

September 12, 2025

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Comments submitted electronically via www.regulations.gov

Re: Centers for Medicare & Medicaid Services (CMS) Request for Information on "Prevention and Management of Chronic Disease" CMS-1832-P

Dear Dr. Oz:

The Society for Women's Health Research (SWHR) is pleased to offer comments in response to the Centers for Medicare & Medicaid Services (CMS) Request for Information on "Prevention and Management of Chronic Disease." As a national nonprofit organization dedicated to advancing women's health and promoting research on sex differences to optimize women's health, SWHR recognizes the impacts of chronic disease on women's health and well-being. As a trusted voice in women's health, SWHR finds it imperative to encourage federal agencies – including CMS – to embrace solutions that are oriented to a lifespan approach and center the role of biological sex in chronic disease burden.

Chronic Disease and Women

Much of SWHR's work is anchored in the contributors to and impacts of chronic disease and conditions that disproportionately, differently, or uniquely impact women. This includes, but is not limited to, work and expertise related to Alzheimer's disease, autoimmune conditions, bone health, cardiovascular disease, and obesity.

In our more than 35 years of operating in this space, it has been made evident that women face disproportionate health-related burdens. Women account for an overall higher prevalence of chronic disease than men – 28.4% of women compared to 25.9% of men – and this gap appears to increase as populations age.¹ Similar disparities are apparent across disease and condition areas. For example, women account for nearly two-thirds of the Alzheimer's disease population in the United States,² more than 80% of autoimmune disease patients are women,³ and 80% of the 10 million Americans over the age of 50 with osteoporosis are women.⁴

¹ Boersma P, Black LI, Ward BW. Prevalence of Multiple Chronic Conditions Among US Adults, 2018. *Prev Chronic Dis.* 2020;17:E106. Published 2020 Sep 17. doi:10.5888/pcd17.200130

² 2024 Alzheimer's disease facts and figures. *Alzheimers Dement.* 2024;20(5):3708-3821. doi:10.1002/alz.13809

³ Angum F, Khan T, Kaler J, Siddiqui L, Hussain A. The Prevalence of Autoimmune Disorders in Women: A Narrative Review. *Cureus.* 2020;12(5):e8094. Published 2020 May 13. doi:10.7759/cureus.8094

⁴ Food and Drug Administration. Osteoporosis. U.S. Food and Drug Administration. Published 2024. Accessed May 27, 2025. <http://fda.gov/consumers/womens-health-topics/osteoporosis>

While women's health remains vastly underfunded and greater scientific understanding is needed to understand exactly why these disparities exist, we know that biological sex and hormonal factors play a key role in influencing chronic disease onset, progression, and treatment response across condition areas. Life stages that are exclusive to women like menarche, pregnancy, and menopause mean that the way in which chronic disease presents and progresses in girls and women is distinct from that of men.

Further, while women bear the burden of chronic disease prevalence, social and economic factors also influence and compound disease outcomes, impacts, and access to care. For example, women are disproportionately represented in caregiving roles for individuals with Alzheimer's disease, which can have a significant impact on psychosocial and physical health, with impacts being more pronounced for women caregivers and caregivers from lower socioeconomic groups.⁵ For women with obesity, disparate experiences with stigma and bias may influence access to adequate and quality care.⁶ Effective management of chronic conditions requires policy interventions that address the underlying social and economic influences.

SWHR acknowledges that comprehensively addressing the root causes of chronic disease and associated socioeconomic contributors is a complex public health issue that cannot be resolved by CMS alone. However, the agency has an indispensable role in this endeavor.

Among adults aged 65 and older, chronic disease prevalence is highest among older adults who are dually eligible for Medicare and Medicaid.⁷ Across all Medicare beneficiaries, hypertension, hyperlipidemia, rheumatoid arthritis, and osteoarthritis are the most prevalent, with each condition having disproportionate or disparate impacts on women.⁸

Through policy, CMS can reduce disease burden and improve outcomes for Medicare and Medicaid beneficiaries. This starts with supporting upstream, preventive care measures and implementing policies driven by evidence, improved provider reimbursements, and patient-centered care. Importantly, chronic disease cannot be untwined from women's health; to resolve the growing chronic disease burden, CMS must ensure that solutions center the needs of women.

CMS Interventions for Prevention and Management of Chronic Disease

To effectively address the root causes of chronic disease, comprehensive and integrated approaches are needed to prevent and manage them. As noted, several chronic conditions disproportionately impact women due to a variety of factors both known and unknown. However, the burden and progression of these conditions can be improved through policies that increase access to appropriate care as well as evidence-based prevention and management strategies. Below, SWHR outlines several areas for the attention of CMS, including recommendations for improving and amending existing policies.

⁵ Sörensen S, Conwell Y. Issues in dementia caregiving: effects on mental and physical health, intervention strategies, and research needs. *Am J Geriatr Psychiatry*. 2011;19(6):491-496. doi:10.1097/JGP.0b013e31821c0e6e

⁶ Phelan SM, Burgess DJ, Yeazel MW, Hellerstedt WL, Griffin JM, van Ryn M. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes Rev*. 2015;16(4):319-326. doi:10.1111/obr.12266

⁷ Boersma P, Black LI, Ward BW. Prevalence of Multiple Chronic Conditions Among US Adults, 2018. *Prev Chronic Dis*. 2020;17:E106. Published 2020 Sep 17. doi:10.5888/pcd17.200130

⁸ Medicare Chronic Condition Charts - Chronic Conditions Data Warehouse. www2.ccwdata.org. <https://www2.ccwdata.org/web/guest/medicare-charts/medicare-chronic-condition-charts>

For the purpose of this comment, we focus on four key areas for intervention: Alzheimer's disease, bone health, heart health, and obesity.

Alzheimer's Disease

Alzheimer's disease and related dementias present a significant and growing public health challenge that disproportionately affect women, with the presentation and progression of Alzheimer's disease differing notably between women and men. Studies have shown that women diagnosed with mild cognitive impairment or Alzheimer's disease often experience more rapid cognitive and functional decline than their male counterparts,⁹ and the menopause transition (and accompanying loss in estrogen) appears to contribute to the higher prevalence of Alzheimer's disease in women.¹⁰ Yet evidence gaps persist in understanding Alzheimer's disease in women. When combined with barriers to accessing screening, diagnosis, and care, such gaps hinder timely diagnosis and limit the development of sex-specific care strategies. Current CMS policy can be improved to meet the needs of beneficiaries experiencing cognitive decline for a more individualized approach.

Diagnostic Tools and Treatments - Medicare policy can improve access to innovative diagnostic and treatment tools, including amyloid PET scans and disease-modifying therapies. Policies such as coverage with evidence development (CED), while well-intentioned, can unintentionally exacerbate existing access issues by limiting timely access to cutting-edge care based on geographic, institutional, or socioeconomic factors. SWHR asks CMS to ensure that the implementation of CED and other evidence-development frameworks do not further restrict access for populations already facing disparities in care.

Comprehensive and Multidisciplinary Care Models - The complexity of Alzheimer's disease – especially when accompanied by comorbidities – demands comprehensive, multidisciplinary care teams. Effective care for this population necessitates going beyond episodic treatment and often includes coordination between physicians, skilled nursing home care, social workers, mental health professionals, dementia care navigators, and community-based support providers. However, current Medicare structures are not well-aligned with this model of care. Fee-for-service reimbursement models fail to adequately compensate for team-based, longitudinal care or non-clinical services that are vital to dementia management, such as caregiver support, home-based care coordination, and social services. Additionally, workforce shortages in geriatrics, neurology, behavioral health, and social work further limit the capacity to deliver this type of integrated care. For these reasons, CMS may consider reforming payment and reimbursement models by expanding supports for unpaid caregivers

Improving Physician Fee Schedule for Alzheimer's Disease - CMS can strengthen the dementia care workforce and infrastructure through the Physician Fee Schedule (PFS) to better reflect the chronic and complex nature of Alzheimer's disease management. Alzheimer's disease is a progressive, multifaceted neurological condition that requires sustained and longitudinal management involving multiple providers, care settings, and community resources. The time and expertise required to manage these tasks are not sufficiently reimbursed under existing PFS codes, limiting the ability of clinicians to provide high-quality, patient-centered dementia care. CMS may consider amending existing care coordination codes to account for the complexity of

⁹ Laws KR, Irvine K, Gale TM. Sex differences in cognitive impairment in Alzheimer's disease. *World J Psychiatry*. 2016;6(1):54-65. Published 2016 Mar 22. doi:10.5498/wjp.v6.i1.54

¹⁰ Conde DM, Verdade RC, Valadares ALR, Mella LFB, Pedro AO, Costa-Paiva L. Menopause and cognitive impairment: A narrative review of current knowledge. *World J Psychiatry*. 2021;11(8):412-428. Published 2021 Aug 19. doi:10.5498/wjp.v11.i8.412

neurodegenerative conditions and establishing dementia-specific care coordination codes that recognize the unique demands of cognitive decline and behavioral symptoms, particularly for patients with multiple comorbidities and those lacking caregiver support. CMS may also consider providing reimbursement for time spent coordinating with caregivers, community-based organizations, and long-term services and supports (LTSS), which are essential but often undercompensated aspects of dementia care.

Bone Health

Poor bone health, which impacts a significant number of Medicare beneficiaries, contributes notably to health care expenditures under this program. In 2016 alone, 1.8 million Medicare beneficiaries experienced approximately 2.1 million osteoporotic fractures.¹¹ These fractures are not only debilitating but also costly, both in terms of health care expenditures and diminished quality of life. One report from the Bone Health and Osteoporosis Foundation (BHOFF) found that “[t]he total annual expense of providing care for osteoporotic fractures among Medicare beneficiaries, including direct medical costs as well as indirect societal costs related to productivity losses and informal caregiving, has been estimated at \$57 billion in 2018, with an expected increase to over in 2040.”¹²

Women are at significantly greater risk for osteoporosis than men due to several biological and hormonal factors. Estrogen helps to build and maintain bone density throughout the life course, leaving women at increased risk of bone fracture after menopause. It is estimated that 1 in 2 women over the age of 50 will break a bone due to osteoporosis, and the consequences can be life-threatening.¹³ One analysis of short-term mortality risk following a hip fracture in found that the risk of death nearly triples within the year after the fracture.¹⁴ This underscores the severe impact such injuries can have on women's health and longevity – and yet, osteoporosis remains underdiagnosed and undertreated, especially following a fracture, despite clear opportunities for intervention.

To reduce the burden of osteoporosis and improve outcomes for women, CMS can implement targeted policy changes that support early detection, coordinated care, and evidence-based treatment.

Integrating Bone Health into Preventive Care Touchpoints - Conversations about bone health must be embedded into key health care entry points for at-risk populations. The “Welcome to Medicare” and Annual Wellness Visits are particularly critical opportunities to screen, educate, and assess patients on their risk for osteoporosis and the need for screening. Adding standardized bone health assessments to these visits would help identify at-risk individuals before fractures occur.

Reimbursement for Bone Density Testing - Dual-energy x-ray absorptiometry (DXA) scans are the gold standard for diagnosing osteoporosis and assessing fracture risk. However, Medicare reimbursement rates for DXA testing have declined sharply over the years, leading to reduced

¹¹ Medicare Costs of Osteoporotic Fractures. Bone Health Policy Institute. <https://www.bonehealthpolicyinstitute.org/state-reports-2021>

¹² Medicare Costs of Osteoporotic Fractures. Bone Health Policy Institute. <https://www.bonehealthpolicyinstitute.org/state-reports-2021>

¹³ Bone Health and Osteoporosis Foundation. What Women Need to Know. Bone Health & Osteoporosis Foundation. Published 2024. <https://www.bonehealthandosteoporosis.org/preventing-fractures/general-facts/what-women-need-to-know/>

¹⁴ LeBlanc ES. Hip Fracture and Increased Short-term but Not Long-term Mortality in Healthy Older Women. *Archives of Internal Medicine*. 2011;171(20):1831. doi:<https://doi.org/10.1001/archinternmed.2011.447>

access, particularly in rural and underserved areas. SWHR encourages CMS to update and improve reimbursement rates for DXA scans to ensure wider access to the diagnostic tool.

Fracture Liaison Services (FLS) - Currently, Medicare coverage does not adequately support follow-up care after a fracture. Fracture Liaison Services (FLS) are a proven, protocol-driven model of coordinated care that addresses the current gap in post-fracture management. FLS programs identify patients with fractures, assess their bone health, and initiate evidence-based treatment to prevent subsequent fractures. This model replaces the current fragmented approach to care with a proactive, team-based system shown to significantly reduce the risk of repeat fractures and mortality and increase treatment adherence.¹⁵ As such, CMS should develop mechanisms to support and reimburse providers for implementing FLS programs.

Obesity

Obesity continues to be a major public health concern, with rates steadily increasing across all age groups. This pressing public health challenge comes with economic implications – with “medical expenditures due to obesity [being] higher for adults covered by public health insurance programs than for those having private health insurance” – and concerning impacts on individual health and well-being.¹⁶ Older adults are particularly vulnerable to encountering challenges with weight management and metabolic health due to a combination of physiological and environmental factors, such as a slowing metabolism, reduced mobility, and limited physical activity^{17,18} These challenges, coupled with existing comorbidities, require a more long-term and individualized approach to prevention and care.

Research shows that obesity affects men and women differently and, accordingly, women face unique health consequences and social determinants that demand focused attention and policy solutions. For example, the menopause transition is associated with hormonal changes – namely, a loss of estrogen and androgen – that can contribute to weight gain and increased abdominal fat.¹⁹ This stage of life can trigger or exacerbate other chronic conditions, especially when compounded by insufficient access to care. Obesity also has also been found to raises the risk of or be associated with cancers that are unique to women, including breast,²⁰ endometrial,²¹ and cervical cancers,²² as well as metabolic and reproductive

¹⁵ Le HV, Van BW, Shahzad H, et al. Fracture liaison service-a multidisciplinary approach to osteoporosis management. *Osteoporos Int*. 2024;35(10):1719-1727. doi:10.1007/s00198-024-07181-7

¹⁶ Cawley J, Biener A, Meyerhoefer C, et al. Direct medical costs of obesity in the United States and the most populous states. *J Manag Care Spec Pharm*. 2021;27(3):354-366. doi:10.18553/jmcp.2021.20410

¹⁷ Mankowski RT, Aubertin-Leheudre M, Beavers DP, et al. Sedentary time is associated with the metabolic syndrome in older adults with mobility limitations--The LIFE Study. *Exp Gerontol*. 2015;70:32-36. doi:10.1016/j.exger.2015.06.018

¹⁸ Eisenstein AR, Prohaska TR, Kruger J, et al. Environmental correlates of overweight and obesity in community residing older adults. *J Aging Health*. 2011;23(6):994-1009. doi:10.1177/0898264311404557

¹⁹ Hurtado MD, Saadedine M, Kapoor E, Shufelt CL, Faubion SS. Weight Gain in Midlife Women. *Curr Obes Rep*. 2024;13(2):352-363. doi:10.1007/s13679-024-00555-2

²⁰ Dehesh T, Fadaghi S, Seyedi M, et al. The relation between obesity and breast cancer risk in women by considering menstruation status and geographical variations: a systematic review and meta-analysis. *BMC Womens Health*. 2023;23(1):392. Published 2023 Jul 26. doi:10.1186/s12905-023-02543-5

²¹ Onstad MA, Schmandt RE, Lu KH. Addressing the Role of Obesity in Endometrial Cancer Risk, Prevention, and Treatment. *J Clin Oncol*. 2016;34(35):4225-4230. doi:10.1200/JCO.2016.69.4638

²² Clarke MA, Fetterman B, Cheung LC, et al. Epidemiologic Evidence That Excess Body Weight Increases Risk of Cervical Cancer by Decreased Detection of Precancer. *J Clin Oncol*. 2018;36(12):1184-1191. doi:10.1200/JCO.2017.75.3442

conditions like polycystic ovary syndrome (PCOS).²³ Emerging evidence also suggests that obesity in midlife may increase the risk of dementia, a condition that disproportionately affects women.²⁴

CMS is uniquely positioned to improve access to evidence-based and comprehensive obesity treatment options. Several policy updates and considerations for the PFS can improve care for Medicare beneficiaries.

Coverage of Anti-Obesity Medications (AOMs) - Under current Medicare rules, medications labeled for “weight loss” or “weight gain” are excluded from Part D coverage. However, modern obesity medications are used for chronic weight management, not cosmetic or short-term weight loss. In April 2024, CMS made progress by allowing Medicare coverage of FDA-approved GLP-1 agonists for patients with obesity and a history of cardiovascular disease. While promising, this policy remains too narrow as many older adults risk losing access to these medications when they transition into Medicare. CMS should update Medicare Part D to explicitly include coverage for all FDA-approved AOMs used for chronic obesity

Intensive Behavioral Therapy (IBT) Coverage - CMS’s 2011 National Coverage Determination (NCD 210.12) allows Medicare to cover intensive behavioral therapy (IBT) for obesity. This was a significant step forward in supporting evidence-based, behavior-focused care. However, the policy includes provisions that limit access, as it restricts IBT delivery in primary care settings and it requires patients to lose a specific amount of weight within six months to continue receiving treatment.

These limitations may prevent patients from receiving care from highly qualified professionals, such as obesity medicine specialists, registered dietitians, and clinical psychologists. Furthermore, the weight-loss threshold disproportionately impacts underserved populations who face barriers to healthy food, safe environments for physical activity, and consistent follow-up care. Updating this NCD to allow for broader provider participation and more realistic treatment timelines would help patients receive comprehensive, equitable care

Medicare Part B Nutrition Coverage - Currently, Medicare Part B only covers medical nutrition therapy for individuals with diabetes or kidney disease. While it includes weight-loss counseling for beneficiaries with a BMI of 30 or higher, registered dietitians are not reimbursed specifically for obesity treatment, which can present a gap in treatment. Nutrition therapy is a cornerstone of obesity care. Therefore, CMS should consider making it accessible to all Medicare beneficiaries with obesity, regardless of comorbidities.

Leveraging the Physician Fee Schedule to Reflect Obesity as a Chronic Disease - The American Medical Association (AMA) recognized obesity as a chronic disease in 2013.²⁵ Since then, nearly 9,800 physicians have earned board certification in obesity medicine, reflecting less

²³ Obesity Action Coalition. Polycystic Ovarian Syndrome (PCOS) and Obesity. Obesity Action Coalition. <https://www.obesityaction.org/resources/polycystic-ovarian-syndrome-pcos-and-obesity/>

²⁴ Obesity at Midlife Tied to Increased Dementia Risk. Fisher Center for Alzheimer’s Research Foundation. Published 2025. Accessed September 3, 2025. <https://www.alzinfo.org/articles/prevention/obesity-at-midlife-tied-to-increased-dementia-risk/>

²⁵ American Medical Association. Recognition of Obesity as a Disease H-440.842. policysearch.ama-assn.org. Published 2013. <https://policysearch.ama-assn.org/policyfinder/detail/obesity?uri=%2FAMADoc%2FHOD.xml-0-3858.xml>

than 1% of the U.S. physician workforce.²⁶ Furthermore, with only about 150 physicians having completed an obesity medicine fellowship and actively practicing, there is a significant provider shortage.²⁷ To better support both clinicians and patients, CMS could update the PFS to reflect the complexity of obesity care and chronic disease care to acknowledge the multifaceted, longitudinal care needs and to further incentivize credited practitioners in this space.

Heart Health

Cardiovascular disease remains the leading cause of death among women in the United States,²⁸ yet existing clinical care and Medicare policy rely on outdated notions about heart disease in women, failing to address the evidenced disparities in diagnosis, treatment, and outcomes that women face.

Women are significantly more likely than men to experience delayed diagnosis and suboptimal treatment for heart ²⁹ Symptoms of heart attacks in women often present differently than in men, leading to under-recognition, missed early interventions, and poorer outcomes. When heart attacks are diagnosed, women are also less likely to receive evidence-based prevention interventions, such as cardiac rehabilitation, statin therapy, and appropriate follow-up care.³⁰

These disparities are well-documented and deeply concerning. For example, women are less likely to be referred to or complete cardiac rehabilitation – a proven intervention that reduces hospital readmissions and mortality.³¹ Preventive care and self-management strategies are underutilized in women, despite their clear impact on long-term cardiovascular health.

To improve cardiovascular care for Medicare beneficiaries, we offer the following physician fee schedule policy recommendations.

Prevention and Self-Management as Core Medicare Care Strategies - Preventive care (e.g. lifestyle counseling, medication adherence support, and chronic disease self-management) is foundational to reducing cardiovascular risk. These services are especially critical for women, who may present later in the disease process.

To improve preventative care and management, CMS could consider:

- Expanding reimbursement for comprehensive risk assessment services
- Promoting the routine integration of self-management support and shared decision-making into primary care visits
- Ensuring parity in access to nutrition counseling, physical activity programs, and tobacco cessation services

²⁶ American Board of Obesity Medicine (ABOM). ABOM Announces October '24 Test Results - American Board of Obesity Medicine. American Board of Obesity Medicine. Published December 16, 2024. <https://www.abom.org/abom-announces-october-24-test-results/>

²⁷ Tchang BG, Callister P, Brandt C, Schmidt SL, Srivastava G, Butsch WS. Obesity Medicine Fellowship Education in the United States: A Descriptive Study. *Diabetes Technology and Obesity Medicine*. 2025;1(1):340-348. doi:<https://doi.org/10.1089/dtom.2025.0071>

²⁸ Centers for Disease Control and Prevention. About Women and Heart Disease. Heart Disease. Published April 29, 2024. <https://www.cdc.gov/heart-disease/about/women-and-heart-disease.html>

²⁹ Al Hamid A, Beckett R, Wilson M, et al. Gender Bias in Diagnosis, Prevention, and Treatment of Cardiovascular Diseases: A Systematic Review. *Cureus*. 2024;16(2):e54264. Published 2024 Feb 15. doi:10.7759/cureus.54264

³⁰ Al Hamid A, Beckett R, Wilson M, et al. Gender Bias in Diagnosis, Prevention, and Treatment of Cardiovascular Diseases: A Systematic Review. *Cureus*. 2024;16(2):e54264. Published 2024 Feb 15. doi:10.7759/cureus.54264

³¹ Supervía M, Medina-Inojosa JR, Yeung C, et al. Cardiac Rehabilitation for Women: A Systematic Review of Barriers and Solutions. *Mayo Clin Proc*. Published online March 13, 2017. doi:10.1016/j.mayocp.2017.01.002

These interventions must be supported by adequate reimbursement mechanisms in the PFS so that physicians are able to dedicate time to preventive care without financial disincentives.

Coverage and Utilization of Cardiac Rehabilitation - Women have historically been under-referred and underrepresented in cardiac rehabilitation programs.³² To rectify this, policy changes at CMS may include targeted efforts to increase referral, access, and adherence these critical secondary preventive services and support flexible delivery models to encourage participation rates and reduce disparities. These models are especially beneficial for women, who often face logistical challenges, like caregiving responsibilities or transportation barriers, that can limit access to traditional facility-based programs.

Care Coordination Payments for Chronic Cardiovascular Management - Heart disease is a chronic and often progressive condition, requiring multidisciplinary coordination and long-term management. CMS should build on recent PFS reforms to ensure cardiovascular care is coordinated across providers, including cardiologists, primary care physicians, pharmacists, and community health workers. There should also be sustainable reimbursement for ongoing engagement, monitoring, and education as women may require more frequent contact with providers and greater support navigating comorbidities, social determinants of health, and caregiver responsibilities.

Additional Comments for Improving the PFS

In addition to the gaps noted above, SWHR would emphasize the time-intensive nature of chronic care, which can create disincentives within PFS for prevention and whole-person care, particularly in women's health. It fails to adequately capture the extensive time and resources required for comprehensive chronic care, especially in primary and specialty care settings.

Many preventive services and care coordination activities do not align with procedure-based billing, leading to restricted fees that can have downstream negative effects, especially in care deserts and under-resourced communities. Women's health specialties – including those already under-resourced – are disproportionately impacted, as providers are discouraged from offering certain treatments or surgical options when not adequately reimbursed for the time.^{33,34,35} Low reimbursement can exacerbate workforce shortages, particularly in underserved rural and high-need areas. For example, according to a report from the American Medical Association, rheumatology – one of the lowest-compensated specialties – has experienced a 20% decline in Medicare physician payments between 2001 and 2021, while practice operating costs have risen by 39%.³⁶ This creates significant financial and logistical challenges that limit providers' ability to care effectively for patients with chronic conditions. Similarly

³² Khadanga S, Gaalema DE, Savage P, Ades PA. Underutilization of Cardiac Rehabilitation in Women: BARRIERS AND SOLUTIONS. *J Cardiopulm Rehabil Prev.* 2021;41(4):207-213. doi:10.1097/HCR.0000000000000629

³³ Newman HR, S. Ghaith, S.S. Voleti, Magtibay PM, Yi J. An Analysis of Medicare Reimbursement Rates in Hysterectomies Performed in Gynecologic Surgery: 2010-2019. *Journal of Minimally Invasive Gynecology.* 2020;27(7):S114-S114. doi:https://doi.org/10.1016/j.jmig.2020.08.182

³⁴ Finney C, Lakey K, Rada K, Reedy MB. Disparities in Gynecologic Oncology: Descriptive Study of Changes in Medicare Reimbursement Rates in the United States [ID 953]. *Obstetrics and Gynecology.* 2025;145(6S):27S27S. doi:https://doi.org/10.1097/aog.0000000000005916.092

³⁵ Gao TP, HoSang KM, Bleicher RJ, Kuo LE, Williams AD. Evolving Economics: The Erosion of Medicare Reimbursement in Breast Surgery (2003-2023). *Ann Surg Oncol.* 2024;31(11):7303-7311. doi:10.1245/s10434-024-15709-8

³⁶ Blair E. Flawed Medicare physician payment system threatens patient access. The Hill. Published October 21, 2022. Accessed September 11, 2025. <https://thehill.com/opinion/congress-blog/3698702-flawed-medicare-physician-payment-system-threatens-patient-access/>

under-compensated services include geriatric care coordination, nutrition counseling, and physical activity assessments and interventions.

We strongly recommend that CMS update the fee schedule to better reflect the time, complexity, and multidisciplinary nature of chronic disease management, with a particular focus on improving access to care in underserved specialties and communities.

Physical Activity, Nutrition and Lifestyle Intervention Supports

As outlined in the preceding sections, holistic and comprehensive support is essential to empower beneficiaries to implement effective lifestyle and treatment interventions for managing chronic conditions. While the prior sections include condition-specific recommendations, we also emphasize the importance of broader, cross-cutting interventions and principles that CMS should adopt. Accordingly, CMS should expand coverage and reimbursement for the full range of services and providers that deliver these critical interventions.

Physical activity - Physical activity plays a critical role in preventing and managing chronic conditions such as cardiovascular disease, obesity, and osteoporosis. However, current coverage under Medicare remains inadequate. Physical therapists, occupational therapists, and exercise physiologists are uniquely positioned to deliver evidence-based interventions that improve patient outcomes, reduce hospitalizations, and enhance quality of life, especially for older adults and those with functional limitations.

Nutrition services - Nutrition services are a cornerstone of effective chronic care, yet Registered Dietitian Nutritionists (RDNs), nutrition educators, and medically tailored meals are not sufficiently reimbursed. These services can be essential for addressing diet-related conditions, supporting recovery post-discharge, and preventing complications in patients with multiple chronic illnesses.

We also encourage CMS to further explore “Food is Medicine” approaches within its policies, with special attention to culturally relevant and appropriate foods that reflect diverse dietary needs. Barriers such as the Supplemental Nutrition Assistance Program’s (SNAP) exclusion of hot meals, may pose an additional burden for certain Medicaid and Medicare beneficiaries, and we urge the agency to be mindful of how structural policy barriers may have compounding impacts on limiting access to effective lifestyle approaches.

Enhancing the Annual Wellness Visit (AWV)

Leveraging the Annual Wellness Visit (AWV) as a structured intervention point can drive better health outcomes, particularly in chronic disease management, yet, the AWV remains underutilized, largely due to structural and billing limitations that hinder its broader adoption despite its critical role in early intervention. Uptake of the AWV is low, in part because of technical barriers such as limited reimbursement options and unclear guidance on the use of validated assessment tools—for example, cognitive assessments. The use of standardized, evidence-based instruments can ensure accurate evaluation and improve care quality. Furthermore, the AWV offers a valuable opportunity to comprehensively assess key areas including physical activity, nutrition, mental health, and fall risk, all of which are vital to preventing and managing chronic conditions. Moreover, the AWV supports early identification of risks and promotes patient self-management. Finally, integrating telehealth services and shared decision-making tools into the AWV process can improve its relevance, accessibility, and patient engagement.

Conclusion

Advancing payment models that reflect the real-world complexity of care – especially for women – must be a central priority for CMS. Women's health often involves overlapping medical, behavioral, and social needs, yet current fee-for-service models frequently overlook these complexities, resulting in fragmented care and missed opportunities for early intervention. As a major driver of health care policy and reimbursement, CMS is uniquely positioned to lead the shift toward value-based models that prioritize prevention, care coordination, and whole-person health. By recognizing upstream care as essential rather than optional, CMS can help reduce preventable chronic diseases, minimize long-term public spending, and improve health outcomes across all populations.

If you have questions about any of the information included above, or if SWHR can be helpful in any way, please contact me at kathryn@swhr.org or (202) 464-5004.

Sincerely,

A handwritten signature in cursive script that reads "Kathryn H. Schubert".

Kathryn Schubert, MPP, CAE
President and CEO
Society for Women's Health Research