



September 14, 2026

Dr. Mehmet Oz
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

RE: CMS-1848-P: CY 2027 Physician Fee Schedule Proposed Rule

Dear Administrator Oz:

USAgings applauds the Centers for Medicare & Medicaid Services (CMS) for its efforts to better serve older adults by recognizing the role of the National Aging Network in the CY 2027 Physician Fee Schedule and appreciates the opportunity to provide comments.

[USAgings](#) is the national association representing and supporting the network of Area Agencies on Aging (AAAs) and advocating for Title VI Native American Aging Programs (Title VI programs) that help older adults, people with disabilities and caregivers live with optimal health, well-being, independence and dignity in their homes and communities. Most older adults prefer to age in their current home and community, and for more than 50 years, through the Older Americans Act (OAA), the nation's AAAs have provided a range of supportive services that help make this possible.

The OAA is the cornerstone of the nation's non-Medicaid home and community-based services (HCBS) system with the National Aging Network providing nearly 14 million older Americans and their caregivers annually with the critical support services they need. Within the federal, state and local Aging Network, our members are the local leaders that develop, coordinate and deliver a wide range of HCBS, including information and referral/assistance, assessment, care planning and care coordination, home-delivered and congregate meals, in-home services, caregiver supports, long-term care ombudsman programs and more to millions of Americans each year.

In addition to their OAA foundational programs and services, 45 percent of AAAs also provide HCBS through contracts with health care entities, such as Medicaid managed care organizations, Medicare Advantage (MA) plans and others.

USAgings is also the home of the [Aging and Disability Business Institute](#), which has been a leader for over a decade in building the business capacity of AAAs, Centers for Independent Living, Community Care Hubs (CCHs) and other aging and disability community-based organizations (CBOs) for health care contracting.

The Business Institute also houses the Center of Excellence to Align Health and Social Care, which is funded by the U.S. Administration for Community Living (ACL), to provide technical assistance to CCHs. CCHs, many of which are AAAs, lead networks of CBOs to drive administrative efficiencies and scale in the delivery of community-based services, supports and interventions as well as evidence-based programs to address upstream drivers of health (UDOH), for older adults, people with disabilities, caregivers and other complex care populations.

USAgings applauds CMS for highlighting the important role our members play in ensuring the health and well-being of older adults. We also thank CMS for the continued efforts in acknowledging the value of the relationships between CBOs and billing practitioners as it relates to providing UDOH-responsive services. Our members' experience and expertise inform our comments and recommendations that follow regarding the CY 2027 Physician Fee Schedule proposed rule.

National Payment Guidelines for Health Coaching CPT Codes

USAgings applauds CMS for proposing to set national payment guidelines for three existing Category III Current Procedural Terminology (CPT) codes describing health coaching. We strongly support the agency's proposal to accept training received through the evidence-based health promotion and disease-prevention programs approved by ACL in addition to other similar training programs to ensure an adequately trained health coaching workforce. We also ask CMS to consider creating HCPCS G-Codes to describe health coaching services for CY 2027 instead of actively pricing the Category III CPT codes. Please find our comments below.

Certification Standards for Auxiliary Personnel

We strongly support CMS' proposal to allow the certification required to provide ACL-approved evidence-based programs to qualify under these codes to provide Medicare-approved health coaching.

This proposal appropriately recognizes the longstanding federal investment in building a skilled, community-based workforce capable of helping older adults and people with disabilities achieve better health outcomes while remaining in their homes and communities. For decades, ACL and the Aging Network have translated evidence-based interventions into practice at the community level, improving participants' ability to manage chronic conditions, reduce falls risk, support caregivers, promote healthy aging, and address social and behavioral factors that influence health outcomes. These interventions are supported by rigorous evidence, implemented with fidelity and continuously evaluated to ensure quality and effectiveness.

While initially created with OAA funding streams, many AAAs now partner and contract with health care providers, Medicare Advantage plans, accountable care organizations, hospitals and federally qualified health centers to offer these services that complement clinical care and address the factors that often determine whether an individual can successfully manage their health outside the clinical setting. The competencies developed through ACL and OAA-supported evidence-based training are directly aligned with the knowledge and skills needed to support high-quality, whole-person care.

USAgings believes that CMS' recognition of the ACL qualifications for Medicare health coaching will allow more beneficiaries who could benefit from these evidence-based coaching services to access them. It also advances CMS' ongoing efforts to strengthen the integration of health care and community-based services. As CMS increasingly promotes prevention, chronic disease management, care coordination and other approaches that address upstream drivers of health, it is critical that certification pathways recognize existing experts in the social care field and the existing training grounded in evidence-based community interventions. These programs equip professionals with specific expertise, training and practical experience working with older adults in their homes and communities, where many of the barriers to achieving positive health outcomes can be identified and addressed to support preventive care. Importantly, recognizing ACL and OAA evidence-based training affirms the essential role that the Aging Network plays in improving beneficiary outcomes.

AAAs have decades of experience delivering and administering evidence-based and other programs at scale, and this expertise has helped build trusted relationships with older adults and caregivers and has demonstrated measurable improvements in health, independence and quality of life.

USAgings strongly encourages CMS to finalize this proposal, and we appreciate CMS' recognition of the contributions the Aging Network can make to the health of beneficiaries and ultimately to CMS' larger goals.

We recommend deferring to ACL to define and establish the standards for evidence-based program training, given the agency's expertise and role in this area. In addition, CMS should clarify that qualifying ACL/OAA evidence-based courses are eligible to satisfy applicable group activity requirements. This would provide greater consistency, recognize the value of evidence-based training and facilitate broader adoption of programs with demonstrated benefit.

Finally, CMS should include in the final rule that the delivery, in accordance with fidelity requirements, of an OAA Title III D evidence-based group workshop constitutes a billable health coaching service under CPT 0593T. Examples of these workshops include, but are not limited to, the Chronic Disease Self-Management Program (CDSMP), Diabetes Self-Management Program (DSMP), Stepping On and EnhanceFitness. These ACL-approved programs meet strict evidence-based criteria for health promotion and disease prevention programs and provide beneficial outcomes for older adults who participate in them.

General Supervision for Health Coaching

USAgings strongly supports CMS' proposal to permit general supervision of health coaching by CBOs, as it is a key step toward making these services more accessible and operationally feasible, especially in rural areas. General supervision would reduce the administrative burden on health care providers while enabling beneficiaries to access services from trusted, experienced AAAs/CBOs in their local community. This is particularly important as evidence from provider and patient surveys suggests that patients may not always feel comfortable sharing complete information about their community living challenges with their health care providers. Overall trust in physicians has never been lower. Between 2019 and 2024, trust in physicians decreased by 12 percent.ⁱ Additionally, clinical providers have limited time to delve into the many UDOH issues a patient may face in daily life. They spend, on average, 18 minutes per patient to diagnose and treat their medical conditions, leaving limited time to

discuss any UDOH challenges.ⁱⁱ AAAs, on the other hand, are specialists in addressing UDOH—that’s literally their mission. They and other CBOs don’t just identify a client’s needs, they provide direct assistance to support the beneficiary’s ability to manage their health and their life, which supports healthy aging and prolongs independence.

AAAs, CBOs and CCHs often serve as the glue within a community to ensure that a coordinated system of health and community care is working efficiently and effectively to meet the whole-person health needs of a beneficiary.ⁱⁱⁱ Therefore, community-based health coaching can provide an additional, trusted point of engagement that complements the clinician’s role and ultimately supports better health outcomes for these beneficiaries

Lastly, making the general supervision permanent would not only positively impact beneficiaries and encourage collaboration between health care and community care providers such as AAAs, but it could contribute to significant health care savings. Recent research suggests that community social care generates a conservative return on investment of approximately \$3.47 in savings for every \$1 invested. This means the Aging Network is responsible for saving approximately \$34 billion in health care spending. The actual impact may be even greater, with proprietary analyses indicating that certain service packages can generate savings of \$8-\$10 for every \$1 invested. The services provided by the Aging Network are not only a high-quality component of care but also a strong financial investment for the federal government and an effective use of federal taxpayer dollars.^{iv}

Braiding and Blending

To ensure the success of CMS’ health coaching proposal, greater clarity is needed regarding how braided and blended funding would work in practice, particularly when a service may be eligible for both Medicare reimbursement and OAA funding. **CMS should provide clear guidance on how health care providers, AAAs, CBOs and CCHs should coordinate billing and funding streams without creating duplication, supplantation or unintended barriers to care. This is especially important for the group coaching code.**

CMS already has established models for coordinating multiple payers that could inform this approach, including its [Medicaid coordination-of-benefits and third-party liability guidance](#). Similar principles could be applied to clarify the

relationship between Medicare reimbursement and OAA funding, as OAA is the payer of last resort. CMS should be informed by models already operating in the field; for example, the northeastern Massachusetts AAA called AgeSpan and their AAA peers have experience offering [evidence-based group programs](#) to participants whose services may be supported through different funding sources. These existing practices could provide useful insight into how braided funding works operationally.

Additionally, a clear principle should be established: when a service is eligible for Medicare reimbursement, Medicare should be the primary payer before OAA funds are used. OAA Title III D Evidence-Based Health Promotion and Disease Prevention funds cannot pay for a service that is simultaneously billed to Medicare, and applicable supplantation requirements must be observed. Therefore, a clear cost-allocation methodology is essential. Organizations that receive both Medicare reimbursement and OAA funding must be able to distinguish Medicare-billable encounters from grant-funded activities. Documentation, accounting and allocation procedures should clearly segregate these funding streams and demonstrate that OAA Title III D dollars are being used only for allowable costs that are not otherwise reimbursable.

If done effectively, this approach would allow Medicare reimbursement to extend the reach, scale and sustainability of evidence-based community programs while preserving finite and federal discretionary Title III D resources for gap-filling purposes. It would also allow AAAs to demonstrate to ACL that OAA funding is being leveraged rather than displaced, a key requirement of the OAA.

This distinction is also critical to prevent compliance concerns and the problem of third parties offering these services under Medicare then making inappropriate, unpaid referrals to AAAs to try and leverage OAA services for their clients despite the third party having received payment from CMS to provide said service.

Lastly, this principle should be incorporated into CMS' education and implementation guidance for providers when the new codes are introduced. Providers need to understand not only how to use the code, but also how it can facilitate referrals to qualifying group-based services and how Medicare reimbursement interacts with OAA-funded programs. Clear guidance will help providers confidently refer beneficiaries to AAAs, CBOs and CCHs without creating uncertainty about who bills, who receives payment and which funding source applies. The payment flow should also be clearly

defined. A provider may identify a beneficiary for whom a community-based group intervention is medically appropriate and refer that individual to a AAA or CBO to deliver the service. The organization performing the service should be appropriately compensated through the applicable Medicare billing or contractual agreement. A provider should *not* receive Medicare payment simply for referring a patient to a community-based group program funded under the OAA, for example; payment should correspond to the health coaching services furnished and billed in accordance with Medicare requirements.

USAgings recommends CMS establish, in collaboration with ACL, a straightforward framework in which: (1) Medicare pays for Medicare-covered services; (2) OAA resources support allowable gap-filling activities and services that are not otherwise reimbursable; and (3) organizations maintain a transparent methodology for allocating costs between funding streams. This would reduce administrative uncertainty, protect against double payment and supplantation, preserve the integrity of OAA funding and create a sustainable pathway for integrating cost-effective community care into Medicare-financed care.

Lastly, the Aging Network's longstanding experience administering the OAA, as well as a broad range of federal, state and local funded programs and grants, provides an important foundation for the effective integration of community-based services into the broader health care system. Beyond assessment and service delivery, the Aging Network's expertise extends into eligibility management, consent, quality assurance, Protected Health Information (PHI) and/or HIPPA data, staff certifications and other requirements and obligations of federal, state and other funders. The Aging Network routinely braids and blends multiple funding streams while maintaining accountability for the respective regulatory requirements. As health care and community care become increasingly integrated, it is critical that entities authorized to provide health coaching have the appropriate experience, infrastructure and qualifications to operate effectively within this environment.

HCPCS G-Codes Should be Created Instead of CPT Codes for CY 2027

While USAgings supports the introduction of new health coaching codes, the code type must be appropriate for the service delivered and match what is recognized by all billing partners. **We strongly recommend CMS create HCPCS G-Codes**

to describe health coaching services for CY 2027 instead of actively pricing the Category III CPT codes.

Establishing HCPCS G-Codes now, instead of waiting months or years for the American Medical Association (AMA) to assign a CPT code, allows these codes to be implemented immediately by clinical and community-based providers and prevents inconsistencies. This will also allow CMS to track usage, collect data and measure outcomes as related to value-based care, and to continue to shape, refine and evolve its upstream whole-person health policies while reducing more costly downstream clinical utilization. As the health coaching service becomes more firmly established, it can be replaced by permanent CPT codes.

Additionally, the development and stewardship of codes for community care should reflect the expertise, infrastructure and data requirements of the social and community care sectors. While the AMA has made a longstanding and significant contribution to the development of CPT codes, social and community care presents distinct considerations that require specific subject-matter expertise and stakeholder engagement from those sectors. Efforts to align social care codes build upon the extensive body of data already in use by federal and state funders.

For codes to support meaningful utilization tracking, data collection and outcome measurement, they should recognize and, ideally align with, established community care data requirements, including those reflected in OAA and Medicaid reporting frameworks. Such alignment would enable CMS to more effectively assess utilization, costs, quality and outcomes across the continuum of care and provide greater confidence that the resulting data accurately reflects the delivered services and achieved outcomes. This only happens when proper alignment is achieved.

We therefore encourage CMS to play a central role in the stewardship of these codes and to ensure they are maintained in the public domain and made broadly available for use without unnecessary barriers or costs. CMS should also ensure that the codes and associated data structures are interoperable with existing community care data and terminology. Establishing this alignment is essential to creating a reliable foundation for understanding the true cost of care and measuring the outcomes associated with community-based services. Additionally, alignment is also a challenge between traditional Medicare and MA. MA plans have substantial flexibility in how they structure utilization management,

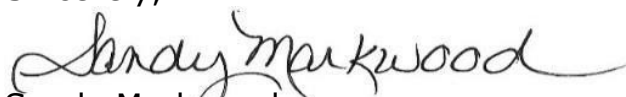
coverage and reimbursement. As a result, differences may arise in medical necessity criteria, prior authorization requirements and contracted reimbursement rates. A standardized coding framework, coupled with clear definitions and data standards, can help improve consistency and transparency across these different payment environments.

Finally, CMS has an important opportunity to establish a clear and consistent definition of health coaching, including a common definition of the service, the qualifications and credentials of individuals authorized to provide it, the circumstances or initiating events that trigger the service and the associated workflows and documentation requirements. We encourage CMS to actively work with USAging, AAAs and CBOs in developing appropriate and adequate codes, workflows and related billing procedures that are practical, specific and reflective of how community-based care is delivered in practice.

Conclusion

We welcome future conversations and collaboration to advance our shared goal of ensuring Medicare beneficiaries have access to the high-quality services they need to live and age well. If you or your staff have any questions about our comments, please contact Amy Gotwals, Chief, Public Policy and External Affairs, at agotwals@usaging.org and Olivia Umoren Ezeuko, Director, Public Policy and Advocacy, at oumoren@usaging.org.

Sincerely,



Sandy Markwood
Chief Executive Officer

ⁱ JAMA Health Forum, *Prescription for Division—Healing the Growing Gap in Physician Trust*, 2025, [Prescription for Division—Healing the Growing Gap in Physician Trust | JAMA Forum | JAMA Health Forum | JAMA Network](#).

ⁱⁱ JAMA Health Forum, *Association of Primary Care Visit Length With Potentially Inappropriate Prescribing*, 2023, <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2802144>.

ⁱⁱⁱ Health Affairs, *Improving Health And Well-Being Through Community Care Hubs*, 2022, [Improving Health And Well-Being Through Community Care Hubs | Health Affairs](#).

^{iv} USAging, *The Economic Value of the Aging Network*, 2026, [02247 USA HealthBrief EconValue FINAL.pdf](#).