

Partnership to Align Social Care

A National Learning
& Action Network

September 12, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services (HHS)
Attention: CMS-1832-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via <http://www.regulations.gov>.

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

Dear Administrator Dr. Mehmet Oz:

On behalf of the Co-Chairs of the Partnership to Align Social Care ([Partnership](#)), which serves as a national learning and action network with the purpose of advancing the alignment between healthcare and community care service delivery systems, and the below signed organizations representing numerous health and community care sector stakeholders, we are writing in response to the Proposed Rule [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*.

Through collaboration and co-design, the Partnership aims to enable cross-sector collaboration to co-design solutions to build aligned health and community care delivery system models using community care hubs to deliver holistic, person-centered care. The Partnership envisions a sustainably resourced, value-based, community care delivery system to address upstream drivers of health impacting individual and population health outcomes that positions CCHs and CBOs to effectively respond to federal, state, and local policy opportunities and evolving market dynamics. Many of the issues addressed in the draft CY2026 Physician Fee Schedule are of great importance to Partnership stakeholders and the communities we serve.

Please see the following comments regarding the CY2026 Physician Fee Schedule proposed rule changes:

1. Community Health Integration and Principal Illness Navigation for Behavioral Health

a. Practitioner Types

- i. We applaud CMS for providing clarification that clinical social workers (CSWs), marriage and family therapists (MFTs), and mental health counselors (MHCs) can bill Medicare directly for CHI and PIN services that they directly perform for the diagnosis or treatment of mental illness. CSWs, MFTs, and MHCs play an essential role in providing CHI and PIN services to persons with behavioral health conditions. The rule clarification confirms that CSWs, MFTs, and MHCs can provide expanded services under CHI and PIN will ensure that affected populations will have greater access to these essential services as part of a whole-person care model.

- ii. **Incident To: While we applaud CMS for providing greater clarification regarding the ability of CSWs, MFTs, and MHCs** to bill Medicare directly for CHI and PIN services that they directly perform, we urge CMS to reconsider the current limitation on CSWs, MFTs, and MHCs, utilizing the services of auxiliary personnel providing CHI and PIN services incident to the billing practitioner’s professional services. CSWs, MFTs, and MHCs should have the authority to provide general supervision of auxiliary personnel in the provision of CHI and PIN. Specifically, CMS should implement a rule change to allow CSWs, MFTs, and MHCs to bill Medicare under the PFS for CHI and PIN services if they were provided by auxiliary personnel incident to their professional services.

CHI and PIN services are routinely performed in community settings with the support of community-based organizations (CBOs). Many community-based organizations have social workers on staff to support the provision of services to address social needs. Community-based organizations also employ community health workers that provide services that would be reimbursable under CHI and PIN. Therefore, a rule change that would allow CSWs, MFTs, and MHCs to bill Medicare for CHI and PIN services that were performed by auxiliary personnel incident to their professional services will support the provision of CHI and PIN services directly by community-based organizations that employ CSWs, MFTs, or MHCs. We strongly urge CMS to use the rulemaking process to define a pathway for CSWs to bill Medicare for CHI and PIN services rendered by auxiliary personnel, incident to the professional services of a CSW.

- iii. **Initiating Visits:** We fully support CMS’s proposal to allow CSWs, MFTs, and MHCs to bill for CHI services they personally perform and include the following services as eligible initiating visits for CHI services: CPT code 90791 (psychiatric diagnostic evaluation) or the Health Behavior Assessment and Intervention (HBAI) services that CPT codes 961156, 96158, 96159, 96164, 96165, 96167, and 96168. A core component of the psychiatric diagnostic evaluation and the HBAI initial encounter is an assessment of the factors that may be exacerbating the person’s condition. During this assessment, the practitioner will uncover upstream drivers and health-related social needs that are negatively impacting the health condition. Therefore, the inclusion of the psychiatric diagnostic evaluation and HBAI as an initiating visit will lead to greater continuity of care for affected populations.

b. Technical Refinements to Revise Terminology for Services Related to Upstream Drivers of Health

- i. **Community Health Integration language revision:** 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.
- ii. **Social Determinants of Health Risk Assessment (HCPCS Code G0136):** CMS has proposed to change the term “Social Determinants of Health (SDOH)” to “Upstream Driver(s)” because the agency states it encompasses a more comprehensive definition of the root causes of the problems that practitioners are addressing through CHI services. The terminology change should apply to the SDOH Risk Assessment by changing the benefit to Upstream Driver(s) Risk Assessment (HCPCS Code G0136). With the understanding that the new terminology will lead to a need to better

understand the root causes of problems impacting health outcomes that will be addressed by CHI services, there will be increased labor for the provider to determine these root causes of Upstream Driver(s). The requirement for increased labor by the qualified practitioner to determine the root causes for Upstream Driver(s) should be recognized in payment policy. CMS should specifically recognize the additional labor to assess for the root causes contributing to the epidemic of chronic disease impacting the U.S. population. This is in alignment with the objectives of the Make America Healthy Again strategy to reduce participation in risk behaviors and improve physical activity. Practitioners must spend additional time and effort to assess for the barriers to improving nutrition, physical activity, and chronic disease self-management. The labor to assess for the impact of these Upstream Drivers is not fully captured in current E/M coding. In support of the goals of the Make America Healthy Again strategy, it is imperative that the labor to assess for root causes of Upstream Driver(s) be recognized in payment policy.

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).

2. Caregiver Training Services

a. Incident To the Professional Services of a Qualified Practitioner

- i. **We strongly urge CMS to change the Caregiver Training Services benefit (codes 97550, 97551, 97552) to services that can be rendered by auxiliary personnel incident to a qualified practitioner under general supervision.** Auxiliary personnel of the provider render many caregiver training services. In addition, caregiver training often occurs in community settings. The requirement that caregiver training only be provided in a clinical setting requires training to occur in a setting that is often not conducive to training caregivers. A rule change that will facilitate the provision of caregiver training services rendered by auxiliary personnel, under general supervision, incident to the professional services of a qualified practitioner will allow for essential caregiver training services to be rendered in community settings to include the caregiver/beneficiary’s home.

An increasing percentage of caregiver services are rendered to persons that are homebound and even bedbound. The current CTS benefit requires the caregiver to travel with a homebound beneficiary to a medical office to receive caregiver training. This presents an undue burden on the caregiver to receive this essential training. The other option for the caregiver is to pay for third-party support services to provide time for the caregiver to travel to a medical office to receive caregiver training. This third-party support would be an additional out-of-pocket expense and presents an additional burden to the caregiver. Both of these options present an unnecessary burden on the caregiver to receive the necessary caregiver training required to support the beneficiary. Therefore, it is particularly important that caregivers of homebound and bedbound beneficiaries should have the option of receiving caregiver training in the home setting, performed by auxiliary personnel incident to the qualified practitioner.

- b. ACL-Supported Evidence-Based Caregiver Training Programs
- i. The Administration for Community Living (ACL), through formula grants and other direct funding mechanisms, provides funding to provide evidence-based caregiver training services. The caregiver training services, funded by ACL, support clinicians and families by providing detailed, evidence-based education and training to caregivers, in trusted community settings. These evidence-based programs improve health outcomes by reducing caregiver burden, which leads to improved support for the beneficiary in need of caregiver services. The ACL-supported, evidence-based caregiver training services are provided in community settings through Area Agencies on Aging (AAAs) and other members of the Aging Network. The ACL-supported caregiver training programs do not have enough funding to meet the demand for expanded caregiver training services. In addition, there is not a clear mechanism for reimbursement for caregiver training in the PFS – even though many practitioners refer caregivers to ACL-supported caregiver training programs. The full range of ACL-supported evidence-based caregiver training programs should be reimbursable under the caregiver training codes, when delivered under general supervision of a qualified practitioner, incident to their professional services.
 - ii. **CMS can facilitate greater access to these essential ACL-supported evidence-based caregiver training programs, by changing the caregiver training benefit to include a rule that allows caregiver training to be performed by auxiliary personnel, under general supervision, incident to the professional services of a qualified practitioner.** In addition, CMS should explicitly state that practitioners can contract with community-based organizations in the delivery of caregiver training services, to include Area Agencies on Aging (AAAs), Community Care Hubs (CCHs), Centers for Independent Living (CILs) and Aging and Disability Resource Centers (ADRCs), if the incident to rules are met and there is clinical integration between the supervising practitioner and the CBO delivering the evidence-based caregiver training program.

The list of ACL-supported, evidence-based caregiver training programs includes the following titles and link to the description of the evidence:

- Powerful Tools for Caregivers: <https://www.ncoa.org/article/evidence-based-program-powerful-tools-for-caregivers/>
- PREPARE for Your Care: <https://www.ncoa.org/article/evidence-based-program-prepare-for-your-care/>
- REACH Community (Resources for Enhancing Alzheimer’s Caregivers Health in the Community): <https://www.ncoa.org/article/evidence-based-program-reach-community/>
- REACH-TX: <https://www.ncoa.org/article/evidence-based-program-reach-tx/>
- Respecting Choices: <https://www.ncoa.org/article/evidence-based-program-respecting-choices/>
- SHARE (Support, Health, Activities, Resources, and Education) for Dementia: <https://www.ncoa.org/article/evidence-based-program-share/>
- Stress-Busting Program for Family Caregivers: <https://www.ncoa.org/article/evidence-based-program-stress-busting-program-for-family-caregivers/>
- TCARE® Support System (Tailored Caregiver Assessment and Referral®): <https://www.ncoa.org/article/evidence-based-program-tcare-support-system-tailored-caregiver-assessment-and-referral/>

3. Proposed Efficiency Adjustment

- a. Application to time-based services

- i. **We support CMS’s proposal to exempt all time-based services from the proposed efficiency adjustment.** Time-based services cannot become efficient over time because efficiency cannot be obtained when the reimbursement is based on time spent. The efficiency of time-based services is represented by less time being spent providing the service. Since the reimbursement is based on time, the reimbursement for the time-based services will be reduced because there will be less time applied in the time-based reimbursement formula. As a result, all time-based services have an inherent efficiency factor built into the reimbursement methodology because the reduction in time spent will lead to a reduction in reimbursement. **The exemption for the efficiency adjustment should apply to all time-based care management services, to include community health integration (CHI), principal illness navigation (PIN), and principal illness navigation – peer support (PIN-PS).**

4. Prevention and Management of Chronic Disease – Request for Information

a. Support for prevention and management, including self-management of chronic disease

- i. **We strongly encourage CMS to create a direct pathway for Medicare reimbursement for beneficiary participation in evidence-based and evidence-informed chronic disease self-management programs.** CMS should create a health coaching benefit and allow the delivery of these evidence-based programs as a reimbursable health coaching benefit. Many of these evidence-based programs are delivered by community-based organizations in community settings. Therefore, these health coaching services should be approved to be delivered by auxiliary personnel (including personnel from CBOs) incident to a qualified practitioner, under general supervision.
- ii. **Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) should be able to bill and receive payment for these services separate from their PPS or AIR-based payment structure.** In addition, **FQHCs and RHCs should be authorized to bill for these services with the same requirements as traditional providers, using the same codes that traditional providers use, and have the payment rate mapped to the National Payment Rate, regardless of the location of the FQHC or RHC.**
- iii. The service should allow for concurrent billing with all care management services and be rendered as long as medical necessity is established without a limit or cap on services rendered.
- iv. Medical necessity should be established by an initiating visit. The initiating visit should have a permanent exemption to allow telehealth under the expanded flexibility to include the beneficiary home.
- v. There are several evidence-based chronic disease self-management programs that have proven outcomes through randomized clinical trials with replication for all populations and markets. Many of these evidence-based chronic disease self-management programs are not covered by existing Medicare payment rules. Therefore, there are defined limitations on the number of persons that can attend these essential evidence-based programs. The limitation on participation in these evidence-based programs is generally limited to available grant funding. **Including disease-self management programs in Medicare reimbursement will ensure that beneficiaries that have medical necessity for disease self-management supports can attend available programming.**
- vi. The listing of evidence-based programs, supported by ACL formula grants, which are not captured by the current physician fee schedule code set: <https://www.ncoa.org/evidence-based-programs/>

b. Social Isolation and Loneliness

- i. There are two evidence-based programs that address depression and social isolation in older adults and persons with disabilities that are most widely implemented:
 - Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors):
<https://www.ncoa.org/article/evidence-based-program-healthy-ideas/>
 - PEARLS (Program to Encourage Active, Rewarding Lives for Seniors):
<https://www.ncoa.org/article/evidence-based-program-pearls-program-to-encourage-active-rewarding-lives/>
 - ii. These two evidence-based programs for depression and social isolation are delivered in community settings by community-based organizations. Trained health coaches deliver the interventions. The trained health coach receives referrals from clinical partners. The person receives an initial screening by the health coach to ensure that the person meets the eligibility criteria and a baseline PHQ-9 is performed. Next, the beneficiary participates in a series of individual interventions to foster increased engagement in activities to improve health and well-being. A key evaluation metric of these interventions is a repeat PHQ-9. **These interventions have been shown to have a demonstrative and lasting (one+ years) impact on depression symptoms in the affected population.** The remission from depression is documented with the reduction in PHQ-9 scores of the life of their participation with each encounter capturing a repeat PHQ-9 score to compare to the baseline score.
 - iii. **We strongly encourage CMS to create a direct pathway for reimbursement in these evidence-based programs for depression and social isolation that includes a provision to allow the services to be rendered by auxiliary personnel, operating under general supervision, incident to the professional services of the qualified practitioner.** The payment pathway for programs that address social isolation, and loneliness could include a new health coaching benefit. **We strongly encourage CMS to create a health coaching benefit with new HCPCS codes that are similar to the current Category III CPT Health and Well Being codes.** The evidence for health coaching is well established and should be implemented without delay and included as a benefit in the CY2026 Final Rule.
 - iv. The service should allow for concurrent billing with all care management services and be rendered as long as medically necessity is established without a limit or cap on services rendered.
 - v. **Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) should be able to bill and receive payment for these services separate from their PPS or AIR-based payment structure.** In addition, FQHCs and RHCs should be authorized to bill for these services with the same requirements as traditional providers, using the same codes that traditional providers use, and have the payment rate mapped to the National Payment Rate, regardless of the location of the FQHC or RHC.
- c. Physical Activity
- i. **Physical activity and fall prevention programs are essential preventive health services. Increasing physical activity and preventing falls in older adults and persons with disabilities are critical to reducing the total cost of care of affected populations.** The STEADI algorithm is an evidence-based framework developed by the Centers for Disease Control and Prevention (CDC) to help healthcare providers assess and reduce fall risk in older adults. STEADI (Stopping Elderly

Accidents, Deaths & Injuries) involves a three-step process including screening for fall risk, performing assessments of modifiable risk factors, and implementing targeted interventions.¹

The STEADI algorithm recommends the following targeted interventions based on the identified fall risk identified during the assessment:

- Physical therapy
- Medication adjustments
- Community-based balance programs

- ii. While the STEADI algorithm is the “Gold Standard” for addressing fall risk and physical activity in older adults, with fall risk, there are key portions of the STEADI algorithm that are not covered under the current Medicare payment policy. The clinician assessment, in the STEADI algorithm, can be reimbursed under standard evaluation and management (E/M) coding. Referrals to physical therapy are covered under existing physical therapy codes. Unfortunately, the STEADI algorithm recommendation for referral to a community-based balance program is not covered under Medicare payment policy. Therefore, persons either receive only a portion of the evidence-based STEADI algorithm or access to the community-based balance program in the algorithm, is limited based on available grant funding to support the delivery of community-based balance programs. The lack of payment policy to support the CDC evidence-based algorithm to refer eligible persons to a community-based balance program severely limits beneficiary access and is contrary to the evidence.
- iii. The CDC estimates that older adult falls costs the Medicare program \$29 billion per year.² **The Medicare program and beneficiaries would greatly benefit by expanding access to evidence-based fall prevention and physical activity programs for persons that have risk for falls.** The key aspect of the STEADI algorithm that must be included in future payment policy is the community-based balance program. **CMS should consider creating a Medicare benefit for participation in a community-based balance and physical activity program. The benefit should have an allowance for delivery in a community setting, by community-based organizations that have auxiliary personnel with appropriate training on the implementation of the evidence-based program.** The community-based fall prevention and physical activity benefit should allow for services to be rendered under general supervision, incident to the professional services of a qualified practitioner. **CMS should explicitly state that practitioners should consider contracting with community-based organizations to deliver these services,** in accordance with the evidence-based STEADI algorithm.

Medical necessity for the community-based fall prevention and physical activity benefit could be established by requiring the beneficiary to have an initiating visit. During the initiating visit, the qualified practitioner would establish medical necessity. Once medical necessity is established, the beneficiary would have a referral/prescription to attend an evidence-based fall prevention or physical activity program, delivered in a community setting. The community-based organization must establish clinical integration with the qualified practitioner that provides general supervision of services rendered by auxiliary personnel at the CBO and bills for services under general supervision, incident to the professional services of the qualified practitioner.

¹ The CDC STEADI algorithm can be found at the following link: <https://www.cdc.gov/steady/index.html>

² <https://stacks.cdc.gov/view/cdc/122747>

- iv. The service should allow for concurrent billing with all care management services and be rendered as long as medical necessity is established without a limit or cap on services rendered.
 - v. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) should be able to bill and receive payment for these services separate from their PPS or AIR-based payment structure. In addition, FQHCs and RHCs should be authorized to bill for these services with the same requirements as traditional providers, using the same codes that traditional providers use, and have the payment rate mapped to the National Payment Rate, regardless of the location of the FQHC or RHC.
- d. Lifestyle Modification / Health Coaching
- i. **We highly encourage CMS to consider creating a payment pathway for lifestyle modification interventions.** Many evidence-based lifestyle modification interventions are delivered with a mix of individual and group interventions – in community settings. The current billing and coding regulations do not provide a payment pathway for lifestyle interventions delivered in community settings – as an individual or group-based encounter. It is not appropriate for these extensive lifestyle modification interventions to occur in clinical settings or an exam room. **Therefore, these essential lifestyle modification interventions should be covered as a health coaching intervention that can be rendered in community settings by auxiliary personnel, under general supervision incident to the professional services of a qualified practitioner.**
 - ii. Lifestyle modification is not represented in current coding. Specifically, the Intensive Behavioral Therapy (IBT) benefit has significant barriers to implementation that prevent the utilization of health coaches to support lifestyle modification, utilizing the intensive behavioral therapy benefit. The IBT benefit is limited to services that are only rendered in clinical settings. The IBT benefit does not allow for general supervision or the utilization of auxiliary personnel in the delivery of the service, because incident to rules do not apply to the IBT benefit. In addition, the IBT benefit has a limited eligibility criteria which prevents large volumes of eligible persons from participating in the benefit. Lastly, the limits on the benefit prevent the delivery of person-centered health coaching models. Therefore, the current structure of the IBT benefit prevents the utilization of this benefit for the provision of health coaching to support lifestyle modification.
 - iii. Currently CPT has a set of Category III CPT codes for health coaching (0591T, 0592T, and 0593T). The Category III CPT codes are not reimbursable under Medicare. **CMS should establish a set of HCPCS codes for health coaching and provide reimbursement for health coaching services.** The time-based billing threshold of 30 minutes is used by CPT as the basis for the Category III CPT Health and Well-Being Codes. **We recommend that CMS use the same time-based threshold of 30 minutes for health coaching under a set of new HCPCS codes.** The health coaching services should allow for the services to be rendered by auxiliary personnel at community-based organizations. The rule should explicitly state that qualified practitioners can contract with community-based organizations and deliver the health coaching intervention in community settings, to include the home. The provision of health coaching services in community settings will facilitate behavior change and lifestyle modification as an extension of the medical intervention as an incident to service.
 - iv. **The health coaching HCPCS codes should allow for individual and group interventions.** The services should be billed as time-based billing. The time-based billing should allow for services to be rendered if medical necessity is established, and the services meet a defined need. There should be no limit or cap on the services. In addition, the health coaching benefit should not have a lifetime

limit. Persons should be able to access health coaching services based on medical necessity. A lifetime limit or specific time-based limit will impair the provision of the service in a person-centered manner. Lifestyle modification, through a health coaching benefit, must be person-centered in the delivery. A person-centered approach does not place arbitrary time limits or lifetime limits on the delivery. The health coaching benefit should consider the beneficiary's need for services based on the current disease state or future presentation of complications related to their disease.

- v. The rate established should be based on the RVU (Relative Value Unit) for Chronic Care Management. We have identified Medicare Advantage Plans that have executed contracts for Health Coaching using the Category III CPT codes. The contract with the Medicare Advantage Plan was structured as a Special Supplemental Benefit for the Chronically Ill (SSBCI). The rate established under the SSBCI benefit was mapped to the Chronic Care Management (CCM) RVU. The CCM codes used to establish the Health Coaching Rate are the following codes: 99490, 99439, 99487, and 99489. We highly recommend that the rate established for health coaching has the same RVU valuation as Chronic Care Management.
- vi. There should be no limit or lifetime benefit imposed on the health coaching benefit. The current lifetime benefit for the diabetes self-management therapy (DSMT) is an example of how a lifetime benefit hampers lifestyle modification. The DSMT benefit has a ten (10) hour lifetime benefit. If a person utilizes their lifetime benefit for diabetes education when they are first diagnosed with diabetes, they are not able to use their education benefit again for the rest of their life. This arbitrary lifetime benefit prevents the person with diabetes from obtaining education when they have complications related to their diabetes – when the beneficiary most needs additional education. We urge CMS to create the health coaching benefit in a manner that considers the documented limitation of the DSMT benefit which limits access to eligible persons when they are most in need of additional education and supports.
- vii. The service should allow for concurrent billing with all care management services and be rendered as long as medical necessity is established without a limit or cap on services rendered.
- viii. A beneficiary should be eligible for health coaching/motivational interviewing if they have 1+ chronic condition.
- ix. Medical necessity should be established during an initiating visit to a qualified practitioner. The initiating visit should be authorized to be delivered by telehealth with permanent flexibility to deliver telehealth in the home setting.
- x. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) should be able to bill and receive payment for these services separate from their PPS or AIR-based payment structure. In addition, FQHCs and RHCs should be authorized to bill for these services using the same requirements and same codes as traditional providers and have the payment rate mapped to the National Payment Rate, regardless of the location of the FQHC or RHC.
- xi. **The qualifications of a health coach should match the current definition of a qualified health coach defined by CPT** (CPT© Copyright. American Medical Association. All rights reserved. AMA and CPT are registered trademarks of the American Medical Association.)
 - Health and Well-Being Coaching: *“Health and well-being coaching is a patient-centered approach wherein patients determine their goals, use self-discovery or active learning*

processes together with content education to work towards their goals, and self-monitor behaviors to increase accountability, all within the context of an interpersonal relationship with a coach... The health and well-being coach is qualified to perform health and well-being coaching by education, training, national examination and, when applicable, licensure/regulation, and has completed a training program in health and well-being coaching whose content includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories.”

- **We strongly discourage CMS from setting the qualifications of a health coach to requirements set by any national credentialing organization.** Limiting health coaches to persons that have been trained by a limited set of national credentialing organizations, or a national certification will severely limit access to this important intervention. In addition, there is an existing national network of community-based organizations providing health coaching, lifestyle modification, and motivational interviewing through ACL-formula grant funded programs. Limiting the access to health coaching to persons that have attended the few programs that meet a single national accreditation or certification standard will eliminate all of the existing programs providing these essential services that have been heavily invested in through ACL formula grants.

e. Motivational Interviewing

- We strongly encourage CMS to create separate coding and payment for motivational interviewing.** The resources required for motivational interviewing are not included in current coding and payment. Motivational interviewing is a core competency of health coaching. Therefore, time spent providing motivational interviewing should be reimbursable under a health coaching benefit. The health coaching benefit, which includes motivational interviewing, should have a provision to allow the service to be rendered by auxiliary personnel, operating under general supervision incident to the professional services of the qualified practitioner that establishes medical necessity during an initiating visit.
 - Motivational Interviewing Definition: *“MI is a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person’s own reasons for change within an atmosphere of acceptance and compassion.”* (Miller & Rollnick, 2013, p. 29)
- Personnel that provide motivational interviewing should operate as auxiliary personnel to a qualified practitioner, under general supervision.** The qualifications should be the same as a health coach and include the following:
 - The health and well-being coach is qualified to perform health and well-being coaching by education, training, national examination and, when applicable, licensure/regulation, and has completed a training program in health and well-being coaching whose content includes behavioral change theory, motivational strategies, communication techniques, health education and promotion theories.
- A beneficiary should be eligible for health coaching/motivational interviewing if they have 1+ chronic condition.
- Medical necessity should be established by an initiating visit by a qualified practitioner. The initiating visit should be authorized to be delivered by telehealth, with permanent flexibility to deliver telehealth in the home setting.

- v. The minimum threshold of time for motivational interviewing should be fifteen (15) minutes.
 - vi. Motivational interviewing is a core competency of health coaching. We recommend that motivational interviewing be covered under coding and payment as part of a broad health coaching benefit. The health coaching benefit should be billed in thirty (30) minute increments in a similar manner to CPT. In addition, the health coaching benefit provides reimbursement for services rendered by auxiliary personnel, operating under general supervision incident to a qualified practitioner that established medical necessity during an initiating visit.
 - vii. The service should allow for concurrent billing with all care management services and be rendered as long as medically necessity is established without a limit or cap on services rendered.
 - viii. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) should be able to bill and receive payment for these services separate from their PPS or AIR-based payment structure. In addition, FQHCs and RHCs should be authorized to bill for these services with the same requirements as traditional providers, using the same codes that traditional providers use, and have the payment rate mapped to the National Payment Rate, regardless of the location of the FQHC or RHC.
- f. Medically Tailored Meals
- i. **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. However, we encourage CMS to consider creating separate coding and payment for **Medically Tailored Meals and Clinically Appropriate Meals**. Please refer to the following definitions for Medically Tailored Meals and Clinically Appropriate Meals:
 - Medically Tailored Meals defined by Coding4Food (C4F): *Meal, providing an estimated 1/3 of the recommended dietary intake(s), per therapeutic, evidence-based dietary specifications for conditions prepared using natural foods*, assigned based on an assessment of the individual's nutritional needs by a Registered Dietitian (RD) or other nutritional professional, intended for use in non-facility/home settings. *Natural: nothing artificial or synthetic (including all color additives regardless of source) has been included in, or has been added to, a food that would not normally be expected to be in that food. (USDA)*
 - Clinically Appropriate Meals: *Clinically appropriate meals must provide well-balanced, nutritionally appropriate meals that adhere to evidence-based nutritional guidelines. Clinically appropriate meals promote health and wellness for enhanced populations. All meals provided must be approved by a Registered Dietitian Nutritionist (RDN) and must adhere to standards informed by appropriate nutrition guidelines.*
 - ii. **We strongly recommend CMS to create separate coding and payment for both Medically Tailored Meals and Clinically Appropriate Meals** because many rural markets have limited access to RDNs. It is more feasible, in a rural market, to meet the definition standard for Clinically Appropriate Meals. It is imperative that rural populations are not prevented from realizing the positive benefit of a meal service due to limited access to RDNs in rural markets. Therefore, the clinician should have the discretion to order Medially Tailored or Clinically Appropriate Meals. Lastly, there is an existing national infrastructure of Meals on Wheels programs that provide home-delivered meals to older adults and persons with disability, supported by ACL-formula grants. Most

of the current Meals on Wheels programs provide Clinically Appropriate Meals according to standards set by ACL. A meal benefit that does not include Medically Tailored Meals and Clinically Appropriate Meals would disqualify many of the critically important Meals on Wheels programs. The clinical impact of Meals on Wheels programs is well documented.³

The tremendous health impact of Meals on Wheels programs must be included in a meal benefit, which mandates that the definition of the service includes **both Medically Tailored Meals and Clinically Appropriate Meals**.

- iii. **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 CHI and PIN benefit structure sets a precedence for CBOs contracting with a qualified practitioner to deliver services to eligible beneficiaries. Therefore, we highly recommend that CMS create a payment and coding pathway that provides reimbursement for Medically Tailored Meals or Clinically Appropriate Meals delivered by Community-Based Organizations as an incident to service, under general supervision.
- iv. **The rate established for Medically Tailored Meals and Clinically Appropriate Meals must consider the higher costs required to deliver home-delivered meals.** In addition, some persons will require hot prepared meals because they have limited caregiver support, homebound status, or require specialized meal preparation, such as pureed meals for persons that have had a stroke. Therefore, the price should not be fixed on the cost of shipping a 4-week box of frozen meals because some of the most vulnerable population that would benefit from the meal benefit would not be able to manage a case containing four weeks of frozen meals. The meal benefit should be person-centered and include in-person delivery and hot meal options based on the clinical needs. Therefore, a rate structure of \$12 - \$15 per meal would be required to accommodate the range of clinical options required to serve the population including rural and special menu preparation options. A rate below \$12 per meal would not provide a viable meal option that many beneficiaries would consider optimal or meet populations with special diet needs – such as hot meal delivery, when the person is not able to store and prepare frozen meals.
- v. **We encourage CMS to consider an expanded interpretation of the qualified practitioner that can bill for services rendered by auxiliary personnel as an incident to service, under general supervision.** The most appropriate practitioner to deliver general supervision for the Medically Tailored Meals or Clinically Appropriate Meals benefit would be an RDN. The RDN is required for the intervention. Therefore, the RDN would be the most appropriate practitioner to bill for the “Meal” benefit. We acknowledge that the current regulations do not allow RDNs to bill for services rendered by auxiliary personnel, incident to the RDN, under general supervision. However, we encourage CMS to consider modifying the rule to allow RDNs to be included in the list of qualified practitioners to render general supervision for a meal benefit rendered by auxiliary personnel as an incident to service. We feel strongly that the RDN would be the most appropriate clinician to bill for this new meal Medically Tailored Meals or Clinically Appropriate Meals benefit as an incident to service. Therefore, CMS should modify the rules to allow RDNs to operate as a qualified practitioner for this

³ <https://www.mealsonwheelsamerica.org/research/more-than-a-meal-addressing-changes-of-condition-for-meals-on-wheels-clients/>

benefit to render services with the support of auxiliary personnel and bill incident to the RDN for this specific benefit.

- vi. The Medically Tailored Meals or Clinically Appropriate Meals benefit should be available to eligible beneficiaries based on the following recommended criteria:
 - Post-discharge (including inpatient admission, observation stay, and nursing home transition).
 - Pre-op
 - Post-op (including procedures performed at ambulatory surgery centers)
 - Qualifying health conditions
 - Diabetes
 - Prediabetes
 - Heart Failure
 - COPD
 - Chronic Kidney Disease
 - Frailty
 - Malnutrition
 - Other health conditions determined medically necessary by the qualified practitioner providing general supervision
- vii. The service should allow for concurrent billing with all care management services and be rendered as long as medical necessity is established without a limit or cap on services rendered.
- viii. Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) should be able to bill and receive payment for these services separate from their PPS or AIR-based payment structure. In addition, FQHCs and RHCs should be authorized to bill for these services with the same requirements as traditional providers, using the same codes that traditional providers use, and have the payment rate mapped to the National Payment Rate, regardless of the location of the FQHC or RHC.

Thank you for the opportunity to provide comments for the CY2026 Physician Fee Schedule proposed rules. Please contact Autumn Campbell (acampbell@partnership2asc.org) if there are questions regarding any of the listed recommendations or suggestions.

Sincerely,

June Simmons and Tim McNeill, Co-Chairs, Partnership to Align Social Care

SIGNING ORGANIZATIONS

National

A2 Associate, LLC, Jamestown, NY
American Association on Health and Disability, Rockville, MD
Camden Coalition, Camden, NJ
Center for Health Law and Policy Innovation of Harvard Law School, Cambridge, MA
Comagine Health, Seattle, WA
Concert Health, San Diego, CA
Independent Living Systems, LLC, Doral, FL
Lakeshore Foundation, Birmingham, AL

Lutheran Services in America, Washington, DC
Meals on Wheels America, Arlington, VA
National Association of Community Health Workers, Boston, MA
National Association of Nutrition and Aging Services Programs (NANASP), Washington, DC
National Council on Aging, Arlington, VA
Partners In Health, Boston, MA
Richard Petty Consulting, Houston, TX
Robinson Ventures, LLC, Hartsville, SC
Second Wind Dreams, Inc., Roswell, GA
Seton Hall University School of Law, Newark, NJ
Social Interventions Research and Evaluation Network (SIREN) at UCSF, San Francisco, CA
Stratis Health, Bloomington, MN
The Camden Coalition, Camden, NJ
The Caregiving Years Training Academy, Park Ridge, IL
YMCA of the USA, Chicago, IL

STATE

AgeOptions, Oak Park, IL
Bay Aging dba VAAACares, Urbanna, VA
Better Health Partnership, Brooklyn Hgts., OH
CareLink, East Providence, RI
Careway LLC dba 1Heart Caregiver Services - Irvine, Tustin, CA
Community Clinical Advances LLC, Portland, OR
Detroit Area Agency on Aging, Detroit, MI
Great Lakes Physicians Organization, Midland, MI
Groundwork Center for Resilient Communities, Traverse City, MI
Healthy Alliance, Schenectady, NY
Iowa Community HUB, West Des Moines, IA
Mass Home Care, Malden, MA
Ohio Association of Area Agencies on Aging, Columbus, OH
Oregon Wellness Network (OWN), Salem, OR
Partners in Care Foundation, San Fernando, CA

LOCAL

AgeOptions, Oak Park, IL
AgeSpan, Inc., Lawrence, MA
Aging & In-Home Services of Northeast Indiana, Inc., Fort Wayne, IN
Aging and In-Home Services of Northeast Indiana, Inc., Fort Wayne, IN
Alzheimer's Los Angeles, Los Angeles, CA
Beach Cities Health District, Redondo Beach, CA
Care Choice Home Care, Vista, CA
Center for Health and Social Care Integration at Rush University Medical Center, Chicago, IL
Central Texas Food Bank, Austin, TX
Colorado Gardens, Conifer, CO
Comfort Keepers, San Diego, CA
Comfort Paradise Home Care Agency, Los Angeles, CA
Community Health Training Institute, DFW, Arlington, TX
Easter Seals North Georgia, Inc, Atlanta, GA
Freedmen's Medicine, Washington, DC

Greater Bergen Community Action, Hackensack, NJ
Green Tree Home Care, Santee, CA
Hand in Hand Healthcare Solutions LLC, Annandale, NJ
Health and Welfare Council of Long Island, Huntington Station, NY
Health Promotion Council of Southeastern Pennsylvania, Philadelphia, PA
Home Safety Consultant, Port St Lucie, FL
Inclusive Alliance IPA, Inc., Syracuse, NY
Jewish Family Services of Greater Kansas City, Kansas City, MO
LifeSpan Resources, Inc., New Albany, IN
Matrix Care Services, LLC, Encino, CA
MettaHealth Partners, Chicago, IL
Navarro Consulting, Los Angeles, CA
Northeast Florida Health Collaborative, Starke, FL
Northern Michigan Health Consortium, Charlevoix, MI
Piedmont Triad Regional Council, Kernersville, NC
Rose's Agency Home Care, Los Angeles, CA
Senior Home Advocates, Irvine, CA
Somerville-Cambridge Elder Services, Somerville, MA
Southwest Washington Accountable Community of Health, Vancouver, WA
Spectrum Generations d/b/a Healthy Living for ME, Augusta, ME
St Louis CHW Coalition, St Louis, MO
St. Louis Integrated Health Network, St. Louis, MO
The Granite YMCA, Manchester, NH
The Network of Behavioral Health Providers, Houston, TX
Trellis, Arden Hills, MN
Western New York Integrated Care Collaborative, Inc., Buffalo, NY
YMCA of Metropolitan Milwaukee, Milwaukee, WI