a Service (SaaS)	We are interested in paying accurately for the management of chronic disease and primary care services, we are seeking to understand how the use of SaaS and AI technology affects those services and how to incorporate these costs into our current strategy for paying for evolving models of care delivery, such as Advanced Primary Care Management and risk-based payment arrangements generally. Therefore, we are requesting public comments on how we should consider paying for SaaS under the PFS, including: • What factors should we consider when paying for SaaS? • What has the experience been of risk-based payment arrangement participants with incorporating SaaS under their payment arrangements? • Have risk-based payment arrangements reflected the underlying value of SaaS to the practice of medicine?	As Registered Nurses are overseeing large populations of patientsthrough care management services, it is imperative that tools are made available to support the ability to efficiently track, communicate, educate, and analyze both process and outcome data.Including SaaS into the direct costs' inputs would ensure that funding is available to provide the tools for more efficient workflows. However, it is important that CMS recognize that software and AI technology can aid, but not fully replace, the clinical reasoning skills of health care professionals. As nursing practice is focused on the human response to health and illness, these skills, which are not currently acknowledged under current CMS reimbursement mechanisms, need to be recognized as critical to establishing relationships with patients which is an important element in care management.
II. Provisions of the Proposed Rule for the PFS **I.** Policies To Improve Care for Chronic Illness and Behavioral Health Needs **2.** Prevention and Management of Chronic Disease—Request for Information	We are broadly soliciting feedback to help us better understand how we could enhance our support management for prevention and management of chronic disease. Specifically, we are requesting commenters consider the following information: • How could we better support prevention and management, including self-management, of chronic disease? • Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.	As the population ages, new systems to support older adults will be required. Our current healthcare delivery system is focused on treatment of conditions, not necessarily prevention. Primary and specialty care practices are not necessarily equipped to provide this level of community services. The role of health promotion has historically been one held by local public health agencies, but the steady decrease in support for public health has all but eliminated the public health system's ability to engage in these kinds of activities. CMS should consider creating a unique billing code for Community Nurse services.

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	• Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, what evidence has supported these services, and what do these services entail? What services have been delivered by Medicare providers or community-based organizations, including area agencies on aging and other local aging and disability organizations? What has been the impact?	Unique models have been created to provide additional support for older adults living in congregate living settings, such as incorporation of a community/wellness nurse.The Department of Housing and Urban development is currently engaged in a large scale randomized control trial incorporating the use of a wellness nurse along with required service provision, which has found that participants highly valued the services of the wellness nurse in supporting their quality of life. More information can be found at https://www.huduser.gov/portal/IWISH_Evaluation.html Another example of how RNs can support chronic disease prevention and coping is through the use of interpersonal psychotherapy (IPT). Nurse care coordinators, in particular, are in a unique position to provide this type of support because of the strong relationships they build with patients. By integrating IPT techniques into routine care, RNs can create safe spaces for patients to problem-solve, express emotions, and adapt to the challenges of living with complex medical conditions such as cancer or irritable bowel syndrome (Hyphantis et al., 2009; Laing et al., 2024). These interventions can reduce feelings of isolation, improve coping, and address associated conditions like depression and anxiety, thereby enhancing patient self-efficacy in managing their health. This is one example of how greater investment in mental health education and organizational support for training would enable RNs to expand their role in this area and further strengthen prevention-focused care models (Bennett, 2021) Furthermore, current reimbursement models fail to provide adequate support for individuals living with dementia and their caregivers. While CMS has included caregiver training as a new billing code under the PFS, supportive services for individuals with dementia and their caregivers is vastly lacking, especially for day programs and respite care options. The new Guiding an Improved Dementia Experience (GUIDE) program available under Medicare (but not

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		Medicare Advantage plans) holds promise in addressing these concerns but needs to be evaluated and likely expanded. Additionally, expansion of services under Programs for All Inclusive Care of the Elderly programs to include Community Nurse wellness services could provide additional options in supporting individuals living with dementia and their caregivers. The Government of Austria has recently completed a large scale pilot project which deployed community nurses in local organizations and town jurisdictions, to provide health promotion, care coordination, and health education to promote self-management of chronic diseases, and assisting family caregivers in accessing services, especially for individuals suffering from dementia. The findings of the project were positive- more information about the project can be found at: https://cn-oesterreich.at/ Additionally, investment in community-based interventions—such as RN-led programs that build local relationships, support community health navigation, and integrate environmental strategies—can further improve health outcomes. Specific opportunities also exist for RN-led diabetes self-management interventions, including diet and nutrition-focused programs, as well as primary care–based follow-up after emergency department visits. Providing reimbursement for services provided by RNs to meet with patients in the community to support health promotion and self-care management would be a laudable step for Medicare. These providers could provide these preventative services as an adjunct to a primary care practice, which would assure coordination between the RN in the community and the primary care provider. RNs are well prepared to address health promotion and prevention, which is a core element of the RN scope of practice. These services should be considered separate from care management services, and must be developed to ensure the value of the RN is taken into account, such as equivalent to a level 4 or 5 E/M visit by the medical provider.

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II. Provisions of the Proposed Rule for the PFS **I.** Policies To Improve Care for Chronic Illness and Behavioral Health Needs **2.** Prevention and Management of Chronic Disease—Request for Information	• Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology? • Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set, and how should these interventions be prioritized? If so, what evidence has supported these services, and what do the services entail? • How would additional coding and payment be substantively different from coding and payment for Intensive Behavioral Therapy? • Should CMS consider creating separate coding and payment for medically tailored meals, as an incident-to service performed under general supervision of a billing practitioner?	While it is encouraging that CMS is attempting to examine opportunities to provide reimbursement for health promotion strategies, we should avoid "medicalizing" all aspects of health. Therefore, we do not agree with developing a billing code for medically tailored meals at this time. There are other healthcare professionals who can support and promote healthy nutrition without requiring a medical order from a physician. While there is clear benefit to interdisciplinary collaboration in supporting patient nutrition, the current level of provider education related to nutrition is minimal, limiting their ability to independently design or implement tailored meal plans. Instead, providers should rely on other professionals, who have the training and expertise to create individualized dietary interventions that align with patient needs. To better support this collaborative approach, CMS needs to figure out a way to establish coding mechanisms to support integration of team based expertise. Additionally, registered nurses may be particularly well suited to provide behavioral coaching, using evidence-based approaches such as motivational interviewing and interpersonal therapy (IPT), further reinforcing long-term patient adherence and outcomes. Tailored-based approaches require additional time and resources from the care team, and integrating the expertise of RNs into this model may be especially helpful in addressing health, lifestyle, and other factors that influence behavioral change. Intensive Lifestyle Interventions: We recommend the creation of additional billing codes for intensive lifestyle interventions. These types of interventions are time-intensive and are not currently reimbursed at rates that provide sufficient incentive for clinics to deliver them consistently. Expanding coding to allow registered nurses and other qualified professionals to provide these services would improve clinic efficiency and enhance patient outcomes by better supporting the delivery of evidence-based, multidisciplinary care.

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II. Provisions of the Proposed Rule for the PFS **I.** Policies To Improve Care for Chronic Illness and Behavioral Health Needs **2.** Prevention and Management of Chronic Disease—Request for Information	Are there technical solutions that would enhance the uptake of the annual wellness visit (AWV), or the improving accessibility, impact, and usefulness of the AWV? How can CMS better support practitioners and beneficiaries related to the AWV? Should CMS consider moving some of the required components of the AWV to optional add-on codes of the AWV instead, with the intent of decreasing burden, improving uptake, and allowing practitioners to select additional AWV elements that may be more relevant to particular patients?	As stated above, the AWV, when conducted correctly and by a qualified health care professional, is an important preventative service leading to the development of an annual health promotion plan. Because of the holistic approach of nursing assessment and clinical reasoning skills of the RN, these visits can also identify important risk factors and other care gaps to be addressed. These visits also provide an opportunity to identify patients in need of care management services. Given the treatment focused nature of our health system, many patients do not fully understand or appreciate the benefits of the AWV. Rather than developing add on codes which may or may not be addressed during an E/M visit, CMS should keep the AWV as a stand- alone billing code and embark on an intensive public education strategy to promote uptake of the AWV. One solution that would improve the AWV usefulness and uptake is to allow for this service, when conducted by a registered nurse, to be provided under general supervision (across all primary care settings, including RHC and FQHCs). CMS should be advised that every element of the AWV falls within the independent licensed scope of the RN. Should CMS consider incorporation of new billing codes to support community wellness RNs and allow AWVs conducted by RNs be under general supervision, they could provide the AWV services in community based settings, thus increasing the uptake of AWV and removing barriers such as transportation.
II. Provisions of the Proposed Rule for the PFS **I.** Policies To Improve Care for Chronic Illness and Behavioral Health Needs **2.** Prevention and Management of Chronic Disease—Request for Information	What types of clinical staff should be able to perform motivational interviewing?	Motivational interviewing is a form of therapeutic communication which is taught to and used by Registered Nurses and other trained healthcare professionals when assessing and planning care for patients. Therefore, as an integral part of nursing practice as outlined in Standard 9 - Communication - and within the scope of practice of an RN, RNs should be considered a qualified professional in use of motivational interviewing.

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		However, CMS is advised that MI is a technique not a service. When determining qualifications, CMS should ensure that staff who are engaging in delivery of services that would warrant use of MI to promote behavior change have been adequately trained in this technique. MI is often a brief interaction and has been shown to be effective in treating conditions such as substance use disorder. It is frequently used in healthcare settings to address health behaviors when motivation is a concern. This approach requires the clinician to believe in the patient's self-efficacy. However, due to the short duration and lack of concrete tools to address deeper cognitive and behavioral patterns, MI may not be effective on its own in addressing complex conditions such as obesity (Barrett et al., 2018). Other techniques, or combinations of evidence-based approaches, may be required depending on the behavioral modification needed. For example, studies have shown that when MI is paired with cognitive behavioral therapy (CBT), outcomes improve for conditions such as substance abuse, anxiety disorders, and obesity, particularly when low motivation may otherwise impede success (Barrett et al., 2018; Randell & McNeil, 2017). With the appropriate training, RNs are well equipped to deliver prevention and health promotion activities such as MI and other behavioral interventions.
II. Provisions of the Proposed Rule for the PFS **I.** Policies To Improve Care for Chronic Illness and Behavioral Health Needs **2.** Prevention and Management of Chronic Disease—Request for Information	• What training is required to effectively perform motivational interviewing? Are there agreed upon national training or certification standards for health coaches? If so, what are they? • Do states have separate training or certification standards for health coaches?	Again, MI is a technique that may be used during provision of services such as care management, as well as health coaching, but is not a specific service to be provided. For example, there is already a nurse coaching certification program that uses an evidenced based curriculum and offers national board certification. As of 2022, holistic nurse coaching provided by Board Certified Nurse Coaches (NC-BC) and Health and Wellness Coaches (HWBC) is allowable under the Category III codes under the following CPT codes: 0591T Health and Well-Being Coaching face-to-face; individual, initial assessment

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		• 0592T individual, follow-up session, at least 30 minutes • 0593T group (two or more individuals), at least 30 minutes. For more information see: https://www.ahncc.org/certification/holistic-nurse-coach/ RNs holding these certifications should be acknowledged as qualified to conduct these services under the PFS.
II. Provisions of the Proposed Rule for the PFS **I.** Policies To Improve Care for Chronic Illness and Behavioral Health Needs **3.** Community Health Integration and Principal Illness Navigation for Behavioral Health	Related to CSWs and MFT not being allowed to use auxiliary personnel to perform CHI or PIN	AAACN applauds CMS for recognizing that certain services should not be delegated to auxiliary personnel by CSWs and MFTs, as it is not in their scope to delegate their services. However, the general assumption that physicians and other medical providers are by default qualified to delegate tasks to auxiliary personnel may not be accurate. Again, like those activities performed during the AWV, both CHI and PIN services fall within the independent scope of practice of the Registered Nurse, and thus, RNs should be listed as qualified to perform these services, along with CSWs and MFTs.
II. Provisions of the Proposed Rule for the PFS **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)** Social Determinants of Health Risk Assessment (HCPCS Code G0136)	(1) Social Determinants of Health Risk Assessment (HCPCS code G0136) In the CY 2024 PFS final rule (88 FR 78932 through 78937), we finalized coding and payment for HCPCS code G0136 (Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes). After further review of utilization information, we have come to believe that the resource costs described by HCPCS code G0136 are already accounted for in existing codes, including but not limited to E/M visits. Therefore, we are proposing to delete this code for CY 2026. Accordingly, we are proposing to remove this code from the Medicare Telehealth Services list.	AAACN believes that removal of the SDOH risk assessment code will negatively impact the frequency by which these elements are assessed during other types of visits. Additionally, ethical standards for screening for SDOH require that there be some type of referral for negative findings. Many primary care practices have not fully implemented SDOH screenings using a validated tool. Ideally, these assessments should be conducted during pre-visit planning by RNs and is essential to ensure that the best treatment plan can be developed for the patient. AAACN recognizes the goals of helping individuals make healthier choices to improve their health, however, research has shown that social drivers play a greater impact on overall health status. Thus, CMS should continue to incentivize providers to assess for these social drivers and to also encourage use of care management services for individuals (by expanding eligibility for care management services) when

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		negative social drivers of health have been identified through this risk assessment. At the very least, these assessments should absolutely be included as part of any AWV and any care management service requirement.
II. Provisions of the Proposed Rule for the PFS **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 **(2)** Community Health Integration Services (HCPCS codes G0019)	We have determined that the term "upstream driver(s)" is more comprehensive and includes a variety of factors that can impact the health of Medicare beneficiaries. The term "upstream driver(s)" encompasses a wider range of root causes of the problems that practitioners are addressing through CHI services. This type of whole-person care can better address the upstream drivers that affect patient behaviors (such as smoking, poor nutrition, low physical activity, substance misuse, etc.) or potential dietary, behavioral, medical, and environmental drivers to lessen the impacts of the problem(s) addressed in the initiating visit.	Indeed, social drivers of health are "upstream" of the health care delivery system but play an important role in overall health status of populations. The healthcare provider community is well- versed in the use of the term "social determinants of health" but also sometimes often assume that these are only negative drivers of health. Social drivers can also have a protective effect onhealth. The root causes of the conditions seen by practitioners are complex and may not be under the control of the individual. The list of "upstream driver" examples provided "such as smoking, poor nutrition, low physical activity, substance misuse, etc." could be considered lifestyle factors as opposed to an upstream driver. More accurate examples of upstream drivers include social and environmental factors which may be outside the direct control of the individual. Historically, these factors have been under the purview of the public health system, which warrants additional investments and likely outside the ability of clinicians providing ambulatory care services to be able to sufficiently impact.
III. Other Provisions of the Proposed Rule **B.** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) **2.** Payment for Care Coordination Services **a.** Background	As a result, we reaffirmed our support of primary care and recognized care management as one of the critical components of primary care by implementing significant changes aimed at better capturing the resources required for care management services, including chronic care management (CCM), principal care management (PCM), general behavior health integration (BHI), chronic pain management (CPM), transitional care management (TCM), remote physiologic monitoring (RPM), remote therapeutic monitoring (RTM), community health integration (CHI), principal illness navigation (PIN), PIN-peer support services and	AAACN applauds CMS for recognizing the important care management services provided in RHCs and FQHCs and establishing payment for these services outside the AIR payment.

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	Advanced Primary Care Management (APCM). For RHCs and FQHCs, we established payment for these suites of care coordination services outside of the RHC AIR and FQHC PPS. That is, payment is made in addition to the otherwise billable visit.	
III. Other Provisions of the Proposed Rule **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) in RHC and FQHC	Therefore, for CY 2026, in alignment with the PFS and goals associated with APCM services, we are proposing to adopt the add-on codes for APCM that would facilitate billing for BHI and CoCM services when RHCs and FQHCs are providing advanced primary care. We believe allowing for the use of these add-on codes would encourage RHCs and FQHCs to provide complementary BHI services, thereby improving access to BHI and CoCM for primary care patients in the RHC and FQHC settings.	As stated in the proposed inclusion of BHI and CoCM into APCM for FFS clinics, we do not agree with including BHI and CoCM into the APCM with additional add on codes in RHCs and FQHCs. Until the current APCM codes have been widely implemented and researched, we suggest the BHI and CoCM services not be integrated into APCM and continue to be allowed in addition to APCM as time based codes.
III. Other Provisions of the Proposed Rule **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) in RHC and FQHC	We believe that we would also need to unbundle HCPCS code G0512 to effectuate that policy. RHCs and FQHCs that are furnishing BHI and CoCM as advanced primary care services would not be able to bill for certain other individual CPT codes, such as, 99492, 99493, and 99484. And the G2214	We do agree that in the case of an RHC or FQHC is not using APCM, the G0512 should be unbundled and therefore the RHC and FQHC would have access to all of the CoCM codes of 99492, 99493, and 99494 to ensure all time is captured and reimbursed when care managing these complicated patients. We further agree with allowing RHCs and FQHCs the use of G2214 for patients who still require some level of CoCM but do not require the full hour.
III. Other Provisions of the Proposed Rule **B.** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) **2.** Payment for Care Coordination Services **c.** Payment for Communication Technology-Based Services (CTBS) and Remote Evaluation Services—HCPCS Code G0071 **(2)** Proposal for CY 2026 for CTBS and Remote Evaluation Services	RHCs and FQHCs that are furnishing CTBS or remote evaluation services as advanced primary care services would not be able to bill for certain other individual CPT codes, such as, G2010, G2250, and 98016. Therefore, we are proposing to require RHCs and FQHCs to report the individual codes that make up HCPCS code G0071 beginning January 1, 2026. Payment for these services will be based on the national non-facility PFS payment rate when the individual code is on an RHC or FQHC claim, either alone or with other payable services, and the payment rates are updated annually based on the PFS amounts for these codes. We are proposing to revise § 405.2464(e) to reflect our proposal for payment of CTBS and remote evaluation services for RHCs and FQHCs.	We agree with the proposal to unbundle G0071 and allow RHCs and FQHCs to bill the separate codes for payment parity. Telephonic triage services provided by RNs across all ambulatory settings are undervalued, and having the ability to bill for these services is an important step towards valuing this work.

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III. Other Provisions of the Proposed Rule **B.** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) **2.** Payment for Care Coordination Services **d.** Aligning with the PFS for Care Coordination Services	(2) RHC and FQHC Care Coordination Services As we discuss in section III.B.2.a. of this proposed rule, over the last several years we have been increasing our focus on care coordination. These services have evolved to focus on preventing and managing chronic disease, improving a beneficiary's transition from the hospital to the community setting, or on integrative treatment of patients with behavioral health conditions. Care coordination services are typically non-face-to-face services that do not require the skill level of an RHC or FQHC practitioner. Any new care coordination HCPCS codes will be paid separately from the RHC AIR methodology or FQHC PPS at the national non-facility PFS payment rate, either alone or with other payable visits. We note that some of the current RHC and FQHC care coordination services are not listed on the current list of designated care management service, however, we will continue to make separate payments for these RHC and FQHC care coordination services as they have been previously adopted through notice and comment rulemaking. These services include CCM, PCM, BHI, CPM, RPM, RTM, CHI, PIN, and PIN-peer support services, and APCM. We seek comment on whether the proposed process to align with the care coordination services paid under the PFS as care management services is sustainable moving forward or is there a more effective approach for adopting new care coordination codes established under the PFS as care management codes that would improve transparency and efficiency for RHCs and FQHCs.	We are in full agreement that as new care management services are added to the PFS, they should all apply immediately to the RHC and FQHC and should be separately billable from the AIR or PPS payment. While a patient's need for care coordination and care management services is present regardless of whether the practice is FFS, RHC or FQHC, patients who seek services at RHCs and FQHCs have a great need of these services. Having a separate billing code will allow practices to hire a qualified RN care manager, who can build a long-term relationship with the patient and understand the patient's values to tailor their care, which is the key to ensuring stability of physical, behavioral, and social needs are met. AAACN urges CMS to consider all care coordination and management services as a health promotion service and not subject to copayment for FFS, RHC and FQHC providers.
III. Other Provisions of the Proposed Rule **B.** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) **3.** Services Using Telecommunications Technology (RHC and FQHC)	Given the information presented by interested parties on safety and effectiveness, we think direct supervision provided via two-way real-time audio-video telecommunications technology meets the statutory requirements specific to RHCs and FQHCs at section 1861(aa)(2)(B) of the Act regarding necessary physician supervision and guidance. We note that in section II.D.2 of this proposed rule, we propose to permanently adopt a definition of direct supervision that allows "immediate availability" of the supervising practitioner using audio/video real-time communications	We agree with the proposal to permanently adopt virtual supervision as direct supervision for services provided by licensed health care professionals other than a physician, PA or ANP. In the case of services being provided by RN that fall within their licensed scope of practice, this removes a true practice barrier. We do, however, have some concerns about direct supervision of auxiliary personnel being conducted virtually. Practice staff who are not independently

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b. Direct Supervision via Use of Two-Way Audio/Video Communications Technology	technology (excluding audio-only), for all services described under §410.26, except for services that have global surgery indicators of, 010, or 090.	licensed to practice or hold any form of licensure should be directly supervised by the medical provider. In addition to allowing virtual supervision to be a form of direct supervision, we encourage CMS to allow general supervision for all services that are within the scope of practice of an RN when an RN is performing the service. This will increase access to care and ensure that patients receive preventive care and maintain stability of current chronic conditions.
III. Other Provisions of the Proposed Rule **B.** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) **3.** Services Using Telecommunications Technology (RHC and FQHC) **c.** Payment for Medical Visits Furnished Via Telecommunications Technology	In the event that Congress no longer authorizes payment to be made for telehealth services furnished via a telecommunications system by RHCs and FQHCs using a payment methodology based upon payment rates that are similar to the national average payment rates for comparable telehealth services under the PFS, we are proposing, on a temporary basis, to facilitate payment for non-behavioral health visits (hereafter referred to in this discussion as "medical visit services") furnished via telecommunications technology using an approach that closely aligns with this methodology. Like the methodology we used during and after the PHE, RHCs and FQHCs would continue to bill for RHC and FQHC medical visit services furnished using telecommunications technology, including services furnished using audio-only communications technology, by reporting HCPCS code G2025 on the claim.	We are grateful for the realization that RHC and FQHCs must be allowed to continue to provide telehealth services. Although the current cost of these services is not in the AIR or PPS payment, we urge you to consider using the AIR or PPS payment and do away with the G2025. The G2025 has a few complications, the biggest complication is that code does not indicate which type of visit was actually done. Many preventative services can be and should be done via telehealth technologies, but the current practice of using G2025 as a telehealth code without using the actual code for the service being provided, makes it difficult to fully capture services being provided and potentially undervalues the service being provided. Furthermore, the pre-visit planning and set up for a telehealth visit is often more time consuming and uses more staff resources than an in-person visit. Therefore, there should be payment parity for telehealth visits that align with the AIR or PPS payment. Additionally, in the case of an AWV being provided using telehealth, not having the associated code for service provided presents challenges for patients who may be receiving a preventative service may inadvertently be billed a co-payment for a preventative service.

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III. Other Provisions of the Proposed Rule **B.** Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) **3.** Services Using Telecommunications Technology (RHC and FQHC) **c.** Payment for Medical Visits Furnished Via Telecommunications Technology **(1)** Alternative Proposal Considered for Payment of Medical Visits Furnished Via Telecommunication Technology	We considered reevaluating the regulations regarding face-to-face visit requirements for encounters between a beneficiary and an RHC or FQHC practitioner in light of contemporary medical practices. That is, we considered proposing a revision to the regulatory requirement that an RHC or FQHC medical visit must be a face-to-face (that is, in-person) encounter between a beneficiary and an RHC or FQHC practitioner to also include encounters furnished through interactive, real-time, audio and video telecommunications technology. This would result in payment for services furnished via telecommunication technology to be made under the RHC AIR methodology and under the FQHC PPS, similar to how we revised the regulations for mental health visits. We believe interested parties may prefer the per visit payment that aligns with the RHC AIR or FQHC PPS.	AAACN commends CMS for recognizing the need to minimize barriers to care for patients in RHC and FQHC settings due to the face to face visit requirements.In some cases, the only way our patients are able to receive care as travel is often impossible due to mobility, limited transportation and or costs. Payment parity for services delivered through these technologies is important, as the same if not more resources go into care provision using these technologies.
III. Other Provisions of the Proposed Rule **E.** Medicare Diabetes Prevention Program (MDPP) **2.** Proposed Changes to § 410.79 (c)(1)(ii) and (e)(3)(iii)(C)	In this proposed rule, we are proposing several changes which are aimed towards increasing the uptake of this important prevention-focused program while empowering beneficiaries and promoting further alignment between MDPP and the CDC DPRP Standards. Specifically, we are proposing changes to 42 CFR 410.79(b) to add definitions for the following terms: Live Coach interaction, Online delivery period, and Online session while modifying the definition of “Online.” We also propose changes to the expanded model by amending § 410.79 (c)(1)(ii) and (e)(3)(iii)(C) to address operational questions and barriers related to weight collection requirements.	We appreciate the increased flexibility that is being proposed in the MDPP program and support any avenue to increase participation in this program.Simplifying the program certification process would be another avenue to increase participation as more Registered Nurses would become certified coaches and an MDPP Supplier.

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