
September 12, 2025

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016.

***via electronic submission***

**Re: CMS-1832-P**
**Medicare and Medicaid Programs; CY 2026 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program**

Administrator Oz and Colleagues:

As executive director and federal policy director of Leaders Engaged on Alzheimer's Disease (the LEAD Coalition)[1] — the uniting voice of over 260 member and allied organizations along with hundreds of researchers dedicated to serving people with Alzheimer's disease and Alzheimer's disease-related disorders (AD/ADRD) and their families — we appreciate the opportunity to provide public comments on the CY 2026 Payment Policies under the Physician Fee Schedule.

[1] http://www.leadcoalition.org Leaders Engaged on Alzheimer's Disease (the LEAD Coalition) is a diverse, national coalition of member and allied organizations including patient advocacy and voluntary health non-profits, philanthropies and foundations, trade and professional associations, academic research and clinical institutions, and home and residential care providers, large health systems, and biotechnology and pharmaceutical companies. The LEAD Coalition works collaboratively to focus the nation's strategic attention on dementia in all its causes -- including Alzheimer's disease, vascular disease, Lewy body dementia, and frontotemporal degeneration -- and to accelerate transformational progress in detection and diagnosis, care and support, and research leading to prevention, effective treatment, and eventual cure.

The U.S. population is aging rapidly – there are 58 million individuals aged 65 and older currently living in the U.S., and this number is projected to rise to nearly 82 million by 2050.[2] Age is the biggest risk factor for Alzheimer's disease and related disorders (AD/ADRD); accordingly, as the aging population grows, so too does AD/ADRD prevalence. With approximately 90% of Medicare beneficiaries aged 65 and older[3], the number of Medicare beneficiaries with a diagnosis of mild cognitive impairment (MCI, often considered a precursor to dementia) or dementia is expected to increase exponentially in the coming years – additionally, an estimated 200,000 Americans under 65 years old are living with younger-onset dementia and qualify for Medicare coverage. Furthermore, the majority of Medicare beneficiaries diagnosed with MCI or dementia due to AD/ADRD are living with other chronic conditions, making their clinical care even more complex and difficult to manage.

In light of the shifting age dynamics within our country and the increasing number of individuals living with MCI or dementia, CMS must take critical steps now to ensure healthcare in the United States is prepared for the years to come. With this proposed rule, we believe CMS is taking actions that will significantly improve the lives of individuals living with cognitive impairment and their care partners, as well as the many more people at-risk for developing dementia. Specifically, we are strongly supportive of efforts outlined within the rule to enhance care for chronic disease management, reduce administrative barriers, and directly improve dementia diagnosis and care. However, there are several revisions outlined in the proposed rule, including the removal of adjustments and quality measures (QMs) related to health equity, which we urge CMS to reconsider. These positions are detailed below.

We applaud CMS for developing a new Merit-based Incentive Payment System (MIPS) improvement activity to support better detection of cognitive impairment in primary care. Per the proposed rule, eligible clinicians are encouraged to increase cognitive assessment use during the Annual Wellness Visit, including tracking and re-measuring on a regular basis using structured tools. This improvement activity will encourage clinicians to better assess and address memory concerns over time, including referring individuals who need additional assessment to a neurologist. Such action has the potential to improve overall outcomes for individuals living with cognitive impairment, especially those with mild cognitive impairment (MCI) or in the very early stages of dementia when interventions are most effective. Though we are entirely supportive of this improvement activity, we urge CMS to provide formal guidance to providers who are qualified to engage in this activity. As currently written, the rule references "the tool provided for this Improvement Activity." Although the field has several strong assessment tools that could be used, there is no one accepted standardized test for detection of cognitive impairment. In lieu of specifying one tool for this activity, we urge CMS– within the text of the rule – to point providers to the National Institute on Aging's website[4] as an important resource to locate validated and structured cognitive assessments for this improvement activity.

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[2] https://www.census.gov/data/tables/2023/demo/popproj/2023-summary-tables.html
[3] https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment#:~:text=68.8M,With%20Medicare%20Part%20D%20Coverage
[4] https://www.nia.nih.gov/health/health-care-professionals-information/alzheimers-and-related-dementias-resources

We commend CMS for seeking additional insights from the public through a Request for Information (RFI) pertaining to the prevention and management of chronic disease. We understand addressing chronic disease is a top priority for the administration and appreciate the effort to collect input from a broad audience, especially regarding services already offered in communities. Specifically, we are pleased that CMS is seeking information on existing services that can improve physical activity, address social isolation, and provide nutritious meals to older adults, to name a few. We expect novel ideas and critical insights will be shared by community-based organizations, professional societies, and others via this RFI and urge CMS to consider this input to inform next steps.

We are grateful for CMS's efforts to reduce administrative burden related to telehealth care, allowing Medicare beneficiaries to receive valuable care in their homes. Updating existing policies, including removing the temporary nature of codes and expanding billing options for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), will streamline access and support care delivery, particularly for beneficiaries living in rural and other underserved communities.

We support the second MIPS improvement activity that encourages eligible clinicians to include an oral health risk assessment and intraoral screening as part of primary care management, and provide education and counseling regarding the importance of oral care. Poor oral health has been associated with an increased risk for Alzheimer's disease[5] and can compromise both the overall physical health (e.g., dangerous weight loss) and quality of life (e.g., untreated pain) for people living with AD/ADRD.. By ensuring that individuals are receiving an oral health assessment along with education on how oral health care can improve overall physical health, these activities have the potential of reducing disease risk and severity for many Medicare beneficiaries.

We are pleased to see modifications to the IA_BMH_1 "Diabetes Screening" improvement activity. We embrace expansion of screening efforts related to antipsychotic medications, aimed at better identifying and serving the complex medical needs of a larger patient population taking these medications. As noted in the rule, antipsychotic medications are used to treat several mental health conditions, including to treat agitation associated with Alzheimer's disease dementia. All patients taking antipsychotics should qualify for increased screening of comorbidities, regardless of the diagnosed condition for which they are taking the medication. In addition to expanding the relevant patient population for screening, we appreciate that CMS has recognized that patients taking antipsychotic medications are at increased risk for conditions other than diabetes (e.g., obesity and hypertension) and is taking action to ensure physicians screen and monitor for several comorbidities via this modification.

We applaud CMS for introducing QMs that support individuals living with dementia and their caregivers/care partners. As falls within this population can lead to dire health outcomes and potential fatalities, we are pleased to see the new QM that aims to capture falls reported by patients – or care partners, as appropriate – with an active diagnosis of a movement disorder,

[5] https://pmc.ncbi.nlm.nih.gov/articles/PMC10669972/

multiple sclerosis, a neuromuscular disorder, dementia, or stroke. We appreciate that CMS is encouraging providers to consider next steps after a fall and potential preventative measures. By ensuring appropriate care plans are in place, this QM will improve the safety and quality of life for all individuals living with dementia and other neurological disorders. We encourage expansion of this QM to ensure falls are reported – and appropriate care plans are developed – for individuals with an MCI diagnosis. In fact, further expansion, to capture all patient populations, is most advisable, as falls may be predictive of underlying cognitive impairment.

We support the addition of QM Q288 "Dementia: Education and Support of Caregivers for Patients with Dementia" to the nutritionist/dietician specialty set. Under this proposed rule, registered dietician nutritionists will be encouraged to communicate with patients living with dementia and their caregivers about disease management and opportunities for additional support resources. Such education is imperative, as there are several nutrition intake challenges associated with dementia, posing risk of weight and muscle loss, bone weakening, undetected or undertreated pain, and other co-occurring conditions. We also encourage CMS to consider expanding this QM to ensure that nutritionists are educating patients who have an active MCI diagnosis as well as their caregivers.

We support the addition of the Neuropsychology MIPS Value Pathway, applicable to nonphysician practitioners who are treating patients within the practice of neuropsychology. Clinical quality measures Q282, Q286, and Q288 – which encourage functional assessment, safety concern and screening, and education and support of caregivers – are appropriate to ensure meaningful and comprehensive assessment of patients living with dementia. We also appreciate inclusion of Mental and Behavioral Health Registry (MBHR) measures – MBHR13, MBHR15, and MBHR18 – which are critical to ensuring accurate assessment, decreasing health disparities, and encouraging timely follow-up to improve outcomes of individuals living with dementia. We encourage CMS also to expand these measures for individuals living with a diagnosis of MCI.

We are encouraged to see many additions to, and revisions within, the PFS proposed rule for 2026. Unfortunately, there are some proposed changes with which we strongly disagree and urge CMS to reconsider.

- We categorically oppose deletion of the Social Determinants of Health (SDoH) Risk Assessment and the G0136 code for this vital service. The SDoH Risk Assessment is critical to aiding physicians in recognizing an individual's collective risk factors and ensuring comprehensive preventive care is delivered. Contrary to the proposed rule's counter-factual assertion, several elements, including but not limited to socioeconomic factors such as poverty, employment, and education, are unaccounted for in other standard assessments used in evaluation and management (E/M) visits. These factors can have major impacts on health outcomes, especially as it pertains to the management of chronic disease. Absent an accurate assessment and record of these factors, providers will lack a comprehensive understanding of their patient and therefore be unable to provide holistic care. Embedding this work into E/M visits, without separate

payment, risks undervaluing the clinical and operational effort required, particularly in practices serving high-risk populations. Rather than eliminate the assessment, we urge CMS to encourage providers to administer the assessment more routinely. In fact, G0136 aligns well with CMS's goal to capture all upstream drivers of health to reduce risk for and improve care and management of chronic disease. If necessary, CMS could rename the "Social Determinants of Health" risk assessment to "Upstream Drivers of Health" risk assessment. Either way, preserving this code is essential to advancing whole-person care and supporting beneficiaries' equal access to comprehensive care delivery.

- We oppose the removal of Q487: Screening for Social Drivers of Health and health equity advancement efforts embedded within quality improvement (QI) activities, and urge CMS to reconsider. These efforts aid in systematically addressing the root causes (or "upstream drivers") of health disparities to ensure equitable outcomes for all populations. More specifically, social drivers of health included in the Q487 screening measure are critical to understanding the well-being of older adults living with MCI or dementia. Drivers such as food insecurity, transportation needs, and housing instability could exacerbate health conditions, leading to increased morbidity and mortality. Eliminating these QM and QI activities will have negative health impacts on the most vulnerable Medicare beneficiaries, increase downstream Medicare costs, and further strain health system capacity.

- We oppose the removal of the health equity adjustment to the Accountable Care Organization (ACO) quality score, which would unravel years of work to mitigate unfair penalties imposed on hospitals, including rural and Southern hospitals, serving disadvantaged populations.

- We oppose the removal of Q508: Adult COVID-19 Vaccination Status. Older adults, especially those with cognitive impairment whether living at home or in long-term care facilities, are much more susceptible to serious infections than younger or generally healthier adults with stronger immune systems. Specifically, there is substantial evidence that COVID-19 infection increases the risk of mortality and other adverse health outcomes for individuals living with dementia.[6] This is due to a range of factors, including difficulties in adherence to other safety measures (e.g., physical distancing, hand-washing, masking, etc.) and the intimate nature of many care tasks they depend on others to perform (e.g., helping with toileting, bathing, oral health, wound care). There also exists a compelling argument to support this measure for all adults: evidence suggests a link between vaccine uptake and decreased dementia risk.[7,8] Accordingly, we encourage CMS to take steps to encourage and incentivize, rather than disincentivize, physicians to talk with their patients about one's COVID-19 vaccination status.

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[6] https://journals.sagepub.com/doi/abs/10.1177/13872877241303934
[7] https://journals.sagepub.com/doi/10.3233/JAD-221231
[8] https://www.sciencedirect.com/science/article/pii/S0264410X25001616

We appreciate the opportunity to share our comments on the CY 2026 Payment Policies under the Physician Fee Schedule. We applaud CMS for proposing several revisions that may significantly improve the lives of individuals living with cognitive impairment and their care partners, as well as many more individuals at-risk for AD/ADRD. While the proposed rule contains many beneficial changes, we strongly oppose the proposed rule's removal or weakening of measures intended to reduce health disparities in our nation. We urge CMS to reconsider these changes.

For questions or additional information, please contact us at ikremer@leadcoalition.org and cwallin@leadcoalition.org.

Sincerely,

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