

September 14, 2026

The Honorable Mehmet C. Oz, M.D.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

VIA ELECTRONIC SUBMISSION

Re: Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program (CMS-1848-P; RIN 0938-AV82)

Administrator Oz:

The Physical Activity Alliance (PAA) appreciates the opportunity to provide comments regarding the Centers for Medicare & Medicaid Services' (CMS) Calendar Year 2027 Medicare Physician Fee Schedule proposed rule.

PAA is the nation's leading coalition dedicated to advancing policies, systems, and environmental strategies that increase physical activity and improve health outcomes for all Americans. Our alliance brings together organizations representing public health, health care, fitness, recreation, transportation, digital health technology, education, sports, academia, and community organizations. Through partnerships with federal agencies and other public and private stakeholders, PAA translates scientific evidence into practical implementation strategies that improve the nation's health.

PAA strongly supports CMS's increased emphasis on prevention, chronic disease management, accountable care, and innovative approaches that help beneficiaries maintain and improve their health. CMS has described its strategy for Original Medicare as aligning spending with value, strengthening accountability, improving beneficiary choice, and shifting health care from treating illness to preventing it. Physical activity is a core preventive and therapeutic intervention and should be integral to that strategy, not treated merely as one element of a generalized lifestyle approach.¹

The federal Physical Activity Guidelines for Americans establish physical activity as an evidence-based intervention that can prevent or help manage numerous chronic diseases, improve brain health and

¹ Centers for Medicare & Medicaid Services (CMS), "Strengthening Original Medicare" (July 16, 2026), <https://www.cms.gov/newsroom/blog/strengthening-original-medicare>; CMS, "CMS Proposes Transformational Medicare Reforms to Expand Accountable Care and Modernize Physician Payment" (July 14, 2026), <https://www.cms.gov/newsroom/press-releases/cms-proposes-transformational-medicare-reforms-expand-accountable-care-modernize-physician-payment>.

physical function, reduce fall risk, and support healthy aging. These benefits are particularly important for the Medicare population. Yet fewer than 15 percent of adults age 65 and older meet both the aerobic and muscle-strengthening recommendations in the Guidelines.²

The CY 2027 proposed rule presents an important opportunity to begin closing the gap between what is known about the health benefits of physical activity and how Medicare assesses, counsels, refers, treats, and follows beneficiaries in routine care.

PAA's overarching recommendation is straightforward: assessment must lead to action. Medicare should establish a connected pathway through which standardized physical activity assessment informs an individualized recommendation or prescription, counseling, referral to an appropriately qualified professional or evidence-based program, supervised exercise when clinically indicated, and follow-up that returns relevant information to the care team.

To advance that goal, PAA recommends that CMS:

1. Finalize coding and payment for Shared Medical Appointments (SMAs), preserve existing E/M billing pathways and separate payment for distinct covered services, and explicitly recognize physical activity assessment, individualized physical activity recommendations or exercise prescription, behavior-change support, referral, supervised exercise when clinically indicated, and follow-up as appropriate components of SMAs addressing lifestyle-modifiable conditions.
2. Finalize national payment for health and well-being coaching, clarify that physical activity adoption and exercise-related goal setting are appropriate coaching functions, apply general supervision when permitted, and establish inclusive, competency-based standards that recognize qualified exercise professionals and other appropriately trained personnel.
3. Establish standardized, evidence-based physical activity assessment as a routine component of the Annual Wellness Visit (AWV), integrate the results into the personalized prevention plan, and clarify the relationship between this requirement and separately payable HCPCS code G0136.
4. Recognize physical activity as an essential component of multidomain intensive lifestyle interventions designed to reduce cognitive decline or slow the progression of Alzheimer's disease and related dementias (AD/ADRD), and incorporate physical activity assessment into the clinical pathway used to identify and manage appropriate beneficiaries.
5. Continue incorporating physical activity into Medicare quality measurement and value-based care, including finalizing the proposed Lifestyle Approaches to Diabetes Remediation improvement activity and advancing measures that connect physical activity assessment with meaningful intervention and outcomes.

² U.S. Department of Health and Human Services, Physical Activity Guidelines for Americans, 2nd ed. (2018), https://health.gov/sites/default/files/2019-09/Physical_Activity_Guidelines_2nd_edition.pdf; Nazik Elgaddal & Ellen A. Kramarow, Characteristics of Older Adults Who Met Federal Physical Activity Guidelines for Americans: United States, 2022, NCHS Report No. 215, at 2 (2024) (reporting an age-adjusted estimate of 13.9%), <https://www.cdc.gov/nchs/data/nhsr/nhsr215.pdf>.

6. Build upon existing federal interoperability standards so that physical activity assessment, goals, referrals, participation, and outcomes can follow beneficiaries between clinical and community settings.
7. Preserve beneficiary choice and facilitate partnerships among physicians, other health care professionals, qualified exercise professionals, and community-based organizations while maintaining appropriate clinical oversight and program-integrity protections.

I. Physical Activity as a Core Medicare Prevention and Chronic-Disease Strategy

PAA strongly supports CMS's stated objective of shifting Medicare toward prevention and high-value care.

Physical activity is not simply a general wellness recommendation. It is an evidence-based preventive and therapeutic intervention relevant to many conditions that drive substantial disease burden and health care utilization among Medicare beneficiaries.

The Physical Activity Guidelines for Americans identify benefits including reduced risk of cardiovascular disease, hypertension, type 2 diabetes, depression, certain cancers, dementia, falls and fall-related injuries, as well as improved cognition, physical function, sleep, and quality of life. Physical activity can also help manage existing conditions, including hypertension, type 2 diabetes, osteoarthritis, anxiety, depression, and dementia.³

CMS has already taken important steps toward recognizing physical activity in Medicare. Most notably, Medicare now covers HCPCS G0136 for administration of a standardized, evidence-based physical activity and nutrition risk assessment, including when furnished as an optional element of the AWW.⁴

The CY 2027 proposed rule provides an opportunity to build upon this foundation. Assessment is important, but assessment alone does not change behavior or improve health. Medicare policy should increasingly support a continuum in which a beneficiary's physical activity status can be assessed, discussed with the beneficiary, incorporated into the care plan, addressed through an appropriate intervention or referral when indicated, and reassessed over time.

This approach is consistent with value-based care. Organizations that are accountable for the cost and quality of care have a direct interest in preventing avoidable disease progression, preserving function, and connecting patients with effective interventions before more intensive and expensive medical care is required.

PAA therefore encourages CMS to view the individual provisions discussed below not as isolated payment policies, but as components of a broader Medicare prevention strategy.

³ U.S. Department of Health and Human Services, *supra* note 2.

⁴ CMS, "Physical Activity & Nutrition Risk Assessment," Medicare.gov (accessed Sept. 9, 2026), <https://www.medicare.gov/coverage/physical-activity-nutrition-risk-assessment>.

II. Shared Medical Appointments

PAA supports CMS's proposal to establish dedicated coding and payment for Shared Medical Appointments through proposed HCPCS code GSMAS.

CMS proposes a voluntary group-based service of up to 10 beneficiaries that combines individualized clinical assessment with education, counseling, peer support, and behavior modification. CMS specifically recognizes diabetes, obesity, hypertension, and hyperlipidemia as conditions that may be modified through lifestyle change and identifies diet and physical activity as behaviors that can influence health outcomes.⁵

This recognition highlights the role group-based models can play in chronic disease prevention and management.

A. Physical activity should be explicitly recognized within SMA services

PAA recommends that CMS explicitly recognize physical activity assessment, individualized goal setting, physical activity recommendation or exercise prescription, behavior-change support, referral, supervised exercise when clinically indicated, and follow-up among the services that may be delivered or arranged within an SMA addressing a lifestyle-modifiable condition.

CMS currently proposes required SMA components including individualized E/M elements, evidence-based education, self-care and disease-management discussion, positive lifestyle changes focused on behavior modification, and medication management when clinically applicable.

PAA supports this framework but recommends greater specificity regarding physical activity. For many lifestyle-modifiable conditions, simply advising a beneficiary to “exercise more” will be insufficient. Effective intervention may require assessing current activity, setting individualized goals, addressing readiness and barriers, providing an appropriate exercise or physical activity recommendation, connecting beneficiaries to qualified professionals or programs, and evaluating progress.

Not every SMA should be required to provide identical physical activity services. The content should reflect the condition, evidence base, beneficiary needs, practitioner judgment, and scope of practice of participating professionals. CMS should nevertheless make clear in final guidance that these activities are appropriate and expected elements when physical activity is relevant to prevention or treatment of the condition addressed.

B. CMS should use an evidence-based, guideline-driven approach to eligible conditions

PAA supports CMS's proposal to make SMAs available for medical conditions that are modifiable through lifestyle change.

⁵ Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies, 91 Fed. Reg. 43842, 43903–43905 (proposed July 16, 2026) (section II.D.(54)), <https://www.govinfo.gov/content/pkg/FR-2026-07-16/html/2026-14327.htm>.

CMS should avoid establishing a closed or exhaustive list of eligible diagnoses. Instead, eligibility should generally be available when authoritative clinical guidelines or a sufficient evidence base recognize lifestyle modification—including physical activity, nutrition, or other health behaviors—as an element of prevention, treatment, or disease management.

This approach would allow Medicare policy to evolve as clinical evidence evolves and would avoid inadvertently excluding beneficiaries who could benefit from evidence-based group care.

C. SMA teams should be multidisciplinary and flexible

PAA supports CMS's proposal that SMAs be billed and led by a physician or qualified nonphysician practitioner while permitting participation by other qualified health care professionals, clinical staff, and other members of the health care team, including qualified exercise professionals.

SMAs are particularly well suited to team-based care. Depending upon beneficiary needs and the condition being addressed, an effective team may include professionals with expertise in medical management, nutrition, physical activity and exercise, health education, behavior change, rehabilitation, and other relevant disciplines.

CMS should preserve flexibility for the billing practitioner to assemble the appropriate team rather than prescribing a single staffing model. All professionals should provide services consistent with applicable law, scope of practice, training and competency, and the billing practitioner should retain appropriate clinical responsibility.

D. Valuation should support sustainable, multidisciplinary care

PAA does not recommend a specific numerical work RVU or time allocation. CMS should, however, ensure that final valuation recognizes the resources required for practitioner leadership, individualized assessment and documentation, coordination of a multidisciplinary team, and evidence-based group education and behavior-change support. An inadequately valued code could discourage use of the very physician-led and team-based models CMS seeks to make available. CMS should monitor early utilization, beneficiary access, and the mix of participating practices and revisit valuation if the code does not support sustainable delivery.

E. Existing E/M pathways and separately payable services should remain available

PAA agrees that Medicare should not pay twice for the same practitioner work or time. At the same time, establishing GSMAS should expand options for delivering shared medical appointments without displacing existing E/M pathways or creating a bundled payment structure that discourages multidisciplinary care.

PAA recommends that CMS treat GSMAS as an additional payment option, not as the exclusive mechanism for billing care delivered through an SMA. When the individualized evaluation and management furnished to a beneficiary during an SMA meets the requirements of an applicable E/M code, existing E/M-based billing pathways should remain available.

PAA is also concerned about CMS's proposal to treat otherwise separately payable services furnished during an SMA as included within GSMAS. CMS specifically identifies group medical nutrition therapy as an example of a service that would not be separately payable when furnished as part of an SMA. A similar approach could discourage the inclusion of physical activity and exercise-related services furnished by appropriately qualified professionals when those services would otherwise meet Medicare coverage and coding requirements.

Bundling these services into a single GSMAS payment creates a financial disincentive to provide the multidisciplinary care that makes SMAs particularly valuable for lifestyle-modifiable chronic conditions. Practices should not face a choice between providing a more comprehensive, team-based intervention and receiving payment for the additional covered services furnished.

F. Telehealth should remain available

PAA supports CMS's proposal to permit SMAs both in person and through telehealth and to add the service to the Medicare Telehealth Services List.

Beneficiary needs vary. Telehealth can expand access for beneficiaries across geographies and may be especially valuable for rural beneficiaries, individuals with disabilities, people with transportation barriers, and beneficiaries who otherwise have difficulty participating in recurring programs. CMS should preserve in-person and virtual options while allowing practitioners and beneficiaries to determine the clinically appropriate modality.

G. Program integrity

PAA supports appropriate safeguards against fraud, waste, and abuse. CMS identifies potential safeguards including evidence-based protocols, fidelity monitoring, defined goals and outcomes, appropriate interventionist training, and beneficiary-specific documentation.

These are reasonable principles. PAA particularly supports:

- beneficiary consent;
- individualized documentation;
- clearly identified clinical goals;
- use of evidence-based interventions;
- appropriate professional qualifications and training;
- documentation of the role of participating team members; and
- periodic reassessment of beneficiary progress.

CMS should balance these safeguards against administrative burden so that legitimate SMAs remain practical for small, rural, and community practices.

III. Health and Well-Being Coaching

PAA strongly supports CMS’s proposal to establish national payment and conditions of payment for CPT codes 0591T, 0592T, and 0593T for individual and group health and well-being coaching.

CMS describes coaching as a patient-centered process in which beneficiaries identify goals, build motivation and skills, learn behavior-change strategies, and self-monitor progress. CMS also recognizes the potential role of community-based organizations in employing individuals who furnish these services.⁶

These services can help address a persistent weakness in traditional health care delivery: clinicians may identify a behavior that needs to change but have limited time and infrastructure to provide the repeated support necessary for sustainable change.

A. Qualification standards should be competency-based and inclusive

PAA supports meaningful training and credentialing requirements. However, CMS should avoid converting the examples in the proposed rule into an exhaustive list of acceptable credentials.

The health care and community workforce capable of supporting health behavior change is diverse and continues to evolve. An overly prescriptive list could inadvertently exclude professionals with equivalent or greater education and competency, including appropriately qualified exercise professionals and personnel employed by community-based organizations.

PAA recommends that CMS establish categorical, competency-based qualification standards. Depending upon the service being furnished, a qualified professional should demonstrate appropriate:

- education and training;
- competency in evidence-based behavior-change principles;
- communication and motivational skills;
- knowledge relevant to the health behaviors being addressed;
- nationally recognized certification or credentialing;
- adherence to scope-of-practice requirements;
- ability to identify circumstances requiring referral or escalation to a clinician; and
- documentation and care-coordination competency.

For coaching focused on physical activity, CMS should recognize qualified exercise professionals and other personnel who demonstrate competency in physical activity and exercise, evidence-based behavior change, communication, safety, documentation, and referral or escalation when a beneficiary requires clinical evaluation. An exercise credential alone need not qualify an individual to furnish health and well-being coaching; conversely, CMS should not exclude a qualified exercise professional certified through an accredited credentialing program who satisfies the coaching competencies and other conditions of payment merely because that individual’s credential is not one of the examples named in the proposed rule.

This approach would establish meaningful standards without privileging a particular profession or credentialing organization and would allow the workforce to evolve with evidence and practice.

⁶ CY 2027 PFS Proposed Rule, 91 Fed. Reg. at 43906–43907 (section II.D.(56)).

B. Community-based delivery should be facilitated

PAA strongly supports CMS's recognition of community-based organizations (CBOs). CMS notes that CBOs often know the populations they serve and have infrastructure that can help practitioners deliver coaching services.

This is particularly relevant to physical activity. Much of the infrastructure that can help people become and remain physically active exists outside traditional medical facilities in community organizations, recreation settings, senior-serving organizations, rehabilitation, fitness settings, and other local programs.

CMS should structure final policy so that physician practices and other billing practitioners can partner with qualified CBOs and community professionals when permitted under Medicare law, rather than requiring unnecessary duplication of community infrastructure within clinical practices.

Clinical accountability should remain with the billing practitioner, but supervision and organizational requirements should be no more restrictive than necessary to protect beneficiaries and program integrity. The proposed rule refers to direct supervision for auxiliary personnel, while also recognizing that individuals employed by CBOs may operate under general supervision and valuing the services by reference to services performed under general supervision. PAA asks CMS to resolve that ambiguity in the final rule and permit general supervision for appropriately trained and certified personnel, regardless of whether they are employed by a qualifying CBO or another compliant partner, when the service, beneficiary's needs, and escalation protocols do not require real-time presence.⁷

C. Coding should provide a durable payment pathway

PAA supports establishing predictable national Medicare payment for health and well-being coaching.

CMS seeks comment on whether permanent HCPCS G-codes would provide a preferable mechanism to active pricing of the Category III CPT codes.⁸

PAA's principal interest is a durable and accessible payment pathway. If CMS determines that permanent HCPCS G-codes would provide greater stability, clarity, or ability to tailor conditions of payment to Medicare beneficiaries, PAA would support such an approach. Regardless of coding mechanism, CMS should avoid unnecessary frequency restrictions when repeated coaching is reasonable and necessary to achieve sustained behavior change.

⁷ Id. at 43906–43907.

⁸ Id.

IV. Physical Activity Assessment, the Annual Wellness Visit, and Referral Pathways

PAA strongly supports CMS's emphasis on strengthening prevention through the Annual Wellness Visit.

The AWV is an especially appropriate setting for systematic physical activity assessment because it is designed to identify health risks and produce a personalized prevention plan.

Current AWV requirements already include physical activity as a behavioral risk addressed in the health risk assessment. CMS also permits HCPCS code G0136 (administration of a standardized, evidence-based physical activity and nutrition assessment for 5 to 15 minutes) as an optional AWV element.⁹

PAA recommends that CMS take the next step and make completion of a standardized, evidence-based physical activity assessment a routine expectation of the AWV, with results documented in the health risk assessment and carried into the personalized prevention plan.

A standardized assessment offers advantages over an unstructured question about whether a beneficiary is "active." CMS should provide guidance on valid, reliable questions that align with the Physical Activity Guidelines for Americans and are included in our HL7 FHIR Physical Activity Implementation Guide, and include moderate-vigorous physical activity and muscle strengthening.

AEROBIC PHYSICAL ACTIVITY

1 For an average week in the last 30 days, how many days per week did the patient engage in moderate-to-vigorous exercise?

2 On those days, how many minutes on average do they exercise?

Days × minutes = total minutes of moderate-to-vigorous physical activity per week.

MUSCLE-STRENGTHENING ACTIVITY

1 In an average week, on how many days does the patient perform muscle-strengthening activities such as weight or resistance training?

These questions have already been included in some EPIC functionality and we are advocating their inclusion in US Core and USCDI+ v. 2 so they can be consistently applied across all electronic health records. Consistent assessment is important for patient care as well as a critical supplement to our national surveillance systems. It also allows practitioners and beneficiaries to understand physical activity relative to federal recommendations, the relationship with overall health, and provides the ability to monitor change over time, identify beneficiaries needing additional assistance, and create data that can be used across different settings.

⁹ CMS, "Physical Activity & Nutrition Risk Assessment," *supra* note 4.

A. Assessment should lead to action

Standardization alone will not improve health unless the result informs care.

CMS should require that the result of physical activity assessment be incorporated, as appropriate, into the beneficiary's personalized prevention plan. For beneficiaries who are insufficiently active or who would benefit from a structured intervention, the plan should support an appropriate next step, such as:

- brief counseling and individualized goal setting;
- a physical activity or exercise recommendation appropriate to the beneficiary;
- health and well-being coaching;
- participation in an appropriate shared medical appointment;
- referral to a qualified health care or exercise professional;
- referral to an evidence-based community program; or
- additional clinical evaluation when health or safety considerations warrant it.

CMS should also encourage reassessment and follow-up. A screening process that identifies physical inactivity but produces no clinical or community response risks becoming another documentation requirement rather than an effective prevention strategy.

B. CMS should clarify interaction with G0136

PAA recognizes the need to avoid duplicative payment. If CMS makes standardized physical activity assessment a routine element of the AWV, it should clearly explain how that requirement interacts with G0136.

Specifically, CMS should distinguish between a brief AWV requirement to identify physical activity risk and the additional time and work captured by G0136, which covers administration of a standardized, evidence-based physical activity and nutrition risk assessment. CMS should preserve separate payment for G0136 when the practitioner performs and documents the full service described by the code and satisfies all conditions of payment, while prohibiting separate billing only when the same work is already included and paid elsewhere.

CMS should also preserve the ability to furnish G0136 outside the AWV in conjunction with eligible E/M or behavioral health services under existing coverage rules. Current Medicare policy covers G0136 not more often than every six months under specified circumstances.¹⁰

The objective should be both routine identification and adequate payment for a meaningful, standardized assessment.

¹⁰ Id.

V. Intensive Lifestyle Interventions for Alzheimer’s Disease and Related Dementias

PAA appreciates CMS’s Request for Information regarding multidomain intensive lifestyle interventions intended to reduce cognitive decline and the risk or progression of AD/ADRD.

CMS specifically recognizes the emerging evidence for multidomain interventions and asks about intervention domains, eligibility, frequency and duration, interdisciplinary teams, supervision, delivery modalities, cost savings, technology, and program-integrity safeguards. CMS also states that future multidomain interventions are likely to include physical activity and nutrition, potentially along with sleep and stress management.¹¹

PAA strongly recommends that physical activity be treated as an essential domain of any Medicare-supported multidomain lifestyle intervention for cognitive health.

The scientific rationale is strong. The Physical Activity Guidelines identify reduced dementia risk and improved cognition among the benefits associated with physical activity.¹² We also encourage the agency to distinguish between interventions intended to reduce risk of cognitive decline or dementia among at-risk older adults and interventions intended to slow progression after a diagnosis of mild cognitive impairment, Alzheimer’s disease, or another dementia. CMS should ensure that intensive lifestyle interventions are not limited only to beneficiaries with diagnosed mild cognitive impairment or early-stage dementia, but also patients at risk given the recent evidence base and prevention-oriented guidance and potential cost-effectiveness.¹³

A. Physical activity assessment should be integrated with cognitive-care pathways

PAA recommends incorporating standardized physical activity assessment into cognitive evaluation and care pathways for beneficiaries at risk for cognitive decline, diagnosed with mild cognitive impairment, or living with early-stage AD/ADRD, including those being considered for an intensive lifestyle intervention.

CMS specifically asks how earlier detection should relate to eligibility for intensive lifestyle intervention. Physical activity status provides actionable information for that decision.

Where CMS develops future coverage specifications, models, or guidance connecting cognitive assessment with lifestyle intervention eligibility, physical activity assessment should be part of the process. This would

¹¹ CY 2027 PFS Proposed Rule, 91 Fed. Reg. at 43950–43952 (section II.G.).

¹² U.S. Department of Health and Human Services, *supra* note 2.

¹³ Baker LD, Espeland MA, Whitmer RA, Snyder HM, Leng X, Lovato L, et al. Structured vs self-guided multidomain lifestyle interventions for global cognitive function: the US POINTER randomized clinical trial. *JAMA*. 2025;334:681–691. doi:10.1001/jama.2025.12923; Crivelli L, Suemoto CK, Sosa AL, Lopera F, Aguilón D, Allegri RF, et al; LatAm-FINGERS Study Group. Multidomain lifestyle intervention for the prevention of cognitive decline in at-risk older adults in Latin America (LatAm-FINGERS): a single-blind, multicentre, randomised controlled trial. *Lancet*. 2026;408:417–429. doi:10.1016/S0140-6736(26)01278-X; Brodaty H, Chau T, Heffernan M, Ginige JA, Andrews G, Millard M, et al. An online multidomain lifestyle intervention to prevent cognitive decline in at-risk older adults: a randomized controlled trial. *Nat Med*. 2025;31:565–573. doi:10.1038/s41591-024-03351-6; Yaffe K, Vittinghoff E, Dublin S, Peltz CB, Fleckenstein LE, Rosenberg DE, et al. Effect of personalized risk-reduction strategies on cognition and dementia risk profile among older adults: the SMARRT randomized clinical trial. *JAMA Intern Med*. 2024;184:54–62. doi:10.1001/jamainternmed.2023.6279; Mendes AJ, Ribaldi F, Sayin O, Khachvani G, Mulargia R, Volpara G, et al. Single-domain and multidomain lifestyle interventions for the prevention of cognitive decline in older adults who are cognitively unimpaired: a systematic review and network meta-analysis. *Lancet Healthy Longev*. 2025;6:100762.

allow the care team to establish a baseline, identify needs and potential safety considerations, develop an appropriate intervention, and measure progress.

B. Multidomain interventions should be longitudinal

Behavior change and physical adaptation occur over time. PAA therefore recommends that CMS not limit a future intervention to a one-time educational encounter.

Coverage should support a recurring, longitudinal intervention with an initial active phase and continuing reinforcement or maintenance, with frequency and duration based on the evidence supporting the program and the beneficiary's needs. The available evidence does not support reducing the service to a single educational encounter or a uniform annual visit. CMS should require each covered program to specify and follow an evidence-based minimum dose, while retaining flexibility to refine national frequency and duration standards as U.S.-based evidence develops.

C. The workforce should be interdisciplinary

The interdisciplinary team should reflect the domains included in the intervention.

Rather than establish a single mandatory team composition, CMS should recognize categories of professionals with appropriate competencies. Teams may include physicians and other qualified health care professionals, nutrition professionals, qualified exercise professionals, rehabilitation professionals, health and well-being coaches, behavioral health professionals, and other trained individuals appropriate to the beneficiary and intervention.

Clinical assessment, diagnosis, medication management, and other medical functions should remain within the scope of appropriately licensed practitioners. Other qualified team members may furnish physical activity programming, coaching, monitoring, and behavior-change support consistent with training, scope, supervision, and beneficiary needs.

D. General supervision should be sufficient for appropriate intervention components

PAA believes that general supervision can provide appropriate accountability for many non-diagnostic lifestyle-intervention components when furnished by qualified personnel under an established plan of care, with appropriate communication and escalation procedures.

CMS should reserve direct supervision for services or circumstances where real-time clinical oversight is necessary for beneficiary safety, rather than imposing it across an entire multidomain intervention.

E. In-person, virtual, and hybrid delivery should be available

PAA recommends that future coverage accommodate in-person, telehealth, and hybrid interventions when clinically appropriate.

A rigid in-person requirement could unnecessarily limit access for rural beneficiaries, individuals with mobility limitations, people without transportation, and others who may benefit substantially from these interventions.

At the same time, certain assessments or exercise services may require in-person evaluation based on a beneficiary's clinical condition and risk. The appropriate modality should therefore be determined by evidence, safety, beneficiary preference, and professional judgment.

F. Program-integrity standards should focus on evidence, qualifications, and outcomes

CMS should establish safeguards including standardized eligibility criteria, evidence-based intervention protocols, appropriate qualifications, beneficiary-specific care plans, documentation, fidelity standards, and outcome monitoring.

PAA would caution against an approach in which Medicare endorses or requires a small number of proprietary commercial programs. CMS should establish evidence and competency standards that allow multiple qualified programs and organizations to participate.

G. Eligibility should include clinically identified at-risk beneficiaries

CMS should not limit eligibility categorically to beneficiaries with mild cognitive impairment or early-stage dementia. A prevention-oriented benefit should also permit participation by beneficiaries whom an appropriately qualified clinician identifies as being at elevated risk for cognitive decline using validated cognitive assessment, relevant clinical history, functional status, and other evidence-based risk criteria. Eligibility and safety screening should remain clinical determinations, and biomarker testing should not be the sole gateway unless the evidence and applicable coverage policy establish that it is necessary.

H. Program-integrity safeguards should address identifiable risks

Potential fraud, waste, and abuse risks include billing for sessions not attended or not furnished, duplicate billing for overlapping services, use of unqualified personnel, delivery of generic education without the individualized elements required by the care plan, failure to follow the intervention's evidence-based protocol or minimum dose, and marketing unsupported claims of preventing or reversing AD/ADRD. CMS can address these risks through beneficiary consent, attendance and time documentation, individualized plans, transparent team-member roles, credential verification, protocol-fidelity review, nonduplication edits, outcome monitoring, and clear standards for truthful beneficiary communications.

I. Technology should support access and the care pathway

CMS's Health Technology Ecosystem should support accessible tools that help beneficiaries understand goals, track activity and other intervention domains, receive reminders and coaching, and share relevant progress with the care team. CMS should favor interoperability, accessibility for beneficiaries with cognitive or functional limitations, caregiver participation with beneficiary authorization, privacy and security, and the ability to exchange data through open standards. Medicare should not require use of a particular

proprietary application or allow technology to substitute for qualified professional support when that support is necessary.

VI. Quality Measurement, Value-Based Care, and Data Interoperability

Payment for individual services is only one component of building a prevention-oriented Medicare program. CMS should also continue incorporating physical activity into quality measurement and accountable-care incentives.

A. Lifestyle Approaches to Diabetes Remediation

PAA supports CMS's proposed new MIPS improvement activity, Lifestyle Approaches to Diabetes Remediation.

The proposed activity recognizes structured, evidence-based interventions addressing nutrition, physical activity, sleep, stress, and behavior change and calls on clinicians to provide education and coaching, track patient progress, and modify interventions as appropriate.

This represents precisely the type of shift PAA encourages, from simply documenting a risk factor toward supporting sustained intervention and monitoring outcomes.

PAA recommends finalization of the activity.

B. Postpartum physical activity and exercise counseling

PAA also supports CMS's proposal to revise the Maternity Care: Postpartum Follow-up and Care Coordination measure to include physical activity and exercise counseling. CMS proposes that qualifying counseling include encouraging appropriate postpartum physical activity and aerobic and strength-conditioning exercise.

PAA supports this addition as an appropriate recognition of physical activity as part of comprehensive preventive care.

C. Quality measurement should evolve from assessment toward a closed loop

As the evidence and technical infrastructure mature, CMS should continue developing physical activity measures that capture more than whether an assessment occurred. A mature measurement framework could evaluate the continuum of: assessment; individualized plan; referral or intervention; participation; follow-up; and outcome.

PAA recognizes that clinicians should not be held responsible for every beneficiary's decision to participate in or adhere to a recommended intervention. Measures should therefore distinguish actions within the clinician's or accountable entity's control from beneficiary behavior. Process measures can reasonably assess whether the care team documented the assessment, developed an appropriate plan, offered or transmitted a referral, and sought follow-up information. They should not condition performance solely on whether the beneficiary enrolled or adhered. Outcome measures used in value-based arrangements should

include appropriate attribution, risk adjustment, and accommodation for patient preference and access barriers.

This approach is particularly aligned with accountable care, where organizations have stronger incentives and infrastructure to coordinate services across settings.

PAA understands that the American Heart Association is developing and validating a physical activity quality measure focused on assessment and referral. This work demonstrates that the field is building the specifications and evidence needed for implementation. PAA encourages CMS to engage with and coordinate with this effort.

D. Build on existing interoperability infrastructure

CMS does not need to build the technical foundation for physical activity data from the beginning.

Physical Activity is included within the Health Status Assessments data class in USCDI, and federal health IT work has recognized standardized physical activity information as part of interoperable clinical data, including in the proposed USCDI+ v. 2.

In addition, the HL7 U.S. Physical Activity FHIR Implementation Guide establishes standards for exchanging physical activity assessment data and supports plans, goals, exercise prescriptions, referrals, monitoring, and reporting among clinical systems, patient applications, payers, health and fitness professionals, and community organizations.

CMS itself asks in the CY 2027 proposed rule whether FHIR-based APIs could submit clinical outcomes or activity data in connection with technology-enabled primary care.

PAA encourages CMS to build upon these existing standards.

In practical terms, CMS should work toward a future in which a standardized physical activity assessment can be recorded in the EHR, incorporated into a care plan, transmitted with an electronic referral to a qualified clinical or community provider, updated with participation and outcome information, and returned to the referring care team.

That closed-loop architecture would support better care while creating the data infrastructure necessary for meaningful quality measurement and value-based payment. CMS should also examine how remote therapeutic monitoring and technology-enabled primary care authorities can support co-management, progress monitoring, and communication across clinical and community settings without making ownership of a particular device or application a condition of access.

VII. Beneficiary Choice, Qualified Professionals, and Community Delivery Infrastructure

Physical activity differs from many health care interventions because much of the work required to help beneficiaries become and remain active occurs outside the physician's office. Medicare policy should recognize this reality.

PAA recommends that CMS preserve beneficiary choice among qualified professionals, programs, and delivery settings consistent with Medicare law and clinical appropriateness.

Beneficiaries differ in medical complexity, functional ability, transportation, geography, culture, personal preferences, and financial circumstances. One beneficiary may be best served by a clinician-led program. Another may need rehabilitation or supervised exercise. Another may benefit from coaching or an evidence-based community program. Others may succeed through a combination of clinical and community support.

The clinician's role is critically important, but effective team-based care does not require every service to be delivered personally by a physician or in a medical office.

CMS itself recognizes in the health and well-being coaching proposal that CBOs can have both knowledge of their populations and infrastructure that can help practitioners provide services. PAA encourages CMS to apply that principle throughout its prevention strategy.

Payment rules should facilitate, rather than impede, appropriate partnerships between medical practices, accountable care organizations, community-based organizations, qualified exercise professionals, and other evidence-based service providers.

Where Medicare statutes and regulations permit, CMS should avoid unnecessary direct-employment or place-of-service requirements when compliant contractual or community partnerships can achieve equivalent clinical accountability, qualification, documentation, and program-integrity protections.

Importantly, expanded community delivery should not mean reduced standards. PAA supports clear expectations for professional competency, evidence-based practice, communication with the referring practitioner, beneficiary safety, documentation, and escalation when clinical issues arise.

The goal should be an accessible system in which the beneficiary reaches the right qualified professional at the right level of care, rather than one in which the site of employment determines whether an evidence-based intervention can be delivered.

VIII. Summary of Recommendations

For these reasons, PAA respectfully encourages CMS to use the CY 2027 Physician Fee Schedule and subsequent rulemaking to further integrate physical activity into Medicare prevention, chronic disease management, and value-based care.

Specifically, PAA recommends that CMS:

- Finalize dedicated payment for Shared Medical Appointments and explicitly recognize physical activity assessment, individualized recommendations or prescription where appropriate, behavior-change support, referral, and follow-up within SMAs for lifestyle-modifiable conditions.
- Use an evidence- and guideline-based standard for SMA eligibility rather than an exhaustive list of covered conditions.

- Preserve multidisciplinary SMA teams and allow qualified professionals to contribute consistent with their education, training, competency, scope of practice, and appropriate supervision.
- Preserve existing E/M-based billing pathways for SMAs and separate payment for distinct covered services furnished during or in conjunction with an SMA, while preventing duplicate payment for the same work or time.
- Preserve in-person and telehealth delivery of SMAs.
- Finalize national payment for health and well-being coaching and establish broad, competency-based qualification standards that recognize appropriately qualified professionals without relying on an unnecessarily restrictive credential list.
- Facilitate partnerships with community-based organizations and permit appropriate supervision models that expand access while maintaining clinical accountability.
- Make standardized, evidence-based physical activity assessment a routine component of the Annual Wellness Visit and incorporate results into the beneficiary's personalized prevention plan.
- Ensure physical activity assessment leads to meaningful counseling, goal setting, referral, intervention, or follow-up when indicated.
- Clarify the interaction between AWV physical activity assessment and G0136 so that Medicare avoids duplicate payment without undermining payment for meaningful assessment.
- Recognize physical activity as an essential domain of future multidomain intensive lifestyle interventions for AD/ABRD and integrate physical activity assessment into the pathway for identifying and managing appropriate beneficiaries.
- Support recurring, longitudinal, interdisciplinary AD/ABRD lifestyle interventions; avoid limiting eligibility categorically to beneficiaries with MCI or early-stage dementia; and permit in-person, virtual, and hybrid modalities when safe and clinically appropriate.
- Apply specific program-integrity safeguards to future AD/ABRD interventions and ensure that technology supports interoperable, accessible care without mandating a proprietary platform.
- Finalize the proposed Lifestyle Approaches to Diabetes Remediation MIPS improvement activity and the proposed addition of physical activity and exercise counseling to the postpartum-care measure.
- Continue developing physical activity quality measures that ultimately connect assessment with referral, participation, follow-up, and meaningful outcomes.
- Build upon USCDI and the HL7 Physical Activity FHIR Implementation Guide to create interoperable, closed-loop clinical and community referral pathways.

- Preserve beneficiary choice and support access to qualified professionals and evidence-based programs across clinical and community settings.
- Integrate physical activity more fully into accountable and value-based care, recognizing its role as an evidence-based strategy for preventing and managing chronic disease, preserving function, supporting healthy aging, and improving quality of life.

IX. Conclusion

PAA strongly supports CMS's goal of strengthening Original Medicare by increasing its focus on prevention, accountable care, beneficiary choice, and value.

Physical activity offers an important opportunity to advance each of these objectives.

Medicare has begun building many of the necessary components: standardized physical activity assessment, health coaching, shared medical appointments, accountable-care incentives, quality measurement, community partnerships, and interoperable health data. The next challenge is connecting those components into a coherent referral and feedback system.

A beneficiary whose physical activity level is assessed should have a meaningful pathway to appropriate counseling or intervention. A clinician recommending increased physical activity should have qualified professionals and programs to refer that beneficiary to. Community providers should be able, when appropriate, to communicate participation and outcomes back to the clinical care team. Value-based organizations should also have the incentive and data needed to invest in interventions that improve health and preserve function.

The CY 2027 proposed rule represents a significant opportunity to move Medicare closer to that model.

PAA appreciates CMS's consideration of these comments and looks forward to continuing to work with the agency to advance evidence-based physical activity assessment, intervention, and referral throughout the health care system.

Thank you for considering these comments.

Sincerely,



Mike Stack
President
Physical Activity Alliance