Healthcare Advisory Committee

Federal Advisory Committee Meeting 3 | November 9, 2026

The Hubert H. Humphrey Building

200 Independence Avenue S.W. Washington, D.C., 20201

Virtual Meeting Zoom Webinar: Join the November 9 HAC meeting via Zoom

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Committee Purpose

The Healthcare Advisory Committee (HAC) will advise HHS Secretary Robert F. Kennedy Jr. and CMS Administrator Dr. Mehmet Oz on ways to improve how care is financed and delivered across Medicare, Medicaid, the Children's Health Insurance Program, and the Health Insurance Marketplace. The Committee will provide non-binding recommendations to inform federal healthcare policy and program administration.

Over its term, the Committee will focus on:

1. Developing actionable policy solutions to prevent and better manage chronic disease
2. Advancing accountability for safety and outcomes while reducing unnecessary administrative burden
3. Expanding the use of real-time data to support a higher quality of care, speed up claims processing, and improve quality measurement
4. Enhancing care for vulnerable populations, including those served by Medicaid
5. Strengthening Medicare Advantage sustainability, including modernizing risk adjustment and quality measurement
6. Identifying and developing actionable ideas to strengthen program integrity to protect taxpayer dollars while preserving access for compliant providers and beneficiaries

Committee Structure

Members will serve a two-year term and meet regularly. Public Committee meetings will be announced through the Federal Register.

Committee Members

Chair

Clive K. Fields, MD

Members

- Robert Bessler, MD
- Kimberly Brandt, JD
- Sebastian Caliri
- Steph Carlton
- David Carmouche, MD
- Elizabeth M. Fago
- William (Bill) J. Gassen, JD
- Jenni Gudapati, PhD, MBA, RN
- Valerie D. Huhn
- Dennis Laraway, MBA
- Dan Liljenquist, JD
- Andrew Lynch, PhD
- Ursel J. McElroy, MA
- Kyu Rhee, MD, MPP
- Tony Robbins
- Russ Thomas, JD
- Linda Thomas-Hemak, MD, FCAP, FAAP

Committee Meeting 3 Objectives

1. Discuss and vote on the Working Groups' proposed recommendations
2. Review each Working Group's refined ideas and next steps for fulfilling their vision
3. Collect public feedback on the Committee's progress

Agenda | November 9, 2026, 9:30 AM

Welcome and Roll Call | Dr. Clive Fields (Chair), Morgan Taylor (Designated Federal Officer)

MAHA by Improving Wellness & Preventing Chronic Disease Working Group

Recommendations and Vote | Dr. Clive Fields (Working Group Lead) and Committee Members

1. Mechanism 1: CMS Fee Schedule Rulemaking

   Condition-Based Collaborative Care Payment

   The Working Group suggests replacing time-based Collaborative Care Model (CoCM) billing with condition- or episode-based payment for Committee consideration. The presentation will address monthly payment structures and allowing federally qualified health centers to bill CoCM services outside the prospective payment system rate.

2. Mechanism 2: State Medicaid Directors Letter

   Medicaid Coverage for Collaborative Care

   The Working Group suggests requiring Medicaid coverage of CoCM services in all states for Committee consideration. The presentation will address coverage across both fee-for-service and managed care programs to expand access to integrated behavioral health care.

   Medicaid Reimbursement for Collaborative Care

   The Working Group suggests requiring Medicaid reimbursement for CoCM services at least on par with Medicare rates for Committee consideration. The presentation will address payment standards across fee-for-service and managed care programs to support sustainable delivery of collaborative care.

   Standardized Behavioral Health Care Manager Requirements

   The Working Group suggests standardizing behavioral health care manager requirements for Committee consideration. The presentation will address removing additional state licensure requirements that exceed Medicare requirements and create barriers to staffing collaborative care programs.

   Removal of Attestation and Prior Authorization Requirements

The Working Group suggests removing additional primary care provider attestation and prior authorization requirements for CoCM services for Committee consideration. The presentation will address reducing administrative barriers and aligning state Medicaid requirements with Medicare.

3. Mechanism 3: Medicare Learning Network Guidance

   Capabilities-Based Registry Requirements

   The Working Group suggests replacing separate registry requirements with defined functional capabilities for Committee consideration. The presentation will address using electronic health record capabilities, including panel- and population-level reporting and tracking assessments over time, to support collaborative care.

   Integration of Collaborative Care Consent

   The Working Group suggests incorporating CoCM consent into standard primary care consent for Committee consideration. The presentation will address simplifying consent procedures and removing separate CoCM consent documentation requirements through updated Medicare Learning Network guidance.

4. Mechanism 4: Three Paths to Remove Patient Cost Sharing

   Removal of Patient Cost Sharing

   The Working Group suggests removing patient cost sharing for CoCM services for Committee consideration. The presentation will address three proposed pathways: reducing or waiving Medicare coinsurance, expanding the Internal Revenue Service preventive-care safe harbor, and pursuing a U.S. Preventive Services Task Force preventive-service classification.

5. Mechanism 5: Legislation and Regulation

   State Collaborative Care Implementation Support

   The Working Group suggests funding state CoCM implementation centers and start-up grants for clinics for Committee consideration. The presentation will address state appropriations to help primary care practices establish and sustain collaborative care programs.

   National Collaborative Care Implementation and Technical Assistance

   The Working Group suggests funding additional national CoCM implementation and technical assistance initiatives for Committee consideration. The presentation will address increasing appropriations for the Substance Abuse and Mental Health Services Administration's Promoting the Integration of Primary and Behavioral Health Care grants to support broader implementation.

Refined Ideas and Next Steps | Committee Members

Additional Participants

1. Dr. Belal Abdallah, MD

2. Dr. Shawn Martin, MD

Improving Care for Vulnerable Populations Working Group

Recommendations and Vote | Dr. Kyu Rhee (Working Group Lead) and Committee Members

Additional Participants

1. Dr. Asaf Bitton, MD, MPH
2. Dr. Dariush Mozaffarian, MD
3. Dr. David Rubin, MD
4. Stuart Archer, FACHE

1. *Medically Tailored Meals as a Covered Benefit for High-Risk Clinical Populations*

   The Working Group suggests that CMS recognize medically tailored meals — fully prepared meals designed by a registered dietitian or nutritionist to meet a patient's medical needs — as a medically necessary, time-defined intervention for Medicaid, Medicare, and Dual-eligible patients with evidence of high clinical risk, such as uncontrolled type 2 diabetes, uncontrolled hypertension, cardiovascular disease, depression, chronic kidney disease, cancer, and other diet-sensitive conditions.

   The Working Group suggests that CMS issue guidance clarifying how medically tailored meals for these populations can be covered as a standard Medicaid benefit — within existing state plan benefit categories, such as home health services and other diagnostic, screening, preventive, and rehabilitative services, and through In Lieu of Services and managed care contracting — and encourage states to adopt standardized eligibility criteria and a common set of utilization, clinical, and cost measures so results can be compared across states. CMS should also pursue pathways for medically tailored meals as a covered benefit for clinically indicated Medicare beneficiaries through Medicare Advantage supplemental benefits, National Coverage Determination, or CMMI pathways.

2. *Pediatric Food and Nutrition Insecurity Screening and Clinical Follow-Up through EPSDT*

   The Working Group suggests that CMS issue guidance clarifying that screening for food and nutrition insecurity with validated tools, such as the two-question Hunger Vital Sign, falls within existing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) expectations for children enrolled in Medicaid and CHIP, and that a positive screen should prompt clinical assessment for diet-related conditions — such as obesity, prediabetes, or poor growth — and coverage of medically necessary follow-up, such as medical nutrition therapy, under EPSDT.

   The Working Group suggests that CMS consider adding a food and nutrition insecurity screening and follow-up measure to the Child Core Set, building on existing candidate measures, so that screening, follow-up, and child health outcomes can be tracked consistently across states.

3. *Care Coordination and Cross-Enrollment with Federal Nutrition Programs*

The Working Group suggests that CMS, in partnership with USDA, issue joint guidance enabling care coordination to connect Medicaid and Medicare enrollees with an identified clinical nutrition need — including recipients of Food is Medicine interventions under Recommendations 1 and 2, children with a positive screen under Recommendation 3, and pregnant and postpartum enrollees — to WIC, school meals and Summer EBT, and SNAP, so that clinical gains can be sustained after a time-defined clinical intervention ends.

The Working Group suggests that this guidance clarify data-sharing and streamlined enrollment options already available to states, such as WIC adjunctive income eligibility for Medicaid enrollees and direct certification of Medicaid-enrolled children for school meals, and identify existing vehicles to support this coordination — community health worker services, managed care contract requirements, and targeted case management — with performance measured by completed enrollment and health outcomes rather than activity alone.

4. *Psychiatric Hospital Regulatory Policy Modernization*

The Working Group suggests that regulations for psychiatric hospitals be updated to reflect the modern psychiatric workforce and patient needs. The Committee believes that these regulatory updates could significantly improve access to psychiatric care without requiring new federal spending.

The Working Group suggests the following three modernizations: (1) updating director of psychiatric nursing qualifications to reflect modern clinical practice, (2) confirming that state-approved clinicians can perform psychiatric evaluations, and (3) modernizing acute psychiatric treatment planning to reflect contemporary care models.

Refined Ideas and Next Steps | Committee Members

Additional Participants

1. Dr. Robert L. Phillips, Jr., MD, MSPH
2. Dr. Yalda Jabbarpour, MD

Crushing Fraud, Waste, & Abuse Working Group

Recommendations and Vote | Russ Thomas (Working Group Lead) and Committee Members

1. *Accelerate Proper Payments, Real-time Payment Integrity Architecture*

The Working Group recommends that CMS build targeted, prepayment integrity capabilities into the ClaimsCore modernization roadmap, using automated, risk-based validation to improve payment accuracy and reduce downstream rework.

Working with ClaimsCore leadership, CMS should identify a phased integration pathway that protects core implementation scope while evaluating opportunities to move appropriate edits earlier into claim-submission and provider workflows, connect relevant provider information, and improve transparency of applicable billing rules. Implementation should preserve timely payment, explainability, and appropriate review and correction pathways.

2. *Coverage Consistency for Patients, Reduce Unwarranted LCD Variation*

The Working Group suggests that CMS build on existing efforts to improve consistency across LCDs, prioritizing differences that create avoidable patient and provider confusion, administrative burden, or opportunities for waste and abuse, while preserving justified local variation and clinical specificity.

Informed by engagement with CCSQ, CMS should use claims data and stakeholder input to identify high-impact coverage gaps and coordinate policy development and implementation across MACs. National review could be considered where appropriate, rather than assuming that greater consistency requires replacing LCDs with NCDs

3. *Reduce Potentially Avoidable Care and Misaligned Incentives*

The Working Group suggests that CMS target payment differences for clinically comparable services where differences are not justified by patient complexity, resource requirements, quality, access, or essential infrastructure obligations, while protecting rural and safety-net access and emergency readiness.

CMS should also prioritize specific upstream decisions that drive avoidable downstream utilization, including unnecessary repeat imaging and laboratory testing. The focus should be on making relevant information available earlier and aligning incentives for appropriate care, while preserving medically necessary repeat services and measuring patient cost-sharing, access, quality, and total cost of care.

Refined Ideas and Next Steps | Committee Members

Lunch

Public Comment | Dr. Clive Fields

Strengthening Medicare Advantage Working Group

Recommendations and Vote | Dr. Robert Bessler (Working Group Lead) and Committee Members

Additional Participants

1. Tommy G. Thompson, JD, Former U.S. Secretary of Health and Human Services

1. *Medicare Advantage and VA Payment Overlap*

The Working Group suggests that CMS and the Department of Veterans Affairs eliminate overlapping Medicare Advantage and VA payments, which would reduce federal spending by $22

billion annually. The agencies should establish the data infrastructure needed to identify duplicate payments when MA beneficiaries receive VA care.

The Working Group suggests that Congress, CMS, and the VA remove barriers to CMS-VA data sharing and implement an enforceable payment-reconciliation mechanism. The solution may involve VA billing of MA plans, interagency reconciliation, or another approach that eliminates duplicative federal spending without limiting beneficiary access.

2. *Agent and Broker Reform*

The Working Group suggests that CMS impose stronger transparency, accountability, and beneficiary-protection requirements on Medicare Advantage agents and brokers. Plan recommendations should reflect beneficiaries' healthcare and financial needs, not insurer compensation or sales incentives.

The Working Group suggests that CMS and Congress establish agents' primary duty to beneficiaries, eliminate compensation structures that favor new enrollment over appropriate retention, require disclosure of compensation and insurer relationships, and hold agents accountable for accurate, beneficiary-specific guidance. CMS should define core coverage-support responsibilities, reassess annual compensation updates, and deploy independent digital and AI-enabled comparison tools with enforceable accuracy, privacy, and consumer safeguards.

3. *Plan and Network Transparency*

The Working group suggests that CMS require MA plans to provide accurate, current, and comparable information on provider networks, prescription drug coverage, out-of-pocket costs, and access to needed services.

The Working Group suggests that CMS create a single comparison experience that allows beneficiaries to confirm provider, hospital, medication, and service coverage and understand likely costs before enrollment. CMS should require standardized, timely plan data; substantially strengthen Medicare Plan Finder; and utilize AI to provide personalized decision support that flags coverage and access risks. These tools should be subject to rigorous accuracy, transparency, privacy, and consumer-protection standards.

Refined Ideas and Next Steps | Committee Members

Reducing Administrative Burden Working Group

Recommendations and Vote | Dan Liljenquist (Working Group Lead) and Committee Members

1. *National Semantic Data Model*

The Working Group suggests that HHS and CMS, in coordination with ONC and other relevant HHS components, sponsor and adopt a robust, machine-readable, open-source semantic data model for defined healthcare use cases. Initial use cases could include aligning clinical data with claims to support fraud, waste, and abuse verification at submission and expanding standardized clinical

data for digital quality reporting and reuse across programs. The model should build on existing national standards, terminology, code sets, FHIR infrastructure, and claims transaction rails, with clear data-quality and conformance requirements for participating payers, providers, contractors, accrediting organizations, and health IT vendors.

ONC should evaluate use of its existing authorities, including the 21st Century Cures Act, to align certified health IT and electronic health information holders with the model and support population-scale access through certified FHIR infrastructure. HHS and CMS should test bounded, high-value use cases and expand adoption only when results demonstrate improved data quality and reduced burden without creating a new reporting layer.

2. *Principles of Quality Reporting*

The Working Group suggests that HHS and CMS establish unified quality-reporting principles across federal programs. Programs assessing the same clinical focus and population should use one measure, specification, and reporting pathway; align measurement and submission periods; rely on standardized, interoperable data that can be submitted once and reused; prioritize valid, feasible, equitable, actionable, and patient-centered outcomes; and permit variation only when clinically, operationally, or statutorily justified.

CMS should establish transparent cross-program governance for adding, changing, harmonizing, and retiring measures; consolidate overlapping measures and reporting pathways; and transition high-burden claims-based and chart-abstracted processes toward reusable digital reporting supported by national standards and certified exchange infrastructure. Implementation should begin in high-burden areas suited for near-term alignment and assess whether changes improve data quality and reduce reporting effort and vendor dependency without weakening comparability, oversight, or patient-centered quality improvement.

Refined Ideas and Next Steps | Committee Members

Deploying Real-Time Data Working Group

Recommendations and Vote | Sebastian Caliri (Working Group Lead) and Committee Members

1. *Streamlining Provider Credentialing through Shared Data Standards and the CMS National Provider Directory*

The Working Group suggests that CMS streamline provider credentialing by establishing a shared core set of credentialing data elements aligned with CMS, private payer, and National Committee for Quality Assurance (NCQA) requirements, and making this information available through the CMS National Provider Directory (NPD).

CMS should work with payers, providers, accrediting organizations, and other industry stakeholders to define this shared dataset and use the NPD to centralize and verify information, including state licensure, board certifications, and federal standing, through real-time connections to authoritative sources. This information should be accessible through standardized Fast Healthcare Interoperability Resources (FHIR) APIs, with CMS policies updated to allow the NPD to serve as a

primary source for credentialing verification. These changes would reduce repeated data submissions and help shorten the time needed for providers to join new organizations or payer networks

2. *Modernizing Medicaid Data Systems to Support Real-Time Program Integrity and Reduce Administrative Burden*

   The Working Group suggests that CMS modernize Medicaid data systems by transitioning states from batch submissions and multiple periodic reports toward standardized, API-based, event-driven data exchange with near-real-time synchronization, while strengthening tools that use data across states to detect and prevent fraud, waste, and abuse.

   CMS should revise the Transformed Medicaid Statistical Information System (T-MSIS) data schema to reduce redundant or unnecessary data elements, incorporate additional information and quality checks needed for program integrity, and derive equivalent analytics directly from state data streams to reduce separate reporting requirements. CMS should also strengthen the Public Assistance Reporting Information System (PARIS) to support real-time checks for enrollment in multiple states and improve the Data Exchange System (DEX) with more timely and comprehensive provider information. Additional efforts should explore rules-based approaches and generative AI tools to identify anomalies and investigate potential fraud, as well as CMS-certified open-source Medicaid Enterprise Systems (MES) modules to support states in transitioning to real-time data exchange.

Refined Ideas and Next Steps | Committee Members

Closing and Next Steps | Dr. Clive Fields, Morgan Taylor