



VIA ELECTRONIC SUBMISSION

September 11, 2026

Centers for Medicare & Medicaid Services
Department of Health and Human Services, Attention: CMS-1848-P
P.O. Box 8016
Baltimore, MD 21244

RIN 0938-AV82

RE: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

Thank you for the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) proposed rule, [*Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program*](#) [CMS-1848-P].

The Global Health Advocacy Incubator (GHA), [*Overdose Prevention Initiative*](#) advances evidence-based, equitable and sustainable federal policy solutions to end the overdose crisis. Given the continued impact of overdose and untreated substance use disorder (SUD) among Medicare beneficiaries, we strongly support policies that expand access to evidence-based treatment, strengthen care coordination and improve patient outcomes. Our comments focus on expanding access to medications for opioid use disorder (MOUD), supporting overdose prevention efforts and advancing data-driven approaches to inform and improve overdose response.

The calendar year (CY) 2027 Medicare Physician Fee Schedule (PFS) proposed rule presents several opportunities to strengthen access to substance use disorder (SUD) care. CMS can improve beneficiary access to evidence-based treatment, support providers delivering integrated care, reduce barriers to care in underserved communities and strengthen overdose prevention efforts through targeted payment and coverage policies.

Substance use disorder and overdose continue to pose significant challenges for Medicare beneficiaries, particularly individuals with co-occurring behavioral health conditions, complex chronic illnesses and barriers to accessing treatment. Evidence demonstrates that



integrated care models, medications for opioid use disorder, peer support services and telehealth-enabled treatment improve engagement in care and health outcomes.

Accordingly, we encourage CMS to finalize and strengthen the following policies:

- Finalize proposed payment and coverage improvements that strengthen behavioral health and primary care integration for SUD services. This includes the proposed revaluation of Collaborative Care Model (CoCM), Advanced Primary Care Management (APCM), Screening, Brief Intervention, and Referral to Treatment (SBIRT), and tobacco cessation codes; inclusion of SBIRT in the Medicare Shared Savings Program (MSSP) beneficiary-assignment definition; continued telehealth access through Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs); and adding relevant SUD-care coordination codes to the RHC/FQHC separately-payable list. These policies would improve early identification and treatment of SUD and continuity of care for Medicare beneficiaries, particularly those in rural and underserved communities.
- Strengthen payment for SUD services by revaluing office-based SUD services to close the payment gap with opioid treatment program (OTP) rates. Create appropriate payment pathways for American Society of Addiction Medicine (ASAM) Level 1.7 and clinically necessary care and clarifying access to SUD services, including MOUD, peer support, Community Health Integration (CHI)/Principal Illness Navigation (PIN) and recovery-support-eligible shared medical appointments, across integrated care and Accountable Care Organization (ACO) models, specifically confirming that Behavioral Health Integration (BHI)/CoCM and MOUD-adjacent care qualify for the proposed ACO Part B cost-sharing waiver. Appropriate reimbursement for SUD treatment services is critical to ensuring provider participation, expanding access to MOUD and reducing gaps in treatment availability across care settings.
- Create safeguards for artificial intelligence (AI) use in SUD-related care. This includes treating the proposed Annual Wellness Visit (AWV) AI risk-flagging function as a request for information rather than authorizing it in this rule, absent evidence of its accuracy, transparency and appropriate safeguards around data privacy, including a meaningful process for reviewing and correcting inaccurate flags; evaluating whether AI-enabled AWVs actually improve SUD screening and treatment outcomes, not simply volume; and requiring, as a condition of payment or participation, that AI systems handling SUD-relevant information across the AWV and other Medicare-supported services meet Part 2-level consent and redisclosure standards, including a prohibition on using that information for AI model development. Because AI-driven tools may affect clinical decision-making and patient trust, CMS should ensure adequate evidence and privacy protections before broader implementation.



- Preserve the integrity and comparability of ACO measurement and terminology frameworks by retaining the Initiation and Engagement of Substance Use Disorder Treatment quality measure in the ACO quality measure set and “social determinants of health” terminology, or an equally specific standard, in the ACO Advance Investment Payment allowable-uses regulation. Without these, SUD-related outcomes and eligible uses of ACO investment funds become harder to track.

GHAI appreciates that CMS adopted several of our recommendations in the CY 2026 PFS final rule, including the CoCM/Behavioral Health Integration (BHI) add-on code structure, RHC and FQHC use of those codes and expanded initiating-visit options for Community Health Integration. These changes meaningfully expand opportunities for integrated behavioral health care. We also encourage CMS to address the remaining recommendations from our CY 2026 comments, including those related to reentry care, the behavioral health workforce, prescribing barriers and CHI/PIN.¹

We thank CMS for the opportunity to comment on the CY 2027 PFS proposed rule. These recommendations would strengthen Medicare's capacity to prevent overdose, expand access to evidence-based SUD treatment, improve care coordination and help beneficiaries remain connected to care. They would also support CMS's ongoing efforts to improve behavioral health outcomes, advance health equity, and ensure that Medicare beneficiaries can access timely, high-quality, patient-centered SUD services.

Should you have questions, please contact Daniel Diana, Research Manager, Overdose Prevention Initiative, at ddiana@advocacyincubator.org.

Sincerely,

Libby Jones
Associate Vice President,
Overdose Prevention, Global Health Advocacy Incubator



Background

The United States has made meaningful progress in reducing overdose deaths. Provisional federal data estimate 69,973 people died from drug overdose in the United States in 2025, nearly 14% fewer than in 2024 and the third consecutive year of national declines in overdose deaths.² This progress reflects sustained federal efforts to expand access to evidence-based SUD treatment and overdose prevention services. However, the opioid crisis remains a nationwide public health emergency (PHE),³ and Medicare beneficiaries across the nation continue to face treatment, geographic-access, workforce and continuity-of-care barriers.⁴

Older adults are increasingly affected by this crisis. While overdose death rates declined for all age groups between 2023 and 2024, older adults aged 65 and older experienced the smallest rate decrease (-8.84%).⁵ Nearly 8,200 adults aged 65 and older died from an overdose in 2024,⁶ and overdose deaths among adults over the age of 55 increased more than tenfold between 1999 and 2019.⁷ This crisis is exacerbated by the introduction of adulterated substances in the illicit drug supply, in particular fentanyl. From 2015 to 2023, fentanyl-related overdose deaths in adults aged 65 and older rose 1,470%, with deaths involving fentanyl-stimulant combinations surging 9,000% over the same period.⁸

The overdose crisis among older adults is particularly concerning because Medicare is their primary source of health coverage, yet beneficiaries continue to face significant barriers to SUD care. As of 2024, just half of all SUD treatment facilities accept Medicare as a type of payment,⁹ contributing to the fewer than one in five enrollees who receive any medication to treat their opioid use disorder (OUD).¹⁰ Older adults may also face unique barriers to care, including stigma, limited screening in primary care, social isolation and medication interactions.¹¹ Even among the beneficiaries who do receive care, quality lags: in 2020, fewer than 40% of beneficiaries with OUD received treatment aligned with nationally recognized quality standards.¹²

Treatment access challenges are especially acute in rural communities, where limited behavioral health workforces, treatment deserts and hospital closures make specialty care difficult to access. Only 16% of U.S. counties had an Opioid Treatment Program (OTP) that accepted Medicare in 2021 and counties with larger rural populations were significantly less likely to have one.¹³ Rural residents also face longer drive times to an OTP than their urban counterparts – up to 2 to 5 times longer.¹⁴ These treatment deserts are compounded by a shrinking rural hospital safety net – 197 rural hospitals have closed or stopped offering inpatient care since 2005,¹⁵ and more than 60% of federally designated Health Professional Shortage Areas (HPSAs) are in rural communities.¹⁶

The PFS is a critical component of the federal response to the overdose crisis because it shapes whether Medicare beneficiaries can access timely, evidence-based SUD treatment in the settings where they most commonly receive care. Payment and quality policies influence provider participation, care integration, workforce capacity and continuity of treatment. Strengthening

these policies can help beneficiaries start treatment earlier, remain engaged in care and avoid preventable hospitalization, overdose and death.

GHAI has engaged in the PFS rulemaking process to advance these goals. In the CY 2026 PFS, CMS adopted several of our recommendations that expanded access to integrated behavioral health care. We appreciate CMS's responsiveness and encourage the agency to address our remaining priorities related to reentry care, the behavioral health workforce, prescribing barriers and Community Health Integration (CHI) and Principal Illness Navigation (PIN) services. The CY 2027 proposed rule provides another opportunity to strengthen Medicare's role in the overdose response. GHAI's comments focus on three priorities: finalizing proposed payment and coverage improvements; strengthening and clarifying payment and delivery of SUD care; and establishing appropriate safeguards for artificial intelligence and SUD-related data.

GHAI's Response

GHAI appreciates the opportunity to comment on the CY 2027 PFS proposed rule and offers the following recommendations in the order they appear in the proposed rule.

§II.D.3.c.(50) Smoking and Tobacco Use Cessation (CPT Codes 99406, 99407) and Screening, Brief Intervention and Referral to Treatment (SBIRT) (HCPCS Codes G2011, G0396, G0397)

GHAI supports CMS's proposal to increase Medicare payment rates by 19.1% for smoking and tobacco cessation counseling (CPT 99406 and 99407) and SBIRT services (HCPCS G2011, G0396 and G0397). CMS is proposing to increase payment for SBIRT services, which support early intervention of SUD, as part of the final year of a four-year effort to update payment rates for timed behavioral health services.¹⁷ The increase is overdue: SBIRT has been shown to decrease substance misuse, yet these codes have not been updated in many years.¹⁸

CMS is also proposing to include SBIRT among the primary-care-services definition used to determine which beneficiaries are assigned to an Accountable Care Organization (ACO). GHAI supports this change because it would give ACOs, which serve most Medicare beneficiaries, a stronger incentive to identify and address early substance use rather than treating SBIRT as a separate, standalone service.¹⁹

Including SBIRT in ACO beneficiary assignment would also strengthen accountability for identifying SUDs early, giving ACOs an opportunity to connect beneficiaries to care before substance use leads to more serious health consequences requiring emergency department visits or hospitalization.

Recommendation: GHAI recommends that CMS finalize the increased Medicare payment rates by 19.1% for smoking and tobacco cessation counseling (CPT 99406 and 99407) and SBIRT services (HCPCS G2011, G0396 and G0397).

Recommendation: GHAI also recommends including SBIRT among the primary-care-services definition used to determine ACO beneficiary assignment to encourage early treatment initiation.

§II.D.3.c.(51) Psychiatric Collaborative Care Model (CoCM) (CPT codes 99492, 99493, 99494, G2214) and APCM BHI Add-On Codes (HCPCS Codes G0568, G0569)

GHAI urges CMS to finalize its proposed payment increases for the CoCM codes (CPT 99492, 99493, 99494 and HCPCS G2214) and the APCM BHI add-on codes (HCPCS G0568 and G0569). GHAI also supports the proposed increase in the Behavioral Health Care Manager clinic labor rate (L057B). These services require substantial care coordination and follow-up, and paying providers adequately is essential to making integrated behavioral health care financially sustainable in primary care and other settings where Medicare beneficiaries with SUD already receive care. This is particularly important for people with opioid use disorder (OUD) because providers are currently not reimbursed for a significant amount of the care-management work they provide. A 2026 analysis found that 44% of documented care manager time for patients with co-occurring OUD did not qualify for reimbursement under current codes.²⁰

CMS is also proposing to apply the same labor-rate increase to the SUD-specific bundled payment codes (HCPCS G2086, G2087 and G2088), reinforcing the need to ensure these services are valued appropriately as well.

Recommendation: GHAI recommends that CMS finalize its proposed payment increases for CoCM codes (CPT 99492, 99493, 99494 and HCPCS G2214) and the APCM BHI add-on codes (HCPCS G0568 and G0569). Finalizing these proposals would better compensate providers for the work required to coordinate care for individuals with SUD and co-occurring mental health conditions, and, in turn, help expand access to integrated treatment.

§II.D.3.c.(54) Shared Medical Appointment (HCPCS Code GSMAS)

In response to feedback from a CY 2026 request for information on chronic disease prevention, CMS is proposing a new HCPCS code, GSMAS, for shared medical appointments. This would be voluntary group visits for up to ten beneficiaries that combine education, peer support, and individual clinical assessment. CMS is proposing to limit these visits to conditions that can be improved through lifestyle changes and is soliciting comments on which conditions should qualify.

Making SUD recovery support eligible for shared medical appointments would give people in recovery an additional, low-cost way to access supports alongside their individual treatment. It would also allow providers to reach more patients with limited behavioral health workforce capacity while helping people stay engaged in recovery services. As CMS proposes, medication dosing and adherence support would continue to be provided through separate visits.

Recommendation: GHAI recommends that CMS include SUD recovery supports among the conditions eligible for these group visits. Peer support, group counseling, relapse-prevention education and

other recovery-support activities can play an important role in helping people sustain recovery. Group visits for buprenorphine treatment are already used in primary care, and patients have reported that the opportunity to connect with peers is especially valuable.²¹

§II.D.3.c.(60) Bundled Payments Under the PFS for Substance Use Disorders (HCPCS Codes G2086, G2087 and G2088)

CMS is soliciting feedback on the gaps in the payment and coding structure for HCPCS codes G2086, G2087 and G2088, which are used for office-based SUD treatment. GHAI recommends making payment more consistent for clinically equivalent services, regardless of where they are provided. Doing so would give beneficiaries more choices, improve access in communities without an OTP and ensure payment policy reflects patients' clinical needs rather than where they receive care.

There are two main gaps. First, office-based SUD treatment is paid at a lower rate than comparable services through the OTP benefit, even though both provide American Society of Addiction Medicine (ASAM) Level 1.7 careⁱ, including medically managed outpatient and withdrawal treatment. The difference is largely based on the regulatory requirements of the setting rather than the complexity of the care or the needs of the patient. Second, Medicare does not currently have a code for ASAM Level 1.7 care. While there is now a code for Level 1.5 treatment,ⁱⁱ there is no corresponding code for Level 1.7. As Medicare increasingly supports SUD treatment in community-based settings, providers need a way to bill for Level 1.7 care that they can already provide. Creating this pathway would help beneficiaries access the appropriate level of care without unnecessarily moving to more intensive settings.

Recommendation: GHAI recommends that CMS increase payment for G2086-G2088 to bring reimbursement closer to OTP rates for clinically equivalent services. Office-based and OTP settings differ primarily in their regulatory requirements, not in the acuity of the patients or the complexity of the services they provide.ⁱⁱⁱ

Recommendation: GHAI recommends that CMS create a new code or code family for ASAM Level 1.7, including medically managed outpatient SUD treatment and withdrawal management. This would allow office-based and other non-OTP settings to bill for a level of care they can already deliver but cannot use codes in their documentation. This change would be especially important for rural and

ⁱ [ASAM Level 1.7 care](#): Medically Managed Outpatient Treatment for patients who need active medical monitoring for withdrawal or physical illness in which treatment planning is led by medical staff and care includes a greater focus on withdrawal management and biomedical services delivered in outpatient settings, including OTPs.

ⁱⁱ [ASAM Level 1.5 care](#): Outpatient Therapy for patients who do not require medical detox in which treatment planning is led by clinical (non-medical) staff, involving fewer than 9 hours of service per week with a focus on psychotherapy.

ⁱⁱⁱ Methadone dispensing for the treatment of OUD is restricted to certified OTPs under [42 CFR Part 8](#).

underserved communities where OTPs are limited.²² New codes should apply for all SUDs, not just OUD.²³

Recommendation: GHAI recommends that CMS allow RHCs and FQHCs to use G2086-G2088 in billing practices separately as care-coordination services, outside their all-inclusive payment rate. These clinics can already separately bill for other care-coordination services, including behavioral health integration (BHI), CoCM, Chronic Care Management, CHI and PIN as of January 1, 2026.²⁴ Adding G2086-G2088 would close the one remaining gap and make it easier for RHCs and FQHCs to provide office-based SUD treatment.

§II.E.5. Technology and AI-Augmentation in Primary Care via the Medicare AWW

CMS is considering using clinical artificial intelligence (AI) to transform the Annual Wellness Visit (AWV) into “a more continuous, data-driven and beneficiary-specific preventive care function.” The proposed uses of AI span the entire visit, including collecting information from beneficiaries before the visit, summarizing their medical and family history, identifying “beneficiaries who may warrant additional assessment” during the visit and generating personalized instructions afterward.

GHAI supports the responsible use of AI to reduce administrative burdens and improve clinical workflows, but there is an important distinction between AI that helps providers manage information and AI that influences clinical decision-making. Administrative uses of AI may offer meaningful efficiencies when appropriate safeguards are in place. AI that directly shapes clinical decisions, however, requires substantially greater evidence, transparency, oversight and patient protections.

CMS’s own proposal reflects significant uncertainty about whether AI-enabled AWWs will actually improve patient outcomes. The rule explicitly solicits comment on how to evaluate whether AI-enabled AWWs are improving patient outcomes, not merely volume, and which outcomes vendors should be held accountable for. This uncertainty is not just a measurement and outcome standard problem: the evidence base for clinical AI performance in primary care settings remains nascent, particularly for SUD-related applications.²⁵ The absence of both an outcome-based standard and a robust evidence base is precisely why scaling this technology without sufficient research before, these tools are deployed poses patient risks. In particular, for people with SUD, unvalidated AI output can delay treatment,²⁶ trigger an inappropriate restriction on care²⁷ or erode trust between patients and providers.²⁸

Several of CMS’s proposed AI functions — collecting information before a visit, summarizing medical histories, and generating follow-up instructions — are primarily administrative and could meaningfully reduce provider burden.²⁹ These functions warrant stronger protections when handling SUD-related information. While 42 CFR Part 2 protections do not technically apply to the

AWV itself,^{iv} the proposed AI functions touch SUD-relevant information, including screening for SUD-related risk factors, and should carry Part 2's heightened protections accordingly.³⁰ The proposed use of AI to flag beneficiaries for additional clinical assessment raises a more serious concern. This function would not simply automate paperwork — it would influence clinical decision-making and potentially the care patients receive. Risk-flagging tools have been shown to contribute to inappropriate restrictions on care for people with pain and SUD, particularly when they lack clinical context or a meaningful way for providers or patients to challenge an inaccurate determination.³¹

CMS has not proposed a mechanism to assess whether AI tools accurately identify patients who need additional assessment, nor a process for providers or patients to challenge an inaccurate flag. The risks are serious: false positives may contribute to stigma or inappropriate restrictions on care, while false negatives may cause clinicians to miss opportunities to connect beneficiaries to treatment. Without a correction mechanism, these errors can persist in a patient's record and continue to misguide their care. CMS should establish a clear process to review AI-generated recommendations and correct inaccurate conclusions. SUD treatment records receive heightened protections under 42 CFR Part 2 because unauthorized disclosure can have serious consequences — including impacts to employment, legal proceedings, and child custody — that may ultimately deter patients from seeking care.³² Even where Part 2 does not formally apply, longstanding policy recognizes that SUD-related information warrants stronger privacy protections than general health data precisely because of these disproportionate consequences.³³

Given this heightened sensitivity, CMS should extend Part 2-level protections to SUD-relevant information collected or generated through the AWV, as a condition of payment or participation. Any AI system processing AWV information should ensure that these protections are kept in place and that Part 2-level protections follow SUD-relevant information regardless of which technology vendor operates the system. CMS should therefore require any AI vendor operating in connection with the AWV to comply with Part 2's consent and redisclosure requirements, rather than relying solely on HIPAA's business-association protections.

These protections should extend beyond the AWV to AI use in any Medicare-supported service that touches SUD-relevant information, regardless of whether that setting is a Part 2 program today. Privacy concerns over SUD treatment records, including the possible unauthorized use of those records by third party AI-vendors, remain among the most commonly reported barriers to seeking treatment.³⁴ Because of the nascent stage of the research, especially in SUD care, any AI tool must maintain the heightened protections around collecting and managing SUD-related information that Part 2 affords patients. As AI tools are increasingly integrated across primary care and other clinical settings, CMS should establish, in this rule or a subsequent rulemaking, that

^{iv} [42 CFR Part 2](#) strictly governs patient records created by federally assisted programs whose primary function is the diagnosis, treatment or referral for treatment of SUD. Since the AWV is a routine preventive care service performed in a general primary care setting rather than a federally assisted specialized SUD program, it is not covered under Part 2.



any AI system used in connection with a Medicare-supported service handling SUD-relevant information must comply with Part 2's consent and redisclosure requirements. CMS must specify these compliance structures are a condition of payment or participation across the full range of AI applications in SUD treatment settings, including administrative tools and AI-enabled clinical decision support.

Separately, CMS should prohibit the use of any Part 2 information for AI model development in this Rule. CMS should require that contractual agreements between covered entities and AI vendors include clear language affirming that Part 2-protected information will not be used for secondary purposes, such as training or fine-tuning AI models. Without safeguards, Part 2-eligible data could be repurposed to develop tools that are deployed against the very patients whose records were used to build them, without their knowledge or consent – undermining the confidentiality protections Part 2 was designed to guarantee.

Recommendation: GHAI recommends that CMS extend Part 2-level protections to SUD-relevant information collected or generated through the AWW, as a condition of payment or participation, and require any AI vendor operating in connection with the AWW to comply with Part 2's consent and redisclosure requirements.

Recommendation: GHAI recommends that CMS establish, in this rule or a subsequent rulemaking, that any AI system used in connection with a Medicare-supported service handling SUD-relevant information must comply with Part 2's consent and redisclosure requirements as a condition of payment or participation.

Recommendation: GHAI recommends that CMS prohibit the use of Part 2-protected information for AI model development in this rule, and require that contracts between covered entities and AI vendors explicitly bar use of Part 2 data for secondary purposes, such as training or fine-tuning.

Recommendation: GHAI recommends that CMS treat the proposed clinical risk-flagging function as a request for information rather than authorize its use in this rule. Before allowing AI to influence clinical decision-making during AWWs, CMS should require evidence demonstrating its accuracy, transparency and appropriate safeguards around data privacy, including a meaningful process for reviewing and correcting inaccurate flags.

Recommendation: GHAI recommends that CMS evaluate AI-enabled AWWs based on whether they actually improve SUD screening, referral and treatment outcomes, not simply whether they increase the amount of information collected. Getting this distinction right before AI-enabled AWWs are widely deployed is essential to ensuring that these tools improve access to evidence-based SUD care rather than inadvertently creating new barriers to treatment.

§III.B.3. Services Furnished Using Telecommunication Technology

CMS is proposing conforming regulatory changes to extend two telehealth flexibilities for RHCs and FQHCs through December 31, 2027.^v These flexibilities allow mental health visits to be provided without first meeting the in-person visit requirement and allow RHCs and FQHCs to provide certain other services through telehealth, including audio-only visits (HCPCS G2025).

GHAI supports extending these flexibilities through 2027. Without them, rural and community health centers could lose important tools for delivering behavioral health care (e.g., initiating buprenorphine treatment) via telehealth without requiring patients to first come for an in-person visit. This flexibility is especially important in rural and underserved communities where transportation barriers, provider shortages and long distances can make in-person SUD treatment difficult to access. One 2024 study found that patients who started buprenorphine treatment through telehealth were less likely to discontinue treatment within six months than patients receiving treatment as usual (3.8% vs 9.7%).³⁵

Recommendation: GHAI recommends that CMS finalize the proposed extension of these telehealth flexibilities through December 31, 2027, to help ensure beneficiaries can continue accessing evidence-based SUD care regardless of where they live.

§III.G. Medicare Shared Savings Program

§III.G.6.a. Proposal to Allow ACOs to Reduce or Eliminate Part B Cost-Sharing

CMS proposes allowing eligible Medicare Shared Savings Program (MSSP) ACOs to waive or reimburse beneficiary cost-sharing for certain Part B beginning in April 2027. Reducing out-of-pocket costs can make it easier for beneficiaries to start and stay in treatment, particularly those with complex medical and behavioral health needs.³⁶

GHAI supports giving ACOs clear authority to use this flexibility to improve access to evidence-based SUD care. CMS should clarify that BHI, CoCM services and care related to medications for opioid use disorder (MOUD) are eligible services when tied to an appropriate clinical goal. This would give ACOs another tool to reduce financial barriers to treatment and support beneficiaries in staying connected to care.

Recommendation: GHAI recommends that CMS clarify that ACOs use the proposed cost-sharing flexibility to support access to evidence-based SUD services, including BHI, CoCM and MOUD-related care.

^v Enacted under Section 6209(c) of the [Consolidated Appropriations Act, 2026 \(P.L. 119-75\)](#), signed February 3, 2026.

§III.G.7.b(5) Proposed Revisions to the Terminology of Allowable Uses

CMS proposes replacing the term “social determinants of health” with “upstream drivers of health” in the regulations governing how ACOs may use Advance Investment Payments (AIP).^{vi} These payments can support staffing, infrastructure and services that address barriers to care, including transportation, utilities and housing assistance.³⁷

GHAI strongly urges CMS to retain the term “social determinants of health.” The term is widely understood by health care providers, researchers, policymakers and community-based organizations and provides greater clarity about how ACOs may use these funds.³⁸ This clarification is important for people with SUD, whose ability to access and remain engaged in treatment can depend on factors such as stable housing, transportation and other basic needs. CMS has previously defined “upstream drivers of health” to include factors relevant to SUD care, but changing the terminology without clear definitions could create unnecessary uncertainty for ACOs. ACOs should be able to confidently use AIP funds to address the practical barriers that prevent beneficiaries with SUD from remaining in care.

Recommendation: GHAI recommends that CMS retain the established term “social determinants of health” in the AIP regulations. If CMS moves forward with “upstream drivers of health,” it should clearly define the term and ensure that it encompasses the same factors currently recognized under established social determinants of health frameworks.

§IV.A.4.b.(2) Updates to Quality Measures in the APP and APP Plus Quality Measure Set

In the CY 2025 Physician Fee Schedule final rule, CMS finalized the inclusion of the Initiation and Engagement of SUD Treatment measure (Quality ID: 305) in the APP Plus quality measure set^{vii} beginning in performance year 2027.³⁹ CMS now proposes to remove the measure before it takes effect, which would leave the MSSP ACOs with no SUD-specific quality measure.

GHAI strongly opposes removing this measure. Quality ID: 305 would be the only measure connecting ACO quality performance to whether Medicare beneficiaries with SUD start and remain engaged in treatment. Removing it sends the wrong signal at a time when CMS is prioritizing BHI and overdose prevention and would eliminate an important source of accountability for SUD care in value-based payment models.

^{vi} Advance Investment Payments (AIP) are an option under the MSSP that provide eligible ACOs – new to the program, inexperienced with program-based risk and classified as low-revenue – with a \$250,000 upfront payment plus up to two years of quarterly per-beneficiary payments to help build infrastructure and address underserved beneficiaries’ needs ([42 CFR § 425.630](#)).

^{vii} The APP Plus quality measure set is the MSSP’s required quality-reporting framework for ACOs, finalized in the [CY 2025 PFS](#) to align ACO reporting with the Adult Universal Foundation measures. ACOs’ performance on this measure set determines whether they meet the quality performance standard required to qualify for shared savings.



CMS cites the burden of adding new measures during the transition to digital quality measurement as the reason for removing the measure. However, this concern applies broadly to the APP Plus measure set and does not explain why Quality ID: 305 should be removed rather than delayed.⁴⁰ If CMS believes additional time is needed before ACOs can report the measure, it should establish a future performance year rather than eliminating the measure without a clear path for its return. Maintaining SUD-specific accountability is particularly important because Medicare beneficiaries with SUD continue to face significant gaps in treatment. Fewer than 40% of Medicare beneficiaries with OUD received care consistent with recognized quality standards in 2020, and Medicare performed worse than Medicaid on every comparable OUD quality measure.⁴¹

Recommendation: GHAI recommends CMS return the Initiation and Engagement of SUD Treatment measure (Quality ID: 305) in the APP Plus quality measure set. If CMS determines that implementation should be delayed due to reporting burden, it should establish a specific future performance year for the measure rather than removing it entirely. A meaningful SUD quality measure is essential to ensuring that people with SUDs remain visible in value-based care models and that ACOs are accountable for improving access to and engagement in treatment.

¹ <https://www.advocacyincubator.org/program-areas/injury-prevention/overdose-prevention/federal-public-comments-and-regulatory-responses>

² <https://www.cdc.gov/nchs/pressroom/releases/20260513.html>

³ <https://www.aspr.gov/about/law-policy-strategy/emergency-declarations/declarations-public-health-emergency/2026-06-nationwide>

⁴ <https://doi.org/10.1001/jamanetworkopen.2022.41128>;
<https://www.healthaffairs.org/doi/10.1377/hlthaff.2023.00148>

⁵ <https://www.ncbi.nlm.nih.gov/books/NBK621157/>

⁶ <https://www.cdc.gov/nchs/products/databriefs/db549.htm>

⁷ <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787930>

⁸ <https://www.abstractsonline.com/pp8/#!/20301/presentation/33320>

⁹ <https://www.samhsa.gov/data/sites/default/files/reports/rpt56703/2024-N-SUMHSS-Annual-Detailed-Tables.pdf>

¹⁰ <https://oig.hhs.gov/reports/all/2025/fewer-than-one-in-five-medicare-enrollees-received-medication-to-treat-their-opioid-use-disorder/>

¹¹ <https://library.samhsa.gov/sites/default/files/cfri-older-adults-pep24-06-008.pdf>

¹² <https://www.healthaffairs.org/doi/10.1377/hlthaff.2025.00207>

¹³ <https://doi.org/10.1377/hlthaff.2023.00148>

¹⁴ <https://www.sciencedirect.com/science/article/abs/pii/S0376871621002222>

¹⁵ <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

¹⁶ <https://data.hrsa.gov/default/generatehpsaquarterlyreport>

¹⁷ <https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other>;
<https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicaid-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other>

¹⁸ <https://pubmed.ncbi.nlm.nih.gov/28074561/>



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- ¹⁹ <https://pubmed.ncbi.nlm.nih.gov/38484900/>
²⁰ <https://link.springer.com/article/10.1007/s10488-026-01503-z>
²¹ <https://pubmed.ncbi.nlm.nih.gov/39910610/>
²² <https://pubmed.ncbi.nlm.nih.gov/36645315/>
²³ <https://www.federalregister.gov/documents/2020/12/28/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>
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