December 3, 2025

The Honorable Vern Buchanan
Chairman
Subcommittee on Health
The House Committee on Ways and Means
1139 Longworth HOB
Washington D.C. 20515

The Honorable Lloyd Doggett
Ranking Member
Subcommittee on Health
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1139 Longworth HOB
Washington D.C. 20515

RE: Hearing on Modernizing Care Coordination to Prevent and Treat Chronic Disease [No. HL-06]

Dear Chairman Buchanan, Ranking Member Doggett, and members of the Health Subcommittee,

On behalf of the Coalition for Metabolic Health (CMH), we appreciate the opportunity to comment on the Committee's recent hearing, "Modernizing Care Coordination to Prevent and Treat Chronic Disease." CMH is a national alliance of researchers, clinicians, philanthropists, nonprofits, business leaders, and advocates ushering in a new era in health care by making metabolic health mainstream. We share a commitment to reducing the burden of chronic disease and advancing evidence-based nutrition and public health policy.

This hearing comes at a pivotal moment. Chronic disease now accounts for the majority of U.S. healthcare spending and preventable deaths. Poor metabolic health drives nearly all of these conditions. Any effort to modernize chronic disease care must, therefore, elevate metabolic health as a measurable outcome, an actionable clinical target, and a foundation for prevention.

CMH is grateful that the Committee is taking a forward-looking approach. We respectfully offer the following recommendations to improve national health outcomes.

One of the Biggest Drivers of Chronic Disease is Metabolic Dysfunction. Almost nine in 10 adults have at least one indicator of metabolic dysfunction. Rising rates of obesity, insulin resistance, hypertension, and prediabetes are driving conditions such as type 2 diabetes, cardiovascular disease, kidney disease, and fatty liver disease. These illnesses account for a significant portion of Medicare spending and contribute heavily to disability, early mortality, and reduced workforce participation.

Despite the central role that metabolic health plays in nearly every chronic condition, federal programs still lack early screening protocols, incentives for early screenings for providers

and patients, and aligned reimbursement coverage pathways that would allow clinicians to detect metabolic dysfunction early and intervene in a timely manner. Dr. Parikh testified that what drives the high cost of healthcare is preventable disease—and that increasing access to preventive care services will help prevent the continued rise in long-term healthcare costs.

Modernizing chronic disease care must begin by focusing on root-cause metabolic dysfunction across Medicare, Medicaid, and relevant HHS agencies.

Chronic disease prevention requires standardized measures of metabolic health. Clinicians cannot improve what is not measured. There is no consistent diagnosis coding structure, reimbursement structure, or incentive-based payment system to incentivize the collection or reporting of many of the most predictive and actionable markers of metabolic dysfunction, such as waist-to-height ratio, triglyceride-to-HDL ratio, fasting insulin level, and other early markers of insulin resistance.

CMH encourages Congress to direct CMS, CDC, and other HHS governmental and non-governmental entities to jointly establish a standardized set of metabolic-health metrics for use in preventive services, to issue clear clinical guidance for early identification of insulin resistance and related conditions, and to define expectations for reporting across participating health systems.

Standardized metrics and reporting would strengthen value-based care models—an approach several witnesses highlighted for reducing healthcare costs by rewarding preventive care and appropriate screenings. A common set of measures would also make it easier for clinicians to track patient progress over time, supporting payment structures that reimburse providers based on outcomes rather than the volume of services rendered.

Such steps would directly support the Committee's goal of modernizing chronic disease care and aligning incentives toward prevention.

Medicare coverage should reflect evidence-based metabolic interventions. Although there is strong evidence for early intervention, Medicare coverage remains tilted toward late-stage disease management, which increases avoidable costs.

Medical nutrition therapy (MNT), for example, is restricted to narrow diagnostic categories even though nutrition is one of the most effective tools for improving metabolic markers such as glycemic control, cholesterol ratios, and weight.

Expanding access to MNT and allowing clinicians greater flexibility to refer patients earlier—before progression to type 2 diabetes or cardiovascular disease—would align coverage with clinical practice and prevention priorities. Allowing various providers, like RDNs, RDs, etc. to deliver MNT would also support clinical teams in utilizing the full scope of each provider's skills and expertise. As Dr. Hoben emphasized during the hearing, when healthcare providers other than physicians (such as dieticians) can administer appropriate care, patients get the best help—and doctors can spend more time with the sickest patients.

Similarly, obesity is a metabolic condition with significant cardiometabolic implications, yet coverage for modern obesity care remains inconsistent or restricted. Continuous glucose monitors are covered for diabetes but not for prediabetes, insulin resistance, or other metabolic conditions, leaving clinicians without tools to track early-stage improvement.

Moreover, as Dr. Hoben emphasized in his testimony, some of the largest drivers of chronic disease include lifestyle choices, limited access to healthy foods, insufficient education and access to exercise, and inadequate incentives to engage in healthy behaviors.

CMH urges CMS to clarify or expand coverage for metabolic-monitoring technologies when clinically indicated, particularly within prevention, metabolic screening, and chronic care initiatives.

CMMI should pilot metabolic-health models focused on prevention. The Center for Medicare & Medicaid Innovation is well-positioned to develop and test new models that integrate metabolic screening and early intervention into primary care, support team-based metabolic health approaches, reward improvement in metabolic markers rather than diagnoses, and incorporate integrated metabolic strategies, including digital tools for continuous monitoring.

These models would generate meaningful evidence about the cost savings associated with preventing progression to diabetes, cardiovascular disease, and advanced fatty liver disease. They would also be fully consistent with the Committee's modernization goals and bipartisan interest in strengthening primary care.

Health and Human Services Agencies Should Align Around Metabolic Health. Metabolic health sits at the intersection of agencies within the Department of Health and Human Services (HHS), specifically the Centers for Medicare & Medicaid Services, the Centers for Disease Control and Prevention, the National Institutes of Health, and the Food and Drug Administration.

To avoid fragmented or contradictory guidance, CMH encourages the Committee to support HHS intra-agency alignment so that prevention strategies, coverage policies, and clinical guidelines reflect the latest evidence and reinforce one another. Clear, coordinated federal leadership will ensure that chronic disease prevention is integrated throughout the healthcare system.

Conclusion: Improving Metabolic Health Will Reduce Healthcare Costs and Reduce Chronic Disease. Improving metabolic health is one of the most effective and fiscally responsible ways to reduce chronic disease burden, lower federal spending, and strengthen the nation's workforce. We urge the Committee to build on the hearing by centering metabolic health in modernization efforts.

Thank you for your leadership and for the opportunity to provide these comments. CMH stands ready to serve as a resource as the Committee continues this important work.

Respectfully,

Coalition for Metabolic Health

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