COALITION FOR METABOLIC HEALTH

September 14, 2026

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244-1850

Submitted via www.regulations.gov
[Docket No. CMS-1848-P]

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (CMS-1848-P)

Dear Administrator Oz:

The Coalition for Metabolic Health ("The Coalition") appreciates the opportunity to respond to the Centers for Medicare & Medicaid Services' (CMS) CY2027 Medicare Physician Fee Schedule Proposed Rule. The Coalition appreciates CMS's continued efforts to strengthen prevention and chronic disease management, support longitudinal primary care relationships, and expand access to innovative approaches that improve beneficiary health.

The Coalition 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.

The Coalition supports CMS's efforts to better integrate prevention, nutrition, lifestyle interventions, and longitudinal care into Medicare payment policy. The Coalition respectfully submits comments on Medical Nutrition Therapy (MNT) and Diabetes Self-Management Training (DSMT), intensive lifestyle interventions for Alzheimer's disease and related dementias, primary care redesign, health and well-being coaching services, and Shared Medical Appointments.

RESPONSES TO SELECT CY2027 PFS PROPOSALS AND QUESTIONS

Support for the Rural Health Clinic (RHC) Medical Nutrition Therapy (MNT)/Diabetes Self-Management Training (DSMT) Stand-Alone Billing Proposal

CMS proposes recognizing Medical Nutrition Therapy (MNT) and Diabetes Self-Management Training (DSMT) as qualifying preventive services that may be furnished as stand-alone billable Rural Health Clinic (RHC) visits.

The Coalition supports CMS's proposal. Recognizing MNT alongside DSMT as a qualified preventive service that may be furnished as a stand-alone billable RHC visit would align RHC treatment with Federally Qualified Health Centers (FQHCs) and physician offices, which already bill MNT as a stand-alone encounter. FQHC and physician office utilization of MNT far outpaces RHC utilization on a per-beneficiary basis, a gap CMS attributes in part to this structural payment barrier.

The Coalition urges CMS to finalize this proposal as written.

While the Coalition supports this proposal, it addresses how MNT is billed in RHCs, not who is eligible to receive it. MNT coverage is limited by statute 42 U.S.C. § 1395x(vv) to beneficiaries with diabetes or renal disease, leaving out many Medicare beneficiaries with other metabolically driven chronic conditions, including prediabetes, obesity, metabolic dysfunction-associated steatotic liver disease (MASLD), polyendocrine metabolic ovarian syndrome (PMOS, formerly PCOS), cardiovascular disease, cancer, inflammatory bowel disease, neurodegenerative disease, and serious mental illness. As detailed in the Coalition's 2025 comments, expanding access to evidence-based nutrition services remains an important opportunity to improve chronic disease prevention and management.[1]

MNT's duration and frequency limits, currently three 3 hours in the first year and two hours in subsequent years, are set by National Coverage Determination (NCD 40.1), not statute. As discussed in the Coalition's 2025 comment, many psychiatric conditions are associated with elevated cardiometabolic risk and may benefit from nutrition interventions as part of comprehensive care.[2] Evidence suggests that more intensive and longitudinal nutrition counseling interventions may improve outcomes across a range of chronic conditions. Studies have demonstrated benefits from multiple MNT encounters over three to six months, while successful intensive behavioral interventions often include 12 or more sessions in the first year, supporting reconsideration of existing MNT duration and frequency limits.[3,4] The Coalition recommends CMS pursue reconsideration of NCD 40.1 to increase these limits for beneficiaries with diabetes or renal disease, including those who also manage co-occurring metabolic or psychiatric conditions.

---

[1]Coalition for Metabolic Health, *Comment in Response to CMS Request for Information on Prevention and Management of Chronic Disease*, CMS-2025-0304-0009 (Sept. 12, 2025). www.regulations.gov/comment/CMS-2025-0304-13040

[2]*Id.*

[3]Mohr AE, Hatem C, Sikand G, Rozga M, Moloney L, Sullivan J, De Waal D, Handu D. Effectiveness of medical nutrition therapy in the management of adult dyslipidemia: A systematic review and meta-analysis. J Clin Lipidol. 2022 Sep-Oct;16(5):547-561. doi: 10.1016/j.jacl.2022.06.008. Epub 2022 Jun 25. PMID: 35821005. www.sciencedirect.com/science/article/abs/pii/S1933287422001829

[4]US Preventive Services Task Force; Curry SJ, Krist AH, Owens DK, Barry MJ, Caughey AB, Davidson KW, Doubeni CA, Epling JW Jr, Grossman DC, Kemper AR, Kubik M, Landefeld CS, Mangione CM, Phipps MG, Silverstein M, Simon MA, Tseng CW, Wong JB. Behavioral Weight Loss Interventions to Prevent Obesity-Relat.ed Morbidity and Mortality in Adults: US Preventive Services Task Force Recommendation Statement. JAMA. 2018 Sep 18;320(11):1163-1171. doi: 10.1001/jama.2018.13022. PMID: 30326502. https://pubmed.ncbi.nlm.nih.gov/30326502/

Separately, 42 U.S.C. § 1395x(ddd) of the Act gives CMS independent authority to cover preventive services with a U.S. Preventive Services Task Force (USPSTF) Grade A or B recommendation, authority already used for Intensive Behavioral Therapy for Obesity (G0447) and Cardiovascular Disease (G0446). The Coalition's 2025 comment offers evidence supporting a revaluation of these codes' payment rates and an updated USPSTF review to broaden their utilization parameters.[5]

The Coalition recommends that CMS:

- Finalize the proposed RHC MNT and DSMT stand-alone billing policy;
- Pursue reconsideration of National Coverage Determination 40.1 to increase duration and frequency limits for eligible beneficiaries, including those managing co-occurring metabolic or psychiatric conditions; reevaluate existing MNT duration and frequency limits, including increasing the current benefit from three hours in the first year and two hours in subsequent years to five hours in both the initial and subsequent years of coverage and allowing additional services when medically necessary; and
- Continue evaluating opportunities to expand access to evidence-based nutrition interventions through existing statutory and regulatory authorities.

Response to the Request for Information (RFI) on Intensive Lifestyle Interventions To Slow Progression of Alzheimer's Disease

CMS seeks information regarding intensive lifestyle interventions to reduce the risk of, or slow progression of, Alzheimer's disease and Alzheimer's disease-related dementias.

Among the questions CMS raises in its RFI on intensive lifestyle interventions (ILIs) to reduce the risk of, or slow progression of, Alzheimer's disease and Alzheimer's disease-related dementias (AD/ADRD) is whether eligibility for these interventions should be restricted to beneficiaries with mild cognitive impairment or early-stage dementia. Insulin resistance biomarkers, hemoglobin A1C (HbA1c), fasting glucose, fasting insulin, and Homeostatic Model Assessment for Insulin Resistance (HOMA-IR), offer a non-invasive, lower-cost complement to biomarkers like p-tau217 for identifying at-risk beneficiaries earlier in the disease course, supporting the primary care biomarker screening recommendations below.

Metabolic dysfunction affects an estimated 90 percent of American adults, and ILIs work by correcting this modifiable root cause before it produces irreversible harm.[6] Insulin resistance, an

[5]Coalition for Metabolic Health, *Comment in Response to CMS Request for Information on Prevention and Management of Chronic Disease*, CMS-2025-0304-0009 (Sept. 12, 2025). www.regulations.gov/comment/CMS-2025-0304-13040

[6]O'Hearn M, Lauren BN, Wong JB, Kim DD, Mozaffarian D. Trends and disparities in cardiometabolic health among US adults, 1999-2018. J Am Coll Cardiol. 2022 Jul 12;80(2):138-151. doi: 10.1016/j.jacc.2022.04.046. PMID: 35728625. https://pubmed.ncbi.nlm.nih.gov/35798448/

early and common signal of metabolic dysfunction, links cognitive decline to the chronic and psychiatric conditions that the Coalition has raised throughout this comment.

The Coalition recommends that CMS:

- Ensure MAHA ELEVATE considers applications that generate evidence regarding metabolic dysfunction beyond Alzheimer's disease and Alzheimer's disease-related dementias;
- Consider the role of insulin resistance biomarkers, including hemoglobin A1C, fasting glucose, fasting insulin, and HOMA-IR, in identifying beneficiaries who may benefit from intensive lifestyle interventions earlier in the disease course; and
- Evaluate opportunities to generate evidence on lifestyle interventions that address metabolic dysfunction as a modifiable risk factor across multiple chronic conditions.

Response to the RFI on Redesigning Primary Care To Make America Healthy Again

CMS seeks input on how Medicare payment can better support prevention, chronic disease management, and longitudinal primary care relationships.

As CMS reconsiders primary care valuation to support its stated goal of shifting toward preventive rather than reactive care, the Coalition recommends that any resulting revaluation of office/outpatient E/M, Annual Wellness Visit, or care management codes explicitly recognize insulin resistance screening, including tests such as HbA1c, fasting glucose, fasting insulin, and HOMA-IR, as a component of high-value longitudinal primary care. Identifying insulin resistance before it progresses to diabetes or cardiovascular disease allows evidence-based nutrition and lifestyle intervention to occur when it is most effective, directly advancing the shift toward preventive care this RFI seeks to achieve.

The Coalition recommends that CMS:

- Recognize metabolic health, nutrition, and lifestyle interventions as foundational components of prevention-focused primary care;
- Consider insulin resistance screening, including hemoglobin A1C, fasting glucose, fasting insulin, and HOMA-IR, as components of high-value longitudinal primary care; and
- Support multidisciplinary approaches that enable early intervention and chronic disease prevention.

Support for Health and Well-being Coaching Services

CMS proposes Medicare payment for health and well-being coaching services, including individual and group-based coaching services.

The Coalition supports CMS’s proposal. Health coaching can help beneficiaries adopt and sustain nutrition, physical activity, and other lifestyle changes that improve metabolic health and

reduce chronic disease burden. Coaching services can complement clinical care by supporting patient engagement, adherence, and long-term behavior change.

The Coalition recommends that CMS:

- Finalize payment for health and well-being coaching services;
- Recognize nutrition and metabolic health goals as appropriate applications of these services; and
- Support integration of coaching services into prevention and chronic disease management programs.

Support for Shared Medical Appointments

CMS proposes establishing a payment pathway for Shared Medical Appointments that integrate education, counseling, peer support, and individualized clinical care.

The Coalition supports the proposed payment pathway. Group-based nutrition and metabolic health programs can provide a scalable approach to chronic disease prevention and management while improving patient engagement and supporting sustainable behavior change.

The Coalition recommends that CMS:

- Finalize payment for Shared Medical Appointments;
- Recognize nutrition, obesity, diabetes, and metabolic health programs as appropriate use cases for Shared Medical Appointments; and
- Maintain flexibility for multidisciplinary care teams participating in these services.

Conclusion

The Coalition reiterates its support for the RHC MNT/DSMT stand-alone billing proposal and urges its finalization. We further recommend CMS evaluate the existing preventive service pathways, respond to the AD/ADRD ILI RFI in a manner that extends its evidence-generation approach to metabolic dysfunction broadly, incorporate metabolic screening into the primary care redesign, finalize payment for health and well-being coaching services to support nutrition, metabolic health, and chronic disease management goals, and finalize payment for Shared Medical Appointments as a scalable approach to delivering multidisciplinary, patient-centered care.

The Coalition welcomes the opportunity to provide further clinical, policy, and scientific expertise as CMS considers these critical reforms.

Sincerely,

Coalition for Metabolic Health

Contact: Cristina Nigro, Ph.D. (cristina@coalitionformetabolichealth.org)