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September 8, 2026

The Honorable Mehmet Oz, MD
Administrator, Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard, Baltimore, MD 21244
Attention: CMS-1848-P (Medicare Program; CY 2027 Payment Policies Under the Physician Fee Schedule)
Submitted electronically via *https://www.regulations.gov*

Re: Health and Well-Being Coaching Services (CPT Codes 0591T, 0592T, and 0593T) — Evidence-Based Comments Supporting Finalization with General Supervision, Permanent Coding, and Preservation of the Proposed Valuation

Dear Administrator Oz:

Executive Summary

This comment package delivers rigorous, peer-reviewed clinical, geospatial, operational, and payment-methodology evidence to strongly support the establishment of the proposed Medicare Part B reimbursement pathway for health and well-being coaching services. Each data element cited in this letter is linked to its published source in the References section. Integrating these services into traditional medical billing represents a critical advancement toward comprehensive, preventive, and patient-centered care. To ensure the programmatic viability of this new benefit and optimize its impact on vulnerable, low-income, and rural Medicare beneficiaries, we present four distinct, data-driven arguments:

- **The Case for General Supervision and Telehealth Integration:** Demonstrating that general supervision is the only operationally viable framework for health coaching, and showing how general supervision is the essential policy linchpin required for telehealth to successfully overcome Health Professional Shortage Area (HPSA) access and completion disparities.
- **Evidence from the CMS Quality Improvement Organization (QIO) Program:** Referencing more than a decade of national QIO experience implementing evidence-based self-management programs to demonstrate that health coaching drives statistically significant improvements in clinical metrics (such as HbA1c reductions) and substantial Medicare cost savings in high-risk priority populations.
- **Support for the ACL Title III-D of the Older Americans Act, Evidence-Based Program Training Pathway:** Endorsing the recognition of Title III-D facilitator

training as a qualifying credential, and requesting that the final rule (a) explicitly confirm that fidelity-bound Title III-D group workshops — which are built on person-centered individual action planning — are billable group health coaching under CPT 0593T, with training qualification scoped to the program(s) in which the individual was trained; (b) formally defer to ACL to define training completion and maintain the qualifying program roster; and (c) formally defer to ACL to issue braided funding and non-duplication guidance designed to scale program delivery to population need rather than to formula-grant capacity.

- **Permanent Coding with Valuation Integrity:** Urging CMS to transition from the temporary Category III CPT codes to permanent HCPCS Level II G-codes (or, subsequently, Category I CPT codes) while holding the proposed Addendum B valuation of CPT 0593T — specifically the 0.44 non-facility practice expense RVU — fully intact. If CMS finalizes a HCPCS substitution, the final rule must contain an explicit, binding commitment that the successor codes carry the 0.44 non-facility PE RVU and the full proposed RVU profile without reduction.

I. Establishing General Supervision as the Sole, Consistent Standard for Health Coaching Services

We urge CMS to establish general supervision as the sole, overarching supervision standard for the new health coaching billing codes (CPT 0591T, 0592T, and 0593T). The proposed rule currently contains a critical internal contradiction: it proposes that these codes may be performed under direct supervision of the billing practitioner, while simultaneously proposing to crosswalk the valuation of the individual codes (0591T and 0592T) to Chronic Care Management codes (CPT 99490 and 99439) — non-face-to-face care management services performed under general supervision — and the group code (0593T) to group Diabetes Self-Management Training (G0109).[11,12] Maintaining a direct supervision standard, even with telehealth flexibilities, will collapse the community-based delivery model and exclude the high-risk populations CMS seeks to serve.

Geospatial and Access Realities in Rural Areas Mandate Location and Scheduling Flexibility

Geospatial analyses and clinical tracking reveal that beneficiaries living in rural and medically underserved areas face severe access barriers that a direct supervision standard would make completely insurmountable:

- **Disproportionate Rural Gaps:** A national analysis published by the National Council on Aging (NCOA), based on the reach of CDSME workshops across 45 states, the District of Columbia, and Puerto Rico, revealed that 80% of areas in the United States lacking health coaching and self-management workshops are rural, confirming a severe disparity in health promotion resources.[2,4]
- **The HPSA Barrier:** Rural residents enrolled in self-management programs present a statistically significant higher average number of chronic conditions (2.6 conditions) compared to urban peers (2.4 conditions, $p < 0.01$) and are more likely to live alone (52.1% vs 47.9%, $p < 0.01$). However, multivariate logistic regression demonstrates that residing in a primary care Health Professional Shortage Area (HPSA) is a statistically significant

barrier that reduces the baseline likelihood of successfully completing self-management programs (OR = 0.93, p = 0.0002).[2]

- **Proven Adherence in Accessible Rural Sites:** Despite these challenges, rural residents are highly motivated. When workshops are offered in closer proximity to their residences in trusted community settings (such as senior housing, faith-based organizations, and local libraries) to bypass transportation deficits, rural participants achieve higher program completion rates than urban participants (78% vs 77%, $p < 0.01$)[2] and attend more sessions on average (4.46 vs 4.27 out of 6).[3] Delivering health coaching outside of traditional office hours and outside clinical offices is critical to sustain this adherence, which is only operationally possible under general supervision.

Telehealth is a Vital Tool to Bridge HPSA Barriers, But Only Under a General Supervision Standard

While placing health coaching codes on the Medicare Telehealth Services List is a critical policy victory, telehealth delivery under a direct supervision standard is an operational contradiction that will neutralize its benefit in the highest-need regions:

- **The Power of Telehealth:** Telehealth is the only viable mechanism to bypass severe local provider shortages and transport deficits by delivering coaching directly into beneficiaries' homes. Telehealth delivery of evidence-based coaching is clinically validated; pilot programs in remote areas (such as the Northern Ontario telehealth CDSMP study and Alaska's 'Living Well Alaska' distance delivery project) have demonstrated statistically significant improvements in participant self-efficacy, medical communication with physicians, self-rated health, and overall confidence in managing multiple chronic conditions.[4]
- **Why Direct Supervision Neutralizes Telehealth in Shortage Areas:** Under direct supervision, even if the coach is virtual, the billing practitioner must remain immediately available to intervene in real-time. In primary care HPSAs, practitioners face extreme patient loads, severe staffing shortages, and high administrative burnout. They simply do not have the capacity to remain virtually 'on call' during evenings, weekends, or for multi-hour group workshops to support coaching activities. Forcing direct supervision collapses telehealth's operational feasibility in the exact shortage areas that need it most.
- **General Supervision Unlocks Telehealth:** Under general supervision, community-based organizations (CBOs) and Community Care Hubs (CCHs) can deploy telehealth coaching directly into beneficiaries' homes. CCHs can centralize resource coordination and resolve technical barriers — such as deploying South Dakota's innovative 'traveling iPad lab' model to address broadband and technology comfort deficits among older adults[4] — while keeping the billing clinician fully informed via shared electronic health records without requiring their real-time virtual presence.

Clinical and Public Health Data Confirm High-Risk Beneficiaries Access Coaching in the Community

Underserved, Rural, and minority populations with severe chronic disease burdens overwhelmingly participate in health coaching and self-management programs outside of traditional clinic walls. Clinical and public health research highlights the following critical parameters:

- **Socioeconomic Vulnerability:** Community locations are essential for reaching economically vulnerable individuals, with 35% of the study cohort residing in highly impoverished neighborhoods (i.e., 200% below the federal poverty level). Importantly, regression analyses demonstrate that residing in an impoverished neighborhood reduces the baseline likelihood of successfully completing these workshops (OR = 0.99, p = 0.024).[1] Requiring direct supervision would impose additional travel and scheduling barriers on these financially constrained families, severely worsening existing health equity gaps.
- **High Community-Based Utilization:** In a landmark national study of 11,895 urban-dwelling African Americans participating in Chronic Disease Self-Management Education (CDSME) programs, 84.6% of participants received these services in community-based locations — specifically, 36.5% at senior centers, 24.1% at residential facilities, 12.8% at faith-based organizations, and 11.2% at community centers/libraries. In stark contrast, only 15.5% received these services within standard healthcare organizations.[1] Forcing health coaching to occur under direct supervision would tether these services to clinical offices, dismantling this vital community delivery network.
- **Severe Chronic Disease Burden:** The population utilizing these community-based interventions is highly medically complex. In the studied urban African American cohort, 44% of participants reported having three or more chronic conditions (multimorbidity). The most common self-reported conditions were hypertension (64%), arthritis (50%), and diabetes (48%).[1] This complex demographic requires close self-care support but cannot easily navigate multiple clinical visits.

II. Clinical and Financial Justification Based on CMS Quality Improvement Organization (QIO) Program Experience

CMS's own Quality Improvement Organization (QIO) Program — specifically executed via the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs) — provides a highly rigorous, decade-long clinical and operational blueprint that justifies the expansion and permanent funding of health coaching under Medicare Part B.[6,8] Over multiple contract cycles, QIN-QIOs have successfully utilized community-based self-management coaching to improve health outcomes and generate substantial financial savings for the Medicare program.

Specific Priority Populations Served Under the QIO Program

Under federal healthcare directives, QIN-QIOs have prioritized the delivery of chronic disease self-management education to the most vulnerable, high-risk Medicare beneficiaries. This targeted experience aligns perfectly with the populations that stand to benefit most from the proposed health coaching codes:

- **Geographically and Socially Disadvantaged Populations:** QIO initiatives explicitly prioritize beneficiaries residing in highly disadvantaged neighborhoods — quantified using the Area Deprivation Index (ADI) to target individuals living within the top 15% of the most disadvantaged neighborhoods nationally — as well as rural residents facing a severe lack of local healthcare infrastructure.[8]
- **Clinical Priority Illnesses:** The QIO Program focuses clinical coaching on highly prevalent, high-cost chronic conditions, including Type 2 Diabeties, requiring Diabetes Self-Management Education (DSME), patients with chronic hypertension, and Chronic

Kidney Disease (CKD) patients who are closely aligned with Medicare's ESRD Network programs to curb disease progression and reduce emergency hospitalizations.[6,8]

- **Co-Morbid and Complex Care Populations:** QIO programs target 'super-utilizer' beneficiaries managing multiple overlapping co-morbidities who are at an elevated risk for drug-drug interactions or systemic health failures, and individuals with documented behavioral health intersections (such as clinical depression, anxiety, or substance use disorders) intersecting with chronic physical illnesses, a group that historically experiences exceptionally low recruitment and retention rates in standard care models.[8]
- **Equity-Focused Demographics:** QIO contracts mandate a focus on dual-eligible beneficiaries (low-income elderly or disabled individuals qualifying for both Medicare and Medicaid, who statistically present much higher rates of chronic illness) and racial and ethnic minorities, utilizing specialized initiatives such as the American Indian Alaska Native (AIAN) QIO Program to deliver culturally tailored preventive wellness coaching.[8]

Quantitative Impact Metrics from the 11th Scope of Work (SOW: 2014-2019)

The 11th SOW represented the largest national community-based self-management education expansion in the QIO Program's history, executed primarily through the 'Everyone with Diabetes Counts' (EDC) national initiative. The documented outcomes prove the exceptional scalability and clinical value of a structured, community-led coaching workforce:

- **Massive Beneficiary Reach and Completion:** Approximately 77,600 underserved, at-risk, and minority Medicare beneficiaries successfully completed structured Diabetes Self-Management Education and Support (DSMES) programs. This volume was made possible because classes were culturally adapted and delivered in 14+ languages (including Spanish, Mandarin, Cantonese, Vietnamese, Tagalog, Russian, and Somali) by community-based leaders.[7]
- **Clinical Outcomes:** Participating beneficiaries achieved sustained and statistically significant clinical improvements, including average HbA1c level reductions exceeding 1.0%, which dramatically lowered their long-term risk for diabetic retinopathy, neuropathy, and nephropathy.[7]
- **Healthcare Provider Engagement:** QIOs successfully educated and activated over 5,300 primary care and community healthcare providers to establish direct, systematic clinical referral pathways to connect high-risk patients with community self-management programs.[7]
- **Unprecedented Admissions Reductions:** This self-management education expansion was a core component of QIO activities that contributed to the national avoidance of approximately 719,840 hospital admissions and 116,100 hospital readmissions, directly demonstrating the power of lifestyle and behavior management to curb inpatient utilization.[7]

Evolution to Clinical Workflow Integration in the 12th Scope of Work (2019-2024)

In the 12th SOW, CMS shifted QIO self-management education away from standalone community classes toward direct integration into clinical provider workflows. This workflow-

integrated model provides the exact operational precursor to the proposed care management model for CPT codes 0591T-0593T, proving its compatibility with standard physician practices:

- **Strategic Alignment with Clinical Quality Measures:** QIO self-management support was directly aligned with standard clinical quality measures, specifically the Million Hearts 'ABCS' framework (Aspirin use, Blood pressure control, Cholesterol management, and Cardiac rehabilitation participation). This alignment ensures that self-management is not treated as a detached wellness activity, but as a core clinical driver of practice-level quality performance.[9]
- **Self-Measured Blood Pressure (SMBP) Integration:** QIN-QIOs built the clinical infrastructure within outpatient practices to deploy home blood pressure monitoring devices alongside structured self-tracking education, bridging the gap between clinical encounters and home-based disease management.[9]
- **Automated Clinical Screening and FQHC Support:** QIOs embedded automated clinical screening models directly into Federally Qualified Health Centers (FQHCs) to identify patients with uncontrolled HbA1c levels (greater than 9.0%) and automatically route them to diabetes self-management education. Regional 12th SOW clinical learning collaboratives increased early renal screening and chronic kidney disease (CKD) workflow diagnosis rates by 29% to 55%.[9]
- **Substantial Medicare Financial Savings:** The financial value of these QIO-supported chronic disease self-management interventions has been heavily documented. For example, the Alliant Quality QIN-QIO Region Impact Summary documented over $11.7 million in total Medicare cost savings across chronic disease and behavioral health initiatives in a single multi-state regional footprint.[10]
- **Pandemic Adaptations & Digital Scalability:** During the COVID-19 pandemic, QIOs rapidly digitized self-management curricula, shifting to virtual learning collaboratives to remotely train clinicians, nursing homes, and community partners on managing medically complex patients. This proved that self-management coaching can be successfully delivered via telehealth without compromising clinical integrity.[9,10]

III. Supporting and Strengthening the Recognition of the ACL Title III-D Training Pathway

We express our strong and enthusiastic support for the proposed workforce qualification standards under § 410.26, which establish that training received through evidence-based health promotion and disease prevention programs, funded under the Older Americans Act and overseen by the Administration for Community Living (ACL), qualifies auxiliary personnel to deliver reimbursable Medicare health coaching services. By aligning Medicare Part B reimbursement with two decades of rigorous, peer-reviewed federal investment in the Aging Network, CMS will instantly unlock a massive, highly structured community-based workforce to improve clinical outcomes for Medicare beneficiaries, living with multiple chronic conditions.

Clinical and National Repository Data Validate the Efficacy and Scale of the ACL Title III-D Workforce

Accepting Older Americans Act Title III-D evidence-based training is backed by the one of the largest community health datasets in the nation:

- **A Standardized, Highly Qualified Workforce:** To be approved as an ACL 'evidence-based program,' an intervention must demonstrate efficacy using an experimental or quasi-experimental design, publish results in a peer-reviewed journal, be fully translated into real-world community settings, and feature standardized dissemination manuals and leader training protocols.[5,15] Facilitators of programs such as the Chronic Disease Self-Management Program (CDSMP) — a peer-led intervention of six highly participative sessions of 2.5 hours each, delivered once weekly for six consecutive weeks under detailed facilitation and fidelity manuals[1,3] — are bound by strict fidelity protocols, ensuring uniform quality that mirrors or exceeds proprietary, clinical coaching credentials.
- **Proven Clinical Outcomes at Massive National Scale:** Rigorous data from the National CDSME Resource Center's data repository — representing 175,973 individuals who participated in 34 ACL evidence-based programs across 45 states — prove the clinical efficacy of this community-led model. The cohort represents a highly complex Medicare-aged population (mean age of 66.1 years, 65.9% female, managing a mean of 2.6 chronic conditions). Among participants with pre- and post-program self-rated health assessments, 24.4% experienced improvement in their general self-rated health (a highly validated subjective indicator that is a powerful predictor of mortality and healthcare utilization), while 65.3% remained stable after program completion ($p < 0.001$), demonstrating a powerful clinical intervention for stabilizing multi-morbid beneficiaries.[5]
- **Established Community Access Infrastructure:** This workforce is already embedded in trusted community-based locations. The 175,973-participant national cohort accessed workshops across a highly diversified setting landscape: 17.0% at senior centers, 13.7% at residential facilities, 6.3% at Area Agencies on Aging (AAAs), 6.1% at community centers, and 20.5% at healthcare organizations, presenting an active, turn-key delivery network ready to immediately serve Medicare beneficiaries upon finalization of this rule.[5]

Critical Recommendations for Regulatory Clarification in the Final Rule

While we strongly support this workforce pathway, the final rule must resolve three operational questions so that billing practitioners and CBOs/CCHs can operationalize this benefit with confidence. In each case, our recommendation is that CMS state the principle in the final rule and formally defer the operating detail to the Administration for Community Living (ACL), which already administers the program roster, the training standards, and the funding rules at issue:

A. Confirm That Fidelity-Bound Title III-D Group Workshops Are Billable Group Health Coaching Interventions, Under Code 0593T

The proposed rule's language describes health coaching as an individualized, patient-directed, behavioral change strategy. ACL Title III-D evidence-based programs meet that definition by design. For example, CDSME is structured around person-centered, individual action planning: participants set their own goals, build weekly action plans, problem-solve barriers, and report back to the group, under a standardized curriculum and fidelity protocol delivered across six consecutive weekly sessions of 2.5 hours each.[1,3] The person-centered action planning that is core to evidence-based program delivery is precisely what constitutes the group portion of a health coaching intervention. Delivery of an ACL Title III-D evidence-based program at fidelity therefore constitutes a billable group health coaching service under CPT 0593T, and Title III-D

training qualifies an individual to facilitate group health coaching — scoped to the specific program or programs in which that individual has completed the ACL-recognized training.

The structure of the proposed health coaching benefit also maps directly onto the Title III-D delivery model. Evidence-based programs begin with an individual screening to determine whether the person meets the criteria to participate, commonly conducted during an orientation or 'Session 0' class.[5] Under the proposed benefit, the formal individual assessment and the development of the individualized action plan occur in the individual health coaching sessions billed under CPT 0591T and 0592T. Beneficiaries who qualify as candidates for the group intervention then proceed into the ACL Title III-D group program, with each group session billed under the group health coaching code, CPT 0593T. The individual codes and the group code are complementary components of a single, coherent care pathway — not alternative interpretations of the same encounter.

If delivering a fidelity-bound Title III-D group workshop is not explicitly recognized as billable coaching under 0593T, the entire business model for CBOs and Community Care Hubs (CCHs) collapses. Individual coaching codes (0591T and 0592T) are visit-based, but the group code (0593T) is where the EBP model scales sustainably. As proposed in Addendum B, CPT 0593T carries 0.69 total non-facility RVUs — approximately $22.66 per 30-minute unit per beneficiary at the proposed CY 2027 conversion factor.[11,12] At that valuation, a standard 15-hour CDSMP workshop (30 units of 30 minutes each) delivers $679.80 in total Medicare-allowable reimbursement per participant ($543.84 at an 80% collection rate). Delivering a workshop to a group of 12 eligible beneficiaries converts a single class into a collective stack of individually billable encounters, generating $8,157.60 in potential Medicare-allowable collections ($6,526.08 at 80%). This allows CBOs to transition from unstable grant dependency to a sustainable clinical revenue model, that can scale to the needs of the local population.

ACTIONABLE REQUEST: CMS must explicitly state in the final rule that delivering an ACL Title III-D approved evidence-based group workshop (such as CDSMP, DSMP, Stepping On, or EnhanceFitness) at fidelity qualifies as a billable group coaching service under CPT code 0593T, provided the general supervision requirements and all other conditions of payment for the health coaching benefit are met; and that an individual's Title III-D training qualifies that individual to furnish group health coaching under 0593T for the specific program(s) in which the training was completed.

The Revenue Geometry of the Group Coaching Code (CPT 0593T)

The table below illustrates the critical financial impact of confirming that standard 15-hour group EBP workshops are billable under CPT code 0593T, calculated at the proposed Addendum B valuation of $22.66 per 30-minute unit[11,12] — and the material erosion of the community delivery model if the non-facility practice expense valuation were conformed downward to G0109's finished RVUs ($15.44 per unit), as detailed in Section IV:

Group Size (Medicare Beneficiaries)	Total Medicare Allowable at Addendum B Valuation ($679.80 per participant)	Potential Clinic/CBO Collected Revenue (80%)	Downside if PE Conformed to G0109 ($463.20 per participant)
1 Beneficiary	$679.80	$543.84	$463.20

Group Size (Medicare Beneficiaries)	Total Medicare Allowable at Addendum B Valuation ($679.80 per participant)	Potential Clinic/CBO Collected Revenue (80%)	Downside if PE Conformed to G0109 ($463.20 per participant)
5 Beneficiaries	$3,399.00	$2,719.20	$2,316.00
10 Beneficiaries	$6,798.00	$5,438.40	$4,632.00
12 Beneficiaries	$8,157.60	$6,526.08	$5,558.40

The delta between the two valuation scenarios exceeds $2,599 per 12-beneficiary workshop — a 32% reduction in unit economics that determines whether CBO participation in this benefit is financeable. This is why the valuation integrity positions in Section IV are inseparable from the workforce pathway positions in this section.

B. Formally Defer to ACL to Define Training Completion and Maintain the Qualifying Program Roster

The proposed rule provides that qualifying training is training received through programs 'funded under the Older Americans Act and overseen by the Administration for Community Living.' That standard is correct in principle but incomplete in operation: 'trained through an ACL program' is an administrative category, not an auditable credential. ACL already maintains the list of approved evidence-based programs and publishes the minimum training requirements for each — leader training, master trainer certification, fidelity and licensure conditions.[15] CMS should not attempt to replicate that infrastructure in the Physician Fee Schedule. Instead, the final rule should formally defer to ACL as the authority that defines what it means to have completed training to deliver one or more Title III-D evidence-based programs, so that billing practitioners and contracted CBOs have a single, official, program-specific standard to verify eligibility and to defend it on audit.

ACTIONABLE REQUEST: CMS should formally defer to the Administration for Community Living to define the criteria under which an individual has completed training to provide one or more ACL Title III-D evidence-based programs, and should direct that ACL maintain, publish, and routinely update an official roster of qualifying evidence-based programs that meet the Title III-D criteria for Medicare health coaching qualification, together with the associated health coach training requirements for each program. That roster and its training requirements should serve as the safe-harbor standard for auxiliary personnel qualification under § 410.26 and for Medicare audit purposes.

C. Formally Defer to ACL to Issue Braided Funding and Non-Duplication Guidance That Scales Delivery to the Need

Federal anti-supplantation and cost-allocation rules dictate that Older Americans Act Title III-D grant dollars cannot be used to pay for a service that is simultaneously billed to Medicare Part B. Community organizations operate almost entirely on grant funding and lack the accounting frameworks to segregate grant-eligible versus Medicare-billable encounters within the same community workshop. Without clear guidance, CBOs will under-utilize this benefit to avoid perceived double-dipping or audit exposure.

The larger issue is capacity. Historically, the number of older adults who would benefit from participating in a Title III-D evidence-based program has far exceeded the reach that Title III-D formula-grant funding can support. Over the 2016–2022 period, ACL grantees reached roughly 176,000 participants across 34 programs and 45 states[5] — a fraction of the Medicare population living with two or more chronic conditions. The health coaching benefit is the first mechanism that allows Title III-D program delivery to scale to the need of the population rather than to the ceiling of the formula grant. Guidance on braided funding should be written with that expansion as its explicit purpose: Medicare Part B reimbursement for eligible beneficiaries, with Title III-D dollars preserved for non-covered participants, outreach, infrastructure, and leader training.

ACTIONABLE REQUEST: CMS should formally defer to the Administration for Community Living to issue explicit guidance on braided funding and non-duplication, and we strongly urge ACL to issue that guidance concurrent with the final rule. The guidance should (1) affirm that Title III-D-supported organizations may bill Medicare Part B for health coaching furnished to eligible beneficiaries under a billing practitioner's general supervision; (2) set out the cost-allocation methodology under which Title III-D funds support non-covered participants, outreach, program administration, and workforce training without supplanting Medicare-reimbursed services; (3) establish the documentation requirements for distinguishing Medicare-billed encounters from grant-funded encounters within a single workshop, including participant eligibility, attendance, and funding-source attribution at the session level; and (4) be expressly framed to support the expansion of Title III-D program delivery as a Medicare health coaching benefit that scales to population need rather than to available formula-grant funding.

IV. Permanent Coding with Valuation Integrity: Transition from Category III CPT Codes While Preserving the Proposed 0.44 Non-Facility Practice Expense RVU

We strongly support the national pricing CMS has proposed for these services, and we equally strongly oppose housing that pricing in temporary CPT Category III codes. These two positions are complementary, not in tension. Our recommendation to CMS is threefold: (1) transition the health coaching benefit from the temporary Category III CPT code set to permanent codes, because temporary codes are structurally rejected across the payer and billing ecosystem; (2) hold the proposed Addendum B valuation of CPT 0593T — in particular the 0.44 non-facility practice expense RVU — fully intact through that transition; and (3) if CMS finalizes a HCPCS Level II G-code substitution, include in the final rule an explicit, binding commitment that the successor codes carry the 0.44 non-facility PE RVU and the complete proposed RVU profile without reduction.

A. The Proposed Valuation Is Correct: CMS Crosswalked Inputs, Not Finished RVUs, and the 0.44 Non-Facility PE Must Stand

Some stakeholders have suggested that because the preamble describes a crosswalk of the work and practice expense inputs for CPT 0593T to G0109 (group Diabetes Self-Management Training),[11] the payment rate should be modeled at G0109's finished non-facility total of 0.47 RVUs (approximately $15.44 per 30-minute unit).[12] This reading conflates two distinct steps in the PFS practice expense methodology, and CMS should reject it.

A crosswalk of PE inputs transfers the direct practice expense inputs — clinical labor minutes, supplies, and equipment — from the reference code. The practice expense RVU itself is then

produced by the PE methodology, which allocates indirect practice costs (rent, administrative staffing, billing infrastructure, and general practice overhead) based on the code's allocation basis and the indirect practice cost indices of the specialties expected to furnish it. G0109's finished PE RVU is depressed by its historical utilization profile, which is concentrated among registered dietitians and hospital-affiliated DSMT programs carrying low indirect cost structures. Health coaching, as proposed, will be furnished predominantly in non-facility community settings where the billing practice and its contracted CBOs and Community Care Hubs bear the full cost of space, scheduling, outreach, technology, and administrative infrastructure. The 0.44 non-facility PE RVU that CMS assigned to CPT 0593T in Addendum B correctly reflects that cost structure.[12] It is the product of CMS's own methodology applied to CMS's own anticipated specialty assignment — not an error to be conformed downward in the final rule.

At the proposed CY 2027 conversion factors,[11] the two readings produce materially different economics for the group code:

Basis (Addendum B, CY 2027 proposed)	Work / PE (NF) / MP	Total NF RVUs	National rate / 30-min unit (non-QP CF $32.8409)	QP CF $33.1693
CPT 0593T as proposed	0.23 / 0.44 / 0.02	0.69	**$22.66**	$22.89
G0109 finished-RVU parity (downside scenario)	0.25 / 0.21 / 0.01	0.47	**$15.44**	$15.59
Difference	—	0.22	**$7.22**	$7.30

Sources: RVUs from Addendum B and GPCI-neutral national pricing; conversion factors from the CY 2027 Regulatory Impact Analysis.[11,12] The $7.22 per-unit difference traces entirely to the non-facility practice expense RVU (0.44 versus 0.21); work and malpractice RVUs approximately offset. Compounded across a standard 15-hour, 30-unit evidence-based workshop, the difference is $216.60 per participant and over $2,599 per 12-beneficiary class — the margin between a financeable community delivery model and one that cannot cover its cost of delivery.

B. Transition from Temporary Category III CPT Codes: The Structural Case

The use of temporary codes for health coaching poses several operational, programmatic, and compliance risks that will suppress adoption regardless of how the codes are valued:

- **Widespread Payer and Billing IT Rejection of Category III Codes:** Many commercial payers, Medicaid Managed Care plans, and standard clinical billing IT infrastructures (including regional clearinghouses and EHR revenue cycle modules) categorically do not support claims filing, processing, or automatic adjudication for CPT Category III codes. Category III codes are designated as emerging-technology tracking codes and are frequently flagged as 'experimental' or 'non-covered' by default.[13] Attempting to deploy health coaching through these temporary codes will lead to massive claims routing failures, elevated denial rates, and administrative burdens.

- **Exclusion from Medicare Advantage Plans:** The use of temporary Category III CPT codes frequently disqualifies or complicates coverage under Medicare Advantage (MA) plans. Standard Medicare billing protocols do not mandate automatic uptake of Category III codes by commercial MA carriers, which currently cover over half of all Medicare beneficiaries nationally.[14] This creates severe health equity disparities, denying health coaching services to a majority of the eligible Medicare population.
- **The Case for Permanent HCPCS Level II G-Codes:** To ensure the long-term durability and immediate nationwide adoption of health coaching, we urge CMS to establish permanent HCPCS Level II codes (e.g., G-codes, similar to G0108 and G0109 for Diabetes Self-Management Training) in the CY 2027 Final Rule. HCPCS Level II G-codes are universally supported by all Medicare Administrative Contractors (MACs), state Medicaid agencies, commercial insurers, and outpatient electronic health record (EHR) billing modules, ensuring seamless claims routing from day one.

C. Any HCPCS Substitution Must Carry an Explicit Valuation Commitment in the Final Rule

CMS solicits comment on whether to establish Medicare-specific G-codes for these services in lieu of pricing the Category III codes.[11] We support that substitution — conditionally. Because newly established G-codes would be valued de novo, a substitution executed without a valuation commitment creates the precise risk described in subsection A: successor codes silently conformed to G0109's finished RVU profile, cutting the group code's payment by approximately one-third and defunding the community delivery model before it launches. A permanent code billed at $15.44 per unit is not an improvement over a temporary code billed at $22.66; it is a different and smaller benefit.

ACTIONABLE REQUEST: If CMS finalizes HCPCS Level II G-codes in place of CPT codes 0591T, 0592T, and 0593T, the final rule must explicitly commit — in both the preamble and Addendum B — that the successor group code carries the proposed valuation of CPT 0593T without reduction, including the 0.44 non-facility practice expense RVU, the 0.23 work RVU, and the 0.02 malpractice RVU, and that the successor individual codes carry the full proposed valuations of CPT 0591T and 0592T. The substitution must be valuation-neutral on its face, with the crosswalk of direct PE inputs and the anticipated specialty assignment documented in the final rule so the indirect PE allocation is preserved and auditable.

D. Conditional Support for CPT Category I Transition

We would support a subsequent transition to permanent CPT Category I codes if and when they are established by the American Medical Association (AMA) CPT Editorial Panel. However, our endorsement of a CPT Category I pathway is strictly contingent on the condition that these permanent codes incorporate and preserve all the patient-centered, community-aligned provisions proposed by CMS, specifically: (1) direct recognition of general supervision as the standard supervision framework; (2) formal recognition of training under ACL Older Americans Act Title III-D evidence-based programs as a qualifying credential; (3) support for telehealth eligibility and multi-session group coaching structures; and (4) preservation of the proposed CY 2027 valuation, including the 0.44 non-facility practice expense RVU for the group service.

V. Recommended Regulatory Text Modifications

To operationalize general supervision, provide the necessary regulatory safe harbors for the community-based and aging-services workforce, and secure the valuation commitments described in Section IV, we recommend that CMS incorporate the following explicit modifications into the final regulation text at § 410.26 and the final rule preamble:

> *"Health and Well-Being Coaching Services (CPT codes 0591T, 0592T, and 0593T / HCPCS G-Codes G-XXX1, G-XXX2, G-XXX3) may be furnished under the general supervision of the billing practitioner, including when performed by auxiliary personnel employed by or contracting with community-based organizations (CBOs) and community care hubs (CCHs).*
>
> *CMS further clarifies that delivering an Administration for Community Living (ACL) Title III-D approved evidence-based group health promotion and self-management workshop (including but not limited to the Chronic Disease Self-Management Program, Diabetes Self-Management Program, Chronic Pain Self-Management Program, Stepping On, and EnhanceFitness), delivered in accordance with its standardized curriculum and fidelity protocols and under the general supervision of the billing practitioner, constitutes a billable group health coaching service under CPT code 0593T or its successor code. Completion of ACL-recognized training for a Title III-D evidence-based program qualifies auxiliary personnel to furnish group health coaching for the specific program(s) in which such training was completed.*
>
> *For purposes of this section, the criteria for completion of training, the roster of qualifying Title III-D evidence-based programs, and the associated training requirements for each program are those defined, published, and maintained by the Administration for Community Living. Guidance on the braided use of Older Americans Act Title III-D funds with Medicare Part B reimbursement for these services, including non-duplication and documentation requirements, shall be issued by the Administration for Community Living.*
>
> *Any HCPCS Level II codes established for these services in place of CPT codes 0591T, 0592T, and 0593T shall be assigned the relative value units proposed for those codes in the CY 2027 proposed rule without reduction, including a non-facility practice expense relative value of 0.44 for the group service, and shall retain national pricing, telehealth eligibility, and the workforce qualification standards finalized for the predecessor codes."*

The proposed Health Coaching benefit, finalized with the clarifications, general supervision standards, permanent coding structure, and valuation commitments outlined above, would establish the final, essential component of a coherent, community-deliverable, whole-person care management architecture within Medicare Part B. We appreciate the Agency's continued leadership in extending the fee schedule to the community-based workforce to drive meaningful public health outcomes.

Respectfully submitted,

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