January 22, 2026

Mr. Abe Sutton
Director, Center for Medicare and Medicaid Innovation (CMMI)
Deputy Administrator, Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Director Sutton,

On behalf of the American Academy of Family Physicians (AAFP), representing over 128,300 family physician and student members, we want to commend CMMI for its bold and forward-thinking approach in launching the MAHA ELEVATE and ACCESS Models. We support the intent and direction of these initiatives to leverage lifestyle medicine and technology-enabled solutions for chronic care management, improve patient outcomes, and modernize care delivery. These models have the potential to be an important step toward transforming care and empowering beneficiaries with innovative tools. As our members and their patients will be both directly and indirectly impacted, we offer the following feedback as you continue to review applicants and operationalize these models.

MAHA ELEVATE: Enhancing Lifestyle and Evaluating Value-based Approaches Through Evidence Model

The AAFP is very supportive of this model and its potential to serve as an important step towards integrating lifestyle-based, whole-person interventions into Medicare. Family physicians have been practicing whole health for as long as the specialty of family medicine has existed.[1] Accordingly, the AAFP is uniquely well-positioned to inform CMMI's work on this model and help ensure it reaches its full potential.

The AAFP recently hosted the Scaling Whole Health Strategies in Primary Care Convening in November of 2025. The convening brought together clinicians, health systems, payers, educators, community partners, and patient advocates to identify the core enablers and barriers to scale the implementation of whole health-oriented strategies in a wide range of primary care settings: precisely the terrain MAHA ELEVATE seeks to navigate. Our findings, due to be published in March, provide a clear roadmap that can help ensure MAHA ELEVATE is successful. Accordingly, we encourage CMMI to consider these key factors in selecting and supporting model participants.

> Financial Incentives: The fee-for-service payment structure of Original Medicare rewards volume over value and even when health systems receive value-based

[1] Gutierrez C, Scheid P. The history of family medicine and its impact in US health care delivery. Accessed March 25, 2025. https://www.aafpfoundation.org/content/dam/foundation/documents/who-we-are/cfhm/FMImpactGutierrezScheid.pdf

payments, individual clinicians are still held to productivity targets that measure the number of encounters or RVUs rather than meaningful whole-health outcomes. This prevents the adoption of critical components of whole health care delivery, such as longer visits, team-based support, nutrition and physical activity coaching, which are either not reimbursed at all or are reimbursed insufficiently to change workflows and care delivery models at scale.

Team-based Care: We encourage CMMI to integrate team-based care and workforce well-being into the model's expectations. We have found that the success of whole health interventions depends on multidisciplinary teams, redesigned workflows, and intentional efforts to address burnout and the entire care team's connection to their purpose.

Community Integration: Truly holistic care extends beyond the clinic walls, requiring integration with sectors that address upstream drivers of health but are not traditionally considered part of the healthcare system. CMMI should ensure that participants are leveraging community resources and partnerships when appropriate and that community care hubs are supported as essential infrastructure to facilitate and optimize their joint efforts.

Data Interoperability: Fragmented data systems significantly impede whole-health, person-centered implementation, making it difficult to share information with community partners or measure outcomes related to well-being, lifestyle change, and person-centered care. This fragmentation increases administrative burden and limits access to quality metrics needed to demonstrate value. CMMI must ensure that the proposals it selects are utilizing the data infrastructure required for whole-person care to succeed, such as the use of Health Data Utilities and/or Health Information Exchanges.

Workforce Training and Development: Historically, medical training and residency programs have often emphasized acute diagnosis and treatment, leaving clinicians less prepared to implement Whole Health modalities. Many lack confidence in using tools like nutrition education, mind-body practices, or health coaching. To this end, the AAFP will host a Whole Health Summit in May 2026 to provide physicians with leadership development, system-redesign strategies, and practical tools to strengthen teams, streamline practice systems, and improve patient outcomes.

ACCESS: Advancing Chronic Care with Effective, Scalable Solutions

We also see ACCESS as a promising opportunity to test technology-driven interventions for chronic conditions. However, we have also received several questions from our members about the model's implementation. As CMMI moves forward with implementation, we encourage the agency to provide clear guidance and guardrails in several key areas to ensure

the model achieves its goals while protecting patients and preserving the integrity of the physician-patient relationship. Specifically, we urge CMMI to address:

Beneficiary enrollment and eligibility. Because beneficiaries may self-enroll in this model without the knowledge of their primary care physician, we encourage CMMI to ensure processes are clearly defined. It is critical to establish a transparent and clinically sound process for verifying diagnoses and determining eligibility with the beneficiary's primary care physician, so that patients receive appropriate services without risk of misdiagnosis or unnecessary interventions. Additionally, safeguards are needed to prevent unintended consequences when patients enroll without their primary care physician's involvement. These protections will help maintain continuity of care and avoid complications if patients are managed by technology vendors without adequate clinical oversight.

Care coordination standards must be robust to prevent fragmentation of care and ensure patient safety. ACCESS participants should have clear expectations for timely, bidirectional communication with primary care physicians and specialists, including minimum frequency and format for sharing care plans, medication changes, and clinically relevant updates. Coordination should ideally move beyond communication and incentivize collaboration. We appreciate that the ACCESS program grouped conditions into clinically related and frequently comorbid categories. Given primary care's longitudinal and comprehensive nature, primary care physicians have been managing their patients' chronic conditions for many years, including developing care plans tailored to meet each patient's unique needs and goals. To foster improved outcomes and successful implementation, we encourage CMMI to have ACCESS Participants regularly communicate and collaborate with a patient's established PCP so that their technologies serve as a complement rather than a substitute or replacement for existing care plans. For example, ACCESS Participants should include allowing the PCP to review and provide input on the care plan developed by the ACCESS Participants. Defining roles and responsibilities for care teams, including a requirement for physician leadership, will help maintain accountability and clinical integrity.

Transparency and data sharing are critical to building trust and ensuring effective collaboration. Requirements for bidirectional data exchange should account for variability in regional health information exchange (HIE) maturity and availability, the preferences and capabilities for each member of the Integrated Care team, as well as avoid imposing expensive, proprietary technology costs on physician practices. We appreciate the requirements for ACCESS Participants to proactively share care updates. However, we encourage CMS to require Participants to check a second trusted source to verify the contact information for the Integrated Care Team if the

first data exchange is unsuccessful. Participants should document all sources and the outcomes to fully demonstrate a good-faith effort. Despite efforts, many of the trusted sources can be incomplete or inaccurate. Checking more than one source would increase the likelihood of a successful connection in instances where the first attempt is unsuccessful. ACCESS participants should also be expected to share evidence supporting their technology solutions, clinical studies, and performance metrics in a way that is timely and accessible to physicians. This transparency will allow clinicians to make informed decisions and ensure interventions are evidence-based, aligned with patient needs and not duplicative or wasteful.

Payment design and accountability. The AAFP appreciates and supports the inclusion of the co-management payment. While ACCESS Participants will be encouraged to provide additional clinical updates, our understanding is that they are only required to provide an update upon initiation and completion of care as well as instances where the Participant transitions the beneficiary to another clinician or care setting. As noted above, we strongly believe that ongoing communication at regular intervals is more appropriate, will foster better collaboration between the Participant and the beneficiary's Integrated Care Team, and lead to better outcomes. As such, we ask that CMMI not limit the co-management payment to once every four months.

The AAFP supports the Substitute Spend Adjustment as one of the guardrails that reduce duplicative Medicare spending without restricting a beneficiary's freedom of choice or access to any covered Medicare service. We ask that CMMI include additional protections to ensure that ACCESS Participants do not offer or position their solutions as a replacement for existing care the beneficiary may be receiving (e.g., continuous glucose monitoring) in an effort to increase their Substitute Spend Rate.

Clear guidance on device or software coverage and cost responsibility will also help prevent confusion for physicians and beneficiaries. We note that the RFA states the outcome adjusted payment (OAP) rate for the eCKM and CKM tracks includes the expected device cost of a cellular network-connected blood pressure cuff as well as an add-on payment for rural patients in these tracks. CMMI explains that they do not believe other tracks will include a device. The AAFP encourages CMMI to provide clear guidance regarding device coverage and beneficiary cost sharing should there be Participants in the other tracks that have a device as well as if the eCKM or CKM track Participants have a device or software other than a blood pressure cuff. We also ask that CMS provide additional guidance on coverage and beneficiary cost sharing for any software, ongoing subscription, or other costs that may be required as part of the ACCESS Participant's technology solution and related services.

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Making this model fair and accessible for all Americans is essential. While technology can be a powerful tool for improving care, not every patient has equal access to broadband or connected devices. CMMI should consider practical solutions for patients in rural or underserved areas, as well as those who may not have the resources or technical literacy to use these tools effectively. The model should also include strong protections against aggressive marketing practices, particularly for seniors or individuals with cognitive challenges, to ensure participation is based on informed choice rather than persuasion. Beneficiaries should also have the right to disenroll at anytime. These steps will help guarantee that innovation benefits every patient—not just those in well-connected communities.

FDA compliance and digital health oversight will be critical to ensuring patient safety. The recently announced TEMPO pilot introduces enforcement discretion for certain devices used in ACCESS, provided manufacturers collect real-world data. While this approach may accelerate innovation, it also raises questions about oversight and accountability. If devices are deployed before full FDA clearance, what safeguards will protect patients from unproven technologies? How will CMMI verify that participants are meeting data collection and reporting requirements—and what happens if they fall short? We urge CMMI to set clear expectations for monitoring, transparency, and corrective action so that the model does not compromise safety in the name of speed. Innovation should never come at the expense of trust or clinical integrity.

We appreciate CMMI's commitment to innovation and look forward to working together to ensure the MAHA ELEVATE and ACCESS models successfully deliver on their promise of expanded access to the best available evidence-based health technology to enhance chronic condition care and improve outcomes for all Americans.

We would welcome the opportunity to discuss our feedback on the model as you begin to work on implementation. For more information or questions, please contact Kate Gilliard, Senior Manager, Federal Policy and Regulatory Affairs, at kgilliard@aafp.org.

Sincerely,

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