September 14, 2026

Dr. Mehmet Oz
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Attention: File Code: CMS-1848-P
Submitted via www.regulations.gov

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:

The undersigned member organizations of the Diabetes Advocacy Alliance (DAA) are pleased to submit comments to the Centers for Medicare & Medicaid Services (CMS) regarding the 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 (CY 2027 PFS).

The DAA is diverse in scope, with our members representing patients, healthcare providers, suppliers, and more all united to change the way diabetes is viewed and treated in America. Since 2010, the DAA has worked with legislators and policymakers to increase awareness of, and action on, the diabetes epidemic.

DAA members share a common goal of elevating diabetes on the national agenda so we may ultimately defeat this treatable, but deadly chronic disease. We are committed to advancing person-centered policies, practical models, and legislation that can improve the health and wellbeing of people with diabetes and prediabetes. An essential component to our goal is addressing health access issues and upstream drivers of health, and the extent to which both are impacted by or can be improved through policy. Our advocacy to policymakers highlights key strategies to prevent, detect and manage diabetes and prediabetes and care for those affected by it, including the National Diabetes Prevention Program (NDPP) and the Medicare Diabetes Prevention Program (MDPP) and the interconnectedness of the two programs, as the NDPP serves as the national recognition body for providers of NDPP and MDPP suppliers.

In our collective review of the CY 2027 PFS, we are pleased to see various proposed changes that address DAA priorities, which we highlight below. We also offer recommendations that could help advance CMS's core goals of expanding access to and affordability of diabetes prevention and treatment in the United States.

Shared Medical Appointments

We appreciate CMS's goal to support the prevention and management of chronic diseases and its consideration of how to encourage sustainable lifestyle and behavioral changes through shared medical appointments (SMAs). However, we would like to request that CMS provide additional clarity on how this would be implemented. For example, CMS states that SMAs would integrate group education, counseling, and peer support with individualized patient clinical assessments and care. However, CMS does not indicate how clinical assessments would be done as part of the SMA. We would appreciate clarity on how the individual clinical assessment of up to 10 beneficiaries would be a part of the same 60-minute session as the group components. Would there be a period between the two sessions? We believe more clarity is needed in the final rule for SMAs to be implemented and the code to be appropriately utilized.

Health Coaching

We appreciate that CMS is considering adding codes to support health and well-being coaching for lifestyle change for beneficiaries with chronic conditions. It is important that Medicare reimburses for evidence-based services associated with prevention of some of the most prevalent conditions impacting the health and quality of life of Medicare beneficiaries. However, we have some concerns with what the creation of these codes will mean for existing services that also provide lifestyle change support to help prevent chronic conditions including diabetes. We also believe the proposed new codes would benefit from additional information and guidance for delivery and billing.

Personnel Types and Supervision Levels

As proposed, the health coaching proposal comingles personnel types and supervision levels under the same reimbursement scheme. CMS has chosen to simultaneously allow this service to be performed under general supervision when performed by community health workers trained to deliver potentially only a single health promotion program from the Administration for Community Living (ACL) while requiring direct supervision when performed by clinic-based personnel with advanced credentialing. We request that all health coaching can be done under general supervision to make sure coaching is accessible for Medicare beneficiaries.

Misalignment with Existing Programs such as MDPP and DSMT

In addition, we are concerned about the implications of health coaching on established, highly regulated programs such as the Medicare Diabetes Prevention Program and Diabetes Self-Management Training (DSMT). Currently, providing ongoing chronic disease management support for people with diabetes or those at risk of developing type 2 diabetes requires adherence to strict national standards that carry substantial compliance burdens to participate in.[1,2] But if CMS begins to pay for health coaching as currently proposed, it may be financially advantageous for these programs to forego their rigorous national accreditations and to instead bill as many of their services as they can under the proposed health coaching standards, in essence creating a reimbursement arbitrage system that we are not sure is what was intended. For DSMT programs, this would mean being paid the exact same amount for group classes (as group DSMT's G0109 is the crosswalk for 0593T) but with no limitations on hours and no oversight by CMS or clinical standards and oversight set by one of the two recognized accrediting organizations (currently the ADA and ADCES per 42 USC 1395x). In another example, Medicare DPPs could use coaches from one or more ACL programs and draw down higher reimbursement per beneficiary for group services billed as health coaching instead of MDPP. We fear this relative lack of regulation alongside a comparatively generous payment rate will ultimately hollow out the existing, highly evidence-based programs currently covered by CMS, and could undercut CMS' own efforts to expand participation in this program.

Recommendations to Improve Health Coaching Codes

If CMS chooses to move forward with a broad definition of qualified personnel, we are concerned that CMS has omitted many individuals who would be similarly, or more so, qualified to provide health coaching services as the individuals eligible under the current proposal. In the clinic setting, CMS should consider registered dietitians (as defined by 42 CFR § 410.72), anyone holding a certification from the Certification Board for Diabetes Care and Education, and any clinical staff of a Diabetes Self-Management Training program (as defined in 42 CFR § 410.140-146) as qualified to provide health coaching. Health coaching is well within the scope of practice of these professionals, but few would hold an additional credential specifically in health coaching because it would be largely redundant. In the case of registered dietitians and any other Medicare billable provider types who may be performing this service, we request they be allowed to bill the service under their own NPI and without additional supervision as long as the beneficiary has been referred to them specifically for this service as is the case for other services they can independently provide and bill for. For clinic staff who cannot work or bill independently for services in the Medicare program, we recommend general supervision to align the supervision level across the code set.

In addition, we believe it was an omission to not include coaches from Medicare Diabetes

[1] https://www.cdc.gov/diabetes-prevention/php/program-provider/program-requirements.html
[2] https://www.cdc.gov/diabetes-toolkit/php/become-provider/dsmes-national-standards.html

Prevention Programs if coaches from ACL programs are to be considered qualified. CMS should include coach training that has been recognized by the Centers for Disease Control (CDC) National Diabetes Prevention Recognition Program (DPRP) as sufficient for this benefit. We note that coaches who have been trained by DPRP programs are permitted to deliver intensive lifestyle behavioral counseling that meets all the components of this proposed service that can be covered by Medicare if the program applies to be a MDPP supplier.

We also recommend that CMS:

- Allow or encourage use of this service for those with a chronic condition for which behavioral counseling for healthy lifestyle is recommended by professional guidelines/standard of care and the USPSTF. This includes those with high cardiovascular disease risk, pre-diabetes, obesity, and overweight.

- Revise valuation so that it includes the costs associated with content development and self-monitoring. It currently does not include these costs in the code valuation. Content development requires research, development, and then delivery of the evidence-based materials, and evidence-based coaching programs often deliver this part of the service through a supported app. In addition, the means for self-monitoring must be created and then maintained in a manner that monitoring can and is shared with a coach, as is required of monitoring of weight in MDPP today. This is a basic evidence-based standard for this service. Ensuring that the reimbursement accounts for material development and ensuring methods for self-monitoring and appropriate documentation will help ensure that there is sufficient supply of health coaches for America's growing population of people with conditions for which coaching can be a benefit and will create standards like those of MDPP today for data capture to reduce the chance of fraud.

- Put in place a pathway for future consideration of asynchronous and hybrid model coaching. Evidence supports these alternative delivery models for lifestyle and well-being coaching, and, if Medicare reimbursement is to be aligned with the evidence base, it should find a way to include these models in the future.

Lastly, we note that CMS has chosen not to put any utilization caps on health coaching based on the assumption that “multiple session in the same calendar month may be needed.” Instead, a standard of “reasonable and necessary” is being applied. We encourage the administration to apply this same standard to Diabetes Self-Management Training (G0108, G0109) and Medical Nutrition Therapy (97802, 97803, 97804), which currently have strict utilization limits as low as 2 hours per year. Health coaching is one aspect of these services, so it does not make sense to force someone to separate from their DSMT or MNT provider due to exhausting those benefits and then begin to see a different professional for health coaching when CMS could instead continue to pay for DSMT and MNT as long as they are considered reasonable and necessary by

the referring provider.

Increasing Access to Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) services in RHCs

In Section III.B.2.c., CMS proposes to begin paying RHCs the all-inclusive-rate (AIR) for DSMT and MNT services provided to individuals and to consider these to be stand-alone billable visits under the RHC benefit. We strongly support the spirit of this proposal for the reasons CMS outlined such as extremely low utilization of these services currently in the RHC setting, the high need for these services in rural areas, and the suppression of access and utilization by previously only allowing these services on the cost report. We also support CMS's goal to "[reduce] differences between RHCs and other settings in which DSMT and MNT are furnished and paid" from a workforce perspective: the fewer differences there are in billing for these services between settings, the easier it will be for experienced providers to be recruited into RHCs that currently do not offer these services and to bring with them their knowledge of coverage and payment rules to ensure RHCs are being appropriately compensated for these new offerings. It is in this last regard that the proposed rule falls short.

Introducing an "incident-to" payment framework to these services and requiring direct supervision within RHCs when these services are explicitly not billable incident-to or performed under supervision in other settings will undermine this goal. We are concerned that CMS is unaware that their proposal is not aligned with other settings given that the proposed rule states that "the physician (or other supervising practitioner) must be in the RHC or FQHC and immediately available to provide assistance and direction throughout the time of the incident to service or supply is being furnished." This is not the case currently in FQHCs where DSMT and MNT can be provided on an individual basis in accordance with the regulations found at 42 CFR § 410.140-146 (for DSMT) and 42 CFR § 410.72 and 42 CFR § 410.130-134 (for MNT) that require a referral for the services but no supervision.

Requiring direct supervision of DSMT programs and registered dietitians providing MNT will artificially limit access to these services in the RHC setting beyond their already challenging limitations in FQHC and traditional clinic settings. Requiring direct supervision and incident-to billing means that DSMT and MNT visits need to be scheduled around both the providers of those services and the presence of the supervising and billing practitioner.

Instead of adding the proposed new paragraph (a)(1)(iii) that introduces supervision and incident-to billing to DSMT and MNT only for the purposes of RHCs, we propose that CMS instead align the coverage of these services in the FQHC and RHC settings by collapsing (a)(2) into (a)(1) to read as follows (bold text indicates additions):

(1) For RHCs **or FQHCs**, a visit is either of the following:

(i) Face-to-face encounter (or, for mental health disorders only, an encounter that meets the requirements under paragraph (b)(3) of this section) between an RHC **or FQHC** patient and one of the following:

(A) Physician.
(B) Physician assistant.
(C) Nurse practitioner.
(D) Certified nurse midwife.
(E) Visiting registered professional or licensed practical nurse.
(G) Clinical psychologist.
(H) Clinical social worker.
(I) Marriage and family therapist.
(J) Mental health counselor.
(K) A qualified provider of medical nutrition therapy services as defined in part 410, subpart G, of this chapter.
(L) A qualified provider of outpatient diabetes self-management training services as defined in part 410, subpart H, of this chapter.

(ii) Qualified transitional care management service.

We are overall heartened by CMS' inclusion of new approaches to address the epidemic of diabetes, which is particularly acute in rural areas. The rates of diabetes illustrate the need for an "all ideas on deck" approach. Accordingly, we urge CMS to implement, in 2027, whether through CMMI or other pilot authorities, programs that test in RHCs and FQHCs the delivery of DSMT using virtual or asynchronous technology, so long as the programs are accredited/recognized through CMS-approved accrediting organizations (as outlined in 42 CFR 410 Subpart H). A number of these programs have already achieved accreditation/recognition and operate in the private insurance and employer market today serving hundreds of thousands of adults.[3]

We would also like to point out an error in the background section of this portion of the rule. CMS states "a dietitian may not be the sole practitioner of the DSMT service," and cites the original 2002 change request[4] from when RDs were added as providers to the Medicare program. However, in 2007, the National Standards for DSMES were updated to allow sole provider programs delivered by a registered dietitian, registered nurse, or pharmacist. However, CMS has yet to update its DSMT quality standards (found at 42 CFR 410.144(a)(4)) or Chapter 15 Section 300.2 of the Medicare Benefit Policy Manual.[5] We strongly request that CMS make these overdue changes to their regulations and sub-regulatory guidance, and we request this be done in the CY2027 final rule since this would simply be codifying what has been

[3] https://www.jmir.org/2026/1/e78321
[4] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/b02062.pdf
[5] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c15.pdf#page=265

the governing policy for over 15 years and not the creation of new policy that needs to undergo a public comment period.

Improvement Activities for MIPS

CMS proposes to add new improvement activities beginning with the CY 2027 performance period/2029 Merit-based Incentive Payment System (MIPS) payment year, including "Lifestyle Approaches to Diabetes Remediation" to be included in the Advancing Health and Wellness subcategory. The undersigned members of the DAA strongly support additional improvement activities to encourage MIPS-eligible clinicians to participate in approaches for diabetes remediation, which reflects the significance this administration is rightly placing on chronic disease management. We do believe this measure would benefit from some additional clarity. For example, it is unclear from the activity description what types of actions clinicians would have to do to meet the requirements of the measure, which we are concerned may discourage clinicians from choosing the measure as an improvement activity. While we appreciate maintaining a degree of flexibility to allow various clinicians to be adaptive to their specific roles, patient populations, and clinical expertise, we think engaging with the groups in our coalition in order to develop illustrative examples would give clinicians greater confidence in operationalizing this activity and would engender its uptake.

There are also small, but important, clarifications that should be made and inaccuracies rectified before the activity is finalized. For example, the American Diabetes Association (ADA) and Association for Diabetes Care and Education Specialists (ADCES) accredit DSMES providers, not the CDC. CMS should clarify the intent behind the measure, given that the evidence-based programs and resources listed in the activity description that participating clinicians can use (DSMES, LEADR, ADA Institute of Learning – Hands on Webinar) have different purposes, audiences, and goals.[6]

Request for Information on Intensive Lifestyle Interventions to Slow Progression of Alzheimer's disease (AD/ADRD)

Several DAA member organizations have spent more than a decade delivering and evaluating the nation's largest evidence-based lifestyle change program, the CDC's National DPP, and its Medicare counterpart, the MDPP. We believe the lessons learned from these programs can help CMS design an AD/ADRD lifestyle intervention benefit that reaches beneficiaries quickly and works as intended.

Build on the National DPP and MDPP supplier network

[6] https://d2g5m5leph8kam.cloudfront.net/s3fs/s3fs-public/2026-06/2027-qpp-proposed-rule-factsheet.pdf?VersionId=R3HfF.xfEIgdOmJuJYIOgToEwLFDPYjW

We urge CMS to begin with the delivery system Medicare has already built and vetted rather than creating a new supplier category. MDPP suppliers are enrolled Medicare suppliers that must achieve and maintain recognition from the CDC's Diabetes Prevention Recognition Program (DPRP). Each recognized organization delivers a CDC-approved, yearlong lifestyle change curriculum through trained lifestyle coaches and submits participant-level performance data to CDC. The curriculum already addresses the domains identified in this RFI, including physical activity, nutrition, sleep, and stress management. We recommend that CMS certify CDC-recognized organizations as qualified delivery entities for a future ILI, with additional AD/ADRD-specific content where the evidence supports it. This approach would reach beneficiaries years sooner and at lower administrative cost than standing up a new supplier type.

Use the DPRP as the model for quality and fidelity standards

The DPRP is a mature federal model for ensuring an intervention is evidence-based and delivered with fidelity. Recognition must be earned and maintained through demonstrated performance, including delivery of an approved curriculum, use of trained lifestyle coaches, defined session requirements, and regular submission of participant-level data on attendance and outcomes. Organizations that do not meet performance benchmarks lose recognition. We urge CMS to adopt this same structure for any ILI benefit. This structure also addresses the program integrity concerns CMS raises in the Shared Medical Appointments discussion elsewhere in this proposed rule.

Permit in-person, telehealth, and asynchronous online delivery from the start.

We applaud CMS for finalizing policies, beginning in CY2026, that permit MDPP services to be furnished online and through distance learning, and we urge CMS to take a similar approach, consistent with our comments on previous PFS proposals supporting asynchronous delivery in the MDPP and providing reimbursement parity across all delivery modalities. The beneficiaries most likely to benefit from an AD/ADRD intervention are older adults, many of whom live in rural areas, have limited mobility, or face transportation and caregiving constraints that make regularly scheduled in-person attendance difficult. Online delivery, including structured curricula, self-monitoring tools, and coach support that does not require a scheduled appointment, has been especially important for sustaining engagement over a full year of programming. Limiting a future ILI to in-person or scheduled telehealth sessions would exclude many of the beneficiaries who need it most.

Define eligibility by risk, not by an MCI or dementia diagnosis.

The foundational trial evidence for multi-domain lifestyle intervention, including the FINGER trial, enrolled older adults who were selected because they were at elevated risk, not because they had a cognitive diagnosis, and lifestyle intervention has its greatest effect before

significant cognitive decline occurs. Documentation requirements at enrollment, particularly required blood tests, are a persistent barrier to participation and eliminate a pool of potential participants who are at risk for prediabetes. These formal MCI or dementia diagnosis depend on access to cognitive assessments which are not only limited in rural and underserved communities, but also by availability of specialists and lengthy wait times for appointments. These requirements will create barriers to participation. We urge CMS to define eligibility using validated risk criteria, similar in approach to CDC's National Diabetes Prevention Program's CDC/ADA prediabetes risk test as an acceptable eligibility screener; screening for age in combination with modifiable risk factors such as prediabetes or diabetes, hypertension, obesity, or physical inactivity.

Recognize that diabetes prevention and management also reduce dementia risk.

The Lancet Commission report cited in this RFI identifies diabetes among the modifiable risk factors for dementia. Medicare's existing diabetes prevention and management services, including referral to the National DPP (which this proposed rule would strengthen through the consolidated Glycemic Screening, Referral, and Management improvement activity), the MDPP, DSMT, and MNT, therefore already contribute to reducing dementia risk. We encourage CMS to consider these cognitive health benefits when evaluating the value and future design of these services, and to design any ILI evaluation to capture benefits that accrue across multiple conditions over time.

Conclusion

The undersigned members of the DAA greatly appreciate this opportunity to provide comments to the CY 2027 Medicare Physician Fee Schedule proposed rule. We share a goal with CMS: to create and expand innovative preventive services and programs for Medicare beneficiaries that address the prevention of diabetes and improve treatment and care for diabetes to stabilize health in a cost-effective manner.

Should you have any questions or seek additional information regarding these comments, please contact DAA Co-Chairs, Lisa Murdock (LMurdock@diabetes.org), with the American Diabetes Association, or April Gutmann (agutmann@diabetespac.org), with the Diabetes Patient Advocacy Coalition.

Sincerely,

The Undersigned Member Organizations of the Diabetes Advocacy Alliance

Academy of Nutrition and Dietetics
American Association of Clinical Endocrinology
American Diabetes Association

Association of Diabetes Care and Education Specialists
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Endocrine Society
National Kidney Foundation
Noom, Inc.
Omada Health
YMCA of the USA