diaTribe

September 9, 2026

The Honorable Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue S.W.
Washington, DC 20201

Submitted via Regulations.gov

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

Dear Administrator Oz:

On behalf of the diaTribe Foundation (diaTribe), we appreciate the opportunity to comment on the Calendar Year (CY) 2027 Payment Policies Under the Physician Fee Schedule Proposed Rule [CMS-1848-P]. diaTribe is pleased by CMS' expansion of quality measures that pertain to the health and well-being of individuals living with diabetes and comorbid conditions (e.g., cardiovascular disease, kidney disease), but we have concerns about proposed changes for remote patient monitoring and appreciate your attention to our recommendations for protecting access to timely care for individuals with chronic and complex conditions.

About diaTribe

diaTribe's mission is to educate and empower people with diabetes and to advocate for action. diaTribe is dedicated to bringing people with diabetes to the conversation on regulatory issues, connecting the field and the diabetes community, and changing the narrative around diabetes. An estimated 12% of the U.S. population has diabetes – a staggering 40.1 million people.[1] Over the past decade, Food and Drug Administration (FDA) approvals of safe and effective drugs and devices have transformed diabetes care. People with diabetes now have access to therapies and devices that not only improve glucose levels, but also support weight management, reduce hypoglycemia, and prevent some of the costly complications associated with diabetes, including cardiovascular and renal disease. However, despite treatment advances to date, people with diabetes still need improved resources and comprehensive care to tackle the daily hurdles and burdens of managing this complex chronic condition. diaTribe maintains a steadfast commitment to advocating for policies that help ensure individuals living with diabetes have access to the care, therapies, and devices they need for maximum health and wellbeing.

Quality Measures

The latest CMS data show that 32% of beneficiaries have been diagnosed with diabetes at some point.[2] As such, we applaud the agency's focus on incentivizing better diabetes care and outcomes through measures in the Quality Payment Program, Merit-Based Incentive Payment System, and Alternative Payment Model Performance Pathway.

With regard to the proposed change to the "Diabetes: Glycemic Status Assessment Greater Than 9%" (Quality ID: 001) measure, we echo, and urge CMS to consider, the separate comments submitted by our partners in the Time in Range Coalition. In order to guide the best care for people with diabetes, we encourage CMS to consider the growing evidence that factors such as genetic hemoglobin variants and kidney disease can interfere with accurate interpretation of A1C, and to incorporate time in range into quality measures. This metric measured by continuous glucose monitoring (CGM) provides more detailed, actionable, and accurate information and has become a central metric informing modern diabetes care, recognized and utilized by leading national diabetes clinical organizations.[3–10]

Remote Patient Monitoring and Telehealth

diaTribe thanks CMS for acknowledging the rising diabetes prevalence and significant access disparities in rural areas, and addressing the need for greater access to diabetes care services in these communities by updating reimbursement for diabetes self-management training (DSMT) and medical nutrition therapy (MNT) in Rural Health Clinics.[11]

Given the established barriers to care that many people with diabetes face, access to telehealth and remote monitoring, more broadly, is also paramount for this population. Measures to broaden telehealth access implemented during the COVID-19 public health emergency proved an effective response to these access barriers and improved continuity of care, a goal we applaud CMS for identifying in the proposed rule.[12–14] Diabetes-specific telehealth interventions have also shown to improve outcomes.[13,15–17] Technologies like CGM can be initiated remotely, facilitate high-quality remote diabetes care, and even improve the kinds of health-supportive behaviors taught in DSMT and MNT.[17–23] CGM also enables clinicians to review glycemic patterns, make informed treatment adjustments, and provide diabetes management support remotely.[13,24–27] Many health systems are beginning to implement remote patient monitoring, using CGM data, to efficiently triage care and intervene sooner, working to address concerning glycemic patterns and areas of need before costly complications take place.[28,29]

In order to ensure telehealth and remote monitoring can continue to serve as effective responses to the barriers CMS has identified and enable better care for people with diabetes, we urge the agency not to finalize the proposed initiating-visit requirement as a blanket requirement applicable at the onset of RPM or RTM even when the beneficiary already has an established relationship with the practitioner and the clinical need for remote monitoring has been appropriately assessed and documented. As proposed, CMS would require RPM or RTM to be initiated by the billing practitioner during a separately reportable face-to-face visit, either in person or via telehealth, at which the monitoring service is discussed. For beneficiaries who would not otherwise require a qualifying visit at that time, this requirement could create an additional appointment, beneficiary cost-sharing, and delay before remote monitoring can begin. We recommend that CMS instead limit the initiating-visit requirement to new patients or patients who have not been evaluated by the practitioner within the previous year.

We are similarly concerned by the proposal to require clinical staff furnishing RPM or RTM services to be direct employees of the billing practitioner or practice. This is particularly consequential in diabetes, given the specialist shortage described below, since remote monitoring is one of the few practical ways to extend clinical oversight to patients who cannot regularly access an endocrinologist.[30] We share CMS' goal of ensuring meaningful practitioner oversight, clinical integration, and accountability. However, prohibiting the use of appropriately supervised contracted clinical staff could make remote monitoring more difficult for smaller, rural, and workforce-constrained practices to provide. We urge CMS not to

finalize a blanket direct-employment requirement and instead establish safeguards that ensure practitioner responsibility, appropriate supervision, documentation, and continuity of care while permitting clinically-integrated contracted staffing arrangements.

diaTribe strongly supports appropriate safeguards to prevent fraud, waste, and abuse in remote monitoring. We are concerned, however, that broad restrictions on legitimate care-delivery arrangements could reduce access without being sufficiently targeted to the practices that prompted CMS' program-integrity concerns. Notably, OIG's own reviews recommended targeted program-integrity measures, such as improved claims documentation and provider education, not the blanket elimination of qualified contracted clinical staff, and we urge CMS to adopt a similarly targeted approach rather than finalizing these provisions as proposed.[31,32]

Protecting Access to Diabetes Care

In addition to the rural barriers to care addressed above, a pervasive and growing shortage of endocrinologists has led many people with diabetes to rely on primary care clinicians to support their diabetes management, regardless of the type of community they live in. In fact, nearly 70% of counties don't have an endocrinologist.[30] As such, diaTribe asks that CMS ensure the 2027 Physician Fee Schedule adequately reimburses all components of comprehensive diabetes management in primary care, including complex visits and care coordination.

People with diabetes often have many intersecting healthcare needs, requiring multiple clinician visits throughout the year. Often, primary care providers need to complete significant diabetes evaluation and management in the same visit as a procedure, as diabetes management requires frequent adjustment and may critically affect other health concerns, such as those associated with a procedure. For example, a clinician may need to provide debridement for a diabetes-related wound and address glycemic management in the same visit, as glycemia impacts the likelihood of the wound healing.

diaTribe is concerned that the proposed reductions in reimbursement for services billed with Modifier -25 may disincentivize clinicians from addressing multiple needs in one visit, further increasing the number of appointments needed. This would place additional burden on people with diabetes to attend yet another visit, and could further strain clinics' limited scheduling capacity. Those who currently experience barriers to accessing healthcare—whether due to work schedules, transportation, or other needs—will face disproportionate burden, may never receive elements of care, and could experience worsened outcomes due to delayed intervention.

We applaud CMS' expressed goal to support longitudinal, complex care, which is essential to improving outcomes for people with diabetes. Accordingly, we respectfully ask that CMS: (1) permit Modifier -25 to be reported in conjunction with the proposed MOD1 and MOD2 visit complexity modifiers; and (2) decline to finalize the proposed same-day payment reduction. If CMS proceeds with this policy, we ask that the agency first analyze its impact on beneficiary access to care, particularly for patients with diabetes and other complex chronic conditions who often require both a procedure and diabetes management in the same visit. Because the proposed policy would reduce payment for whichever service is of lower value, clinicians could face a direct financial disincentive to manage diabetes during a procedure visit. Should CMS's analysis confirm this access risk, we urge the agency to exempt visits involving comprehensive chronic disease management from the same-day payment reduction.

Conclusion

The CY 2027 Physician Fee Schedule rule expresses many admirable goals that we believe are in line with the best interests of people with diabetes, including addressing access to care in rural areas, incentivizing quality, comprehensive metabolic management, and supporting continuity of care. However, we ask that CMS ensure the proposed mechanisms for reaching these goals incorporate modern diabetes management data, avoid undue burden on telehealth and remote monitoring, and protect timely access to chronic disease management and complex care.

We stand ready to partner with CMS on improving diabetes care. Should you have any questions, please do not hesitate to contact us, via julie.heverly@diaTribe.org, at any time.

Sincerely,

Jim Carroll
CEO and President, The diaTribe Foundation

Julie K. Heverly
Vice President, Time in Range Coalition and Patient Advocacy

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