



September 14, 2026

Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244

Re: CMS-1848-P, CY 2027 Payment Policies Under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

On behalf of the National Alliance to Impact Social Determinants of Health (NASDOH), we appreciate the opportunity to provide comments on the calendar year (CY) 2027 Physician Fee Schedule proposed rule.

Founded in 2018 by Governor Mike Leavitt and Dr. Karen DeSalvo, NASDOH is a multi-sector coalition of stakeholders seeking to make a material improvement in the health of individuals and communities by advancing the adoption of effective policies and programs to address upstream drivers of health, such as food insecurity, housing instability, interpersonal safety, and transportation insecurity. NASDOH brings together stakeholders from different geographic regions with expertise in health care, public health, social services, patient and consumer perspectives, information technology, and business to share learnings, develop policy recommendations, and build consensus on solutions to support health. Our website lists all the NASDOH [members](#).

NASDOH appreciates CMS's focus on strengthening preventive care and reorienting the health care system toward the upstream drivers of health that shape long-term outcomes. The Make America Healthy Again movement underscores the importance of moving beyond a reactive, illness-centered model and investing in approaches that help individuals and communities stay healthy in the first place. Medicare payment policy can play a critical role in advancing this shift by giving clinicians, community-based organizations, and other partners the flexibility to prevent disease and address upstream drivers of health by connecting people to the community-based services and supports that happen outside what is traditionally viewed as the health care system but are shown to positively influence an individual's health and wellbeing. The comments below provide feedback on specific opportunities for CMS to align the CY 2027 Physician Fee Schedule with these goals.

Request for Information: Redesigning Primary Care to Make America Healthy Again

In the CY 2027 PFS proposed rule, CMS seeks comments on how the agency might reconsider primary care service valuation to better support a shift from "sick care" to preventive medicine in the U.S. health care system.

Enable Whole-Person Care

NASDOH strongly supports efforts to strengthen primary care and believes that prospective payment models can provide an opportunity to move beyond a narrow focus on individual medical services toward comprehensive, whole-person care. In particular, a well-designed prospective primary care payment (PPCP) approach could give primary care practices greater flexibility to address patients'

upstream drivers of health, build partnerships with community organizations, and invest in the workforce and infrastructure necessary to coordinate medical and community care.

Primary care clinicians are often under substantial administrative and clinical burdens associated with traditional health related symptoms and conditions and have limited if any training in identification of community care needs. Additionally, historical CMS policy has provided health care practitioners with limited flexibility to address needs that fall outside traditional medical services even though those factors significantly impact a patient's overall health and health-care utilization. We support CMS' use of PPCP to reduce these constraints and give primary care practices greater flexibility to deliver whole-person care by encouraging partnerships with experts on upstream drivers of health and associated needs.

For example, a primary care practice could use prospective payment resources to support evidence-based fall-prevention interventions for older adults, including connections to community-based services that address home safety, mobility, nutrition, physical fitness and other factors contributing to fall risk. These interventions typically do not fit neatly within traditional clinical services, but they can meaningfully affect health outcomes, avoid preventable utilization, and support patients' ability to remain healthy and independent.

CMS should therefore ensure that PPCP provides sufficient flexibility for primary care practices to partner with community-based organizations when doing so is clinically appropriate and supported by evidence.

Incorporate Food Is Medicine Approaches

NASDOH also encourages CMS to recognize the role of nutrition and food access in addressing nutrition-sensitive conditions. There is a growing body of evidence demonstrating the potential of food-based interventions to improve outcomes for individuals with conditions such as diabetes and hypertension and for individuals during pregnancy and the postpartum period.

PPCP could provide an important mechanism for primary care practices to incorporate Food Is Medicine approaches into routine care. Depending on the needs of their patient populations, practices could use prospective payments to support nutrition counseling, medically tailored meals, produce prescriptions, food insecurity interventions, or partnerships with community organizations and other entities that provide nutrition-based services.

CMS should explicitly consider how prospective primary care payments can support evidence-based Food Is Medicine interventions and partnerships, particularly where such interventions can prevent or manage chronic disease, reduce utilization, and improve outcomes for populations experiencing food insecurity or other barriers to nutrition education or healthy food access.

Build Community-Based Capacity into Prospective Payment

Successful integration of social care and primary care will require more than simply encouraging clinicians to screen for and identify patients' social needs. Practices also need the community partnerships necessary to address workforce, relationships, technology, and operational infrastructure to respond effectively.

NASDOH encourages CMS to design PPCP to support community health workers, social care coordinators, and other members of interdisciplinary teams who can help patients navigate available resources. To accomplish this goal, prospective payment should allow practices to partner with social

care network lead entities and other community-based organizations that can provide specialized expertise, resource coordination, management, and technical infrastructure to identify and address health related social needs. This flexibility is particularly important for smaller and independent primary care practices.

Favor a Hybrid Payment Approach

NASDOH supports a hybrid payment approach that combines prospective payments with appropriate fee-for-service payments. A hybrid model can preserve access to traditional payment for necessary clinical services while providing primary care practices with a predictable source of funding that can be used more flexibly to address patients' broader needs.

This flexibility would allow practices to make investments that are difficult to support through fee-for-service reimbursement and enable practices to tailor their approach to the needs of their patient populations. Practices serving communities with high levels of food insecurity, housing instability, transportation barriers, or other health related social needs should have the flexibility to direct resources toward the interventions and partnerships most likely to improve outcomes for their patients.

CPT Codes for Health Coaching

CMS proposes conditions of payment and valuation for CPT codes for health coaching. These codes cover initial assessment, follow-up sessions, and group sessions.

NASDOH appreciates CMS's efforts to establish a sustainable Medicare payment pathway for health coaching services. Health coaches can help Medicare beneficiaries adopt healthy behaviors, manage chronic conditions, and connect with community-based resources that support health and well-being.

Support General Supervision

NASDOH supports CMS's proposal to allow community-based organizations—including community care hubs, community action agencies, housing agencies, Area Agencies on Aging, Centers for Independent Living, Aging and Disability Resource Centers, and other nonprofit social service organizations—to furnish qualified health coaching under general supervision. General supervision would support optimal efficiency for integration of these community care experts into interdisciplinary care teams and strengthen partnerships between Medicare-enrolled providers and community-based organizations. This flexibility is particularly important in rural areas, where requiring direct supervision would create practical barriers to delivering health coaching services because of workforce shortages, travel distances, and limited provider availability and training.

CMS should also ensure that health-related social needs data generated through health coaching is captured consistently across organizations, rather than left to vary by practice or community-based organizations. We recommend that any associated data elements align with existing national standards, such as the USCDI Social Determinants of Health domains developed through the Gravity Project, to keep this data usable and comparable as the evidence base for these services grow.

Recognize Existing Training and Workforce Capacity

NASDOH requests that CMS explicitly recognize qualifying Older Americans Act (OAA) and Administration for Community Living (ACL) training programs or defer to ACL to publish a list of qualifying programs. Recognizing existing workforce capacity would reduce duplicative requirements and allow CMS to leverage trusted community-based organizations with demonstrated experience delivering evidence-based services.

Provide Clear Guidance on Braided Funding

NASDOH also encourages CMS to provide clear guidance on braided funding so community-based organizations can appropriately combine Medicare reimbursement with other public and private funding streams to ensure efficient use of federal funds. CMS should clarify non-duplication and cost-allocation requirements and provide examples of how organizations may braid or blend funding between Title III-D and Medicare Part B.

Additionally, community-based organizations combining funding streams also need a practical way to track and report outcomes across those streams without duplicative data entry. We encourage CMS to account for this operational reality in its guidance, and to engage data-holding organizations, including health information exchanges, health data utilities, and all-payer claims databases, in structuring workable reporting approaches.

Clarify the Role of Group-Based Evidence-Based Programs

CMS should clarify that participation in a qualifying evidence-based program delivered in a group class format can satisfy applicable intervention requirements. Group-based interventions are widely used by community-based organizations and can provide both behavior-change support and valuable peer connection.

Establish Permanent Codes to Support Investment

Finally, NASDOH encourages CMS to establish permanent G-codes for health coaching services. Permanent codes would provide greater certainty for providers, community-based organizations, and health coaches as they invest in workforce development, partnerships, and service delivery infrastructure. Permanence also matters for the evidence base itself: codes that change from year to year make it difficult to track outcomes longitudinally, since researchers and CMS lose a stable unit of measurement over time.

NASDOH appreciates CMS's consideration of these recommendations and looks forward to working with the agency to advance payment and delivery system reforms that enable primary care to address the full range of factors that influence health and well-being. For more information on NASDOH and our members, please visit our website at www.nasdoh.org. Should you have any questions or wish to discuss our comments further, please contact Laura Pence at Laura.Pence@LeavittPartners.com.

Sincerely,

Laura Pence

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Advisor to NASDOH