



ADVOCATES FOR
COMMUNITY
HEALTH

September 12, 2025

Dr. 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: Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule

Dear Administrator Oz,

Thank you for the opportunity to provide a response to the proposed changes outlined in the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule. On behalf of our member community health centers (CHCs) and the 4 million patients they serve, Advocates for Community Health is pleased to share our feedback.

[Advocates for Community Health](#) (ACH) is a member organization focused on advocacy initiatives to affect positive change for CHCs, the patients they serve, and the entire nation's health care system. Our 45 members represent 23 states, Puerto Rico, and the District of Columbia.

We truly appreciate the thoughtful inclusion of community health centers in the agency's direction toward comprehensive care that prioritizes prevention. Below are our more detailed responses to priority issues for your consideration.

1. ACH supports optional add-on codes for Advanced Primary Care Management (APCM) services.

Given the increasing behavioral health needs of the aging population, health centers need increased financing flexibility to support evidence-based behavioral health care. ACH supports the creation of optional add-on codes for Advanced Primary Care Management (APCM) services that would facilitate providing complementary behavioral health integration (BHI) or psychiatric Collaborative Care Model (CoCM)

services if such codes provide additional billing options for health centers. We strongly support designating these services as care management for the purposes of separate payment under the PFS. Aligning Medicare policy across settings of care improves transparency and predictability for rural health clinics (RHCs) and CHCs. Additionally, this add-on structure would streamline the process for providers – removing some of the time-based documentation practices when BHI or CoCM codes are provided by the same practitioner in the same month.

Many ACH members use integrated care models that embed behavioral health within their primary care visits, which would be strengthened by this proposal.

Recommendation: ACH urges CMS to finalize the proposed APCM add-on codes, ensuring that CHCs and RHCs are explicitly eligible to bill for these services.

2. ACH urges CMS to include additional preventive services in the APCM billing codes.

For nearly 34 million patients, community health centers are a cornerstone of delivering comprehensive primary care: often serving as the main, and sometimes only, source of care in rural and underserved areas. For these patients, preventive services are critical to avoiding costly hospitalizations, detecting disease early, and improving long-term health outcomes.

ACH urges CMS to consider including additional preventive care services to APCM billing. Incorporating services such as annual wellness visits, chronic disease screenings (e.g. cholesterol, hypertension, diabetes), and mental health screenings (e.g. depression, anxiety, substance abuse disorder), would significantly streamline billing and allow health centers to continue providing the comprehensive, whole-person care that health centers deliver every day.

Many ACH members highlight the value of expanded preventive services. For example:

1) Mariposa Community Health Center (AZ): Operates a maternal and child health program which includes community health worker home visiting and health education. Preventive services such as perinatal screenings and early childhood health assessments are essential to improving health outcomes for mothers and their children.

2) Camarena Health (CA): Integrates preventive cancer screenings into chronic disease management visits, ensuring patients with complex health needs also

receive critical preventive care during routine encounters.

3. ACH strongly supports the waiver of cost-sharing for APCM services.

Since the inception of the APCM policy, ACH members have encountered the challenging issue of the cost-sharing requirement. Many patients served by health centers live at or below the federal poverty line and are unable to afford cost-sharing, and health centers are prohibited from covering that cost due to anti-kickback statutes. This creates an untenable barrier for patients and undermines access to the very services APCM is designed to promote.

We strongly agree and support CMS' rationale for waiving cost-sharing for the existing APCM. The APCM bundle already contains preventive elements which should be exempt from cost-sharing – and treatment elements that are not. It would be impracticably burdensome to apply cost sharing to just one part of the service.

Recommendation: ACH urges CMS to waive cost-sharing for the current APCM service codes. Doing so will remove financial barriers for vulnerable patients, simplify administrative burden for health centers, and ensure that preventive and coordinated care, central to APCM, remain accessible to Medicare beneficiaries in underserved communities.

4. ACH supports the coverage of devices used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD).

Health centers play a critical role in identifying and managing behavioral health conditions, including ADHD, and are often the only point of diagnosis and treatment for patients in rural and underserved communities. Many of these communities lack access to specialty psychiatric services due to workforce shortages, geography, and economic constraints, making the integration of ADHD care into primary care essential.

Devices and digital technologies, in conjunction with ongoing behavioral health plans, can be essential to the treatment of ADHD. In addition to treatment monitoring and medication adherence, these tools support providers in assessing complex behavioral patterns and coordinating follow-up care. Community health centers and other primary care providers treating patients with ADHD currently face challenges engaging families

and caregivers,¹ and fully assessing the nature of the presenting problem.² Equipping health centers with necessary tools, including devices, to diagnose and treat ADHD in the primary care setting could lead to things like earlier identification, improved treatment monitoring and adherence, and enhanced caregiver engagement. ACH members are already delivering care that would be strengthened by this policy, including:

- 1) **CommWell Health (NC):** Provides comprehensive behavioral services, including ADHD screening, psychiatric care, and substance use disorder treatment. By incorporating digital ADHD assessment and monitoring devices, they can better support ongoing treatment for patients in rural North Carolina.
- 2) **SIHF Healthcare (IL):** Operates a large integrated behavioral health program with school-based centers across southern Illinois. Coverage for ADHD treatment devices would help enable SIHF to expand early screening and treatment monitoring in school-based settings, reaching children who might otherwise go undiagnosed.

Recommendation: ACH urges CMS to provide coverage for devices and digital technologies that support the diagnosis and treatment of ADHD. Doing would give health centers the ability to deliver earlier more effective, and more coordinated care, particularly in areas where specialty behavioral care is limited.

5. ACH supports the establishment of coding and payment policies for other digital therapy devices used as a complement to mental health treatment plans of care.

CHCs are often at the frontlines of addressing the nation’s behavioral health crisis yet continue to face workforce shortages and rising patient demand. Integrating digital therapy devices into primary care and mental health treatment plans can enhance patient access to care and support consistent engagement. Digital tools and devices may provide symptom/treatment management between visits therefore expanding access to care, strengthening care continuity, and continuous support for patients between visits. Devices and monitoring tools can also help supplement limited mental health provider availability & offer remote monitoring options for physicians. However, it

¹Effects of a Primary Care-Based Engagement Intervention for Improving Use of ADHD Treatments
Waxmonsky, James G. et al. Journal of Pediatric Health Care, Volume 37, Issue 5, 537 - 547

² <https://www.acofp.org/news-and-publications/journal/article-detail/vol-16-no-3-fall-2024/adhd-family-medicine-setting#anchor7>

must be noted that the safety, quality, and rigor of these tools needs to be thoroughly vetted – which is hard to do well in this rapidly growing sector. We urge caution and close oversight of any digital solution that does not involve a trained clinical provider.

Recommendation: CMS should recognize digital therapy devices as a reimbursable component of mental health treatment plans that have been vetted for safety and quality or are used by a trained clinical provider.

6. Telehealth/Direct Supervision

ACH strongly supports permanent adoption of a definition of direct supervision that allows the physician or supervising practitioner to fulfil supervision requirements virtually through real-time audio and visual interactive telecommunications (excluding audio-only).

ACH also supports CMS' proposal allowing RHCs and CHCs to bill for non-behavioral telehealth and audio-only visits via HCPCS code G2025 through December 31, 2026. This will ensure continued access for underserved patients without reliable broadband access.

Several ACH members utilize telehealth to provide essential care specific to their communities. Some ACH member examples include:

- 1) Yakima Valley Farm Workers Clinic (WA/OR):** Uses video visits to bring care to agricultural workers in remote rural areas, overcoming transportation and scheduling barriers inherent to farm laborers.
- 2) Great Lakes Bay Health Centers (MI):** Manages chronic disease follow-ups (e.g. diabetes and hypertension) through telehealth, keeping patients engaged and reducing complications.
- 3) Morris Heights Health Center (NY):** Offers a wide array of telehealth services, including primary care, behavioral health, family planning, dermatology, etc. These services transition to in-person care as needed, but by offering them remotely they are able to improve care continuity to patients in the community.

Recommendation: ACH urges CMS to finalize the proposed policies that permanently extend direct supervision in audio-visual telecommunications and extend CHC and RHC telehealth flexibilities, including audio-only options, through at least December 31, 2026.

7. Changes in Practice Expense

ACH supports CMS' proposal to exempt time-based services from a downward adjustment to the components of Medicare payment that are related to work Relative Value Units (RVUs) every three years to Physician Fee Schedule codes. We also support the use of real world, empirical data in assessing potentially misvalued codes.

Historically, primary care has been undervalued relative to specialty care. While clinicians practicing in CHCs do not typically bill the Physician Fee Schedule, ACH strongly supports the systematic revaluation of primary care. The proposed efficiency adjustment is an important step that begins to correct decades of systematic undervaluation of primary care – ensuring fair compensation to support stability in the primary care and community health setting.

Recommendation: ACH urges CMS to finalize the exemption of time-based services from downward adjustments and to continue using real world, empirical data to guide valuation. These changes represent important steps in correcting the long-standing undervaluation of primary care, which will ultimately strengthen the financial and workforce stability of community health centers nationwide.

8. Submission of 340B Claims Data

ACH does not support the potential move toward a 340B repository of claims data. For health centers, the 340B program is a lifeline that enables expanded access to dental, behavioral health, care coordination, and other specialty services that would otherwise go unfunded. Imposing duplicative submission requirements puts the stability of this critical resource at risk.

While the submission in 2026 is optional, the submission of claims data is both administratively burdensome and unnecessary. Providers would be responsible for collecting and submitting large data quantities – taking away from other essential responsibilities. Furthermore, CMS can use existing claims modifiers to evaluate and assess 340B claims and their interactions with other pharmaceutical claims. Using existing claim modifiers maintains transparency and oversight without burdening already busy health center staff.

Most ACH members rely on relationships with contract pharmacies, and many operate in-house pharmacies to meet the needs of low-income and uninsured patients in their communities. Current reporting requirements already demand extensive reconciliation across pharmacy partners, and duplicating this process will add administrative burden without a clear benefit to the patients.

Recommendation: ACH urges CMS to refrain from creating a new 340B claims data repository. Rather, CMS should rely on the existing 340B claims modifiers already in use, which provide sufficient transparency and oversight without creating additional burden.

Thank you again for the opportunity to provide feedback on the Calendar Year (CY) 2026 Medicare Physician Fee Schedule (PFS) Proposed Rule. For more information, please contact me at apearskelly@advocatesforcommunityhealth.org and/or Stephanie Krenrich, Senior Vice President of Policy and Government Affairs, at skrenrich@advocatesforcommunityhealth.org.

Sincerely,

A handwritten signature in black ink, appearing to read 'Amanda Pears Kelly', with a stylized flourish at the end.

Amanda Pears Kelly
Chief Executive Officer
Advocates for Community Health