Healthcare Advisory Committee Meeting 1 Public Comments

Public comments are provided for informational purposes only. The enclosed comments were submitted by members of the public and do not necessarily reflect the views or positions of the Healthcare Advisory Committee, Centers for Medicare & Medicaid Services, or the U.S. Department of Health and Human Services.

1. Received on 5/12/26: Matthew Hornberger, Chief Executive Officer & Hannah Martin, Director of Advocacy at Association of Diabetes Care & Education Specialists (ADCES)
2. Received on 5/12/26: Lynn Barr, Private Citizen
3. Received on 5/12/26: Nathan Baugh, Executive Director & Sarah Hohman, Director of Government Relations at National Association of Rural Health Clinics (NARHC)
4. Received on 5/12/26: Laura Culberson Farr, Executive Director at American Association of Naturopathic Physicians (AANP)
5. Received on 5/13/26: Esmé Grewal, President and Chief Executive Officer at Senior Care Pharmacy Coalition (SCPC)
6. Received on 5/13/26: Michael Baxter, Vice President of Government Affairs at American Pharmacists Association (APhA)
7. Received on 5/13/26: Kim Karr Director of Payment Policy at American Occupational Therapy Association (AOTA)
8. Received on 5/13/26: Angela Ross, Executive Director at Washington Association of Naturopathic Physicians (WANP)

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125 South Wacker Drive, Suite 600, Chicago, Ilinois 60606 800.338.3633 DiabetesEducator.org

May 12, 2026

Healthcare Advisory Committee
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services

Re: Vision of the Healthcare Advisory Committee

Dear Committee Members:

On behalf of the Association for Diabetes Care and Education Specialists (ADCES), we are looking forward to the work of the newly formed Healthcare Advisory Committee (the "Committee"). Improving Medicare, Medicaid, and the Health Insurance Marketplace, specifically through prevention and better management of chronic disease, is critical to the administration's *Make America Healthy Again* mission.

ADCES is an interdisciplinary professional membership organization dedicated to improving prediabetes, diabetes, and cardiometabolic care through innovative education, management, and support. With more than 11,000 professional members including nurses, dietitians, pharmacists, and others, ADCES has a vast and diverse network of practitioners working to optimize care and reduce complications. ADCES supports an integrated care model that lowers the cost of care, improves experiences, and helps its members lead so better outcomes follow.

As this Committee sets a vision for its work, we encourage you to focus on the gaps in our healthcare system for people with or at risk of developing diabetes. The U.S. spends more on care for individuals living with diabetes than any other chronic disease. This totaled more than $306 billion in direct medical costs in 2022 with over $100 billion more in indirect costs associated with diabetes-related disability, presenteeism, and premature deaths.[1]

Within Medicare, there are long-standing gaps in coverage for treatment of obesity, prediabetes, and diabetes. For individuals with obesity, Medicare's weight loss counseling benefit (Intensive Behavioral Therapy for Obesity) restricts the service to 15-minute visits with primary care providers and Medicare's Medical Nutrition Therapy (MNT) benefit does not cover visits for obesity, leaving beneficiaries without access to registered dietitians, obesity medicine specialists, and others with extensive training in obesity. Until the GLP-1 Bridge model launches this summer, Medicare beneficiaries will have had no access to obesity medications since the inception of the Part D program, and coverage in 2028 after the Bridge model sunsets remains unclear.

For those with prediabetes, there is coverage for the Medicare Diabetes Prevention Program (DPP)—with new modalities recently covered as of this year—but uptake has remained very low due to onerous

[1] Parker ED, Lin J, et al. Economic Costs of Diabetes in the U.S. in 2022. *Diabetes Care* 2024;47(1):26-43. https://diabetesjournals.org/care/article/47/1/26/153797/Economic-Costs-of-Diabetes-in-the-U-S-in-2022

requirements set forth by CMS for participating DPPs. Similarly for individuals with obesity, Medicare's MNT benefit also does not cover visits for prediabetes.

Once a beneficiary develops diabetes, they gain access to MNT and to Diabetes Self-Management Training (DSMT). While both evidence-based benefits are proven to improve beneficiary outcomes, they suffer from tight restrictions on the number of hours available, an overly narrow list of who can refer for the services, and other benefit design challenges, leaving utilization of these cost-saving services quite low.[2,3] Payment rates for Medicare Part B providers that do not keep pace with medical inflation also threaten beneficiary access to care.

As Medicare often sets the standard in coverage and benefit design, similar problems exist to varying degrees across Medicaid and Health Insurance Marketplace plans leaving Americans from all walks of life sicker and with fewer ways to take control of their health.

We appreciate the substantial charge of this Committee and the opportunity to provide our thoughts as you pursue this important work. If you have any questions as you commence your efforts, please contact ADCES director of advocacy Hannah Martin (hmartin@adces.org).

Sincerely,

Matthew Hornberger, MBA
Chief Executive Officer

Hannah Martin, MPH, RDN
Director of Advocacy

[2] Duncan I, Birkmeyer C, Coughlin S, Li QE, Sherr D, Boren S. Assessing the value of diabetes education. *Diabetes Educ*. 2009;35(5):752-760. https://journals.sagepub.com/doi/10.1177/0145721709343609

[3] Strawbridge LM, Lloyd JT, Meadow A, et al. Use of Medicare's diabetes self-management training benefit. *Health Education Behavior* 2015;42:530-8. https://journals.sagepub.com/doi/abs/10.1177/1090198114566271

May 13, 2026

Healthcare Advisory Committee
c/o Office of the Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted Electronically

RE: Recommendation to Establish a National All-Payer Claims Database (APCD) to Deliver on the Committee's Mandate for Real-Time Data, Outcomes Accountability, and a Healthier America

Dear Members of the Healthcare Advisory Committee:

America runs the most expensive health care system in the world, and it is not making us healthier. We spend more than $15,000 per person each year[1], nearly three times what other wealthy nations spend, and health care now consumes roughly 18%[2] of our entire economy. Yet Americans live shorter lives[3], American mothers are up to three times more likely to die in childbirth than women in peer nations[4], and Americans are more likely to die from chronic diseases and conditions such as heart attacks and strokes[5]. Additionally, medical debt is one of the leading causes of bankruptcy in the U.S., as nearly half of Americans cannot afford an unexpected $500 medical bill[6].

My name is Lynn Barr, and I am a former health care executive and a current health care philanthropist and Medicare Payment Advisory Commission (MedPAC) Commissioner, although these comments do not represent the opinions of MedPAC. Throughout my career in the private sector and government, I've seen how these problems affect patients and families across the country. I've also seen how this problem won't be fixed unless claims data from the various parts of the health care system are brought together so policymakers can effectively use the information to drive real change.

The problems with our health care system are not failures of doctors, nurses, or hospitals. American medicine is innovative and world-class. The failure is structural. We are running a $5 trillion system[7] without a single, transparent set of books. I write to urge the Committee to issue a formal recommendation to Secretary Kennedy and Administrator Oz endorsing the creation of a National All-

[1] https://www.oecd.org/en/publications/health-at-a-glance-2025_15a55280-en/united-states_3517f35e-en.html
[2] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet#:~:text=Historical%20NHE%2C%202024:%20NHE%20grew%207.2%25%20to,for%2018.0%25%20of%20Gross%20Domestic%20Product%20(GDP).
[3] https://www.oecd.org/en/publications/health-at-a-glance-2025_15a55280-en/united-states_3517f35e-en.html
[4] https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/insights-us-maternal-mortality-crisis-international-comparison
[5]https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2848779?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2026.6147
[6] https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/
[7] https://doi.org/10.1377/hlthaff.2025.01683

Payer Claims Database (APCD). This is the foundational reform that makes every other reform in the Committee's charge possible.

A $5 Trillion System Without a Set of Books

Only about 10% of Americans[8], those in traditional Medicare, have claims data that the federal government can systematically analyze for waste, fraud, abuse, cost, or outcomes. For the other 90%, claims are scattered across more than a thousand private insurers, self-funded employer plans, Medicare Advantage organizations, Medicaid managed care plans, and ACA marketplace carriers, each operating under different rules, formats, and systems.

Imagine if the federal government tried to track tax revenue using a thousand incompatible accounting systems. That is how we run health care, and it is financially, and by extension, literally killing us.

The consequences are exactly what one would predict. Administrative costs consume roughly a quarter of total U.S. health care spending[9], several times higher than peer nations. Providers submit bills to countless insurers in countless formats. Employers cannot meaningfully compare prices. Patients are left guessing what anything costs until the bill arrives. We do not spend more simply because Americans are sicker. We spend more because the system is opaque, fragmented, and built to obscure prices.

The Solution: A Standardized, National All-Payer Claims Database

The first and most consequential step to improving the health care system is a single, transparent backbone for accumulating health care claims across all payers, public and private.

APCDs in 24 states have demonstrated the effectiveness of this tool. Studies using state APCDs have documented price variation of 5-10x for identical procedures within the same market, identified low-value and unnecessary care, supported maternal mortality investigations, exposed surprise billing patterns that informed the No Surprises Act, and helped Medicaid programs detect fraud[10]. A national database is necessary, however, because the Supreme Court's 2016 decision in *Gobeille v. Liberty Mutual* exempted ERISA self-funded employer plans, which cover roughly 65% of workers with employer-sponsored coverage, from state APCD reporting. Only federal action can close that gap and produce a complete national picture.

Core design elements should include:

- **A claims repository** accessible by policymakers, researchers, and the public, with mandatory submissions from commercial insurers, self-funded employer plans, Medicare Advantage organizations, and Medicaid managed care plans.
- **Standardized reporting** of medical and pharmacy claims, provider identifiers, allowed and paid amounts, diagnoses, and procedures.

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[8] https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/#:~:text=Key%20Facts,report%20fair%20or%20poor%20health.

[9] https://jamanetwork.com/journals/jama/article-abstract/2752664#:~:text=Prior%20studies%20estimated%20that%20approximately,US%20health%20care%20spending%20remains

[10] https://www.patientrightsadvocate.org/pricevariationreport

- **Modern analytics and AI-enabled detection** of fraud, overbilling, and pricing disparities in real time, giving patients real price transparency rather than marketing slogans, and giving CMS the tools to protect taxpayer dollars at scale.
- **Strong privacy protections** consistent with HIPAA, including de-identification protocols, tiered secure access controls, and patient opt-out rights parallel to those that already exist for electronic health record exchange.
- **Coordination with existing state APCDs** to avoid duplicative reporting and improve interoperability, building on the common data layout work already developed by the APCD Council and the National Association of Health Data Organizations.

Why a National APCD Is Indispensable to the Committee's Charge

Each of the Committee's five priority areas, as announced by HHS on March 27, 2026, depends directly on the data infrastructure a National APCD would provide:

- **Preventing and managing chronic disease.** Population-level claims data are the foundation for identifying high-risk patients and measuring what works. Imagine being able to compare best treatments across 35 million diabetes patients, or 120 million Americans with some form of heart disease. Today, that analytic power is confined to the Medicare fee-for-service population (only one in ten Americans).
- **Advancing accountability for safety and outcomes while reducing administrative burden.** An APCD enables national outcome measurement across payers and providers and replaces the duplicative payer-by-payer reporting that today consumes hundreds of billions in administrative waste annually.
- **Expanding real-time data for quality of care and claims processing.** The Committee's mandate explicitly calls for this. There is no way to deliver it at scale without a national, standardized claims data backbone. A national APCD is, in effect, the operating system that the Committee's real-time data agenda requires.
- **Enhancing care for vulnerable populations, including Medicaid beneficiaries.** An APCD that includes Medicaid managed care, which now covers the large majority of Medicaid enrollees, would give policymakers visibility they currently lack into utilization, access barriers, and disparities in maternal and infant health, where the United States ranks last among peer nations.
- **Strengthening Medicare Advantage sustainability and modernizing risk adjustment.** Medicare Advantage covers more than half of Medicare beneficiaries, yet plan-submitted encounter data remain notoriously incomplete and difficult to validate. A standardized national APCD, with MA plan submissions on equal footing with other payers, is the most direct path to integrity in MA payment, risk adjustment, and quality measurement.

Economic Oxygen for the American Family, Worker, and Taxpayer

Even if we reduced U.S. health care costs by one-third, we would still be the highest-spending nation on Earth. But that reduction would save roughly $1.5 trillion per year, nearly equivalent to the annual federal deficit.

That is not a minor reform. It is economic oxygen.

The savings opportunity is well-documented. Waste, fraud, and abuse account for an estimated 10–30% of excess costs[11]. Honest price transparency could reduce costs and coinsurance by up to an additional 10%[12]. None of these savings are achievable without comprehensive cross-payer claims data. A national APCD is the precondition for capturing them.

Reform as Leadership, Not Punishment: A "Healthcare Patriot" Framework

Reform need not be framed as punishment. It can be framed as leadership. Hospitals, insurers, pharmaceutical companies, and provider groups that voluntarily embrace transparent data integration and measurable cost reduction should be publicly recognized for doing so. The Committee should consider recommending a national "Healthcare Patriot" recognition program honoring institutions that materially lower costs, improve outcomes, and share data responsibly in the national interest.

In a $5 trillion system, prestige and public trust matter. Employers would favor recognized institutions. Patients would seek them out. Investors would reward them. Transparency becomes a competitive advantage rather than a regulatory burden, and the most innovative players in American medicine become the public face of system reform.

Addressing the Predictable Objections

- **"This is a step toward government-run health care."** It is not. An APCD does not set prices, dictate treatment, or alter coverage. It records what is already happening in transactions between payers and providers and makes that information usable.
- **"It threatens patient privacy."** State APCDs have operated for years under HIPAA-aligned frameworks with strong de-identification, tiered access, and use restrictions. Patients should retain the right to opt out of data exchange, just as they do with electronic health records—but most Americans want lower costs and better results, not higher prices and more secrecy. The current fragmented system is itself a privacy and cybersecurity liability; a properly designed national APCD is more secure than the status quo, not less.
- **"Payers will resist the reporting burden."** Many payers already report to state APCDs in multiple incompatible formats. A single, standardized federal layout, developed in coordination with industry, could reduce aggregate reporting burden over time.

Specific Request to the Committee

I respectfully urge the Committee to issue a formal recommendation to Secretary Kennedy and Administrator Oz that HHS, in coordination with Congress where statutory authority is required, establish a National All-Payer Claims Database, with the design elements described above. This single action would do more to advance the Committee's entire mandate - chronic disease management, outcomes accountability, real-time data, vulnerable populations, and Medicare Advantage sustainability - than any other policy reform within the Committee's purview.

Americans deserve a health care system as disciplined as their family budgets, they deserve to know what things cost, and they deserve a system that pools health data responsibly to Make America Healthy Again.

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[11] https://jamanetwork.com/journals/jama/article-abstract/2752664#:~:text=Prior%20studies%20estimated%20that%20approximately,US%20health%20care%20spending%20remains

[12] https://jamanetwork.com/journals/jama/fullarticle/1917438

America does not lack medical innovation. We lack system accountability. The Committee has been given a historic opportunity to recommend the foundational infrastructure that will make every subsequent reform possible.

I would welcome the opportunity to provide additional analysis, technical detail, or testimony to support the Committee's deliberations. Thank you for your service and for considering this recommendation.

Sincerely,

Lynn Barr, MPH
lynnbar2020@gmail.com

Note: These comments are my own and do not represent the opinions of the Medicare Payment Advisory Commission (MedPAC)

May 12, 2026

Meeting 1 Comments – Healthcare Advisory Committee (HAC)

Dear Healthcare Advisory Committee:

On behalf of the National Association of Rural Health Clinics (NARHC) and the over 5,700 federally certified Rural Health Clinics (RHC), we are pleased to provide the following comments ahead of the first meeting of the newly formed HHS Healthcare Advisory Committee (HHS HAC).

We applaud the formation of this committee and look forward to its work advising CMS on the delivery of high-quality, affordable health care.

Since 1977, CMS-certified Rural Health Clinics have served an indispensable role in the country's health care safety net, increasing access to outpatient services in rural, medically underserved areas. RHCs serve over 40 million patients annually. The RHC program is separate and distinct from the Federally Qualified Health Center or Community Health Center program. RHCs receive cost-based traditional Medicare and Medicaid reimbursement, subject to caps, but do not have dedicated federal appropriations.

As the RHC program is the primary facility type offering outpatient care to rural Americans, we believe that RHCs are uniquely situated in their continued ability to be part of solutions this committee aims to create and accomplish. Included below are a variety of recommendations within HHS authority to **reduce administrative burden, tackle chronic disease, and leverage technology** within rural communities.

Reducing Administrative Burden for Better Care

Group Visit Limitation

CMS Guidance (Medicare Benefit Policy Manual Chapter 13) states that "group services," other than certain exceptions, are non-RHC services, which prohibits RHCs from offering a variety of behavioral health, lifestyle management, and other services.

NARHC encourages HAC to recognize the burden that this outdated rule creates for patients and providers and recommends that CMS revisit this guidance and remove this prohibition.

Behavioral Health Limitation

RHC statute reads that a Rural Health Clinic is "only a facility which... (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases." CMS interpretation of the statute has long held that RHCs can only provide up to 49% of their services as behavioral health

services, without clear regulatory or sub-regulatory guidance as to how these services should be counted, unnecessarily increasing facility burden and reducing patient care access to these essential services.

In the immediately prior clause of the statute, CMS follows the intent of the statute "is not a rehabilitation agency" by defining a rehabilitation agency. Therefore, NARHC believes it is appropriate, and in line with statutory authority, to define a facility which is primarily for the care and treatment of mental diseases.

If a facility is not a rehabilitation agency, nor a facility which is primarily for the care and treatment of mental diseases, and it provides primary care, the facility should meet RHC provisions of care eligibility. Notably, other safety-net providers, such as Federally Qualified Health Centers, are not limited in the amount of behavioral health that their facilities can provide.

NARHC encourages HAC to recognize the burden that arbitrarily limiting the amount of behavioral health services an RHC is allowed to provide places on patients and providers and recommends that CMS revisit this guidance to better align with statutory intent.

Tackling Chronic Disease

Annual Wellness Visits

For Annual Wellness Visits (AWVs) furnished in RHCs on the same day as another medical visit, other than initial preventive physical examinations (IPPEs), RHCs receive their all-inclusive rate for only a single billable visit as these services are not eligible for same day billing, i.e., two visits billed on the same day and separately reimbursed.

RHC patients are more likely to face challenges in safe, reliable, and accessible transportation, meaning that the most clinically appropriate time to furnish preventive services are often when the patient is already in the facility for an acute or chronic condition visit. However, given CMS billing rules, this would still only generate one reimbursement for all services provided to that patient in a single day.

As CMS continues to make significant strides towards increasing access to preventive care for Medicare beneficiaries, it is essential that RHCs are adequately reimbursed when these services are provided to their patients. Notably, FQHCs receive an upward adjustment to their reimbursement of 34.16 percent when an IPPE or AWV is furnished. CMS has previously stated that the 34.16 percent increase accounts for greater intensity and resource use associated with these services.

NARHC strongly encourages HAC to ensure adequate reimbursement for these preventive services regardless of the facility they are provided in and recommend that CMS adjusts payment rules accordingly.

Further, RHCs are only able to bill for AWVs or IPPEs if the patient is seen by an RHC practitioner (physician, nurse practitioner, physician assistant). In traditional, fee-for-service office settings, these preventive services are billable when performed by health educators, dieticians, nurses, and other

medical professionals. This ensures greater accessibility of preventive services by using all staff members to the top of their license. Aligning these reimbursement rules for RHCs is essential to access to preventive services for rural beneficiaries.

Access to Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) Services
Currently, DSMT and MNT services provided by a registered dietician or nutritional professional at an RHC are not billable encounters. These are, however, billable visits in FQHCs. These evidence-based education and lifestyle change programs are in strong alignment with Make America Healthy Again initiatives, but current limitations remove access to these services for RHC patients.

NARHC encourages HAC to recommend to CMS the creation of a separate payment for DSMT and MNT services performed by a registered dietician or nutritional professional in an RHC.

Leveraging Technology

Telehealth
Expanded telehealth flexibilities in place over the last six years have made it very clear that telehealth has significant potential to improve access to care in rural areas. However, the current telehealth policy threatens RHCs, giving fee-for-service providers stronger incentives to invest in telehealth than safety-net providers. The longer this remains the case, the more likely it is that RHCs and FQHCs will fall behind in the adoption of telehealth relative to their traditional peers.

RHCs and FQHCs were not included in HHS' emergency expansion of telehealth policy via waivers in early 2020. As a result, for a few weeks at the beginning of the COVID-19 pandemic, fee-for-service providers were able to offer telehealth services to their patients, while RHC and FQHC patients were forced to come in-person to receive a Medicare-covered healthcare service. Thanks to Congress, the CARES Act rectified this issue and allowed RHCs and FQHCs to serve as distant site providers, but that legislation did not allow RHCs and FQHCs to bill for telehealth normally. Instead, the CARES Act created a "special payment rule" that pays RHCs outside their normal All-Inclusive Rate methodology at a level that is significantly less than what RHCs receive for in-person services. This stands in stark contrast to traditional physician offices which receive payment parity between in-person and telehealth services.

NARHC is concerned with this "special payment rule" methodology for several reasons.

1. The payment is significantly less than what most RHCs and FQHCs would receive for providing the same service in person, disincentivizing safety-net providers from offering the service via telehealth.
2. The current rules require RHCs and FQHCs to "carveout" all telehealth costs from their cost report, which adds significant administrative burden to the cost-reporting process.
3. The use of a single telehealth code, G2025, billed whenever an RHC provides one of the 200+ telehealth services reimbursable by Medicare, has prevented RHCs from tracking annual wellness visits and other services provided via telehealth properly, which hinders their ability to properly participate in Accountable Care Organizations and other quality programs.

For mental health telehealth services, CMS used their authority to establish permanent Medicare telehealth coverage and allow RHCs and FQHCs to use their normal coding and reimbursement mechanisms. This policy is working well, and we believe that telehealth should work this way for all services, not just mental health services.

NARHC encourages HAC to recommend to CMS the establishment of reimbursement parity for medical telehealth services. If CMS does not believe they have this authority and that telehealth payment policy is solely in Congressional authority, we urge CMS to at least establish normal coding and cost-reporting guidance for telehealth services, to reduce administrative burden and allow for better participation in quality-based programs.

We look forward to working with the committee and seeing their efforts advising CMS on the delivery of high-quality, affordable health care. We urge HAC to include RHCs in that important mission in recognition of their critical role in the provision of medical and behavioral health services in rural communities across the nation.

Please don't hesitate to contact Sarah Hohman at Sarah.Hohman@narhc.org with any questions or to discuss further.

Sincerely,

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Delivered via Electronic Submission

May 12, 2026

HHS Healthcare Advisory Committee
Health & Human Services
200 Independence Avenue, S.W.
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Re: Comments to the HHS Healthcare Advisory Committee (HAC) regarding Chronic Disease Prevention and Workforce Utilization

Dear Members of the Healthcare Advisory Committee,

On behalf of the American Association of Naturopathic Physicians (AANP), we thank the HHS Healthcare Advisory Committee for the opportunity to provide comments as you begin your vital work. We strongly support the focus on redirecting national attention toward understanding and drastically lowering chronic disease rates.

The AANP represents 8,000 licensed naturopathic doctors (NDs), a healthcare workforce trained as prevention-focused primary care providers licensed in 26 US jurisdictions **whose services are currently recognized by private insurance, Medicaid, and Medicare Advantage programs, but have yet to be recognized in any federal health care program.**

Naturopathic medicine is recognized by the National Institutes of Health as a distinct system of integrative health care and was lauded by Congress in 2014 through Senate Resolution 420 as "safe, effective, and affordable health care…[encouraging] the people of the United States to learn about naturopathic medicine and the role that naturopathic physicians play in preventing chronic and debilitating illnesses and conditions."

Licensed naturopathic medicine has been a system of health care in the US for over a century, with an educational model consistent to that of conventional medicine grounded in biomedical physiology and diagnostics, but with a reprioritization of the order of therapeutics. Specifically, naturopathic medical training's core therapeutic focus is on lifestyle-oriented self-care, preventive behaviors, physical activity, stress-management, clinical nutrition, herbal medicine, and hands-on manual therapies — only resorting to more-costly prescription drug therapies or surgical interventions when appropriate.

Naturopathic medicine focuses on addressing the underlying causes of illness rather than just treating

symptoms, which is essential for disease reversal.

Alignment with the MAHA Commission Executive Order

The Executive Order (EO) calls for "fresh thinking on nutrition, physical activity, healthy lifestyles, and over-reliance on medication and treatments," and mandates that agencies "must focus on reversing chronic disease."

This is the very foundation of naturopathic medicine. Licensed NDs are trained as primary care providers whose core therapeutic focus is on lifestyle-oriented self-care, clinical nutrition, and preventive behaviors, only resorting to costly prescription drugs or surgery when absolutely necessary.

Naturopathic physicians are the only licensed primary care physician-level provider who receive an average of 150 hours of clinical nutrition during medical school.[1]

A body of literature, too vast to enumerate here, supports the cost-effectiveness of lifestyle-oriented self-care, nutrition, preventive behaviors and other modalities that are grounded in the approach used by naturopathic doctors to manage, improve, or reverse chronic disease conditions. The preventive focus of naturopathic care addresses many modifiable risk factors – lifestyle behaviors, physical activity, sedentariness, obesity, alcohol consumption, dietary choices, and environmental exposures – associated with the increased cost of chronic diseases.

A recently released Health Technology Assessment (HTA) provides an evidence-based summary of naturopathic practice and the safety, economics and effectiveness of naturopathic care. The scope of the HTA was informed by research conducted by the international naturopathic community over the last thirty years encompassing over 2000 peer-reviewed scientific articles, of which more than 300 clinical studies involving over 100 different health populations are included. Key findings have included:

- Naturopathic researchers have conducted original clinical research involving over 100 different health populations.[2]
- 81.1% of the studies on the effectiveness of naturopathic clinical practice identified a positive response to at least one primary or secondary outcome measure.[3]
- Naturopathic physician care has been shown to reduce employee sick days and cost, while improving productivity.[4,5]

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[1] Association of Accredited Naturopathic Medical Colleges Brochure, *ND, MD/DO, NP - What's the Difference?* Accessed May 11, 2026

[2] https://worldnaturopathicfederation.org/project/health-technology-assessment-naturopathy/, accessed 10/20/24.

[3] Lloyd, I., Steele, A., and Wardle, J., *Naturopathy, practice, effectiveness economics & safety.* World Naturopathic Federation. Section 3, Chapter 8. 2022.

[4] Herman, P.M., Szczurko, O., Cooley, K., and Mills, E.J., *Cost-effectiveness of naturopathic care for chronic low back pain*. Alternative Therapies in Health & Medicine, 2008.

[5] Noe, B. *Vermont Car Dealers Help to Quantify the Benefits of Naturopathic Care*, in 21st Annual Conference of the American Association of Naturopathic Physicians. 2006. Portland.

- Numerous studies have demonstrated that using non-invasive, non-toxic approaches lowers health care costs.[6,7] Patients with the greatest disease burden show the most significant reduction in total medical expenditures when utilizing integrative medicine.[8]
- A systematic review of randomized clinical trials found that use of natural health products such as those recommended by naturopathic doctors has the potential to reduce costs compared to conventional treatment by up to 73%.[9]

Removing Federal Policy Barriers to Expand Treatment Options

Section 2(d) of the Executive Order directs agencies to "ensure the availability of expanded treatment options and the flexibility for health insurance coverage to provide benefits that support beneficial lifestyle changes and disease prevention." To meet this objective, the Committee must address the "root cause." One of the primary root causes of our workforce shortage and inability to manage chronic diseases is that outdated statutory definitions prevent our healthcare system from utilizing those parts of our existing healthcare workforce that prioritizes prevention, nutrition, lifestyle and whole-person healthcare to its fullest potential - and instead incentivizes expensive, specialty and hospital-based care.

Addressing the federal barriers that currently restrict patient access to licensed healthcare providers like naturopathic physicians, who focus on prevention, nutrition, lifestyle and whole-person healthcare, is an essential component of addressing the root cause, and expanding treatment options.

Policy Solutions

1. Modernize the Definition of "Physician" in the Social Security Act

The definition of "physician" in §1861 (42 U.S.C. 1395x(r)(1)) of the Social Security Act is outdated and does not reflect the current landscape of licensed and qualified providers. This omission prevents 65 million Medicare beneficiaries from accessing whole-health, prevention-based care from licensed NDs, even in states where they are authorized to practice as primary care providers.

We urge the Committee to recommend and support Congressional efforts to modernize this definition to include licensed NDs.

2. Harmonize Medicaid Coverage

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[6] Herman PM, Szczurko O, Cooley K, Seely D. A naturopathic approach to the prevention of cardiovascular disease: cost-effectiveness analysis of a pragmatic multi-worksite randomized clinical trial. J Occup Environ Med. 2014 Feb;56(2):171-6. doi: 10.1097/JOM.0000000000000066. PMID: 24451612; PMCID: PMC3921268.

[7] Tais S, Oberg E. The economic evaluation of complementary and alternative medicine. *Natural Med J*. 2013;5(2).

[8] Sarnat RL, Winterstein J, Cambron JA. Clinical utilization and cost outcomes from an integrative medicine independent physician association: an additional 3- year update. J Manipulative Physiol Therapeutics 2007; 30(4): 263-269.

[9] Kennedy DA, Hart J, Seely D. Cost effectiveness of natural health products: a systematic review of randomized clinical trials. eCAM 2009; 6(3) 297-304.

Currently, only five states cover ND services in Medicaid, creating arbitrary trade barriers and limiting access for low-income populations. The Committee should recommend that CMS require or incentivize states receiving federal Medicaid funding to use all prevention and whole-person focused licensed providers, like naturopathic physicians, to the full extent of their education and training. This would address workforce shortages in community clinics and FQHCs while utilizing a workforce proven to reduce costs and improve health outcomes.

3. Inclusion in the Veterans Health Administration and Department of Defense

Despite severe staffing shortages, the VA and DoD do not recognize licensed NDs as an eligible provider type. As experts in non-pharmacologic options for pain and disease, licensed NDs are uniquely qualified to deliver the "whole person" care these agencies strive to provide.

We respectfully ask the Committee to recommend that the Secretary of HHS urge and support the Secretaries of both DoD and the VHA take the necessary steps to include and recognize licensed naturopathic physicians to the full extent of their training and education.

4. Include a Naturopathic Doctor on the HAC

To maximize the utility of this committee, the charter of the HAC indicates that “the CMS Administrator shall appoint up to 20 individuals to serve on the Committee,” and it currently consists of 18 members, 2 of whom are ex-officio members. Licensed naturopathic physicians meet the criteria of tactical experience and expertise working in the US healthcare systems “with regard to issues related to chronic disease prevention and management, expanding access to primary care, reducing healthcare costs, and driving other improvements in the healthcare system for patients and providers.”

We urge the CMS Administrator to appoint a licensed naturopathic physician to the HAC to leverage the expertise of our profession and academic institutional knowledge in the delivery of preventive medicine focused on nutrition, lifestyle, whole-health, and non-pharmaceutical approaches to care.

Alignment of Federal Agency Policy Development

Independent policy initiatives developing within separate governmental and regulatory “silos” - in particular the Departments of Health and Human Services and the Department of Education - may unintentionally be moving toward conflicting long-term outcomes. On one hand, many national policymakers and stakeholders are increasingly emphasizing prevention, chronic disease reduction, nutrition, lifestyle-based interventions, patient choice, whole-health approaches, and reduction of long-term healthcare costs.

At the same time, however, evolving higher education accountability, accreditation, workforce, and reimbursement frameworks may unintentionally place increasing pressure on portions of the educational infrastructure responsible for preparing segments of the workforce most closely aligned with those objectives, in particular programs that focus on training providers in the Complementary and Integrative Health (CIH) space.

We hope that the Healthcare Advisory Committee will discuss the potential long-term implications of these converging policy developments and the importance of ensuring that future education accountability systems are methodologically appropriate for prevention-oriented licensed health professions.

Rationale for Full Workforce Utilization

Policymakers should ensure the ability of licensed healthcare professionals, like naturopathic doctors, who prioritize these kinds of cost-effective modalities that lead to better outcomes to perform to the top of their scope of practice, and to be recognized and covered as eligible providers in all federal programs.

In the face of a growing health crisis and workforce shortage, government policy must prioritize licensing, credentialing, and covering every qualified provider who can help reverse the chronic disease epidemic. We stand ready to work with the HAC to ensure all Americans have access to the whole-person, preventive care they deserve.

Sincerely,

Laura Culberson Farr
Executive Director
American Association of Naturopathic Physicians

Distinguished Members of the Healthcare Advisory Committee
U.S. Centers for Medicare and Medicaid Services
Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244
Delivered by email to: HAC@cms.hhs.gov

May 13, 2026

Dear HAC Committee Members,

On behalf of the **Senior Care Pharmacy Coalition (SCPC)**, the national trade association representing long-term care (LTC) pharmacies, I write to congratulate you on your appointment and to offer our partnership as you begin this critical work. SCPC and its members stand ready to serve as a resource to the Committee as you seek to strengthen our nation's healthcare system.

LTC pharmacies are a distinct and specialized sector of American pharmacy. Our members provide **comprehensive medication services** to patients in skilled nursing facilities, assisted living facilities, mental health institutions, substance abuse treatment centers, PACE centers, and other long-term care settings. LTC pharmacies predominantly serve complex senior populations and our pharmacies depend mostly on Medicare Part D for reimbursement, but their services intersect directly with Medicare Part A, Part C, Medicaid, TRICARE, and other payers. For decades, LTC pharmacists have delivered specialized dispensing, individualized packaging, around-the-clock availability, and rigorous clinical medication reviews that have kept vulnerable patients safe and reduced unnecessary costs across federal programs.

Medication Management: An Underrecognized Crisis

As your committee charts its priorities, we urge you to place medication management near the top of the agenda. Our aging population is growing rapidly, and complex, multi-medication patients represent one of the highest-risk — and highest-cost — segments of the healthcare system. Medication errors and non-adherence are among the most prevalent and preventable drivers of poor outcomes. The data are sobering:

- **$528 billion** in avoidable medical spending annually due to non-optimized medication therapy[1]
- **125,000 avoidable deaths** per year attributable to medication non-adherence[2]

- **50% of patients with chronic disease** do not take medications as prescribed, driving preventable disease progression[3]
- **20–33% of preventable emergency department visits** are medication-related, particularly among Medicare beneficiaries[4]

The LTC Pharmacy Solution

LTC pharmacies have developed evidence-based systems specifically designed to address these challenges. Our pharmacists conduct structured medication regimen reviews, identify dangerous drug interactions, and work directly with prescribers to optimize therapy for medically complex patients and importantly deprescribe. Our specialized unit-dose packaging reduces administration errors. Our on-call pharmacists provide 24/7 support to care facilities. These are not incidental features; they are the core of what distinguishes LTC pharmacy. These high standards that have been set over the course of decades are why millions of patients in long-term care settings receive safer, more effective medication management every day than the average patient.

Despite this track record, LTC pharmacy is frequently overlooked in healthcare policy discussions. SCPC believes that closing this gap represents a meaningful opportunity to reduce costs, prevent harm, and improve quality of care at scale.

We would welcome the opportunity to brief the Committee on our members' outcomes data, share examples of best practices in medication management, and identify where targeted policy changes could generate the greatest impact. LTC pharmacy has a strong story to tell and a genuine role to play in the solutions this Committee is charged with finding.

Thank you for your service and your commitment to improving the health of Americans. Please do not hesitate to contact me directly.

Sincerely,

Esmé Grewal
President & CEO
Senior Care Pharmacy Coalition (SCPC)
egrewal@seniorcarepharmacies.org
Cell: (202) 744-8925

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[1] *Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug–Related Morbidity and Mortality.* Ann Pharmacother. 2018;52(9):829–837. https://doi.org/10.1177/1060028018765159

[2] Centers for Disease Control and Prevention. Medication Adherence: Working Together to Improve Health Outcomes. https://www.cdc.gov/dhdsp/pubs/docs/medication_adherence.pdf

[3] World Health Organization. Adherence to Long-Term Therapies: Evidence for Action. Geneva: WHO, 2003. Approximately 50% of patients with chronic diseases in developed countries do not adhere to prescribed medication regimens.

[4] Centers for Medicare & Medicaid Services Innovation Center. Part D Enhanced Medication Therapy Management (MTM) Model Fact Sheet. https://innovation.cms.gov/innovation-models/enhancedmtm

APhA
American Pharmacists Association

May 13, 2026

[Submitted electronically to HAC@cms.hhs.gov]

Clive K. Fields, MD
Chair
Healthcare Advisory Committee
U.S. Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

RE: [FR. Doc. 2026-09444] Healthcare Advisory Committee (HAC); Announcement of the HAC Meeting – May 18, 2026

Dear Chair Fields and HAC Committee Members,

The American Pharmacists Association (APhA) appreciates the opportunity to provide comments to you and HAC on your upcoming meeting. APhA stands ready to help HAC identify ways HHS and CMS can leverage pharmacists and pharmacies to advance its mission of delivering high-quality, affordable health care to Americans while deterring waste and prioritizing patients.

APhA represents pharmacists, student pharmacists, and pharmacy technicians in all practice settings, including but not limited to community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA congratulates you on your selection as the Chair of HAC. As you have stated, "one of the most underutilized resources that we have in this country is our use of pharmacists [and] … they are also exceptionally well-trained."[1] The work of this committee has the potential to greatly impact how Americans receive health care. APhA strongly encourages HAC to consider leveraging pharmacists and pharmacies to increase access to transform health care, reduce costs, and improve patient health across the country.

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[1] *Walgreens & VillageMD Partnership with Guests Dr. Kevin Ban and Dr. Clive Fields*, Business of Primary Care 7:20 (Apr. 26, 2023). Available at: https://www.thebusinessofprimarycare.com/podcast/rethinking-healthcare-with-guests-dr-kevin-ban-and-dr-clive-fields.

As the country continues to struggle with a primary care shortage, states have enacted legislation to broaden pharmacists' scope of practice to meet patient needs and align with the extensive training pharmacists receive in a Doctor of Pharmacy (PharmD) program.[2] Depending on the state, pharmacists can provide smoking cessation counseling, health and wellness screenings, immunizations, and other preventive care services, as well as disease state and medication management. Additionally, pharmacists in many states can prescribe buprenorphine, naloxone, HIV PrEP and PEP, hormonal contraceptives, and oral antivirals across the country. Pharmacists are widely integrated into Federally Qualified Health Center (FQHC) health care teams and routinely provide medication management and chronic disease care services, including comprehensive medication management (CMM), polypharmacy management, deprescribing, and Collaborative Drug Therapy Management (CDTM) under state law. FQHC pharmacists also provide preventive and population health services, such as immunization assessment and administration, cardiovascular risk reduction, tobacco cessation, health screenings and education, care coordination and transitions, medication reconciliation (post-hospital or emergency department discharge), adherence monitoring, and formulary optimization. States have taken action to ensure patients do not go without care, and this committee can help HHS and CMS maximize their efforts.

While private and state payors have already recognized pharmacists' expanded roles and the positive return on investment[3] by reimbursing pharmacist-provided patient care services, Congress has yet to unlock the full potential of pharmacists with direct Medicare Part B reimbursement for these services. As you noted in your interview on the "Business of Primary Care" podcast, the idea of fixing this problem by training more primary care doctors or mid-level providers is "inaccurate," and other solutions, like pharmacist-provided care, may need to be considered more closely.[4] This committee has the opportunity to take such action and modernize how patients access care nationwide.

A specific area HAC could start in that does not require legislative change is pharmacist-led deprescribing. Earlier this month, CMS, ACF, HRSA, and SAMHSA sent a Dear Colleague letter following the Mental Health and Overmedicalization Summit that highlighted the important role of deprescribing in patient care. As part of routine practice, pharmacists make evidence-based recommendations to physicians and other providers to discontinue duplicate or unnecessary medications, substitute medications due to potential adverse effects or known

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[2] *Health Workforce Projections*, Health Resources & Services Administration. Available at: https://bhw.hrsa.gov/data-research/projecting-health-workforce-supply-demand (noting that the National Center for Health Workforce Analysis estimates an overall shortage of 141,160 physicians in 2038, including a shortage of 70,610 primary care physicians).

[3] Armando S. Almodovar, et al., *Return on Investment of Pharmacists' Services Among Non-Hospitalized Patients: A Scoping Review*, 21 Research in Social and Administrative Pharmacy 321 (2025). Available at: https://www.sciencedirect.com/science/article/pii/S1551741125000129.

[4] *Walgreens & VillageMD Partnership with Guests Dr. Kevin Ban and Dr. Clive Fields*, Business of Primary Care 6:14 (Apr. 26, 2023). Available at: https://www.thebusinessofprimarycare.com/podcast/rethinking-healthcare-with-guests-dr-kevin-ban-and-dr-clive-fields.

contraindications, and suggest tapering medications that should not be used long-term. As you noted in the previously mentioned interview, pharmacists are "experts in medication and medication therapy management, better than any doctor I have ever known in terms of understanding drug-drug interactions, understanding how to deprescribe – something that physicians in general don't know how to do."[5] However, the Medicare billing framework fails to recognize the value of and need for pharmacist-provided services, such as deprescribing, to the overall health care system because it does not permit physicians and non-physician practitioners (NPPs) to bill appropriately for these services.

Deprescribing is the perfect place to start, given pharmacists' expertise in this area and the potential cost savings to the overall health care system (in one study, **pharmacists' deprescribing recommendations were accepted 96.7% of the time by the patient's primary care provider and resulted in the potential annualized cost avoidance of $184,221 across 63 patients**).[6] Currently, CMS restricts physicians and NPPs from utilizing pharmacists to the full extent of their training and expertise under incident to models, as it only permits billing at the lowest E/M code (99211), which has an estimated time commitment of 7 minutes. Because of this restriction, physician and NPP engagement with pharmacists in team-based care models has been limited. While CMS has the authority to change the incident to billing framework right now, they have yet to act. With HAC's recommendation, CMS may consider making this change. By permitting physicians and NPPs to bill for pharmacist services using the full range of E/M codes necessary for team-based care, there will be greater uptake by our nation's pharmacists, leading to better patient outcomes.[7]

Thank you for allowing us to submit comments on this meeting. If you have any questions or would like to meet with APhA and our nation's pharmacists, please contact Corey Whetzel, APhA's Senior Manager, Regulatory Affairs, at cwhetzel@aphanet.org.

Sincerely,

Michael Baxter

Michael Baxter
Vice President, Government Affairs

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[5] *Id.* at 8:21.

[6] Emily Rea, et al., *Pharmacist-Driven Deprescribing Initiative in Primary Care*, 64 Advances in Pharmacy Practice 102161. Available at: https://www.japha.org/article/S1544-3191%2824%2900182-1/fulltext.

[7] Sara Berg, *Add a Pharmacist to the Team to See Better Outcomes*, American Medical Association (July 6, 2018). Available at: https://www.ama-assn.org/practice-management/scope-practice/add-pharmacist-team-see-better-outcomes.

American Occupational Therapy Association

Submitted via email to HAC@cms.hhs.gov

Healthcare Advisory Committee (HAC)
Re: Advancing Whole-Person Health Through Occupational Therapy and Payment Reform

Dear Members of the MAHA Healthcare Advisory Committee,

The American Occupational Therapy Association (AOTA) is the national professional association representing more than 245,000 occupational therapists, occupational therapy assistants, and students across the United States. AOTA's mission is to advance the quality, availability, and effective use of occupational therapy through advocacy, evidence-based practice, education, and policy engagement, with a core focus on enabling individuals and populations to participate fully in daily life and maintain health, function, and independence over time. This mission aligns directly with the Healthcare Advisory Committee's chartered priorities to improve chronic disease prevention and management, enhance healthcare quality and outcomes, and strengthen the effectiveness and sustainability of federally administered healthcare programs.

We appreciate the opportunity to provide comments for consideration as the Committee takes up its responsibility to advise the Secretary of Health and Human Services and the Centers for Medicare & Medicaid Services (CMS) on improving the operation and outcomes of federally administered healthcare programs. We recognize the Committee's charge to develop actionable policy recommendations that promote chronic disease prevention and management, improve quality and outcomes, reduce administrative burden, and support the long-term sustainability of programs such as Medicare, Medicaid, and Medicare Advantage.

In the context of these priorities, AOTA respectfully offers that current healthcare payment and delivery structures remain predominantly oriented toward acute, diagnosis-driven care, rather than prevention, functional health, and sustained behavior change. While alternative payment models have advanced important reforms, many continue to rely on episodic, medically focused service definitions that do not fully account for the role of daily habits, routines, and environmental factors in shaping health outcomes. This misalignment limits the system's ability to achieve meaningful progress in chronic disease prevention and management, which the Committee has been charged to advance.

At the same time, structural features of existing payment models constrain the participation of the full healthcare workforce in achieving these goals. In many cases, accountability, attribution, and financial risk remain concentrated within physician-led entities or large health systems. This structure can limit participation by non-physician

practitioners, including occupational therapy practitioners, from contributing to, or leading care design, assuming accountability for outcomes, and receiving reimbursement for services that directly support prevention and chronic condition management. These constraints have been further reinforced by recent payment reductions under Medicare—occupational therapy practitioners are among some of the most impacted by recent conversion factor reductions—and market consolidation. These changes have disproportionately affected smaller, community-based and home-based occupational therapy practitioners, discouraging innovation in home-based care.

These limitations are relevant to multiple areas identified in the Committee's charter, including opportunities to improve care for vulnerable populations, reduce unnecessary administrative burden, and strengthen accountability for outcomes. Without broader inclusion of the interdisciplinary workforce and alignment of payment with functional outcomes, federal healthcare programs may continue to realize incremental gains within existing structures rather than achieving the more substantive improvements in health outcomes envisioned under the Make America Healthy Again initiative.

Evidence-based, interdisciplinary models offer a pathway to better alignment. The CAPABLE (Community Aging in Place—Advancing Better Living for Elders) model demonstrates how integrating occupational therapy into home-based, team-based care can improve functional outcomes[1], reduce hospital utilization, and delay institutionalization for high-need Medicare beneficiaries. CAPABLE operationalizes several priorities reflected in the Committee's charge, including chronic disease management, improved outcomes for vulnerable populations, and more efficient use of healthcare resources[2]. However, as previously noted by AOTA, the limited and inconsistent coverage of preventive, functional, and environmental interventions under existing Medicare payment structures has constrained broader adoption of this and similar models.

Occupational therapy practitioners are trained to address the interaction between health conditions, daily activities, and the environments in which individuals live. This includes supporting the development and maintenance of health-promoting routines, improving adherence to treatment plans, and mitigating environmental risks that contribute to avoidable utilization. These services are directly aligned with the Committee's focus on chronic disease prevention and management, as well as improving quality and outcomes across federally administered programs. However, their impact is not consistently reflected in current payment methodologies, quality measurement frameworks, or attribution models. For example, as highlighted in AOTA's comments on the Medicare Physician Fee

[1] https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.17383
[2] https://capablenationalcenter.org/

Schedule, occupational therapy practitioners are currently unable to report Health and Behavior Assessment and Intervention (HBAI) codes, despite their training and established role in addressing behavioral factors that influence physical health outcomes. Additionally, there remains an ongoing lack of clarity and consistent recognition within Medicare policy regarding occupational therapy practitioners' ability to furnish and bill for mental health services, limiting the integration of behavioral and mental health supports into routine care. Taken together, these limitations illustrate broader structural gaps that prevent full utilization of occupational therapy in advancing prevention, managing chronic conditions, and improving overall health outcomes.

Consistent with the Committee's charge to identify actionable policy initiatives and structural opportunities for improvement, AOTA encourages consideration of policies that support broader participation of the healthcare workforce in federal payment and delivery models. This includes evaluating barriers to direct reimbursement and attribution for non-physician providers, reassessing assumptions regarding physician-centric model design, and expanding recognition of functional and behavioral outcomes as core indicators of health system performance. Additionally, continued exploration of interdisciplinary, home- and community-based models may help advance the Committee's goals related to prevention, quality improvement, and cost sustainability, particularly for populations with complex chronic conditions.

AOTA appreciates the Committee's focus on advancing meaningful improvements in healthcare delivery and outcomes. Ensuring that payment and delivery models fully incorporate prevention, function, and the capabilities of the interdisciplinary workforce will be critical to achieving the objectives outlined in the Committee's charter. AOTA stands ready to provide further information and to support the Committee's efforts in this regard.

Sincerely,

Kim Karr, OTR/L, FAOTA, RAC-CT, CPHQ
Director, Payment Policy
American Occupational Therapy Association (AOTA)

WASHINGTON ASSOCIATION OF NATUROPATHIC PHYSICIANS

SUPPORTING NATUROPATHIC PHYSICIANS FOR OVER 90 YEARS

13 May 2026

HHS Healthcare Advisory Committee
Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
HAC@cms.hhs.gov

Re: Comments to the HHS Healthcare Advisory Committee (HAC) regarding Chronic Disease Prevention and Workforce Utilization

Dear esteemed committee members:

I am writing on behalf of the Washington Association of Naturopathic Physicians (WANP) to urge the HHS Healthcare Advisory Committee to **keep naturopathic physicians top of mind** as it engages in work around chronic disease prevention and workforce utilization.

Naturopathic physicians have been recognized in statute in Washington State since 1919, and they have been codified as primary care physicians here for well over a decade. They are fully integrated in our state's Medicaid and workers' compensation programs, having first been included in these programs in 1936 and 1939, respectively. At present, there are over 1,650 licensed naturopathic physicians in Washington State actively providing care for an estimated 1 million Washingtonians. Naturopathic physicians licensed in Washington enjoy a broad scope of practice, full inclusion in both public and private insurance, and consistent data demonstrating that they are among the safest practitioners providing primary care in our state.

Naturopathic physicians are trained, poised, and ready to play a much more significant role in improving healthcare across the state (and the country) with their focus on nutrition, lifestyle, and high impact/low cost approaches to preventive primary care, but the **lack of recognition and inclusion in any federal health care program creates an incredible barrier**.

Here in Washington, the most significant federal challenge naturopathic physicians face is exclusion from the definition of "physician" in the Social Security Act. This exclusion has significant and lasting negative consequences for our doctors and their ability to help shift the paradigm of healthcare in this country toward better alignment with the foundational tenets of the "Make America Healthy Again" movement.

Because naturopathic physicians are not recognized as "physicians" in §1861 (42 U.S.C. 1395x(r)(1)) of the Social Security Act:

- They cannot provide the full range of care to the nation's elderly and others qualified to receive care under Medicare.
- Their access to post-graduate residencies is extremely limited, as they do not qualify for Medicare-funded opportunities.
- They are often overlooked for jobs in hospitals, community health clinics, and federally qualified health centers (FQHCs) because they cannot take on patient panels heavy in Medicare patients.

These realities force the majority of licensed naturopathic physicians into private practice and out of impactful professional positions with the potential of shifting the system. Especially as access to federal student loans changes and post-graduate income is evaluated under emerging metrics, there is a real possibility that naturopathic physicians will be unable to keep their clinic doors open to serve patients who are truly interested in holistic, human-centered, preventive healthcare. The reduction or loss of naturopathic physicians in the workforce is antithetical to the stated aims of the Health and Human Services Secretary, as far as we understand them.

Therefore, we respectfully request that this committee seriously consider and work to implement the policy solutions proposed by the American Association of Naturopathic Physicians (AANP):

1. Modernize the Definition of "Physician" in the Social Security Act

The definition of "physician" in §1861 (42 U.S.C. 1395x(r)(1)) of the Social Security Act is outdated and does not reflect the current landscape of licensed and qualified providers. This omission prevents 65 million Medicare beneficiaries from accessing whole-health, prevention-based care from licensed naturopathic physicians – even in states like Washington where they are authorized to practice as primary care providers.

We urge the Committee to recommend and support Congressional efforts to modernize this definition to include licensed naturopathic physicians.

2. Harmonize Medicaid Coverage

Currently, only five states (including Washington) cover naturopathic physician services in Medicaid, creating arbitrary trade barriers and limiting access for low-income populations. The Committee should recommend that CMS require or incentivize states receiving federal Medicaid funding to use all prevention and whole-person focused licensed providers, like naturopathic physicians, to the full extent of their education and training. This would address workforce shortages in community clinics and FQHCs while utilizing a workforce proven to reduce costs and improve health outcomes.

The full inclusion of naturopathic physicians in Washington's Medicaid program has been highly successful – both for patients and for the state – and could be used as a model for implementation.

3. Inclusion in the Veterans Health Administration and Department of Defense

Despite severe staffing shortages, the VA and DoD do not recognize licensed naturopathic physicians as an eligible provider type. As experts in non-pharmacologic options for pain and disease, these physicians are uniquely qualified to deliver the "whole person" care these agencies strive to provide.

We respectfully ask the Committee to recommend that the Secretary of HHS urge and support the Secretaries of both DoD and the VHA take the necessary steps to include and recognize licensed naturopathic physicians to the full extent of their training and education.

4. Include a Naturopathic Physician on the HAC

To maximize the utility of this committee, the charter of the HAC indicates that "the CMS Administrator shall appoint up to 20 individuals to serve on the Committee," and it currently consists of 18 members, 2 of whom are ex-officio members. Licensed naturopathic physicians meet the criteria of tactical experience and expertise working in the US healthcare systems "with regard to issues related to chronic disease prevention and management, expanding access to primary care, reducing healthcare costs, and driving other improvements in the healthcare system for patients and providers."

We urge the CMS Administrator to appoint a licensed naturopathic physician to the HAC to leverage the expertise of our profession and academic institutional knowledge in the delivery of preventive medicine focused on nutrition, lifestyle, whole-health, and non-pharmaceutical approaches to care.

We are deeply grateful for the work this committee is doing to explore solutions to chronic disease and workforce shortages. Thank you so much for your time and your earnest consideration of naturopathic physicians in this work.

In health,

Angela Ross, ND
Executive Director