American Association on Health & Disability

110 N. Washington Street Suite 407 Rockville, MD 20850
T. 301-545-6140 F. 301-545-6144 www.aahd.us

AAHD - *Dedicated to better health for people with disabilities through health promotion and wellness*

LAKESHORE

September 11, 2025

The Honorable Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Attention: CMS-1832-P,
P.O. Box 8016 Baltimore, MD 21244–8016

Re: CMS-1832-P: 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; and Medicare Prescription Drug Inflation Rebate Program

Submitted electronically via Regulations.gov

Dear Administrator Oz:

The American Association on Health and Disability and the Lakeshore Foundation appreciate the opportunity to provide comments on proposed rules governing the Medicare Physician Fee Schedule.

The American Association on Health & Disability (www.aahd.us) is a national cross-disability organization that conducts research, engages the community, and facilitates the development and implementation of programs to advance public health and healthcare policy for the health and wellness of people with disabilities. Through these actions, AAHD is committed to eliminating systemic barriers to healthcare and drive health equity for people across all disabilities, valuing the diverse and intersecting identities within the disability community. AAHD connects people with disabilities, disability advocates, health practitioners,

researchers, and policy makers to accessible cross-disability health data and resources—creating a more inclusive society where data-driven healthcare leads to more equitable health outcomes.

The Lakeshore Foundation (www.lakeshore.org) mission is to enable people with physical disability and chronic health conditions to lead healthy, active, and independent lifestyles through physical activity, sport, recreation and research. Lakeshore is a U.S. Olympic and Paralympic Training Site; the UAB/Lakeshore Research Collaborative is a world-class research program in physical activity, health promotion and disability linking Lakeshore's programs with the University of Alabama, Birmingham's research expertise.

Our comments are consistent with those submitted by:

Academy of Nutrition and Dietetics
[Focused on medically tailored meals and nutrition as a component of a health and wellness program.]

Coalition To Preserve Rehabilitation
[AAHD and Lakeshore joined these comments.]
[Comments focused on conversion payment rates, service valuation, and telehealth, impacting physical rehabilitation services.]

Families USA Consumers First with the American Academy of Family Medicine; American Benefits Council; FUSA; and Purchaser Business Group on Health.
[AAHD and Lakeshore joined these comments.]
[Comments addressed multiple topics.]

National Health Council
[AAHD is a NHC member]
[Comments addressed multiple topics.]

No Health without Mental Health and allied organizations
[AAHD and Lakeshore joined these comments.]
[Comments focused on Prevention and Management of Chronic Conditions.]

Partnership To Align Social Care
[AAHD and Lakeshore joined these comments.]
[Comments focused on: Community Health Integration and Principal Illness Navigation for Behavioral Health; Caregiver Training Services; Proposed Efficiency Adjustment; and Prevention and Management of Chronic Conditions.]

Primary Care Collaborative

[Focused on the importance of primary care and Advanced Primary Care Management.]

Overarching Health Policy Priority Goals

AAHD and the Lakeshore Foundation prioritize services and supports to persons with the most severe disabilities and mental illnesses and persons with chronic health conditions, including persons with co-occurring health conditions.

AAHD and the Lakeshore Foundation reinforce the National Health Council submitted overarching health policy goals:

1. Payment Stability and Predictability
2. Access To Care
3. Data-Driven and Transparent Valuation
4. Integration of Physical. Behavioral, and Social Care
5. Support of Safety-Net Providers
6. Meaningful Patient Engagement (including Patient-Reported Outcome Measures (PROMs)

AAHD-Lakeshore Comments Foci

Our comments here focus on:

1. Prevention and Management of Chronic Conditions
2. Bi-Directional Integration of Primary Care and Behavioral Health
3. Patient-Centered and Patient-Reported Quality Measures
4. Upstream Drivers of Health
5. Access to Rehabilitation Services Through Accurate Services Valuation
6. Telehealth Upgrades

Prevention and Management of Chronic Conditions

We joined the No Health without Mental Health (NHMH) and allies, and Partnership To Align Social Care, comments focused on persons with chronic conditions. CMS should support treatment in one integrated, multi-condition intervention (as documented in the evidence-based science). Nearly 40% of patients with a chronic medical condition also have a co-occurring mental health or substance use disorder (Kathol, 2015). Of patients with a serious mental illness, 50-80% have one or more concurrent chronic medical conditions (Scott et al, 2016; Druss & Walker, 2011). 40% of patients with a primary medical reason for their emergency department visit also have a BH condition (Richmond et al, 2017). Major depression is prevalent among patients with diabetes and coronary heart disease (American Diabetes Association; Smith et al, 2006) and is a risk factor for poor self-care, complications, and death (Kathol, 2005; Katon & Seelig, 2008; van

Schijndel et al,2022). There is growing evidence that integration of behavioral health (BH) services in primary care can generate downstream medical savings by improving management of comorbid chronic disease and BH issues (Reiss-Brennan et al, 2016; NASEM, 2021).

We encourage CMS and Medicare consistency with the **Administration for Community Living (ACL) "Chronic Disease Self-Management Program" and Medicaid Home-and-Community-Based Services (HCBS) "Self-Directed Services and Supports" programs.** The concepts and experiences of "self-management" and "self-direction" (when appropriate) are important.

We strongly recommend that CMS create separate coding and payment for **medically tailored meals.** The creation of separate coding and payment for medically tailored meals is central to the goals of the Make America Healthy Again Commission. Therefore, CMS should make separate coding and payment for medically tailored meals in the CY2026 Final Rules. The tremendous health impact of **Meals on Wheels** programs must be included in a meal benefit.

We support CMS creating a payment and coding mechanism for a meal benefit that specifically allows qualified practitioners to contract with community-based organizations, operating under general supervision, as an incident to service. However, we highly recommend that CMS explicitly state that qualified practitioners can contract with community-based organizations to provide meals as an incident to service. The Community Health Integration (CHI) and Principal Illness Navigation (PIN) benefits each allow for services to be rendered by auxiliary personnel from a community-based organization. The rate established for Medically Tailored Meals must consider the higher costs required to deliver home-delivered meals.

Bi-Directional Integration of Primary Care and Behavioral Health

We are grateful for the Administration's efforts to promote the integration of behavioral health and primary care and recognizing the bi-directionality of integrated medical-behavioral care with its Innovations for Behavioral Health (IBH) model, given the need for integrated care for individuals with serious mental health conditions. We support CMS' focus on enhancing the quality of primary care by improving upstream chronic disease management and utilizing payments and policies to increase access to advanced primary care for beneficiaries in traditional Medicare.

Increased Medicare payment through Advanced Primary Care Management (APCM) billing codes should encourage more primary care clinicians to care for more Medicare beneficiaries including those with behavioral health conditions.

Underinvestment in primary care adversely impacts the delivery of integrated care to patients, and the pipeline of future primary care clinicians, contributing to a growing provider workforce shortage. Many patients with chronic medical conditions also have co-occurring behavioral health conditions, untreated behavioral health issues in primary care result in a doubling and quadrupling of medical care expenditures and thus total healthcare costs (Milliman, 2018, 2020). way.

We urge CMS to: (1) Finalize Adding Behavioral Health Integration Services into the Advanced Primary Care Management (APCM) Model; (2) Address Co-Insurance as a Barrier to Care: Co-insurance is a barrier to care by precluding individuals from engaging in models of care that have been shown to improve outcomes and we urge CMS to determine a pathway to waiving cost sharing for APCM and integrated care add-on codes to scale these important models. And (3) Increase the Reimbursement Rate for the Collaborative Care and General Behavioral Health Integration codes in both the existing and add-on codes.

Patient-Centered and Patient-Reported Quality Measures

All the sister organizations we previously cite have advocated patient-centered quality measures.

We recommend CMS promote development of a new advance patient-centeredness quality measure to be part of Advanced Primary Care Management (APCM) services, in addition to clinical quality measures, for integrated multi-condition chronic disease prevent and management.

The NHMH and allies letter listed a number of important quality measure topic areas. We also encourage **consistency with the American Board of Family Medicine (ABFM) three authored and sponsored quality measures:** continuous patient-physician relationships; person-centered primary care; and comprehensiveness of care. We recommend patient-reported outcomes measures for integrated, multi-condition treatment of co-morbid medical and behavioral health chronic conditions, including: patient quality of life, patient social participation, patient continuity of care, patient comprehensive care, patient physical functioning, and patient pain interference.

We further recommend zero patient cost-sharing for integrated, multi-condition chronic disease management in primary care as an essential way to engage patients in this intervention.

Upstream Drivers of Health

We support CMS's proposal to use an alternative term for social determinants of health. CMS proposal to change the term to "Upstream Drivers" will incorporate the broad range of non-medical factors that can negatively impact the ability to treat or diagnose a health condition. We agree that the term Upstream Driver(s) is more comprehensive and will allow for a broader understanding of the qualifying factors that may make a beneficiary eligible for this important service. We anticipate that the use of the term Upstream Driver(s) will support the expanded utilization of CHI services as more beneficiaries will be determined eligible since the term encompasses a wider range of root causes of problems that practitioners are addressing through CHI services. We have been using "social drivers of health" and "health-related social needs" during the past few years. The word "determinants" has been negatively responded to by many in the disability, mental health, aging, and home-and-community-based services communities.

We disagree with the proposal to terminate the Social Determinants of Health Risk Assessment (HCPCS Code G0136) because the labor to investigate the root causes of Upstream Driver(s) for CHI services is beyond the scope of standard evaluation and management (E/M) coding. However, the terminology revision should apply to HCPCS code G0136 by changing the name of the benefit to "Upstream Driver(s) Risk Assessment". Changing the terminology of the Social Determinants Risk Assessment to the "Upstream Driver(s) Risk Assessment" will continue to recognize the additional practitioner labor required to assess for the root causes of problems that negatively impact the ability to treat or diagnose a health condition. We advocate for CMS to change the terminology of the Social Determinants of Health Risk Assessment to the Upstream Driver(s) Risk Assessment and retain the benefit in its current structure as a reimbursable service that fully recognizes the additional labor required to complete the necessary assessments to determine the root causes of Upstream Driver(s).

Preserving Access to Rehabilitation Services Through Accurate Service Valuation

We join the Coalition To Preserve Rehabilitation (CPR) appreciation of CMS's recognition that Medicare's current code valuation process often fails to account for efficiency gains in procedural services while undervaluing time-intensive, cognitive, and care coordination services. Historically, the Physician Fee Schedule has relied on survey-based estimates of the time required to perform services, many of which are rarely updated—if at all—despite advances in technology and clinical techniques. In contrast, the work of diagnosing conditions, managing multiple chronic illnesses, supporting behavioral change, and coordinating care for medically complex patients does not become more efficient over time. As a result, Medicare has long undervalued the time-intensive services that complex patients with multiple chronic illnesses need, relative to other services. Given the current

Administration's emphasis on reducing chronic illness, the proposal appears to under undervalue the agency's broad agenda.

The proposed triennial "efficiency adjustment" to the time-related components of payment—Work Relative Value Units ("RVUs") and intraservice time—represents an important first step in addressing this inequity. CPR strongly supported CMS's proposal to exempt time-based services that are foundational to primary care—including therapy services, care management, and most evaluation and management services—thereby allowing the relative value of these services grow appropriately over time.

Telehealth Upgrades

We share the National Health Council and Coalition To Protect Rehabilitation support for the proposed continued supports and upgrades to telehealth services. Telehealth services allow many Medicare beneficiaries to more safely and easily access medically necessary health care services by avoiding numerous other complications and difficulties that have always been associated with in-person medical care.

Thank you for the opportunity to comment. If you have any questions please contact Clarke Ross at clarkeross10@comcast.net.

Sincerely,

E. Clarke Ross, D.P.A.
American Association on Health and Disability
And
Lakeshore Foundation

E. Clarke Ross, D.P.A.
AAHD Public Policy Director
Lakeshore Fd Washington Representative
clarkeross10@comcast.net
301-821-5410

Karl D. Cooper, Esq.
Executive Director
American Association on Health and Disability (www.aahd.us)
110 N. Washington Street, Suite 407

Rockville, MD 20850
301-545-6140 ext. 204
301 545-6144 (fax)
kcooper@aahd.us

Amy Rauworth
Chief Research and Innovation Officer
Lakeshore Foundation (www.lakeshore.org)
4000 Ridgeway Drive
Birmingham, Alabama 35209
205.313.7487
amyr@lakeshore.org