September 11, 2025

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

Submitted electronically via http://www.regulations.gov.

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

Dear Dr. Oz,

On behalf of the Milwaukee County Commission on Aging, we appreciate the opportunity to comment on the CY 2026 Physician Fee Schedule (PFS) proposed rule (CMS-1832-P). The Milwaukee County Commission on Aging affirms the dignity and value of older adults in our county through advocacy, leadership, and service. As the designated Area Agency on Aging for Milwaukee County, we coordinate the use of Older Americans Act funding to support the health and well-being for more than 190,000 older adults in Milwaukee County.

We are grateful that the proposed rule recognizes the critical role of programs funded through the Administration for Community Living. Socialization, nutrition, evidence-based wellness, and caregiving programs offered through Area Agencies on Aging increase access to upstream drivers for older adults and individuals with disabilities and we are supportive that the rule continues to affirm this and family caregivers.

I. Responding to the Request for Information included in the proposed rule seeking input about how CMS can improve support for prevention and management of chronic disease

We appreciate the Request for Information included in the proposed rule seeking input to better understand how CMS can enhance support for the prevention and management of chronic disease. (90 FR 32507) In considering recommendations and resulting policy changes, we urge CMS to consider the vital role that family caregivers play in preventing and managing chronic disease for Medicare beneficiaries, and the impact that chronic disease has on overall caregiver health and capacity to provide adequate support to care recipients.

Chronic disease directly impacts caregivers and care recipients

Family caregivers provide an estimated $600 billion in uncompensated care while serving as essential partners to both patients and healthcare providers.[1] Despite their critical role, research shows that one in four caregivers struggles to maintain their own health. According to a 2024 CDC report, family caregivers experience a higher disease burden across numerous health risk factors than non-caregivers.[2] These risk factors include smoking, heavy or binge drinking, physical inactivity, poor self-rated health, mental distress, diagnosed depression, physical distress, heart disease, stroke, chronic obstructive pulmonary disease, arthritis, diabetes, obesity, diagnosed asthma, one or more chronic physical health conditions, having no health coverage, and inability to see a doctor because of cost. Caregivers were also at higher risk of social isolation or disconnection than non-caregivers.

This reality affects general caregiver well-being and compromises the quality of care they can provide for their loved ones. In response to the RFI about how CMS can improve support for prevention and management of chronic disease, we urge CMS to understand that to truly modernize American healthcare and create better options for patients, we must recognize and support family caregivers.

CMS serves a key role in aligning health and community services to better support family caregivers and care recipients

We commend CMS for recognizing that a myriad of evidence-based and evidence-informed (EB/I) programs, often funded and/or administered through the Administration for Community Living (ACL), *"have demonstrated impact in effectively treating chronic disease, preventing disease, and helping older adults and people with disabilities to adopt healthy behaviors, improve their health status, reduce disability and injury, and reduce their use of hospital services and emergency room visits."*

We appreciate that CMS calls out that the 56 State Units on Aging, more than 600 Area Agencies on Aging, and the networks of tens of thousands of service providers that have a history of coordinating and delivery these critical services, but that, *"the needs exceed available* [discretionary] *federal funding."* CMS asks, *"Are there certain existing or new Physician Fee Schedule codes and payment, or Innovation Center Models* [CMMI]*, which could better support practitioner provision of successful interventions through partnerships between health care entities, AAAs, community care hubs, and other local aging and disability organizations?"* (90 FR 32508) The Milwaukee County AAA has had to decrease and, in some cases, eliminate services related to nutrition, housing support, and transportation due to having inadequate federal funding to full cover the needs of older adults. Other services, such as Caregiver Support, have had to place participants on waitlists. Increased federal funding or other

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[1] Susan C. Reinhard, Selena Caldera, Ari Houser, Rita B. Choula. AARP. Valuing the Invaluable: 2023 Update Strengthening Supports for Family Caregivers. Washington, DC: AARP Public Policy Institute. March 2023. https://doi.org/10.26419/ppi.00082.008

[2] Centers for Disease Control and Prevention. *Changes in Health Indicators Among Caregivers — United States, 2015–2016 to 2021–2022*. August 2024. https://www.cdc.gov/mmwr/volumes/73/wr/pdfs/mm7334a2-H.pdf.

payments strategies, such as allowing programs to be considered billable services through Medicare Part B would lead to increased access and utilization of these valuable services.

We also encourage CMS to consider payment strategies and innovation models that aim to improve caregiver health and to address the chronic conditions of care recipients. Despite their essential role, caregivers are rarely seen as part of the care team. They are often excluded from care planning discussions, discharge instructions, and quality improvement processes. This lack of visibility undermines both caregiver and patient outcomes. A National Academies report emphasized the need for formal caregiver inclusion in care teams and reimbursement structures.[3]

Additionally, we urge CMS to consider how allowing for evidence-based and evidence-informed programs can be scaled to be reimbursable as a Medicare Part B benefit.

For example, the GUIDE (Guiding an Improved Dementia Experience) Model explicitly recognizes and compensates care partners (caregivers) as integral members of the dementia care team, providing them with training, respite services, and a 24/7 support line. This model demonstrates how payment systems can be redesigned to formally incorporate caregivers, offering a blueprint for expanding this approach to other populations with serious illness, complex care needs, and chronic conditions. By providing dedicated funding for caregiver support services, GUIDE validates the essential role of family caregivers and creates a sustainable framework for their inclusion in care delivery.

Supporting family caregivers will promote goals outlined in the RFI regarding preventing and managing chronic disease

We appreciate that CMS requests details regarding opportunities for Medicare Part B to address the root causes of chronic disease, social isolation, improve physical activity, and offer other proven lifestyle interventions for Medicare beneficiaries. We encourage policy makers to reference the wide array of evidence-based and evidence-informed programs supported by ACL[4] and the Aging and Disability Network to effectively treat and prevent chronic disease, help older adults and people with disabilities to adopt healthy behaviors, improve population health, reduce disability and injury, and reduce the use of hospital services and emergency room visits. (90 FR 32508)

In 2023, 51,935 older adults (65+) went to the emergency department due to a fall. The average cost of an emergency department visit due to a fall is $5,921, meaning more than $307,485,190 was spent on falls-related emergency department visits that year. Medicare covered 89 percent of charges. Instead of funds covering costly emergency department visits, funds could be invested in preventative health programs that cost less to implement and provide greater health benefits. Programs like Stepping On decrease the incidence of falls, improve balance and strength, and help older adults navigate fall hazards.

We also encourage CMS to recognize and consider opportunities to encourage payment pathways to support the array of EBP/I programs focusing on chronic disease self-management, falls prevention, physical activity, behavioral health, and nutrition, which are specifically designed to address the unique

[3] National Alliance for Caregiving and Act on RAISE Campaign. Strengthening the National Strategy to Support Family Caregivers: A Medicare Policy Framework. June 2025. https://www.caregiving.org/wp-content/uploads/2025/06/NAC-AOR-Medicare-Policy-Brief_June-2025.pdf

[4] https://acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs

health and social needs of caregivers and their care recipients. According to the National Council on Aging (NCOA), between 2019 to 2024, over 14,000 caregivers participated in 32 types of chronic disease self-management education (CDSME) programs, making up nearly a quarter of all participants. CDSME programs have shown to improve participants' self-reported health, reduce days of depression, and enhance overall quality of life, and lead to tangible outcomes like fewer emergency room visits, saving an average of $364 per person.[5]

Furthermore, EB/I programs focused specifically on improving caregiver skills, support, and engagement, including, but not limited to, Building Better Caregivers, Powerful Tools for Caregivers,[6] Caring for Carers (C4C),[7] Active Caregiving: Empowering Skills (ACES), Care of Persons with Dementia in their Environments (COPE), and IDEA! Behaviors & Alzheimer's[8] are proven effective, have high participation rates, and underscore the need for these valuable resources.

II. Eliminating the Social Determinants of Health (SDOH) Risk Assessment code (HCPCS code G0136) and updating the term SDOH to "upstream driver(s)" of health

As we have echoed in previous comments to CMS, we support the opportunities adopted under the Healthcare Common Procedure Coding System (HCPCS) codes that provide a pathway to reimburse a range of activities to address non-medical, social, and health-related needs of Medicare Part B beneficiaries. These codes, Community Health Integration (CHI), Principal Illness Navigation (PIN), and Principal Illness Navigation-Peer Support (PIN-PS) HCPCS codes advance opportunities to integrate health and social care to improve clinical outcomes by providing payment for the labor extended to support persons who have unmet community/social health-related needs or require case management or health navigation services to address complex health conditions.

The Milwaukee County Area Agency on Aging engaged in grant work with a local pharmacy chain to address social isolation in older adults. The validated 3-item UCLA Loneliness Scale was administered by pharmacy professionals and consenting individuals who scored "high" for loneliness were referred to a contracted mental health service provider, who conducted an in- depth risk factor assessment, with questions that touched on many risk factors for social isolation and loneliness, such as living alone, limited social support, financial debt, limited mobility, difficulty preparing meals/getting proper nutrition, memory concerns or dementia diagnosis, caregiver status, unresolved grief/loss, self-identified as having poor or fair health, living with chronic conditions, uninsured or underinsured, and concerns anxiety/depression or suicidal thoughts. Participants received personalized referrals to Area Agency on Aging and social support programs offered by other community partners based on their assessment responses, such as a telephone reassurance program, transportation services, caregiver support specialists, dementia care specialists, financial clinic, senior centers, dining sites and meals on wheels, late life counseling, evidence-based health promotion programs, and Milwaukee County Behavioral Health Services.

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[5] National Council on Aging. *How to Engage Caregivers in Evidence-Based Programs*. September 2025.https://www.ncoa.org/article/how-to-engage-caregivers-in-evidence-based-programs/.
[6] Ibid 15.
[7] The Better Care Playbook. *The Caring for Caregivers Program: Practical Approaches for Improving Caregiver and Patient Outcomes*. June 2024. https://bettercareplaybook.org/resources/caring-caregivers-program-practical-approaches-improving-caregiver-and-patient-outcomes
[8] Benjamin Rose Institute. Best Programs for Caregiving Website Serves Professionals and Family Caregivers. https://institute.benrose.org/evidence-based-and-informed-programs/best-programs-for-caregiving/

This grant allowed us to strengthen our existing relationship with the pharmacy network and establish a clinical-community linkage between a traditional healthcare provider and connection to Area Agency on Aging programming that address upstream non-medical drivers of health. It also allowed the pharmacy not only to refer clients to healthy improvement resources that support the prescribed pharmaceutical intervention but extend their work to assist their clients with health and social needs that cannot be addressed with medication. With the pharmacist often seen as being the most accessible healthcare provider, supporting AAA work through the expansion of billable services allows a more streamlined and effective referral process with known programs that improve the health of older adults. The AAA network is a proven and effective leader in delivering programs and services that improve factors such as financial stability, connection, food access, health access, and housing stability. If these services were billable through Medicare Part B the AAA would have expanded capacity to increase services and programming that would lead to better access and higher utilization of services.

Addressing these unmet needs supports both family caregivers of Medicare enrollees and caregivers who are Medicare enrollees who may also have unmet needs. Because CHI, PIN, and PIN-PS services can be billed as incident-to services and provided by non-physician practitioners under the direct supervision of a physician or non-physician practitioner, they provide important opportunities to integrate clinical and community providers to address non-clinical health needs. We are grateful that CMS maintained these payment pathways in the draft CY 2026 PFS.

In the CY 2026 PFS, CMS proposes eliminating the stand-alone G code—also established in the CY 2024 final rule—describing a Social Determinants of Health (SDOH) Risk Assessment, G0136, as CMS believes, "that the resource costs described by HCPCS code G0136 are already accounted for in existing codes, including but not limited to E/M visits." While we do not directly oppose eliminating G0136, if doing so streamlines access to services to address unmet health-related and non-medical drivers of health, we request that CMS to work closely with stakeholders to ensure that the elimination of SDOH Risk Assessment services does not compromise the provider's ability to identify and treat unmet needs. (90 FR 32510)

Similarly, we take note of the CMS proposal to *"replace the term "social determinants of health (SDOH)" with the term "upstream driver(s)"* [based on the justification that CMS has] *determined that the term "upstream driver(s)" is more comprehensive and includes a variety of factors that can impact the health of Medicare beneficiaries."* CMS contends that, *"the term "upstream driver(s)" encompasses a wider range of root causes of the problems that practitioners are addressing through CHI services,"* and that, *"This type of whole-person care can better address the upstream drivers that affect patient behaviors (such as smoking, poor nutrition, low physical activity, substance misuse, etc.) or potential dietary, behavioral, medical, and environmental drivers to lessen the impacts of the problem(s) addressed in the initiating visit."* (90 FR 32510 and 90 FR 32511)

We do not directly oppose this change and agree that the term "upstream drivers" could capture additional non-clinical drivers of health than previously used terms. However, we recommend that CMS work closely with providers and practitioners to avoid confusion regarding frequent terminology changes, and to ensure that these updates do not have unintended consequences that present unforeseen or new barriers for CHI/PIN implementation efforts or care.

III. Continued support for family caregivers

One in four Americans make up our nation's community of unpaid family caregivers. These 63 million family caregivers, who often go unrecognized, form the backbone of our long-term care system. It is these families and families of choice, who help older adults, people with disabilities, and people with serious illness manage their health and wellness.[9]

We appreciate that the CY 2026 Medicare PFS proposed rule preserves recently implemented policy and payment opportunities included in the 2024 and 2025 Medicare Physician Fee Schedules final rules that advance systemic changes to recognize and honor the vital role family caregivers serve as part of healthcare teams. In a rapidly changing federal funding and healthcare policy environment, fee-for-service Medicare is increasingly important in supporting family caregivers and their essential role serving millions of older adults, people with disabilities, and individuals with complex illness and care needs.

The population of older adults, who make up 90 percent of Medicare beneficiaries,[10] is growing at a historic rate,[11] and this growth increases the demands placed on family caregivers. According to *Caregiving in the US 2025*,[12] a joint report of the National Alliance for Caregiving (NAC) and AARP, between 2015 and 2025, the number of family caregivers increased by 20 million to 63 million Americans, and the ratio of available caregivers to those who need care—is declining.[13] We urge CMS—and especially the Center for Medicare—to identify additional opportunities to do more to support this growing community as these challenges will become more acute with demographics shifts and recent federal policy changes and dramatic funding cuts impacting Medicaid and Medicare programs and the health of millions of enrollees.

The existing infrastructure for Caregiver Support Services delivered through the AAA network could be bolstered and scaled up as a way to improve social and physical health for caregivers and care recipients. These services are funded through the National Family Caregivers Support Program (NFCSP) which provides grants to states and territories to fund various supports that help family and informal caregivers care for older adults in their homes for as long as possible. Agencies funded through NFCSP provide services that include information and resource connection, respite care, training, individual counseling, and other supplemental services. Caregivers who receive support through NFCSP have reported that the services enabled them to provide care longer than would have been possible otherwise, that the services helped them be a better caregiver, and that the services helped prevent premature institutionalization of their loved one. [14] The capacity to serve family caregivers is limited by the federal funding received by the AAA network and its providers. The Milwaukee County Caregiver Support Program consistently has to enter into a waitlist for services due to not having sufficient funds

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[9] AARP and National Alliance for Caregiving. *Caregiving in the US 2025*. Washington, DC: AARP. July 24, 2025. https://doi.org/10.26419/ppi.00373.001

[10] https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment#:~:text=68.8M,With%20Medicare%20Part%20D%20Coverage

[11] Population Research Bureau. *Fact Sheet: Aging in the U.S. January 2024*. *https://www.prb.org/resources/fact-sheet-aging-in-the-united-states/*.

[12] *ibid 1*.

[13] AARP Public Policy Institute. *The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers*. August 2013. https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf

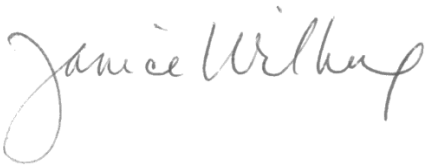
[14] Administration for Community Living. *National Family Caregiver Support Program*. Washington, DC: AARP. May 27, 2025. https://acl.gov/programs/support-caregivers/national-family-caregiver-support-program

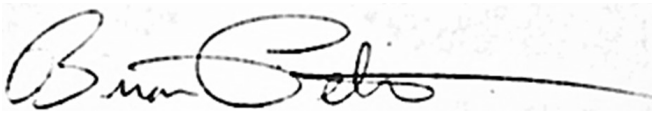
to meet the needs of the growing population of family caregivers in Milwaukee County. Imagining new funding opportunities, such as allowing caregiver navigation, caregiver training, and respite to be billable to Medicare Part B by NFCSP grantees could greatly expand the impact of this program.

The Milwaukee County Commission on Aging recognizes and appreciates CMS's commitment to supporting and expanding access to critical caregiver training services and to advance coordinated community-based continuums of services and supports available through Medicare and the CY 2026 PFS proposed rule to ensure family caregivers are valued and supported in their vital role with Medicare beneficiaries.

Please reach out if you have any questions on this or other aging items of interest.

Sincerely,





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