

D. Medicare Diabetes Prevention Program (MDPP)

The Centers for Medicare & Medicaid Services' (CMS') Medicare Diabetes Prevention Program Expanded Model (hereafter, "MDPP" or "MDPP expanded model") is an evidence-based behavioral intervention that aims to prevent or delay the onset of type 2 diabetes for eligible Medicare beneficiaries diagnosed with prediabetes. MDPP is an expansion in duration and scope of the Diabetes Prevention Program (DPP) model test, which was initially tested by CMS through a Round One Health Care Innovation Award (2012-2016).³⁰⁹ The DPP model test successfully met statutory criteria for model expansion,³¹⁰ demonstrating 5 percent weight loss from their starting weight by participants (a key metric of the program's success) along with statistically significant reductions in Medicare spending, emergency department (ED) visits, and inpatient stays.³¹¹ The MDPP expanded model was implemented through the rulemaking process in two phases, in the CY 2017 PFS (81 FR 80459 through 80483) and CY 2018 PFS final rules (82 FR 53234 through 53339).

MDPP was established in 2017 as an "additional preventive service,"³¹² covered by Medicare and not subject to beneficiary cost-sharing, in addition to being available once per lifetime to eligible beneficiaries. To facilitate delivery of MDPP in a non-clinical community setting (to align with the certified DPP model tested by The CMS Innovation Center), CMS created a new MDPP supplier type through rulemaking in the CY 2017 PFS final rule (81 FR 80471), in addition to requiring organizations that wish to participate in MDPP to enroll in Medicare separately, even if they are already enrolled in Medicare for other purposes.

MDPP is a non-pharmacological behavioral intervention consisting of up to 22 intensive sessions furnished over 12 months, which consists of 16 core sessions delivered weekly over 6 months followed by core maintenance sessions delivered monthly in the following 6 months. MDPP sessions are delivered by a trained Coach who provides training on topics that include long-term dietary change, increased

³⁰⁹ The Health Care Innovation Awards funds awards to organizations that implemented the most compelling new ideas to deliver better health, improved care, and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs. The CMS Innovation Center announced the first batch of awardees for the Health Care Innovation Awards on May 8, 2012, and the second (final) batch on June 15, 2012. For more, see <https://www.cms.gov/priorities/innovation/innovation-models/health-care-innovation-awards>.

³¹⁰ Paul Spitalnic. Certification of Medicare Diabetes Prevention Program. Mar. 14, 2016. <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/Diabetes-Prevention-Certification-2016-03-14.pdf>.

³¹¹ Rojas Smith, L., Amico, P., Hoerger, T. J., Jacobs, S., Payne, J., & Renaud, J.: Evaluation of the Health Care Innovation Awards: Community Resource Planning, Prevention, and Monitoring Third Annual Report Addendum — August 2017 <https://downloads.cms.gov/files/cmimi/hcia-crppm-thirdannrptaddendum.pdf> (pp. 858-914).

³¹² 42 CFR 410.64 - *Additional preventive services*.

physical activity, and behavior change strategies for weight control and diabetes risk reduction. All sessions must adhere to a Centers for Disease Control and Prevention (CDC) approved National Diabetes Prevention Program (National DPP) curriculum³¹³ and must be 1 hour in length. The primary goal of the MDPP expanded model is to help Medicare beneficiaries reduce their risk for developing type 2 diabetes by achieving at least 5 percent weight loss from the first core session (81 FR 80465).

Eligible organizations seeking to furnish MDPP began enrolling in Medicare as MDPP suppliers on January 1, 2018, and began furnishing MDPP on April 1, 2018 (82 FR 53237). As of March 2025, there were 331 approved MDPP suppliers.³¹⁴ The most recent MDPP evaluation report reflected that between April 2018 and September 2024, approximately 9,015 beneficiaries have participated in MDPP. Of these, 4,396 were Medicare FFS beneficiaries and 4,650 were MA beneficiaries.³¹⁵ Through the Diabetes Prevention Recognition Program (DPRP), CDC administers a national quality assurance program recognizing eligible organizations that furnish the National DPP through its evidence based DPRP Standards,³¹⁶ which are updated every 3 years. The CDC established the DPRP in 2012 and possesses significant experience assessing the quality of program delivery by organizations throughout the United States, applying a comprehensive set of national quality standards. For further information on the DPP model test,³¹⁷ the CDC's National DPP,³¹⁸ and DPRP Standards,³¹⁹ please refer to the CY 2017 (81 FR 80471) and CY 2018 PFS (82 FR 52976) final rules and related websites.

The Public Health Emergency (PHE) for COVID-19 prompted changes to allow live, virtual delivery via distance learning for MDPP, among other changes (85 FR 84830 through 84841). Changes to MDPP in the in the CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (88 FR 78818) included a simplified payment structure to allow for FFS payments for beneficiary attendance while retaining the performance-based payments for diabetes risk reduction (that is, weight loss). Beginning January 1, 2024, payments are made to an MDPP supplier

³¹³ CDC National Diabetes Prevention Program PreventT2 Curriculum and Handouts https://www.cdc.gov/diabetes-prevention/php/lifestyle-change-resources/t2-curriculum.html?CDC_AAref_Val=https://www.cdc.gov/diabetes/prevention/resources/curriculum.html

³¹⁴ Medicare Provider Enrollment, Chain, and Ownership System (PECOS). Unpublished data.

³¹⁵ RTI International. Evaluation of the Medicare Diabetes Prevention Program. March 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt>.

³¹⁶ Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppcsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

³¹⁷ Health Care Innovation Awards. <https://www.cms.gov/priorities/innovation/innovation-models/health-care-innovation-awards>.

³¹⁸ <https://www.cdc.gov/diabetes/prevention/index.html>.

³¹⁹ <https://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf>.

if an MDPP beneficiary attends any core session in the first 6 months or core maintenance session in the second 6 months, allowing payment for up to 22 sessions in a 12-month timeframe. The CY 2024 PFS final rule also extended certain PHE flexibilities, including the option to deliver some or all MDPP sessions via distance learning and for beneficiaries to virtually self-report weight for MDPP distance learning sessions, until December 31, 2027 (88 FR 79241).

CDC released the 2024 DPRP Standards³²⁰ to replace the 2021 DPRP Standards in June 2024. The CY 2025 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies (89 FR 97710) made conforming changes to align with the 2024 CDC DPRP Standards and further clarify regulatory language pertaining to program delivery and claim submission by adding new MDPP terms for “in-person with a distance learning component” and “combination with an online component.” The CY 2025 PFS final rule also updated self-reporting weight requirements for an MDPP distance learning session by providing beneficiaries with a new option to self-report their weight using two photos for distance learning sessions. In addition, the CY 2025 PFS final rule added a HCPCS modifier for reporting a make-up session on the same day as a regularly scheduled MDPP session, and bridge payments were removed from MDPP’s FFS payment structure.

While the CY 2024 and CY 2025 PFS final rules included changes to MDPP, which included enhancements that simplified payment structure and extended the ability for MDPP suppliers to deliver some or all MDPP sessions via distance learning, additional changes to MDPP through the CY 2026 PFS final rule is necessary to increase uptake of MDPP. Participation in MDPP has been low, with less than 1 percent of eligible beneficiaries participating in the program. While an estimated 9.3 million Medicare FFS beneficiaries are potentially eligible for the program (that is, have a prediabetes diagnosis but not a diabetes diagnosis in claims), fewer than 10,000 Medicare beneficiaries have participated in MDPP during the first 6 years of the program.³²¹ Increasing the uptake of MDPP among both suppliers and beneficiaries is necessary to increase the impact and success of the program.

³²⁰ Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppcsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

³²¹ RTI International. Evaluation of the Medicare Diabetes Prevention Program. March 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt>.

We proposed several changes which are aimed towards increasing the uptake of this important prevention-focused program while empowering beneficiaries and promoting further alignment between MDPP and the CDC DPRP Standards. Specifically, we proposed changes to 42 CFR 410.79(b) to add definitions for the following terms: Live Coach interaction, Online delivery period, and Online session while modifying the definition of “Online.” We also proposed changes to the expanded model by amending § 410.79(c)(1)(ii) and (e)(3)(iii)(C) to address operational questions and barriers related to weight collection requirements. In addition, we proposed to extend flexibilities allowed during the PHE for COVID-19 through December 31, 2029, by modifying the definition of extended flexibilities period in § 410.79(b). Finally, we proposed to test the inclusion of an asynchronous delivery modality by modifying § 410.79 by revising paragraph (b) adding paragraph (f) and amending § 424.205(c)(10), (f)(2)(i), and (f)(5), which would allow MDPP suppliers to deliver the Set of MDPP services Online through December 31, 2029, clarify that MDPP suppliers are not required to maintain in-person delivery capability through December 31, 2029, and introduce a new G-code and payment for Online sessions. These changes are expected to expand beneficiary access to MDPP, reduce barriers to participation, improve MDPP session attendance and retention, and promote safety.

1. Changes to § 410.79(b)

The 2024 CDC DPRP Standards include the following delivery modes with definitions: “In-person,” “Distance learning (live),” “In-person with a distance learning component,” “Online (non-live),” and “Combination with an online component.”³²² These delivery modes also serve as organization codes for CDC DPRP recognition. As indicated in § 410.79(b), distance learning refers to a MDPP session that is delivered by trained Coaches via remote classroom and is furnished in a manner consistent with the DPRP Standards for distance learning sessions. The Coach provides live (synchronous) delivery of session content in one location and participants call-in or video conference from another location.

The CY 2024 PFS final rule introduced and defined “distance learning” for MDPP and provided a definition for “Online delivery” (88 FR 79243). The CY 2025 PFS final rule modified the definition for

³²² Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppcsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

“Online delivery” at § 410.79(b), to align with the 2024 CDC DPRP Standards³²³ by revising the term from “Online delivery” to “Online” to align with both the MDPP “Distance learning” term and CDC DPRP “Online (non-live)” term (89 FR 98045). We also finalized the definition for the MDPP “Online” delivery mode to provide that sessions that are delivered 100 percent through the internet via smartphone, tablet, or laptop in an asynchronous (non-live) classroom where participants are experiencing the content on their own time without a live (including non-artificial intelligence (non-AI)) Coach teaching the content. These sessions must be furnished in a manner consistent with the DPRP Standards for Online sessions. Live Coach interaction must be offered to each participant during weeks when the participant has engaged with content. E-mails and text messages can count toward the requirement for live Coach interaction if there is bi-directional communication between the Coach and participant, whereby both parties engage in the interaction. Chat bots and AI forums do not count as live Coach interaction. This modified definition added the term “non-live” and further clarified that Chat bots and AI forums do not constitute live interaction.

We proposed to amend § 410.79(b) by adding definitions for Live Coach Interaction and Online session while modifying the definition for “Online” at § 410.79(b) to clarify the Online delivery modality and remove requirements in the “Online” definition that would be outlined at § 410.79(f). We also proposed adding the definition of “Online delivery period”, which refers to the 4-year period (January 1, 2026 to December 31, 2029) to test the inclusion of the Online delivery modality, described at § 410.79(f), to apply. During this time, MDPP suppliers may deliver the Set of MDPP services Online.

The CY 2024 PFS final rule extended certain PHE flexibilities finalized in the CY 2021 PFS final rule, including the option to deliver some or all MDPP sessions via distance learning and for beneficiaries to virtually self-report weight for MDPP distance learning sessions, until December 31, 2027 (88 FR 79241). In the CY 2024 PFS final rule, we finalized that during the Extended flexibilities period, MDPP suppliers may provide virtual services as long as they are provided in a manner consistent with the CDC DPRP standards for distance learning. The extension of these flexibilities allowed beneficiaries to obtain the Set of MDPP services either in-person, through distance learning, or through a combination of in-

³²³ Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppcsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

person and distance learning for a proposed period of 4 years. The extended flexibilities definition refers to § 410.79(e)(3)(iii) and (iv), and the extended flexibilities period described at § 410.79(b) refers to the 4-year period (January 1, 2024 to December 31, 2027) for the extended flexibilities to apply.

Prior to the PHE for COVID-19, MDPP suppliers delivered the program predominantly in-person. Delivery modes have shifted over time, with an increasing number of beneficiaries participating through the virtual delivery option. The most recent evaluation report indicates that from April 2018 through March 2024, 59 percent of MDPP beneficiaries predominantly attended the program in person, 7.5 percent of MDPP beneficiaries attended the program through a mix of in-person and virtual sessions, and 33.5 percent predominantly attended the program virtually.³²⁴ Among beneficiaries who participate in MDPP via distance learning or in-person with a distance learning component (hybrid), most expressed their satisfaction by citing the flexibility the choices provided when faced with challenges such as inclement weather or travel restrictions that made in-person participation difficult.³²⁵

We also proposed to extend flexibilities allowed during the PHE for COVID-19 through December 31, 2029 by revising the dates included in the definition for “extended flexibilities period” at § 410.79(b). In addition, we proposed extending this flexibility to promote continued access to MDPP for beneficiaries. In particular, beneficiaries in geographic areas with a limited number of in-person MDPP suppliers or other areas (for example, rural) where travel to an in-person session may be challenging and may be further exacerbated under certain circumstances, for example, during inclement weather.

This proposed change would ensure that all delivery modalities for MDPP are available during the same period of time (that is, through December 31, 2029) creating greater alignment, reducing potential confusion amongst beneficiaries and suppliers, and streamlining the program. Additionally, the proposed change would provide MDPP suppliers with a variety of modes in which to deliver the program and facilitate consistency across delivery modalities adhering to this same timeframe.

We proposed to amend § 410.79(b) and sought comments on these proposals. The following is a summary of the comments received and our responses.

³²⁴ RTI International. Evaluation of the Medicare Diabetes Prevention Program. March 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt>.

³²⁵ RTI International. Evaluation of the Medicare Diabetes Prevention Program. March 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt>.

Comment: Several commenters supported to CMS’ proposal to amend § 410.79(b) to add definitions for “Live Coach interaction, Online session, and Online delivery period,” while modifying the definition of “Online.” A commenter requested enhanced specificity in the definition for “Online” by incorporating the term "asynchronous" into the definition to distinguish between distance learning and Online sessions to reduce billing confusion.

Commenters expressed broad support for extending the PHE flexibilities for COVID-19 through December 31, 2029 by revising the dates included in the definition for “extended flexibilities period” at § 410.79(b). Many commenters emphasized that these flexibilities, particularly the distance learning modality, have demonstrated significant value in maintaining program access while enhancing session attendance, retention, and completion rates among beneficiaries. Commenters highlighted that the extended timeline would ensure operational continuity for MDPP suppliers while maintaining effective and flexible service delivery options to beneficiaries. In the March 2025 Evaluation of the Medicare Diabetes Prevention Program, beneficiaries participating in MDPP through distance learning or in-person with a distance learning component reported high satisfaction with flexibilities associated with these modalities.³²⁶

Some commenters suggested that CMS remove the once-per-lifetime use of MDPP at § 410.79(f), while other commenters advocated for making MDPP a permanent Medicare benefit to provide long-term stability and encourage continued beneficiary and supplier participation.

Response: We appreciate the suggestion to incorporate "asynchronous" into the definition of “Online” to distinguish it from distance learning. However, we proposed this definition to align with the 2024 CDC DPRP Standards, ensuring consistency across Federal programs. The definition for Online includes the term “asynchronous” in its description and establishes a 4-year testing period from January 1, 2026, to December 31, 2029, during which MDPP suppliers may deliver the complete Set of MDPP services Online using asynchronous delivery methods. Additionally, CMS will continue providing billing guidance and technical assistance throughout the Online delivery period. In response to public comments, we are finalizing the proposal to extend flexibilities allowed during the PHE for COVID-19 through

³²⁶RTI International. Evaluation of the Medicare Diabetes Prevention Program. March 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finalevalrpt>.

December 31, 2029 as described at § 410.79(b) under “extended flexibilities period”.

We appreciate the commenters’ support for making MDPP a permanent Medicare benefit. We continue to explore pathways to ensure sustainability of diabetes prevention services and will continue to monitor program outcomes and beneficiary engagement to evaluate the program's success in preventing diabetes and achieving weight loss among Medicare beneficiaries. Additionally, comments regarding the once-per-lifetime requirement for MDPP and requests to establish MDPP as a permanent benefit are out-of- scope for this rule. Currently, CMS allows an exception to the once per lifetime requirement for MDPP beneficiaries to restart their MDPP program if their services were interrupted by the PHE for COVID-19 (85 FR 19283). We will continue to monitor use of this flexibility to approximate the demand for beneficiaries to restart their program for other reasons. After consideration of public comments regarding the proposed changes to amend § 410.79(b), we are finalizing the proposal to add definitions for “live Coach interaction”, “Online session”, and “Online delivery period,” while modifying the definition of “Online”.

2. Changes to § 410.79(c)(1)(ii) and (e)(3)(iii)(C)

Our policies for obtaining weight measurements for baseline weight and performance-based weight loss achievement goals are described at § 410.79(c)(1)(ii), and for the MDPP expanded model emergency policy, summarized at § 410.79(e)(3)(iii). Currently, these policies permit weight measurements used to determine the achievement or maintenance of the required minimum weight loss to be taken in person by an MDPP supplier during an MDPP session, or via digital technology during the Extended flexibilities period. Specifically, these policies permit an MDPP supplier to obtain weight measurements for MDPP beneficiaries for the baseline weight and any weight loss-based performance achievement goals in the following manner: (1) in-person, when the weight measurement can be obtained safely and in compliance with all applicable laws and regulations; (2) via digital technology, such as scales that transmit weights securely via wireless or cellular transmission; or (3) via self-reported weight measurements from the at-home digital scale of the MDPP beneficiary (89 FR 98046).

The CY 2025 PFS policies regarding beneficiary weight self-reported measurements and virtual weight collection (89 FR 98045) provided additional flexibilities for beneficiaries to self-report their weights by providing 1 or 2 date-stamped photo(s) or a video recording of the beneficiary's weight, with

the beneficiary visible on the scale, submitted by the MDPP beneficiary to the MDPP supplier. The photo(s) or video must clearly document the weight of the MDPP beneficiary as it appears on their digital scale on the date associated with the billable MDPP session. If choosing to submit one photo, this photo must show the beneficiary's weight on the scale with the beneficiary visible in their home. If choosing to submit two photos, the first photo must show the beneficiary's weight on the digital scale, and the second photo must show the beneficiary visible in their home.

Overall, commenters on the proposed MDPP Extended flexibilities in the CY 2024 PFS and CY 2025 PFS rules were very supportive of CMS continuing to allow virtual weight collection (88 FR 79240 through 79256 and 89 FR 98046). However, CMS received several comments regarding barriers to virtual weight collection experienced by MDPP suppliers and beneficiaries. This problem has become even more relevant as suppliers continue to provide distance learning to help reach beneficiaries in rural and underserved areas, sometimes across state lines.

For example, several commenters reported that many of their beneficiaries are unable to take a picture while standing on their home scales due to risk of injury and physical health limitations. The current weight collection requirements discourage individuals with mobility concerns from participating in MDPP due to risk of injury while self-reporting weight from home. Beneficiaries with mobility concerns may need to obtain weight at a medical office using a special scale (for example, wheelchair scale). Currently, beneficiaries do not have the option to submit medical record data as proof of weight, contributing to participant burden. Additionally, we have received feedback from suppliers stating that the requirement that beneficiaries must self-report weight by providing date-stamped photo(s) or video which must show the beneficiary's weight on the digital scale and the visible in their home is restrictive.

We acknowledge in our responses to these comments that some MDPP beneficiaries may lack the technology or capacity to provide a date-stamped photograph to document their body weight measurements. We previously stated that in situations in which beneficiaries may be unable to self-report their weight according to the MDPP conditions of coverage, suppliers may want to consider collecting weight measurements from the MDPP beneficiary in person (88 FR 79249). However, this may not be a practical option for beneficiaries who have chosen distance learning based on not living within driving

distance from an MDPP supplier location, lack access to transportation, or are participating from a location outside of their home or an in-person delivery site.

Therefore, we proposed revising § 410.79(c)(1)(ii) to allow for weight measurements used to determine the achievement or maintenance of the required minimum weight loss to be based on weight documented in the beneficiary's medical record within 2 days of the completion of the MDPP session. Currently, beneficiaries must weigh in during their in-person MDPP session or self-report weight measurements on the date associated with the billable MDPP session. We anticipated that suppliers and beneficiaries would appreciate the additional flexibilities surrounding weight collection for MDPP as current requirements may limit the ability of a beneficiary to report their weight from locations outside of an in-person delivery site or their home and prevent beneficiaries from submitting weight measurements documented in a medical record. We expected these additional flexibilities to empower beneficiaries, improve MDPP beneficiary engagement, session attendance, retention, and program completion. We considered alternative timeframes ranging from 3 to 5 days for this proposed change. We believe a 2-day documentation window prevented significant overlap between session documentation periods, considering core sessions occur weekly. We believe a shorter timeframe would be overly restrictive for suppliers and beneficiaries. We solicited public comments on this proposed timeframe and welcomed feedback on whether the 2-day documentation window was appropriate, or if alternative timeframes would better serve MDPP suppliers and MDPP beneficiaries while maintaining program integrity.

Additionally, we proposed revising § 410.79(e)(3)(iii)(C) to allow beneficiaries to self-report weight from a reasonable location outside of an in-person delivery site. Examples of a reasonable location outside of an in-person delivery site include, but are not limited to fitness centers, medical facilities, and temporary abodes (for example, travel accommodations or a family member's home). Currently, beneficiaries must submit photo(s) or video documenting their weight on a digital scale from their home, which limits their ability to submit required weight measurements when on vacation or away from their home. We continue to require the date-stamp on photo(s) to ensure program integrity in the virtual setting.

We proposed amending § 410.79(c)(1)(ii) and (e)(3)(iii)(C). We solicited comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters were overwhelmingly supportive of our proposal at § 410.79(c)(1)(ii),

where we proposed to allow for the submission of weight collected as part of a medical record, dated within 2 days of a scheduled MDPP session, to reduce burden, promote safety, and increase access. In addition, a commenter believes that the ability to “use weight data from clinical visits or other reliable sources within the 2-day window (would) also help MDPP suppliers improve data integrity and reduce administrative burden.” Another commenter believes the proposed change would “increase flexibility and better align with CDC DPRP standards, with the goal of boosting beneficiary uptake.”

However, a few commenters raised concerns about the 2-day window between the scheduled MDPP session and weight documented in a medical record. Concerns ranged from no proposed allowance for weekends and holidays to inherent difficulties for beneficiaries residing in health professional shortage areas (HPSAs), where access to medical care is more limited. The majority of those maintaining these concerns suggested that we consider a 5- to 7-day period for weight collection as part of the medical record.

Response: We reconsidered the originally proposed 2-day timeframe used to determine the achievement or maintenance of the required minimum weight loss to be based on weight documented in the beneficiary's medical record, which commenters indicated was overly restrictive. In the proposed rule, we initially considered timeframes ranging from 3 to 5 days and determined that a 2-day window would prevent overlap between session documentation periods for weekly core sessions. We are not extending the timeframe to 7 calendar days because this would place the documentation requirement too far from the actual session date and too close to the next weekly session, resulting in overlap between session documentation periods. After consideration of public comments, we are finalizing the changes to the provision at § 410.79(c)(1)(ii) to allow for weight measurements used to determine the achievement or maintenance of the required minimum weight loss to be based on weight documented in the beneficiary's medical record with an updated timeframe of 5 calendar days, which provides sufficient flexibility while maintaining clear separation between sessions.

Comment: In § 410.79(e)(3)(iii)(C), CMS proposed to update weight collection requirements to allow beneficiaries to self-report weight for MDPP sessions from home or a reasonable location outside of an in-person delivery site. Commenters supported this proposal and stated the change would increase flexibility, align with CDC DPRP standards, and increase beneficiary participation. More specific

feedback indicated that this change would be especially helpful for participants who face barriers to timely in-person weigh-ins, especially "rural populations, participants who are traveling, individuals with mobility challenges, transportation issues or caregiving responsibilities." Particularly, the current weight collection requirements limit the ability of a beneficiary participating from reporting weight from other reasonable locations outside of an in-person delivery site or home, such as a medical office if a beneficiary is unable to self-report weight safely from home, or hotel if the beneficiary is on vacation but otherwise able to participate in MDPP sessions.

While support for the proposed update to weight collection requirements to allow beneficiaries to self-report weight for MDPP sessions from home or a reasonable location outside of an in-person delivery site was nearly universal, CMS also received concerns about beneficiary safety and administrative burden. A commenter noted safety risks due to poor balance, poor coordination and physical limitations which could make weight self-reporting burdensome for MDPP. Similarly, other commenters considered technical requirements such as a date-stamped photo to be impractical and burdensome. Commenters requested that we consider other options, such as allowing multiple photos as a substitute for a date-stamped photo or explicitly allowing for weight reporting through Bluetooth™ scales via secure transmission.

Commenters requested additional guidance on acceptable technical parameters for weight collection. For example, a commenter noted that metadata and time stamp requirements on photos and videos taken on smartphones could satisfy weight collection requirements. Other commenters believe that digital scales and Wi-Fi technology should serve as acceptable substitutes for current weight collection requirements. Some commenters supported expanding MDPP performance metrics to include A1C measurements to better align with clinical outcomes.

Response: We are finalizing the proposal at § 410.79(e)(3)(iii)(C) to update weight collection requirements to allow beneficiaries to self-report weight for MDPP sessions from home or a reasonable location outside of an in-person delivery site due to strong support from commenters as proposed.

In response to public comments about safety risks associated with beneficiary weight self-reporting, we take these concerns seriously and have carefully considered feedback to ensure program integrity, flexibility, and beneficiary safety. The CY 2025 PFS final rule maintained safeguards for self-

reported weight measurements while specifying that beneficiaries can choose from a variety of methods to self-report weight. Specifically, the CY 2025 PFS final rule clarified that self-reported weights must be obtained during live, synchronous online video technology, such as video chatting or video conferencing, wherein the Coach observes the beneficiary weighing themselves and views the weight indicated on the at-home digital scale, or the MDPP supplier receives one or two date-stamped photo(s) or a video recording of the beneficiary's weight, with the beneficiary visible on the scale, submitted by the MDPP beneficiary to the MDPP supplier (89 FR 98047). The proposed changes to allow for weight measurements used to determine the achievement or maintenance of the required minimum weight loss to be based on weight documented in the beneficiary's medical record, and to allow beneficiaries to self-report weight for MDPP sessions from home or a reasonable location outside of an in-person delivery site, are aimed toward providing additional flexibility for beneficiaries to obtain weight measurements safely. We maintain that these multiple documentation options provide flexibility, maintain program integrity, and address safety concerns raised by commenters.

Additionally, regarding the comments requesting that photo metadata be used for the required date-stamp for self-reporting weight for an MDPP session, MDPP requires a date-stamped photo to provide verifiable documentation that weight measurements were taken on the session date, ensuring accurate reporting and preventing fraudulent submissions. At this time, and due to the out-of-scope nature of these comments in relation to our proposals, we are not further defining what constitutes a date stamp for the purpose of MDPP videos and photos under this regulation. We rely on suppliers to ensure a reasonable and reliable indication of the date connected to a picture or video. A physical date on the photo or video would satisfy this requirement. Similarly, we require photo documentation along with self-submitted weight measurements to ensure program integrity by providing visual verification that the beneficiary personally conducted the weight measurement, preventing potential fraud resulting from unauthorized individuals using shared household scales.

Finally, we acknowledge the support for including A1C measurements as accepted MDPP performance metrics. However, these comments are out-of-scope for this rule. MDPP remains a lifestyle intervention program focused on diabetes prevention through behavioral changes such as dietary change, physical activity, and weight loss. Weight loss serves as an appropriate outcome measure, as it directly

reflects the program's core objectives. Unlike A1C testing, which requires laboratory work, weight measurement is a less burdensome approach that maintains program scalability while supporting CMS' performance-based payment structure, which is designed to provide payments for achieving 5 and 9 percent weight loss milestones. The original DPP research demonstrated that achieving a 5 to 7 percent weight loss reduced diabetes risk by 58 percent,³²⁷ validating weight as the primary success metric. CMS will continue to monitor feedback from interested parties and evaluate the demand for alternative performance metrics to ensure the program remains responsive to evolving clinical standards and participant needs.

3. Changes to §§ 410.79(f) and § 424.205(c)(10), (f)(2)(i), and (f)(5)

In the CY 2018 PFS final rule, we stated our intention to align MDPP with CDC DPRP Standards whenever possible (82 FR 53245). The CDC DPRP Standards have included virtual, online modalities and approaches since 2015³²⁸. MDPP has included in-person delivery of the Set of MDPP Services since it began serving beneficiaries in 2018. The MDPP expanded model emergency policy (85 FR 84831) broadened the delivery of the Set of MDPP services through synchronous distance learning to provide greater flexibility during the PHE for COVID-19, and later extended distance learning, and other related flexibilities through December 31, 2027, as part of the CY 2024 PFS final rule (82 FR 53249).

In the CY 2021 PFS final rule, we established that virtual sessions performed under flexibilities finalized in that rule could only be performed by MDPP suppliers who offered in-person services (85 FR 84830) and maintained CDC DPRP “in-person” recognition (85 FR 84830 and 84831). In the CY 2024 PFS final rule, we extended flexibilities allowed during the PHE for COVID-19 for 4 years, or through December 31, 2027 (88 FR 79241). We also confirmed that suppliers who exclusively delivered MDPP services virtually via distance learning without maintaining in-person delivery capability were not permitted to furnish the Set of MDPP services because MDPP beneficiaries may elect to return to in-person services, and MDPP suppliers need to be able to accommodate their request (88 FR 79248).

The CY 2025 PFS final rule confirmed that only MDPP “in-person,” “distance learning,” and “in-person with a distance learning component” delivery modes are acceptable delivery modalities for MDPP

³²⁷ Diabetes Prevention Program (DPP) Research Group. The Diabetes Prevention Program (DPP): description of lifestyle intervention. *Diabetes Care*. 2002 Dec;25(12):2165-71. doi: 10.2337/diacare.25.12.2165. PMID: 12453955; PMCID: PMC1282458.

³²⁸ 2015 CDC DPRP Standards: <https://stacks.cdc.gov/view/cdc/44247>.

during the Extended flexibilities period, as finalized in the CY 2024 PFS final rule (88 FR 79241). The CY 2025 PFS final rule did not include “Online” nor “combination with an online component” as accepted delivery modalities for MDPP. For the MDPP Extended flexibilities period, we finalized in the CY 2024 PFS final rule to limit virtual delivery to the CDC DPRP definition of “distance learning” (88 FR 79243). We stated that the MDPP Extended flexibilities do not include Online delivery (or asynchronous virtual), as defined in the CDC DPRP Standards through the “Online” modality, including virtual make-up sessions (88 FR 79244). The 2024 CDC DPRP Standards allow for National DPP make-up sessions to be furnished using any delivery mode, including Online.³²⁹

The MDPP expanded model was certified as a primarily in-person program. Virtual-only providers include those that deliver the National DPP services solely by distance learning or Online delivery. Although “telehealth” is included in CDC’s definition of distance learning, CMS stated in the CY 2017 PFS final rule (82 FR 53235) that the Set of MDPP services delivered via a telecommunications system, or other remote technologies do not qualify as telehealth services. Additionally, we have stated that through utilizing distance learning, participants may still interact with their Coach and other participants in their cohort in real-time, allowing for relationship building and peer support, unlike the Online modality which is delivered asynchronously (88 FR 79244).

We have responded to previous public comments requesting that CMS allow asynchronous delivery of MDPP and virtual-only providers to offer MDPP in previous rules (89 FR 98045). In past years, commenters have expressed that the exclusion of an asynchronous delivery modality is misaligned with the CDC DPRP Standards, which permit “Online” asynchronous participation. Suppliers have commented that the exclusion of asynchronous modality significantly limits program participation. Advocacy group members pursued legislation that would require CMS to open the MDPP to suppliers of asynchronous “Online” MDPP programs through the Prevent Diabetes Act.³³⁰ in April 2024. Although this bill was not enacted into law, suppliers continue to encourage CMS to meet the demand for asynchronous delivery of MDPP. After the PHE went into effect in March 2020, more than 90 percent of all MDPP sessions were delivered virtually via distance learning. To date, average weight loss for MDPP

³²⁹ Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

³³⁰H.R. 7856 (118th): PREVENT DIABETES Act, <https://www.govtrack.us/congress/bills/118/hr7856/text>.

beneficiaries is 4.9 percent of starting body weight. Among beneficiaries that attend their sessions primarily in person, the average weight loss was 4.6 percent, compared with an average weight loss of 5.3 percent among those that attend sessions virtually via distance learning.³³¹

We proposed adding paragraph (f) to 45 CFR 170.79 to test the addition of coverage of an Online delivery modality during the Online delivery period (until December 31, 2029). Consistent with the 2024 CDC DPRP Standards, organizations are required to submit a separate application for each delivery mode used to the CDC. This will result in a separate organization code (orgcode) for each delivery mode. Therefore, organizations are required to obtain an Online organization code from CDC prior to delivering Online sessions for MDPP.³³²

As referenced above, the MDPP expanded model was certified as a primarily in-person program, and CMS previously opposed inclusion of an asynchronous delivery modality for MDPP for various reasons. We consider the proposed change to include the Online, asynchronous delivery modality as an MDPP delivery modality a test during the Online delivery period. To evaluate the efficacy of Online delivery during the Online delivery period, beneficiary outcomes from asynchronous (that is, Online) will be evaluated to determine if this delivery modality reduces costs and improves quality. We continuously monitor MDPP trends and believe that the inclusion of Online delivery during the Online delivery period will build upon previous changes to introduce distance learning during the PHE for COVID-19 (85 FR 84830 through 84841) and respond to innovations in health care delivery and the increased provision of remote services. In addition, we anticipate that the inclusion of the Online delivery modality will promote beneficiary access to services, remove the barrier of beneficiaries having to wait for a cohort to start due to the on-demand nature of this proposed modality, build on the inclusion of the distance learning delivery modality, and align with the CMS Innovation Center Strategy to Make America Healthy Again by promoting evidence-based prevention, empowering people to achieve their health goals, and driving choice and competition for people.³³³ In the CY 2024 PFS final rule, CMS reminded MDPP suppliers that

³³¹ RTI International. Evaluation of the Medicare Diabetes Prevention Program. March 2025. <https://www.cms.gov/priorities/innovation/data-and-reports/2025/mdpp-finaevalrpt>.

³³² National Diabetes Prevention Program FAQ: Delivery Mode <https://nationaldppcsc.cdc.gov/s/article/FAQ-Delivery-Mode-1526419438273#:~:text=Organizations%20may%20offer%20the%20program,Minutes%20in%20the%20DPRP%20Standards%20>.

³³³ CMS Innovation Center Strategy to Make America Healthy Again <https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again>

they are required to maintain capacity to deliver the MDPP Set of services in-person.³³⁴ However, we proposed at § 410.79(f)(2) to explicitly not require MDPP suppliers to maintain in-person delivery capability during the Online delivery period. This will allow for distance learning and Online-only organizations to enroll in Medicare as an MDPP supplier and streamline the process to allow for Online delivery of the Set of MDPP services. In hopes of further increasing program participation among suppliers and beneficiaries and promoting alignment between MDPP and the 2024 CDC DPRP Standards, we proposed adding coverage of the delivery of the Set of MDPP services using the Online modality during the Online delivery period to test if outcomes, for MDPP beneficiaries, including weight loss, are similar to the in-person and distance learning delivery modalities.

Additionally, at § 410.79(f)(2)(i), we proposed that Online sessions must be furnished in a manner consistent with the DPRP Standards regarding program format, Coach interaction, and program intensity and duration to qualify for payment. Online sessions must be delivered 100 percent through the internet via smartphone, tablet, or laptop in an asynchronous (non-live) classroom where participants are experiencing the content on their own time without a live (including non-artificial intelligence ([AI]) Coach teaching the content. We proposed at § 410.79(f)(2)(i)(A) that Live Coach interaction must occur between MDPP beneficiaries and Coaches during the weeks when the beneficiary has engaged with content to qualify for payment. MDPP suppliers may not use AI or Machine Learning (ML) to replace Live Coach interaction.

Additionally, we proposed that weight collection procedures referenced in the MDPP expanded model emergency policy at § 410.79(e)(3)(iii)(C) as well as the proposed (c)(1)(ii) apply during the Online delivery period for MDPP services, as defined at § 410.79(b). Beneficiaries must submit weight measurements on the date on which the Online session is completed. We also proposed at § 410.79(f)(2)(i)(B) that MDPP suppliers must ensure safeguards are in place to ensure the accuracy of beneficiary weight measurements. These safeguards may include but are not limited to quality controls, diagnostic testing of hardware or software, and monitoring of trends (for example, rapid beneficiary

³³⁴ Medicare and Medicaid Programs; CY 2024 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program (88 FR 79249), Thursday November 16, 2023. <https://www.federalregister.gov/documents/2023/11/16/2023-24184/medicare-and-medicare-programs-cy-2024-payment-policies-under-the-physician-fee-schedule-and-other#page-79249>.

weight loss within a short timeframe), are in place to ensure the accuracy of beneficiary weight measurements. For example, if organizations choose to use a website or mobile application to deliver the Set of MDPP services Online, integrations with hardware such as smart/Bluetooth™ scales may be used to collect beneficiary weight measurements. Scales may be set up to automatically transmit weight measurements directly to the MDPP supplier and MDPP suppliers may opt to perform data validation checks and flag suspicious entries or ensure necessary firmware updates are deployed to ensure the accuracy and/or security of such scales. As described in at § 410.79(f)(2)(i)(B), MDPP suppliers delivering the Set of MDPP services must ensure necessary technological safeguards to ensure the accuracy of weight collected through Bluetooth™ scales, transmitted through an application, or utilizing any other means that do not involve direct Coach interaction or Coach review of photos/video. For instance, CMS expects organizations to ensure safeguards to avoid fraud, waste, and abuse (including but not limited to hardware or software errors and data manipulation) and organizations may be subject to audits to ensure compliance.

While CDC DPRP Standards define “combination with an Online component” as a yearlong National Diabetes Prevention Program Lifestyle Change Program (National DPP LCP) delivered as a combination of Online (non-live) with in-person and/or distance learning, we proposed that MDPP suppliers deliver MDPP via in-person, distance learning, in-person with a distance learning component, or Online modalities. While MDPP suppliers may offer synchronous and asynchronous modalities, they may not intermingle asynchronous (for example, Online) and synchronous (that is, In-Person, In-person with a distance learning component, and Distance learning) delivery modalities for individual beneficiaries. The Set of MDPP services, inclusive of make-up sessions, must be delivered to individual beneficiaries fully synchronously (that is, in-person, distance learning, or In-person with a distance learning component) or fully asynchronously (that is, Online). To evaluate the efficacy of the Online delivery modality during the Online Delivery Period, beneficiary outcomes from synchronous (that is, in-person, distance learning, or in-person with a distance learning component) delivery of the Set of MDPP services must be compared to beneficiary outcomes from asynchronous (that is, Online); therefore, these modalities must be delivered separately for individual beneficiaries in order to evaluate whether Online results, including weight loss, are similar to in-person and distance learning delivery modalities.

If organizations choose to provide the Set of MDPP services Online, we proposed that organizations must adhere to requirements consistent with CDC DPRP Standards regarding program format, Coach interaction, and program intensity and duration to qualify for payment, as described at § 410.79(f)(2)(i).³³⁵ Specifically, we proposed during the Online delivery period at § 410.79(f)(2)(i)(D) that organizations must ensure that participants enrolled in self-paced programs engage with the content through use of one or more of the following: documented completion of videos/presentations and other learning modules in the application; knowledge checks (multiple choice or short answer); participant contributions to group discussions on a community board; and participant responses to the Coach via email, text message, or in-app messaging.

Though the 2024 CDC DPRP Standards indicate live lifestyle Coach interaction is required for Online delivery and should be offered to each participant during weeks when the participants have engaged with program content, we proposed that live Coach interaction must occur between the Coach and MDPP beneficiary during the weeks when the beneficiary has engaged with content to qualify for payment for that session at § 410.79(f)(2)(i)(A). Consistent with the CDC DPRP Standards, E-mails and text messages can count toward the requirement for live Coach interaction as long as there is bi-directional communication (that is, organizations may not simply send out an announcement via text or e-mail and count that as live coach interaction; the participant must have the ability to respond to and get support from the live coach) and both parties engage in some sort of communication. In alignment with CDC DPRP Standards, we proposed that Coaches be required to track beneficiary engagement and completion of Online modules. Additionally, proactive outreach by the Coach may be used to encourage session completion and reporting of weight. To promote consistency with the 2024 CDC DPRP Standards and to ensure that beneficiaries receive Live Coach interaction across delivery modalities, we proposed that MDPP suppliers may not require that beneficiaries initiate Coach interactions and MDPP suppliers may not use AI or machine learning (ML) to replace live coaching, as described at § 410.79(f)(2)(i)(A). We also proposed to revise § 424.205(c)(10) to allow the minimum number of

³³⁵ Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppcsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

required MDPP core sessions and core maintenance sessions to be delivered Online during the Online delivery period.

At § 424.205(c)(10)(i), we proposed to require 16 in-person, distance learning, or Online core sessions no more frequently than weekly for the first 6 months of the MDPP services period, which begins on the date of attendance at the first such core session. Next, at § 424.205(c)(10)(ii), we proposed to require one in-person, distance learning, or Online core maintenance session each month during months 7 through 12 (6 months total) of the MDPP services period.

We also proposed to amend § 424.205(f)(2)(i) to include the Online modality among acceptable session types for session documentation. We proposed at § 424.205(f)(5)(i) through (iv) to incorporate changes necessary for other proposed changes, including the addition of references directly at § 410.79(c)(1)(ii), and removal of references to “in person” in regard to how weight loss must be measured. These proposed changes provide greater clarity regarding the MDPP supplier’s records in regard to claim submission for weight loss and are aligned with the proposed changes allowing for weight documented in a medical record.

We anticipate that beneficiaries will appreciate the option to participate in MDPP via the Online modality, which will expand beneficiary access to MDPP, reduce barriers to participation, and improve health outcomes. MDPP suppliers and advocacy groups will also appreciate the inclusion of the Online modality, as these entities have commented that the exclusion of the Online modality significantly limits program participation, particularly for beneficiaries living in areas without a nearby in-person MDPP delivery site (for example, rural areas) or access to transportation.

We proposed to amend §§ 410.79(f) and 424.205(c)(10), (f)(2)(i), and (f)(5). We solicited comments on these proposals. The following is a summary of the comments received and our responses.

Comment: Many commenters expressed support for adding coverage for asynchronous Online delivery of MDPP through December 31, 2029. Several commenters highlighted that Online delivery for MDPP would better align with CDC DPRP Standards and significantly increase program accessibility for beneficiaries who face barriers to attending synchronous sessions, including those with scheduling conflicts and transportation challenges. Many commenters noted that asynchronous, virtual delivery options align with modern healthcare delivery trends and could improve program participation.

Additionally, commenters supported the existing alignment of MDPP program requirements with the 2024 CDC DPRP Standards to obtain separate orgcodes for each distinct delivery mode, viewing this alignment as a way to enhance both program integrity and operational flexibility.

Response: We appreciate the support from commenters regarding the addition of Online delivery during the Online delivery period. This change aims to increase program participation. We are pleased that commenters recognize this alignment with the 2024 CDC DPRP Standards as providing operational flexibility to suppliers. After consideration of public comments received, we are finalizing §§ 410.79(f) and 424.205(c)(10), (f)(2)(i), and (f)(5) as proposed.

Comment: Some commenters opposed CMS' proposed requirement for live Coach interaction as a requirement for payment in Online delivery, stating that while CDC DPRP Standards require live Coach interaction, suppliers should not be denied payment for services rendered if beneficiaries fully engage with lesson content. Specifically, the commenters stated that this requirement creates administrative complexity and penalizes suppliers if participants complete lesson content but do not respond to follow-up outreach.

Response: We maintain that the live Coach interaction requirement is fundamental and integral to program success, as evidenced by its inclusion in all accepted delivery modalities for MDPP and directly aligns with CDC DPRP Standards. This requirement maintains program integrity and quality standards, ensuring Medicare beneficiaries receive comprehensive, evidence-based support to reduce type 2 diabetes risk.

Comment: Some commenters suggested that CMS implement caps of 1,000 beneficiaries per year (per MDPP supplier) for Online delivery during the Online delivery period to enable rigorous evaluation and prevent market destabilization, while others suggested limiting Online delivery of eligible suppliers to those with CDC DPRP full or full plus recognition to ensure only the most experienced virtual suppliers are eligible to participate. Several commenters expressed concern that without appropriate guardrails, large online entities could dominate the market and undermine local suppliers. These commenters noted that in-person and distance learning sessions provide valuable support for addressing social isolation and connecting participants to additional community services, benefits that purely Online delivery cannot replicate.

Response: The final rule tests the addition of coverage of an Online delivery modality during the Online delivery period (until December 31, 2029) without implementing participation caps. Our primary goal is to increase access to MDPP and enable as many eligible Medicare beneficiaries as possible to participate in and benefit from the program in their preferred session format. Implementing a cap of 1,000 Online delivery participants per organization per calendar year would be inconsistent with our goal to increase access to this program. Given that our estimates indicate that over 9 million FFS Medicare beneficiaries are eligible for MDPP, we believe removing barriers to participation is essential to maximize MDPP's public health impact. While we understand commenters' concerns, we do not anticipate that Online suppliers will saturate the market to such an extent that it would compromise our ability to evaluate program effectiveness or generalize findings across different supplier types.

Similarly, we acknowledge commenters' suggestions to limit Online delivery to organizations with CDC DPRP Full or Full-Plus recognition during the Online delivery period. While we recognize that organizations with Full or Full-Plus recognition have demonstrated substantial experience in delivering the National DPP Lifestyle Change Program, we believe that limiting participation to only these organizations would be inconsistent with our primary goal of increasing access to MDPP for as many Medicare beneficiaries and suppliers as possible. The CDC DPRP recognition system includes multiple recognition levels, all of which demonstrate that organizations meet established quality standards for delivering evidence-based diabetes prevention services. By allowing organizations with any level of CDC DPRP recognition to participate in Online delivery, we can expand the network of available MDPP suppliers and promote beneficiary choice. This approach supports our commitment to maximizing program reach while maintaining quality standards through the existing CDC recognition status framework. We will continue to monitor program performance across all supplier recognition status levels to ensure effective program delivery and beneficiary outcomes.

Finally, we acknowledge that in-person and distance learning delivery options provide valuable support for addressing social isolation and connecting participants to additional community services. The inclusion of Online delivery is intended to expand access to beneficiaries who may face barriers to in-person or distance learning participation, such as transportation challenges, mobility limitations, or geographic constraints. Beneficiaries who prefer live, group-based MDPP programs for socialization

benefits may continue to choose in-person or distance learning participation, as these remain accepted delivery modalities for MDPP. Providing beneficiaries with a variety of participation formats for MDPP ensures program accessibility while preserving the socialization benefits that participants value.

Comment: Some commenters requested that CMS allow a combination of delivery methods rather than restricting participants to single modalities as proposed at § 410.79(f)(2)(i)(C), to allow for broader reach. Another commenter suggested that restricting a combination of delivery modalities may create selection bias during the evaluation period, rendering evaluation results non-generalizable.

Response: After careful consideration of public comments, we are finalizing the proposal at §410.79(f)(2)(i)(C) that MDPP suppliers may not mix delivery modalities by billing for a combination of Online, In-Person, and Distance learning sessions during the Online delivery period. The Set of MDPP services must be delivered to individual beneficiaries either as Online sessions or fully synchronously (that is, In-person, Distance learning, or In-person with a distance learning component) during the Online delivery period. While we acknowledge commenters' concerns that restricting participants to a single modality may limit flexibility, we believe that maintaining separate delivery modalities is essential for a rigorous evaluation during the Online delivery period. By evaluating synchronous and asynchronous modalities separately, CMS can obtain data that will allow for more definitive conclusions about the effectiveness of each modality, ultimately informing future program improvements that best serve Medicare beneficiaries.

We appreciate commenters' concern about maintaining rigorous evaluation and protecting community-based MDPP suppliers who predominantly deliver the program in-person. We recognize that many beneficiaries aged 65 and older value in-person delivery for its socialization benefits, suggesting sustained demand for face-to-face interaction in healthcare programs. The MDPP expanded model was certified as a primarily in-person program. Competition between delivery modalities is driven by beneficiary choice and demand, and offering a variety of MDPP delivery modalities aligns with the CMS Innovation Center Strategy to Make America Healthy Again by driving choice and competition for people.³³⁶ We recognize the continued demand for in-person and distance learning MDPP sessions, and

³³⁶ CMS Innovation Center Strategy to Make America Healthy Again <https://www.cms.gov/priorities/innovation/about/cms-innovation-center-strategy-make-america-healthy-again>.

are introducing Online delivery to increase supplier capacity and availability for beneficiaries who choose to participate asynchronously. Beneficiaries inclined to participate In-person or via Distance learning will retain those participation options. Suppliers reserve the option to deliver services in-person and via distance learning. Online delivery will provide an additional option available to MDPP suppliers if they choose to utilize this delivery format to reach a larger number of eligible beneficiaries. CMS does not expect suppliers to modify their existing business models to offer all accepted delivery modalities for MDPP. We will continue to monitor program implementation and supplier participation to ensure robust evaluation and program delivery across modalities.

Comment: Some commenters noted that the Online delivery period described at § 410.79(f) from January 1, 2026, to December 31, 2029 is temporary in nature, and that suppliers may face resource challenges while implementing delivery models under temporary authorization.

Response: We acknowledge commenters' concerns regarding challenges that MDPP suppliers, particularly community-based organizations, may face when implementing Online delivery methods under temporary authorization. At § 410.79(f) we proposed to implement the Online Delivery Period from January 1, 2026, to December 31, 2029, to evaluate whether the Online modality produces similar outcomes for MDPP beneficiaries compared to In-person and Distance learning modalities. During this period, MDPP suppliers may deliver services using the Online modality. This test period will allow CMS to gather data to evaluate Online delivery modality, and CMS will monitor results that may inform future policy decisions.

We are finalizing the definition and timeframe of the Online delivery period as proposed to facilitate program evaluation.

Comment: Some commenters requested enhanced CMS monitoring efforts for Online delivery to ensure successful implementation and effective service delivery.

Response: In response to public comments requesting enhanced monitoring efforts for Online delivery to ensure successful implementation—we emphasize that MDPP suppliers must adhere to the established session structure described at § 424.205(c)(10)(i) to qualify for payment for MDPP sessions. Regardless of delivery modality, MDPP sessions structure consists of up to 22 intensive sessions furnished over 12 months, which includes 16 core sessions delivered weekly over 6 months followed by

core maintenance sessions delivered monthly in the following 6 months. These requirements align with “Requirements for Pending, Preliminary, Full, and Full Plus Recognition,” described in the 2024 CDC DPRP Standards.³³⁷ MDPP suppliers must ensure beneficiaries complete 1 core session per week, or every 7 calendar days.

At § 424.205(c)(10)(ii), we proposed to require 1 in-person, distance learning, or Online core maintenance session each month during months 7 through 12 (6 months total) of the MDPP services period. This established session structure is critical for accurately measuring program outcomes, particularly weight measurements that are tied to session completion. MDPP suppliers are responsible for ensuring compliance with CMS-established session structure requirements when delivering sessions through Online delivery. For example, for Online delivery, MDPP suppliers may consider implementing content module releases on a weekly basis to prevent beneficiaries from completing multiple sessions within timeframes that are not consistent with the required session structure. MDPP suppliers may also consider Coach outreach strategies to remind beneficiaries of the established session structure and encourage consistent participation as they progress through MDPP sessions asynchronously.

In response to comments requesting enhanced monitoring for Online delivery and upon further review of existing regulations at § 410.79(b), we have determined that current requirements for make-up sessions do not adequately address Online delivery. The clarification of make-up session requirements serves as a critical safeguard against potential program integrity issues, including the risk of beneficiaries accessing multiple sessions within compressed timeframes that would be inconsistent with the established session structure. Make-up sessions for Online delivery were referenced in the proposed rule at § 410.79(f)(2)(i)(C), which states the Set of MDPP services, inclusive of make-up sessions, must be delivered to individual beneficiaries fully synchronously (that is, in-person, distance learning, or in-person with a distance learning component) or fully asynchronously (that is, Online).

Specifically, at § 410.79(d)(1), we are revising existing requirements which state “an MDPP supplier may offer a make-up session to an MDPP beneficiary who missed a regularly scheduled session. MDPP make-up sessions may only use in-person or distance learning delivery.” We are revising this

³³⁷ Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppcsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

language to indicate that Online delivery is also an accepted delivery modality for make-up sessions by specifically stating that “an MDPP supplier may offer a make-up session to an MDPP beneficiary who missed a regularly scheduled session. MDPP make-up sessions may only use in-person, distance learning, or Online delivery.” We emphasize that the existing requirements at § 410.79(d)(1)(i), (ii), and (iii) describe make-up sessions. Specifically, § 410.79(d)(1)(i) states that the curriculum furnished during the make-up session must address the same CDC-approved DPP curriculum topic as the regularly scheduled session that the beneficiary missed. Section 410.79(d)(1)(ii) states that the MDPP supplier may furnish to the beneficiary a maximum of one make-up session on the same day as a regularly scheduled session; and (iii) the MDPP supplier may furnish to the beneficiary a maximum of one make-up session per week. Additionally, existing requirements at § 410.79(d)(2) remain unchanged and describe requirements for virtual make-up sessions. Specifically, § 410.79(d)(2)(i) states virtual make-up sessions must be furnished in a manner consistent with the DPRP standards for virtual sessions; § 410.79(d)(2)(ii) states that an MDPP supplier may only offer virtual make-up sessions based on an individual MDPP beneficiary's request. Section 410.79(d)(1)(iii)(A) states an MDPP supplier may offer an MDPP beneficiary no more than 4 virtual make-up sessions within the core services period, of which no more than 2 virtual make-up sessions are core maintenance sessions. These revisions provide necessary clarification to ensure that requirements for Online delivery, including make-up sessions, are represented under this regulation. In direct response to public comments emphasizing the need for enhanced CMS monitoring of Online delivery, these clarifications establish clear parameters that promote effective oversight of program compliance and prevent beneficiaries from circumventing the established MDPP session structure, such as completing multiple sessions in rapid succession.

Comment: A commenter requested that CMS should require all asynchronous MDPP programs to meet section 508 compliance standards to ensure equal access to Online delivery.

Response: In response to the comment regarding section 508 compliance for Online delivery, we emphasize that the application of section 508 of the Rehabilitation Act, which requires Federal agencies to make their electronic and information technology accessible to people with disabilities, is unaffected.³³⁸

³³⁸ Information and Communication Technology Revised 508 Standards and 255 Guidelines <https://www.access-board.gov/ict/>

The CDC National Diabetes Prevention Program curriculum and materials³³⁹ are designed to be section 508 compliant. Adherence to section 508 standards is part of an organization's existing legal obligations when providing services that involve Federal programs or funding. We believe that referencing existing legal requirements in this rule will be redundant, as these compliance obligations are already established through Federal law and apply to all relevant organizations.

Comment: Many commenters supported adding coverage for Online delivery of MDPP through December 31, 2029, with many offering specific recommendations for the rollout of this delivery method. The top suggestion from commenters was for CMS to implement a robust beneficiary outreach campaign, including partnering with providers, to increase the visibility of the program with patients and clinicians. Commenters noted that CMS should generate and distribute more provider and member-directed materials that describe the MDPP program, its benefits, and coverage. Commenters also suggested that CMS should actively educate providers that MDPP is a preventive service without cost-sharing and does not require a referral or prescription. They noted that beneficiaries looking for MDPP resources often encounter directories reflecting only In-person delivery options, with map-based listings that exclude virtual (that is, distance learning, Online delivery) options. Several commenters requested that CMS update Medicare.gov and related beneficiary-facing resources to include virtual suppliers in provider directories. Other commenters suggested that CMS should streamline enrollment and provide technical assistance for smaller suppliers. Finally, a commenter emphasized the potential benefit of leveraging pharmacies for MDPP, noting the demonstrated impact pharmacists contribute to diabetes prevention and management, and encouraging CMS to use pharmacy sites and teams to expand access.

Response: We appreciate commenters' suggestions related to the rollout of Online delivery. We will ensure efforts to enhance beneficiary and provider awareness of MDPP and will support prospective and existing MDPP suppliers through outreach efforts, website and resource updates, and technical assistance offerings. We will continue to explore partnerships to expand access and ensure successful implementation of this important preventive benefit. Additionally, we appreciate the commenters' input regarding expanding pharmacist participation in MDPP. Pharmacies are able to enroll as MDPP

³³⁹ CDC National Diabetes Prevention Program PreventT2 Curriculum and Handouts https://www.cdc.gov/diabetes-prevention/php/lifestyle-change-resources/t2-curriculum.html?CDC_AAref_Val=https://www.cdc.gov/diabetes/prevention/resources/curriculum.html.

suppliers under existing program requirements, and several pharmacies are successfully delivering the MDPP to Medicare beneficiaries at this time.

Comment: Many commenters expressed support for clarifying that MDPP suppliers are not required to maintain in-person delivery capability during the Online delivery period through December 31, 2029 at § 410.79(f)(2). Many commenters stated that this clarification would reduce operational burdens on suppliers, particularly those specializing in virtual delivery models. Many commenters noted that this policy change would allow suppliers to ensure beneficiary access to the program.

Response: We appreciate the supportive comments regarding the clarification at § 410.79(f)(2) that MDPP suppliers are not required to maintain in-person delivery capability during the Online delivery period through December 31, 2029. This policy aims to reduce operational burdens on suppliers while ensuring continued beneficiary access to MDPP through a variety of delivery modalities, including Online delivery. Due to strong support for the proposal at § 410.79(f)(2) to explicitly not require MDPP suppliers to maintain in-person delivery capability during the Online delivery period to allow for distance learning and Online-only organizations to enroll in Medicare as an MDPP supplier and streamline the process to allow for Online delivery of the Set of MDPP services, we are finalizing this policy as proposed.

4. Changes to § 414.84

MDPP, as defined at § 410.79(b), consists of up to 16 sessions offered during the core session period (Months 1 to 6) and 6 monthly maintenance sessions offered during the core maintenance session interval period (Months 7 to 12), (collectively the “core services period”). While MDPP has an attendance-based fee-for-service payment structure as finalized in the CY 2024 PFS final rule (88 FR 79251), MDPP suppliers are also rewarded for successful outcomes for beneficiaries (weight loss), motivating them to not only retain participants, but also deliver a high-quality program that achieves better outcomes through performance-based payments. The fee-for-service payment structure finalized in the CY 2024 PFS final rule (88 FR 79251) added a distance learning HCPCS G-code, taking into consideration the Extended flexibilities.

We proposed edits throughout § 414.84 by revising paragraphs (b)(1) introductory text and (b)(2) introductory text to update language to include all accepted MDPP delivery modes for performance goals in which beneficiaries achieve weight loss milestones. We also proposed adding paragraph (c)(3) to

indicate payment for Online delivery, including the inclusion of a new HCPCS G-code, G9871, for Online delivery (Behavioral counseling for diabetes prevention, online, 60 minutes). Finally, we proposed redesignating paragraphs (c)(3) and (c)(4) as paragraphs (c)(4) and (c)(5) respectively and revising the redesignated paragraph (c)(4)(ii) to include a payment rate for a core session or core maintenance session furnished Online during the Online delivery period (\$18).

Table B-E1 displays the proposed CY 2026 MDPP payment structure for the Set of MDPP services delivered Online.

TABLE B-E1: MEDICARE DIABETES PREVENTION PROGRAM (MDPP) EXPANDED MODEL CALENDAR YEAR (CY) 2026 ONLINE PAYMENT STRUCTURE

HCPCS G-Code	Payment Description*	CY 2026
G9871	Behavioral counseling for diabetes prevention, online, 60 minutes	\$18
G9880	5 percent WL Achieved from baseline weight	\$153
G9881	9 percent WL Achieved from baseline weight	\$ 27
G9888	Maintenance 5 percent WL from baseline in months 7-12	\$8

Note: Medicare pays up to 22 sessions. Online sessions billed with code G9871 cannot be combined with G9886 or G9887, in a 12-month period:

Months 1-6: one Online session every week (up to 16)

Months 7-12: one Online session every month (up to 6)

Months 7-12, once participant achieves 5 percent WL, suppliers delivering the Set of MDPP services Online may submit Maintenance of 5 percent WL claim with attendance claim (G9888 + G9871). Medicare will pay for Maintenance 5 percent WL up to 6 times in months 7-12.

As indicated in Table B-E1, performance payments for 5 percent weight loss achieved from baseline weight (G9880) and 9 percent weight loss achieved from baseline weight (G9881) will remain the same regardless of delivery modality for MDPP. For each beneficiary, MDPP suppliers must either bill claims with G9886, G9887, a combination of G9886 and G9887, or G9871. The proposed G9871 for behavioral counseling for diabetes prevention, online, 60 minutes is for the Set of MDPP services delivered Online, asynchronously. The existing G9886, behavioral counseling for diabetes prevention, in-person, group, 60 minutes, and G9887, behavioral counseling for diabetes prevention, distance learning, 60 minutes are delivered synchronously. Therefore, we proposed that for each beneficiary, suppliers may not bill for the Set of MDPP services that were delivered through a combination of synchronous and asynchronous delivery modalities. Specifically, for MDPP beneficiaries, MDPP suppliers may not bill for Online Sessions as well as In-Person or Virtual Sessions during the Online delivery period. The Set of MDPP services must be delivered to individual beneficiaries as exclusively Online sessions (fully asynchronous) or exclusively In-person, distance learning, or In-person with a distance learning component sessions (fully synchronous). To evaluate the efficacy of Online delivery during the Online

Delivery Period, beneficiary outcomes from synchronous (that is, In-person, Distance learning, or In-person with a distance learning component) delivery of the Set of MDPP services must be compared to beneficiary outcomes from asynchronous (that is, Online), therefore, these modalities must remain mutually exclusive for individual beneficiaries. While the 2024 CDC DPRP Standards define “Combination with an online component” as sessions that are delivered as a combination of online (non-live) with in-person or distance learning, this will not be an accepted delivery modality for MDPP while Online delivery is being tested through December 31, 2029.

In summary, we proposed to amend § 414.84 by revising paragraphs (b)(1) introductory text and (b)(2) introductory text; adding paragraph (c)(3); redesignating paragraphs (c)(3) and (c)(4) as paragraphs (c)(4) and (c)(5) respectively; and revising the redesignated paragraph (c)(4)(ii). We sought comments on these proposals. The following is a summary of the comments we received and our responses.

Comment: Commenters noted that the proposed Online delivery payment rate at \$18 per session represents a 28 percent reduction that translates to 21 percent lower maximum program payments, compared to \$26 for in-person and distance learning modalities, despite evidence that virtual delivery achieves similar program outcomes.

Many comments emphasized that while virtual care has the potential to improve health outcomes at lower overall costs, CMS should ensure Online delivery suppliers receive compensation that accounts for their unique operational costs. Some commenters emphasized that virtual MDPP providers face significant upfront investments, particularly in technology platforms and medical-grade equipment such as scales for MDPP beneficiaries. Some commenters requested that CMS include the cost for cellular-enabled weight scales to beneficiaries in the proposed payment rate for Online delivery, stating that these devices enable continuous data collection and reliable at-home weight tracking.

Another commenter suggested that CMS restructure payments for Online delivery to tie compensation directly to weight loss milestones, such as \$500 for 5 percent weight loss and \$268 for 9 percent loss rather than tying payments to lesson completion, or implementing a bundled payment model similar to Maryland Medicaid's approach with higher upfront enrollment payments to offset device distribution costs, reduced per-session fees, and maintained outcome-based bonuses.

Response: We appreciate input regarding payment parity for Online delivery. We proposed at § 414.84 (c)(3) to indicate payment for Online delivery, including the inclusion of a new HCPCS G-code, G9871. The proposed \$18 payment rate for G9871 (Behavioral counseling for diabetes prevention, online, 60 minutes) was established through a comprehensive analysis of expected service costs informed by market research. This rate reflects the unique operational characteristics of Online delivery, including reduced overhead costs due to the elimination of physical location requirements during the Online delivery period, while maintaining the required live Coach interaction associated with each session. The rate was benchmarked against comparable healthcare services and market rates for similar digital health interventions, considering that Coaches provide 1 full hour of interaction with beneficiaries through in-person and distance learning modalities, whereas Online sessions involve reduced direct Coach interaction time per participant per week. The requirement for qualified Coaches to provide live, personalized support to each beneficiary justifies the established rate structure. Additionally, when determining the \$18 rate, CMS referenced HCPCS code 98016 for virtual check-ins and e-visits, which is slightly less than \$18, as part of the broader market analysis that informed the proposed rate. Online delivery offers increased scalability and financial viability for MDPP suppliers by eliminating the need to wait for group cohorts to form, allowing for rolling enrollment where beneficiaries can begin the program immediately—unlike in-person and distance learning delivery modalities that strive to achieve full group capacity prior to program delivery. We believe the proposed payment rate for G9871 appropriately reflects the value and costs associated with Online delivery at this time. Therefore, we are finalizing the proposed changes to § 414.84 (c)(3) to indicate payment for Online delivery, including the inclusion of a new HCPCS G-code, G9871.

We appreciate commenters' feedback regarding the technology costs associated with virtual MDPP delivery, particularly concerning cellular-enabled weight scales and other medical-grade equipment. However, after careful consideration, we are not revising the MDPP payment methodology to separately account for cellular-enabled weight scales or similar technology costs. Under § 424.210, MDPP suppliers already have the flexibility to provide Beneficiary Engagement Incentives (BEIs) to

support program goals.³⁴⁰ While we acknowledge that cellular-enabled scales may facilitate weight tracking, the regulation already permits the provision of technology that advances the clinical goal of weight loss as a BEI. We encourage virtual MDPP suppliers to leverage MDPP's existing BEI guidance to support beneficiary success. We will continue to monitor the implementation of MDPP services and may consider future refinements to the payment methodology based on demand, program experience, and outcomes data.

Additionally, we acknowledge the commenter's suggestion regarding lump outcome-based payments for 5 and 9 percent beneficiary weight loss. After careful consideration, we maintain its current approach of tying performance payments to session completion. Through the CY 2024 PFS final rule (88 FR 79251), CMS responded to feedback from interested parties regarding payment structure complexity by introducing FFS attendance-based payments while preserving performance payments associated with beneficiary weight loss. This revision aligned MDPP payments with similar Medicare preventive services, such as IBT and DSMT, and increased efficiency by reducing HCPCS G-codes from 15 to 6 to encourage streamlined claim submission. While we recognize the appeal of lump outcome-based payments, the current payment structure ensures program integrity and prevents fraud by associating weight loss outcomes with a preventive service. Additionally, the current payment structure results in more frequent payments to MDPP suppliers in an effort to promote supplier retention. We will continue to monitor the effectiveness of this approach and welcome continued stakeholder feedback on program improvements.

Comment: Outside the scope of the proposed changes to MDPP regarding payment for Online delivery, multiple commenters stated that the current payment rates for G9886 (Behavioral counseling for diabetes prevention, in-person, group, 60 minutes) and G9887 (Behavioral counseling for diabetes prevention, distance learning, group, 60 minutes) do not reflect the true costs of service delivery. These commenters expressed concerns about the existing MDPP payment rates being insufficient to sustain program operations including Coach training and retention, marketing, recruitment, HIPAA and CMS compliance requirements, billing and reporting obligations, and program oversight expenses. The most frequently cited recommendation was to raise payment rates to at least \$40 per In-person or distance

³⁴⁰§ 424.210 Beneficiary engagement incentives under the Medicare Diabetes Prevention Program expanded model. <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-I/section-424.210>.

learning session, with several commenters specifically requesting this amount to achieve parity with Diabetes Self-Management Training (DSMT) and Intensive Behavioral Therapy (IBT) programs, while another commenter requested at least a 20 percent increase to all attendance and weight-loss milestone payments to cover real operating costs such as participant recruitment, Coach training and retention, marketing, and data reporting requirements. Some commenters requested that CMS adopt a Relative Value Unit (RVU)-based approach to better account for suppliers' work, practice expenses, and malpractice costs when determining reimbursement rates. These commenters highlighted that in-person and distance learning delivery modalities require substantially higher labor and operational costs compared to Online delivery, stating that the proposed \$8 differential between Online (\$18) and synchronous delivery (\$26) inadequately reflects these cost disparities. Another commenter provided a recommendation that CMS allow MDPP to be integrated with primary care services by permitting it to be billed as an add-on G-code alongside same-day advanced primary care management and incorporating an administrative component into the reimbursement structure.

Response: In response to comments outside of the scope of the proposed rule regarding MDPP payment rates for in-person and distance learning compared to DSMT and IBT, we clarify that MDPP payment rates do not provide a direct comparison to these programs due to fundamental differences in program structure, requirements, and delivery methods, which justify MDPP's payment methodology.

MDPP and DSMT serve distinct populations and purposes within Medicare's approach to diabetes care. MDPP is a lifestyle intervention program designed for Medicare beneficiaries with prediabetes who are at risk of developing Type 2 diabetes, focusing on structured lifestyle changes such as weight loss, increased physical activity, and dietary change. DSMT is for Medicare beneficiaries who have already been diagnosed with Type 1 or Type 2 diabetes, providing training on how to effectively manage a beneficiary's existing condition. MDPP emphasizes prevention through lifestyle modification in a group setting, while DSMT can be delivered individually or in a group setting.³⁴¹

For MDPP, Coaches must be trained according to the CDC Diabetes Prevention Recognition Program Standards.³⁴² No additional clinical credentials are required. On the other hand, DSMT providers

³⁴¹ Diabetes Self-Management Training <https://www.medicare.gov/coverage/diabetes-self-management-training>.

³⁴² Centers for Disease Control and Prevention Diabetes Prevention Recognition Program. Standards and Operating Procedures. Requirements for CDC Recognition. June 2024. <https://nationaldppcsc.cdc.gov/s/article/DPRP-Standards-and-Operating-Procedures>.

must meet the National Standards for Diabetes Self-Management Education and Support.³⁴³ DSMT providers should also be accredited through a CMS-certified accrediting organization and must be trained in diabetes care and education. Additionally, MDPP does not require a provider referral for participation, while DSMT services require a referral from the physician, nurse practitioner (NP), physician assistant (PA), or certified nurse specialist (CNS) who's treating the patient for diabetes.³⁴⁴

CMS covers intensive behavioral therapy for obesity (IBT), for the prevention or early detection of illness or disability. IBT counseling must be furnished by a qualified primary care physician or other primary care practitioner in a primary care setting. IBT definitions for “primary care physician” and “primary care practitioner” are consistent with existing sections 1833(u)(6), 1833(x)(2)(A)(i)(I) and 1833(x)(2)(A)(i)(II) of the Act.³⁴⁵

Unlike IBT for Obesity, MDPP may currently be furnished in a variety of community settings, administrative locations, or virtually. Additionally, MDPP Coaches must be trained according to the CDC DPRP Standards but are not required to maintain additional clinical credentials. While MDPP offers a variety of delivery modalities for up to 22 sessions in a 12-month period, IBT must be furnished face-to-face with the following session format over a 12-month period: one face-to-face visit every week for the first month; one face-to-face visit every other week for months 2 to 6; and one face-to-face visit every month for months 7 to 12, if the beneficiary meets the 3 kg weight loss requirement.³⁴⁶

MDPP, DSMT, and IBT for Obesity have different program requirements and coverage rules under Medicare. MDPP's requirements regarding Coach qualifications, group format, and flexible delivery options justify the current payment rate for In-person and Distance learning MDPP sessions. The Medicare procedure codes and national average payment rates for the DSMT claim are G0108 – DSMT, individual, per 30 minutes (\$53.57) and G0109 – DSMT, group (2 or more), per 30 minutes (\$15.39). The national average reimbursement rates for procedure codes required by Medicare for the IBT for Obesity claim are G0447 for individual, face-to-face obesity counseling, 15 minutes (\$31.70) and G0473

³⁴³ 2022 National Standards for Diabetes Self-Management Education and Support. *Diabetes Care* 1 February 2022; 45 (2): 484–494. <https://doi.org/10.2337/dc21-2396>.

³⁴⁴ Provider Information on Medicare Diabetes Self-Management Training <https://www.cms.gov/files/document/mln909381-provider-information-medicare-diabetes-self-management-training.pdf>.

³⁴⁵ Compilation of the Social Security Laws, Part E—Miscellaneous Provisions. DEFINITIONS OF SERVICES, INSTITUTIONS, ETC. https://www.ssa.gov/OP_Home/ssact/title18/1861.htm#act-1861-r.

³⁴⁶ Medicare Coverage Database National Coverage Determination (NCD) Intensive Behavioral Therapy for Obesity <https://www.cms.gov/medicare-coverage-database/view/ncd.aspx?NCID=353>.

for group counseling, 30 minutes (\$11 to \$13 across MACs).³⁴⁷ The procedure codes currently required by Medicare for MDPP are G9886 – Behavioral counseling for diabetes prevention, in-person, group, 60 minutes (\$26), and G9887 – Behavioral counseling for diabetes prevention, distance learning, group, 60 minutes (\$26).³⁴⁸

As a group-based preventive service, the financial viability of MDPP programs is directly dependent on beneficiary participation. To ensure sustainability, it is strongly encouraged that organizations offering MDPP services maintain full group capacity. This strategy is critical because the group-based nature of MDPP means that suppliers must achieve adequate participant enrollment volume to make the program economically viable while maintaining the quality and effectiveness that MDPP's structured group format is designed to deliver.

We acknowledge the suggestions to adopt an RVU-based approach for MDPP reimbursement and to allow MDPP to be integrated with primary care services by permitting it to be billed as an add-on G-code alongside same-day advanced primary care management and incorporating an administrative component into the reimbursement structure. However, we believe MDPP's current FFS and performance-based methodology is most appropriate. Unlike traditional physician services using RVUs, MDPP focuses on specific health outcomes over time. MDPP's payment structure is designed to incentivize measurable outcomes such as 5 and 9 percent weight loss.

Comment: A commenter requested that CMS add diabetes-specific medically tailored meal benefits to MDPP.

Response: We acknowledge commenters' feedback regarding the addition of medically tailored meal benefits to MDPP. At § 424.210, MDPP suppliers have the flexibility to provide Beneficiary Engagement Incentives (BEIs) to support program goals.³⁴⁹ Since medically tailored meals are considered a BEI, we are not revising the MDPP payment methodology to separately account for medically tailored meals at this time.

³⁴⁷License for Use of Current Procedural Terminology, Fourth Edition (“CPT®”).
<https://www.cms.gov/medicare/physician-fee-schedule/search>.

³⁴⁸Medicare Diabetes Prevention Program (MDPP) Expanded Model Calendar Year (CY) 2025 Payment Rates
<https://www.cms.gov/files/document/mdpp-cy2025-hpcs-g-codes.pdf>.

³⁴⁹§ 424.210 Beneficiary engagement incentives under the Medicare Diabetes Prevention Program expanded model.
<https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-424/subpart-I/section-424.210>.

Comment: No public comments were received regarding changes at § 414.84, in which we proposed redesignating paragraphs (c)(3) and (c)(4) as paragraphs (c)(4) and (c)(5) respectively.

Response: While we did not receive public comments regarding this redesignation, upon further review, we have identified that current requirements at redesignated (c)(5) do not adequately address same-day make-up sessions delivered Online. The clarification of make-up session requirements serves as a critical safeguard against potential program integrity issues, including the risk of beneficiaries accessing multiple sessions within compressed timeframes that would be inconsistent with the established session structure. To ensure regulatory clarity, we are finalizing revisions to existing requirements at redesignated paragraph (c)(5) which currently state “Current Procedural Terminology (CPT) Modifier 76 (repeat services by same physician) must be appended to any claim for G9886 or G9887 to identify a MDPP make-up session that was held on the same day as a regularly scheduled MDPP session.” We are revising this language to include the new G-code for Online delivery, G9871 (Behavioral counseling for diabetes prevention, online, 60 minutes), among the HCPCS codes for same-day make-up sessions by specifically stating that “Current Procedural Terminology (CPT) Modifier 76 (repeat services by same physician) must be appended to any claim for G9886, G9887, or G9871 to identify a MDPP make-up session that was held on the same day as a regularly scheduled MDPP session.”