Partnership to Align Community Care

September 14, 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) — Comments Supporting Finalization with General Supervision, Recognition of the ACL OAA Title III-D Workforce, Permanent Coding, and Preservation of the Proposed Valuation

Dear Administrator Oz:

The Partnership to Align Community Care (Partnership) submits these comments on behalf of Partnership leaders and the below signed organizations. The Partnership is a learning, sharing, and cross-sector change collaborative including Community Care Hubs (CCHs), community-based organizations (CBO) partners, health systems, health plans, and national organizations aimed at advancing and scaling sustainable community care delivery systems leveraging CCHs to promote whole-person health. Many of our coalition member organizations deliver evidence-based health promotion and disease self-management programming to older adults and people with disabilities, including Medicare beneficiaries, in thousands of communities across the country.

We strongly support the establishment of a Medicare Part B payment pathway for health and well-being coaching included the proposed CY 2027 Medicare Physician Fee Schedule. We appreciate that CMS policymakers and leaders have recognized the potential of these programs to complete a coherent, community-deliverable, whole-person care management architecture and dramatically improve health outcomes and lower costs for countless beneficiaries and their families. **We are eager to work with the agency to implement these important benefits.**

Our comments are informed by numerous conversations with Partnership members and echo the more comprehensive detail provided in the comment memo submitted by Partnership's Co-Chair, Tim McNeill, of Freedmen's Health Consulting.

We have outlined six specific recommendations for the final rule that we believe will determine whether the benefit is operable by the experienced, trusted, qualified, community-based workforce necessary to achieve scalable interventions.

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Summary of Recommendations to Incorporate in the CY 2027 Medicare PFS Final Rule

1. **Establish that general supervision meets the supervision standard** for the proposed CPT 0591T, 0592T, and 0593T Health Coaching Codes, and resolve the internal contradiction between the proposed direct supervision standard and the care-management codes CMS cross walked for valuation.
2. **Confirm that fidelity-bound Older Americans Act (OAA) Title III-D group workshops are billable group health coaching interventions** under CPT 0593T, with training qualification scoped to the program(s) in which the individual was trained.
3. **Formally defer to the Administration for Community Living (ACL) to define training completion and maintain the qualifying evidence-based program roster** and treat that roster as the safe-harbor standard for auxiliary personnel qualification under § 410.26.
4. **Formally defer to ACL to issue braided funding and non-duplication guidance,** concurrent with the final rule, framed to scale OAA Title III-D delivery to population need rather than to current formula-grant capacity.
5. **Transition from temporary Category III CPT codes to permanent HCPCS Level II G-codes** while holding the proposed Addendum B valuation—particularly the 0.44 non-facility practice expense (PE) Relative Value Unit (RVU) for the group service—fully intact.
6. **Include an explicit binding valuation in the final rule** if CMS finalizes HCPCS Level II G-codes in place of the CPT codes, to ensure that the substitution reflects the .44 non-facility PE RVU.

Recommendations 1 through 4 are important to ensure that the community workforce can furnish the proposed benefit, and recommendations 5 and 6 determine whether the delivery model can be financed and implemented at scale. These recommendations are interdependent. The proposed benefit must be both operationally deliverable and adequately valued to successfully reach beneficiaries.

Establish that General Supervision Meets the Supervision Standard for the Proposed Health Coaching Codes

> **RECOMMENDATION 1.** CMS should establish general supervision as the supervision standard for CPT codes 0591T, 0592T, and 0593T and their successors, including when the services are furnished by auxiliary personnel employed by or contracting with community-based organizations and Community Care Hubs.

The proposed rule contains an internal contradiction that we ask CMS to resolve in favor of general supervision. It proposes that these codes may be "performed under direct supervision of the billing practitioner, as defined by § 410.26(a)(3)." However, 42 CFR 410.26(a)(3) defines "general supervision" *not* "direct supervision", which is defined in 42 CFR 410.26(a)(2).

The proposed rule also proposes 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 that are performed under general supervision—and the group code (0593T) to group Diabetes Self-Management Training (G0109).[1, 2]

A general supervision standard is essential to the community-based delivery model, for three reasons:

- *Beneficiaries currently receive these services in the community, not in clinical offices.*

In a national study of nearly 12,000 urban-dwelling African Americans participating in Chronic Disease Self-Management Education (CDSME) programs, 84.6 percent received these services in community-based locations. Only 15.5 percent received them within a standard healthcare organization.[3] The national CDSME data repository shows the same pattern across 175,973 participants in 34 evidence-based programs in 45 states: senior centers, residential facilities, Area Agencies on Aging, and community centers together account for the large majority of delivery sites.[4]

Furthermore, this population is medically complex— 44 percent of the studied cohort reported three or more chronic conditions[5], which is the population the proposed benefit is designed to reach. A direct supervision standard for health coaching would prohibit the current delivery network from reaching the intended beneficiaries.

- *Rural and shortage-area access depends on off-site, off-hours delivery.*

A national analysis of workshop reach across 45 states, the District of Columbia, and Puerto Rico found that 80 percent of U.S. areas currently lacking health coaching and self-management workshops are rural.[6, 7] Rural residents enrolled in these programs carry a higher average chronic-condition burden than urban peers and are more likely to live alone; separately, residence in a primary care Health Professional Shortage Area (HPSA) is itself a significant barrier to completing these programs.[8] Yet when workshops are offered close to home in trusted community settings such as senior housing, faith-based organizations, and local libraries, rural participants complete programs at higher rates than urban participants and

[1] Centers for Medicare & Medicaid Services. Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule (Proposed Rule, CMS-1848-P). Federal Register document 2026-14327 (July 16, 2026): preamble section II.D.3.c.(56), https://www.federalregister.gov/d/2026-14327/p-610.

[2] Centers for Medicare & Medicaid Services. CY 2027 PFS Proposed Rule Addenda: Addendum B (proposed relative value units; CPT 0593T and HCPCS G0109) and Addendum E (geographic practice cost indices). https://www.cms.gov/files/zip/cy-2027-pfs-proposed-rule-addenda.zip.

[3] Mingo CA, Smith ML, Ahn S, Jiang L, Cho J, Towne SD Jr, Ory MG. Chronic Disease Self-Management Education (CDSME) program delivery and attendance among urban-dwelling African Americans. Frontiers in Public Health. 2015;2:174. doi:10.3389/fpubh.2014.00174. https://pubmed.ncbi.nlm.nih.gov/25964907/

[4] Coyle P, Tripken J, Perera S, Juarez GA, Spencer-Brown L, Cameron K, Brach JS. Dissemination and implementation of evidence-based programs for people with chronic disease: the impact of the COVID-19 pandemic. Frontiers in Public Health. 2024;11:1276387. doi:10.3389/fpubh.2023.1276387. https://pmc.ncbi.nlm.nih.gov/articles/PMC10808618/

[5] *Supra note 3.*

[6] Towne SD Jr, Smith ML, Ahn S, Ory MG. The reach of chronic-disease self-management education programs to rural populations. Frontiers in Public Health. 2015;2:172. doi:10.3389/fpubh.2014.00172. https://pubmed.ncbi.nlm.nih.gov/25964906/

[7] National Council on Aging. Offering Chronic Disease Self-Management Education in Rural Areas: Tips, Success Stories, Innovative Approaches, and Resources. Arlington, VA: NCOA. https://www.ncoa.org/article/offering-chronic-disease-self-management-education-in-rural-areas/

[8] *Supra note 6.*

attend more sessions on average.[9, 10] That result depends on delivering coaching outside clinical offices and outside traditional office hours, which is only operationally possible under general supervision.

- *Direct supervision neutralizes the telehealth flexibility CMS has proposed.*

Placing health coaching on the Medicare Telehealth Services List is a significant step, and we enthusiastically support it. But, under a direct supervision standard the billing practitioner must remain immediately available to intervene in real time—including during evenings, weekends, and multi-hour group workshops. In primary care HPSAs, where practitioners face extreme patient loads and severe staffing shortages, that capacity does not exist. Direct supervision would prevent telehealth delivery of health coaching services in exactly the shortage areas that need it most.

However, under general supervision community-based providers can deploy telehealth health coaching directly into beneficiaries' homes. Specifically, Community Care Hubs can centralize resource coordination and resolve the technical barriers to delivery[11] while keeping the billing clinician fully informed through shared electronic health records without requiring real-time virtual presence. Telehealth delivery of evidence-based coaching is clinically validated, with pilot programs in remote areas demonstrating significant improvements in self-efficacy, communication with physicians, and confidence managing multiple chronic conditions.[12]

CMS's own QIO Program has already proven the model at national scale.

The Agency does not need to take this delivery model on faith. Through the Quality Innovation Network-Quality Improvement Organizations, CMS has run community-based self-management coaching for more than a decade, targeting the same priority populations the coaching codes are designed to serve: beneficiaries in the top 15 percent most disadvantaged neighborhoods by Area Deprivation Index, rural residents, dual eligibles, racial and ethnic minorities, and beneficiaries with behavioral health comorbidities.[13, 14] The documented results of nearly 78,000 participants demonstrate statistically significant improvements in Average HbA1c reductions; ~720,000 hospital admissions and more than 116,000 readmissions avoided; nearly $12 million in documented Medicare savings; and more than 5,300 providers engaged to connect high-risk patients to community programs. [15]

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[9] *Supra note 6.*
[10] Smith ML, Towne SD Jr, Herrera-Venson A, Cameron K, Kulinski KP, Lorig K, Horel SA, Ory MG. Dissemination of Chronic Disease Self-Management Education (CDSME) programs in the United States: intervention delivery by rurality. International Journal of Environmental Research and Public Health. 2017. https://pmc.ncbi.nlm.nih.gov/articles/PMC5486324/

[11] *Supra note 7.*
[12] *Supra note 7.*
[13] Centers for Medicare & Medicaid Services. Quality Improvement Organizations: Program Overview and Past Work. https://www.cms.gov/medicare/quality/quality-improvement-organizations.

[14] U.S. Department of Health and Human Services / CMS. Quality Improvement Organization Program Report (QIN-QIO priority populations, Area Deprivation Index targeting, dual-eligible and AIAN QIO initiatives). https://www.govinfo.gov/content/pkg/CMR-HE22-00184743/pdf/CMR-HE22-00184743.pdf.

[15] Centers for Medicare & Medicaid Services. QIO Program Annual Report to Congress, Fiscal Year 2017 (11th Scope of Work outcomes; "Everyone with Diabetes Counts" initiative). https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityimprovementorgs/downloads/annual-report-to-congress-qio-program-fiscal-year-2017.pdf. The Medicare savings figure is drawn from Alliant Health Solutions, QIN-QIO Program Impact Booklet: 12th Scope of Work Regional Impact

The CMS QIO Program 12th Scope of Work (SoW), completed in 2024, integrated this coaching directly into clinical workflows—aligning it to the Million Hearts ABCS framework, deploying self-measured blood pressure infrastructure, and embedding automated screening in FQHCs that raised CKD screening and diagnosis rates by 29 percent to 55 percent.[16] That workflow-integrated model is the direct operational precursor to the benefit CMS now proposes, and it operated under a general supervision logic. QIOs also digitized these curricula during the COVID-19 pandemic without compromising clinical integrity.[17, 18]

Confirm That OAA Title III-D Group Workshops Are Billable Group Health Coaching Interventions Under CPT 0593T

> **RECOMMENDATION 2.** CMS should state explicitly in the final rule that delivering an ACL OAA 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 0593T, provided general supervision requirements and all other conditions of payment are met; and that an individual's OAA 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.

We strongly support the workforce qualification standards in the proposed rule, which recognize training received through evidence-based programs funded under the Older Americans Act and overseen by the Administration for Community Living qualifies as appropriate certification/training for auxiliary personnel as defined in § 410.26(a)(1) to deliver these services. **By aligning Part B reimbursement with two decades of federal investment in the Aging Network, CMS would unlock an existing, structured, credentialed community workforce rather than building a new one.**

That workforce is not informally trained. To be approved as an ACL evidence-based program, an intervention must demonstrate efficacy under experimental or quasi-experimental design, publish in a peer-reviewed journal, be translated into real-world community settings, and maintain standardized dissemination manuals and leader training protocols.[19, 20] Facilitators

Summary (2024), documenting over $11.7 million in Medicare cost savings across chronic disease and behavioral health initiatives. https://quality.allianthealth.org/wp-content/uploads/2024/09/QIN-QIO-Program-Impact-Booklet-FINAL_508.pdf.

[16] Comagine Health. QIN-QIO 12th Scope of Work Highlight: Chronic Disease (SMBP deployment, FQHC HbA1c screening integration, 29 percent–55 percent CKD screening and diagnosis rate increases). https://comagine.org/article/qin-qio-12th-scope-work-highlight-chronic-disease.

[17] *Supra note 16.*

[18] Alliant Health Solutions, supra note 15.

[19] *Supra note 4.*

[20] Administration for Community Living. Health Promotion: Evidence-Based Disease Prevention Program Criteria. https://acl.gov/programs/health-wellness/disease-prevention.

work under strict fidelity protocols that match or exceed proprietary clinical coaching credentials. And the model performs.[21, 22]

OAA Title III-D programs meet the proposed rule's own definition of health coaching.

The proposed rule describes health coaching as an individualized, patient-directed behavioral change strategy. OAA Title III-D evidence-based programs meet that definition by design. 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.[23, 24] That person-centered action planning is precisely what constitutes the group portion of a coaching intervention.

The proposed benefit's structure also maps directly onto the OAA Title III-D delivery model. Evidence-based programs begin with an individual screening to determine eligibility to participate, commonly during an orientation or "Session 0."[25] Under the proposed benefit, the individual assessment and development of the action plan occur in the individual sessions billed under 0591T and 0592T; beneficiaries who qualify then proceed into the group program, with each session billed under 0593T. The individual and group codes are complementary components of one care pathway, not competing interpretations of the same encounter.

Adequately valued individual and group codes are essential to the viability of a community-based delivery model.

Individual coaching codes are visit-based. The group code is where the evidence-based program model can scale 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.[26, 27] A standard 15-hour CDSMP workshop is 30 such units, or $679.80 in Medicare-allowable reimbursement per participant. Delivered to a group of 12 eligible beneficiaries, one workshop generates $8,157.60 in potential Medicare-allowable collections. That is what allows a community-based organization to move from grant dependency to a sustainable revenue model that scales to local need.

Table 1. Group coaching revenue at the proposed valuation (and the downside if practice expense is conformed to G0109)

[21] Among 175,973 participants in the national CDSME repository — mean age 66.1, managing a mean of 2.6 chronic conditions — 24.4 percent improved on self-rated health and 65.3 percent remained stable after program completion. Self-rated health is a validated predictor of mortality and utilization; stabilizing a multimorbid Medicare population is a clinical outcome, not a wellness activity.

[22] *Supra note 4.*

[23] *Supra note 3.*
[24] *Supra note 10.*
[25] *Supra note 4.*
[26] *Supra note 1.*
[27] *Supra note 2.*

Group size (Medicare beneficiaries)	Total Medicare allowable at Addendum B ($679.80 / participant)	Potential collected revenue (80 percent)	Downside if PE conformed to G0109 ($463.20 / participant)*
1 beneficiary	$679.80	$543.84	$463.20
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 percent reduction in unit economics that determines whether community participation in this benefit is financeable at all.* ***This is why the valuation positions in Section V are inseparable from the workforce positions here.*

Defer to ACL to Define Training Completion and Maintain the Program Roster

> RECOMMENDATION 3. 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 OAA Title III-D evidence-based programs, and should direct that ACL maintain, publish, and routinely update an official roster of qualifying programs together with the associated coach training requirements for each. That roster should serve as the safe-harbor standard for auxiliary personnel qualification under § 410.26(a)(1) and for Medicare audit purposes.

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.[28] CMS should not replicate that infrastructure inside the Physician Fee Schedule. Deferring to ACL would give billing practitioners and their contracted community partners a single, official, program-specific standard against which to verify eligibility before furnishing the service and to defend it on audit afterward. It also spares CMS the burden of maintaining a roster that changes as programs are added and training protocols are revised.

[28] *Supra note 20.*

Defer to ACL to Issue Braided Funding and Non-Duplication Guidance

> **RECOMMENDATION 4.** CMS should formally defer to ACL to issue explicit guidance on braided funding and non-duplication, and we urge that the guidance be issued concurrently with the final rule.

Federal anti-supplantation and cost-allocation rules mean that Older Americans Act Title III-D grant dollars cannot pay for a service that is simultaneously billed to Medicare Part B. Community-based providers operate substantially on grant funding, and clear guidance will be essential to ensuring that community providers can confidently implement the proposed health coaching benefit without risking perceived double-dipping or audit exposure.

The larger issue is capacity. The number of older adults who would benefit from an OAA Title III-D evidence-based program has always far exceeded what formula-grant funding can support: from 2016–2022, ACL grantees reached roughly 176,000 participants across 34 programs in 45 states[29]—a small fraction of the Medicare population living with two or more chronic conditions. **This benefit is the first mechanism that lets OAA Title III-D delivery scale to population need rather than to the ceiling of the grant.**

Guidance should be written with that expansion as its explicit purpose: Part B reimbursement for eligible beneficiaries, with OAA Title III-D dollars preserved for non-covered participants, outreach, infrastructure, and leader training.

Specifically, we ask that the guidance:

- Affirm that OAA Title III-D-supported organizations may bill Medicare Part B for health coaching furnished to eligible beneficiaries under a billing practitioner's general supervision.
- Set out the cost-allocation methodology under which OAA Title III-D funds support non-covered participants, outreach, program administration, and workforce training without supplanting Medicare-reimbursed services.
- Establish documentation requirements for distinguishing Medicare-billed from grant-funded encounters within a single workshop, including participant eligibility, attendance, and funding-source attribution at the session level.
- Be expressly framed to support expansion of OAA Title III-D delivery to population need rather than to available formula-grant funding.

Move to Permanent Coding While Preserving the Proposed Valuation

> **RECOMMENDATION 5.** CMS should transition the health coaching benefit from the temporary Category III CPT code set to permanent codes and should hold the proposed Addendum B valuation of CPT 0593T—in particular the 0.44 non-facility practice expense RVU—fully intact through that transition.

[29] *Supra note 4.*

The proposed valuation is correct: CMS cross walked inputs, not finished RVUs.

Some stakeholders have suggested that because the preamble describes a crosswalk of work and practice expense inputs for CPT 0593T to G0109,[30] the payment rate should be modeled at G0109's finished non-facility total of 0.47 RVUs, roughly $15.44 per 30-minute unit.[31] However, we believe this approach conflates two steps in the PFS practice expense methodology, and we ask CMS to reject it.

A crosswalk of PE inputs transfers direct inputs (clinical labor minutes, supplies, equipment, etc.) from the reference code. The practice expense RVU itself is then produced by the PE methodology, which allocates indirect costs (rent, administrative staffing, billing infrastructure, general 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, **concentrated among registered dietitians and hospital-affiliated DSMT programs with low indirect cost structures.**

As proposed, **health coaching would be furnished predominantly in non-facility community settings, where the billing practice and its contracted CBOs and Community Care Hubs bear the full indirect costs** of space, scheduling, outreach, technology, and administrative infrastructure.

The 0.44 non-facility PE RVU CMS assigned to 0593T in Addendum B correctly reflects that cost structure.[32] 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.

Table 2. Proposed valuation versus G0109 finished-RVU parity, per 30-minute unit (CY 2027)[33]

Basis (Addendum B, CY 2027 proposed)	Work / PE (NF) / MP	Total NF RVUs	Rate, non-QP CF $32.8409	Rate, 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

[30] *Supra note 1.*

[31] *Supra note 2.*

[32] *Supra note 2.*

[33] RVUs from Addendum B and GPCI-neutral national pricing; conversion factors from the CY 2027 Regulatory Impact Analysis. 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. Across a standard 15-hour, 30-unit 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.

Temporary Category III codes will suppress adoption regardless of valuation.

- **Payer and billing IT rejection.** Many commercial payers, Medicaid managed care plans, and standard billing infrastructures do not support claims filing, processing, or automatic adjudication for Category III codes, which are designated as emerging-technology tracking codes and are frequently flagged as experimental or non-covered by default.[34] Deploying the benefit through temporary codes invites routing failures, elevated denials, and administrative burden.
- **Medicare Advantage exclusion.** Category III codes frequently complicate or disqualify coverage under MA plans, which now cover over half of Medicare beneficiaries nationally.[35] Finalizing in temporary codes would deny the benefit to much of the eligible population.
- **Permanent G-codes solve both.** HCPCS Level II G-codes—as with G0108 and G0109 for Diabetes Self-Management Training—are universally supported by MACs, state Medicaid agencies, commercial insurers, and outpatient EHR billing modules, ensuring clean claims routing from day one.

Any HCPCS Substitution Must Carry an Explicit Valuation Commitment

> **RECOMMENDATION 6.** If CMS finalizes HCPCS Level II G-codes in place of CPT 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 0591T and 0592T.

CMS solicits comment on whether to establish Medicare-specific G-codes in lieu of pricing the Category III codes.[36] While we support that substitution, **if CMS establishes HCPCS Level II G-codes, the agency must include a valuation commitment that reflects the currently proposed RVUs.**

Because newly established G-codes would be valued de novo, a substitution executed without a valuation commitment creates precisely the risk described in Recommendation 5. **Successor codes automatically conformed to G0109's finished RVU profile would cut the group code's payment by roughly a third.** 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. The substitution should 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.

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[34] American Medical Association. CPT Category III Codes (emerging technology, temporary tracking code set). https://www.ama-assn.org/practice-management/cpt/category-iii-codes.

[35] KFF (Kaiser Family Foundation). Medicare Advantage Enrollment Update and Key Trends (annual analysis; MA enrollment exceeds half of eligible Medicare beneficiaries). https://www.kff.org/medicare/

[36] *Supra note 1.*

On CPT Category I. We would support a subsequent transition to permanent Category I codes if and when the AMA CPT Editorial Panel establishes them, contingent on those codes preserving the community-aligned provisions at issue here: general supervision as the standard supervision framework; recognition of ACL OAA Title III-D training as a qualifying credential; telehealth eligibility and multi-session group structures; and the proposed CY 2027 valuation, including the 0.44 non-facility PE RVU for the group service.

Recommended Regulatory Text

To operationalize the six requests above, we recommend that CMS incorporate the following into the final regulation text at https://www.federalregister.gov/d/2026-14327/p-615:

"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) OAA 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 an OAA 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 OAA 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 OAA 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."

In Conclusion

We appreciate the opportunity to comment on the proposed CY 2027 Medicare Part B Physician Fee Schedule, and the Agency's leadership to further extending the fee schedule to the community-based workforce. If finalized with the recommended supervision standard, workforce recognition, coding structure, and valuation commitments as detailed in this letter we believe the health coaching benefit would significantly enhance a community-deliverable, whole-person care management architecture within Medicare Part B that community-based stakeholders are trusted, trained, and staffed to operate. We appreciate, and we welcome the opportunity to provide any additional operational detail the Agency would find useful. Please contact Autumn Campbell (acampbell@partnership2acc.org) should you need clarification or have questions.

Sincerely,

June Simmons, CEO, Partners in Care Foundation
Tim McNeill, CEO, Freedmen's Health Consulting
Co-Chairs, Partnership to Align Community Care

Undersigned Organizations

101 Ways NFP, Cahokia Heights, IL

A2 Associates, LLC, Jamestown, NY

acac Fitness & Wellness Centers, Charlottesville, VA

Access Care Partners, Inc., Holyoke, MA

AgeOptions, Oak Park, IL

AgeSpan, Inc., Lawrence, MA

Aging & In-Home Services of Northeast Indiana, Inc., Fort Wayne, IN

American Association on Health and Disability, Rockville, MD

ARCHI (Atlanta Regional Collaborative for Health Improvement), Atlanta, GA

Ascension DePaul Community Health Centers, Gould, AR

Beach Cities Health District, Redondo Beach, CA

Camden Coalition, Camden, NJ

Care Transitions Intervention National Office, Portland, OR

CATCH Greater Houston, Houston, TX

Center for Health and Social Care Integration, Chicago, IL

Center in the Park, Philadelphia, PA

CenterPlace Health, Sarasota, FL

Collective Action Lab, LLC, Minneapolis, MN

Community ConneXor - MOMENTUM Hub, Nashville, TN

Community Health 360, Salem, OR

EODD Area Agency on Aging, Muskogee, OK

Florida Community Health Worker Coalition, Starke, FL

Freedmen's Health Consulting, Washington, DC

Health Empowerment Alliance of Long Island, Huntington Station, NY

Health Foundation for Western & Central New York, Buffalo, NY

Health Promotion Council, Philadelphia, PA

Health Quality Partners, Warrington, PA

HealthHive, PBC, Short Hills, NJ

Healthy Alliance Foundation, Inc., Schenectady, NY

Human Health Project, Los Angeles, CA

Inclusive Alliance IPA Inc, SYRACUSE, NY

Independent Living Systems, LLC, Miami, FL

Iowa Community HUB, West Des Moines, IA

Jewish Family Service LA, Los Angeles, CA

Juniper, Minneapolis, MN

Lakeshore Foundation, Birmingham, AL

LifeStream Services, Inc., Yorktown, IN

Matrix Care Services, LLC, Encino, CA

National Association of Nutrition and Aging Services Programs (NANASP), Washington, DC

National Consortium of Community Care Hubs, Salem, OR

Partners in Care Foundation, San Fernando, CA

Perham Health, Perham, MN

Pharmacy Care Compass, Chadron, NE

Practice Flow, Seattle, WA

Quality First Support Group, Voorhees, NJ

Region IV Area Agency on Aging, St. Joseph, MI

Resources for Independence Central Valley, Visalia, CA

Rhode Island Nutrition Therapy, LLC, North Kingstown, RI

Robinson Ventures, LLC, Hartsville, SC

SARCOA/CCS, Dothan, AL

Second Wind Dreams, Inc., Perkinston, MS

Southwest Colorado Cares, Durango, CO

Southwest Community Care Partners, Tucson, AZ

Taylor & Payne, Santa Monica, CA

The Granite YMCA, Manchester, NH

The Institute for Advanced Learning and Research, Danville, VA

The Regional Engagement to Advance Community Health (REACH) Partnership, Danville, VA

USAging, Washington, DC

Western New York Integrated Care Collaborative, Buffalo, NY

Zero Overdose, Moore, SC