CIVITAS
Networks for Health

September 12, 2025

Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

RE:CY26 Payment Policies Under the Physician Fee Schedule and Other Changes Proposed Rule [CMS-1832-P]

Dear Administrator Oz:

Civitas Networks for Health ("Civitas") appreciates the opportunity to submit public comments on the CY26 Physician Fee Schedule (CMS-1832-P), published in the *Federal Register* on July 16.[1] Civitas is a national nonprofit association comprised of more than 175 member organizations—health information exchanges (HIEs), regional health improvement collaboratives (RHICs), quality improvement organizations (QIOs), All-Payer Claims Databases (APCDs), and service providers to meet their needs—working to use data frameworks, information infrastructure, and collaborative approaches to improve health for individuals and communities. We educate, promote, and guide the private sector and policymakers on matters of interoperability, quality, coordination, and efficiency within the health system.

Civitas applauds the renewed focus of CMS on empowering patients and providers through cross-network collaboration and enhanced quality measurement that cuts costs and produces better outcomes. As the leading edge of AI-enabled health information technology rapidly advances, integrating more data from a wider range of sources becomes ever-more valuable for delivering the kind of person-centered care at scale that is needed to tackle America's chronic disease epidemic. This integration depends not only on having sufficient digital infrastructure and technical standardization to connect healthcare providers to each other, and to the key social and community services that can address "upstream drivers" of health (CMS' proposed new and broader term for non-clinical determinant factors, which Civitas supports); it also requires that the right data be collected and analyzed so it can be put to use in the right way.

Among Civitas members, the infrastructure components are furnished by statewide and regional HIEs (as well as the proprietary EHRs and national networks they often connect to), while the data content and standards—their underlying value basis, and how to best capture it—is often the province of QIOs and RHICs which likewise operate in specific regions or localities. The clinical and upstream service providers working with patients are the heart of the design, who manage secure inputs at the point of care and well beyond it; and around whom the other moving parts are intended to revolve. The resulting closed-loop referral systems allow multiple providers to follow case data longitudinally in real time, and they have become fixtures of activity that Civitas members have adopted in their service areas to great effect. Projects supported by states and the private sector as well as CMS' own Innovation Center pilots around the country (Accountable Health Communities, IBH, AHEAD) have shown the efficacy of these arrangements for high-risk, high-need, and high-cost beneficiaries. In recent years, closed-loop

referral systems have also been used by growing numbers of State Medicaid Agencies as components of section 1115 demonstration waivers focused on value-based care, behavioral health, care transitions, and community services.

Civitas members have been key partners in both types of projects, which is why we want to highlight several proposals in the CY PFS NPRM that would create additional avenues of support for providers to participate (or participate more often) in referral systems, and briefly describe their impact:

- ***The permanent redefinition of "direct supervision" under 42 CFR 410.26 to cover "virtual presence through audio-visual real time communications technology" contingent on the "immediate availability" of the supervising practitioner***. This change would entrench the flexibility and utilization gains for a huge range of clinical activities (excluding some surgeries) that have been made since telehealth remote supervision was introduced during the COVID-19 Public Health Emergency. In doing so, it gives practitioners greater latitude themselves while continuing to expand the reach and billable portfolios of auxiliary personnel. Auxiliaries (RNs, PAs, LSWs, CHWs) will be able to engage more beneficiaries (especially those in rural areas), deliver a higher volume of services, and more readily coordinate care—incorporating telehealth into referral networks more easily. This convergence is particularly relevant as more Civitas member networks become CMS-aligned in accordance with the new Interoperability Framework, which highlights telehealth functionality (via FHIR) as one of its key objectives.
- ***Clarifying and expanding the scope of billable practice for mental health counselors (MHCs), marriage and family therapists (MFTs), and clinical social workers (CSWs).*** The proposal would confirm that MHCs and MFTs can serve as auxiliary personnel under virtual-presence direct supervision arrangements or bill Medicare directly for services that they personally perform, in the same way the CSWs can (though none of them can supervise auxiliaries themselves). The distinction is relevant for the community health integration (CHI) and principal illness navigation (PIN) codes, which cover a range of activities to assess upstream drivers, develop plans to address them, and work with patients to implement those plans in concert with other providers. In a further important change, all three specialties would be able to use two pre-existing code sets within their direct scope of practice as initiating visits for CHI, in the same way that other practitioners currently use E/M and annual wellness visits. The two code sets—for psychiatric diagnostic evaluation and health behavior assessment and intervention (HBAI) services—are particularly well-aligned with the efforts of Civitas members to improve access to mental health treatment and recovery services up and down their referral pipelines by engaging more practitioners in care coordination and streamlining the process.
- ***Integrating behavioral health into the newly introduced Advanced Primary Care Management (APCM) billable services***. In last year's CY25 PFS Final Rule, CMS "bundled" a set of primary care codes for monthly capitated billing to align the time and effort practitioners spend treating multiple chronic conditions with a value-based payment structure. The three tiers of APCM coding are scaled to the number of conditions per beneficiary and cover 13 "service element" activities organized around individual comprehensive care plans, which include managing care transitions, medication reconciliation, and electronic health information exchange (among others). During the CY25

proposed rule stage, Civitas recommended that CMS move forward with APCM coding as an incentive for more providers to deepen statewide and regional connectivity, and to participate in their community-based referral networks with other stakeholders and service providers. However, we also questioned the lack of any billable service elements for social determinants of health assessment attached to the codes.

This year, the CY26 NPRM has stepped part of the way in that direction—at least for purposes of referral system participation and volume—by proposing to allow practitioners to furnish general behavioral health integration (BHI) and psychiatric collaborative care model (CoCM) services under APCM across three untimed "designated care service" codes. These add-on codes would be optional and complementary to the other APCM activities, and would be deliverable by auxiliary personnel or the practitioners themselves. We encourage CMS to finalize this concept as a major assist to Civitas members working to build and maintain closed loops in rural and underserved areas with higher rates of substance abuse disorder and limited capacities to address them.

On behalf of Civitas and our members, thank you again for your consideration of our comments. The Civitas community is deeply engaged in multiple corners of the health data policy and regulation space, and we stand ready to collaborate to achieve our shared goal of creating a higher-value health system.

Please do not hesitate to reach out if you have any questions or comments for us.

Sincerely,

Jolie Ritzo
CEO, Civitas Networks for Health