Public RFI Response Submitted Online to and accepted by CMS September 5, 2025 in response to CY 2026 CMS Medicare Physician Fee Schedule Proposed Rule on prevention and management of chronic illness care.

(submission below):

This public comment is being submitted by the following organizations:
NHMH – No Health without Mental Health
American Association on Health & Disability
Clinical Social Work Association
International Society for Psychiatric Mental Health Nurses
Lakeshore Foundation
National Association of Addiction Treatment Providers

CMS QUESTION: How can CMS better support prevention and management of patients' chronic health conditions, improve administrative burden, and constrain the growth in healthcare costs?

Our RESPONSE:

RECOMMENDATION #1: We recommend CMS better supports prevention and management of patients' chronic conditions by targeting naturally-occurring clusters of chronic conditions for treatment in one integrated, multi-condition intervention, an approach robustly supported by the scientific literature evidence base.

We urge CMS to prioritize widespread dissemination and implementation of the proven integrated, multi-condition TEAMcare intervention (McGregor et al, 2011, Journal of Ambulatory Care Management, 34: 152-62; Katon et al, 2010, NEJM, 363:27). The TEAMCARE intervention has the potential to be widely adopted as a practical approach to managing multiple chronic diseases commonly found in primary care such as diabetes, heart disease and depression.

Since 75%-90% of total healthcare expenditures in the U.S. is attributed to care for chronic diseases (CDC, UHC, Mathematica), effective approaches to prevention and management of such complex care are needed especially when there is medical-behavioral comorbidity. One successful proven approach for managing care for primary care patients with multiple chronic illness is to identify clusters of coexisting diseases with compatible management guidelines and treat them in one multi-condition intervention such as the TEAMcare intervention for comorbid diabetes and depression, and/or heart disease and depression, or diabetes plus heart disease plus depression.

TEAMcare's success has been replicated over the past 10+ years nationally and internationally with the:
2012-2015 U.S. CMS/CMMI COMPASS (Care of Mental, Physical and Substance Use Syndromes) spread project;
2015 Canadian TeamCare Primary Care Networks (PCN) RCT trial;
2016 Australian Implementation of Team-Based Care for COPD study; and the
2020 German TEACH (Teamcare for Coronary Heart Disease with Psychosocial Distress) trial.

These multiple, large-scale implementation studies have extended the TEAMcare approach to even broader, real-world settings. They reinforce TEAMcare's effectiveness in improving depression remission and or symptom improvement, glycemic control for diabetes and blood pressure control for coronary artery disease.

Depression should be treated alongside other chronic conditions as major depression is prevalent among patients with diabetes and coronary heart disease (American Diabetes Association; Smith et al, 2006). It is also a risk factor for poor self-care, complications, and death (Kathol, 2005; Katon & Seelig, 2008; van Schijndel et al,2022). Depressed people have a harder time managing disease-related, self-care strategies such as medication adherence, proper nutrition, weight loss or physical exercise; face a higher risk of disability and early death; have high personal health costs; use a high percentage of national healthcare resources; and face a higher risk of disability and premature death (Lin et al, 2010).

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).

While disease management interventions focusing on single conditions have been shown to improve control of that condition, interventions focused only on one chronic disease seem fragmented to patients and are complex and costly for primary care practices and health systems to provide separately and individually (Katon, 2010).

Success has been achieved with integrated, multi-condition approaches for chronic medical illness for such frequent diseases as diabetes and heart depression and depression with results showing marked improvement of medical and behavioral outcomes, lowered costs and better patient experience of care.

RECOMMENDATION #2: CMS should support and incentivize a new '*advanced* patient-centeredness' quality measure for use in integrated, multi-condition chronic disease management programs as part of high-quality Advanced Primary Care Management (APCM) services, in addition to clinical quality measures. Successful multi-condition chronic disease interventions such as TEAMcare and its progeny have been shown to owe much of their success to their pragmatic, patient-centered, patient-care team partners-in-care approach.

Remarkably, these interventions involved a patient population often viewed as the most difficult to treat, having poor self-care skills, unlikely or unable to follow-up clinicians' care suggestions, considered the most treatment resistant. *And still,* these extraordinarily patient-centered interventions achieved outstanding outcomes for patients with depression, coronary heart disease and diabetes.

Accountability must be clearly and explicitly built in to new, high-quality advanced primary care services, with clear, lean, and less administratively burdensome quality measures. Measures that can evaluate the quality of new habits and skills needed by both patients, and the integrated care team, and the quality of external cooperative partnerships as recommended by the National Academies of Sciences, Engineering and Medicine (2021) including community social services entities.

Chronic illness treatment for complex, comorbid patients shown to be most successful have been ones that have from the outset, in care delivery design, through to planning, and execution, concentrated on patient-centered care. This includes explicit patient control over healthcare goals and care plans, and use of limited, practical patient educational materials, as well as a laser-focus on achieving improved outcomes.

Patient-centered processes that have led to success in integrated, multi-condition chronic care management programs have included:

--co-created care plan designs: care plans co-created by the PCP + care team and stress patient control and choices;

--co-developed goal setting: treatment goals that are clear, shared by care team and patient, and and regularly reviewed by both;

--behavioral strategies:	behavioral strategies as part of treatment that are consistently reviewed and updated by both patient and care team;
--patient self-monitoring:	patient-self monitoring goals that are co-created with the care team, clearly defined, and work in conjunction with the clinicians' measurement-informed care;
--medication measurement:	regular, joint patient-team review of the patient's medications regimen, and revision of the medication list to reflect what the patient is actually taking.

We recommend the following patient-reported outcomes measures for integrated, multi-condition treatment of co-morbid medical and behavioral health chronic conditions shown to improve outcomes and patient engagement:

patient quality of life	patient social participation
patient continuity of care	patient comprehensive care
patient physical functioning	patient pain interference
patient cost of care	Patient-Centeredness Index score

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.

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. And we commend CMS for considering and analyzing 'medically tailored meals' as part of a comprehensive chronic disease program.

RECOMMENDATION #3: We urge CMS to stress patient *self-care* strategies and activities as part of providing high-quality, patient-centered care via Advanced Primary Care Management (APCM) services. Further that CMS prioritize innovative and cost-effective research and development of new 21st c means of patient self-care for complex patients with comorbid chronic medical and behavioral health conditions. Successful integrated, multi-condition chronic disease management treatment programs have demonstrated that self-care by patients is paramount to effect meaningful patient behavior change that translates into improved health outcomes and lowered total costs.

Among the most effective self-care and related activities identified to date for this complex, comorbid patient population have been:

(1) Patients ability to be co-creators of their own care plan working together with their primary care physician (PCP) and care manager (CM) to design a practical, individualized written plan to increase self-care activities;
(2) Use of home monitoring techniques with chronic care patients as many such patients have conditions that could be monitored at home e.g. blood pressure monitoring, blood glucose tracking, heart function monitoring;
(3) Emphasis on the simple and practical to encourage patient readiness to health behavior change and maintaining change with regard to such self-care activities as physical exercise, or diet/nutrition; studies show that when it comes to integrating self-care plans into their daily lives, most patients made improvements using simple strategies;
(4) Patients seen in-person until the collaborative care manager-patient relationship is established and the patient is making progress towards their goals;
(5) Attention to transition to maintenance care includes developing parameters to guide and help patients move

from acute phase to maintenance phase to relapse prevention phase. However, we believe medicine, science and technology are only at the earliest stage of discovering new forms of patient self-care activities.

We also encourage 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.

###