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

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 Administrator Oz:

The New York State Adult Day Services Association (NYSADSA) represents home and community-based services (HCBS) providers operating under Title 9 Codes, Rules, and Regulations of the State of New York (CRR-NY) 6654.20, serving thousands of older adults and adults with disabilities across New York. Our members deliver structured, non-medical supports—including nutrition, socialization, caregiver respite, and physical activity—through contracts with Area Agencies on Aging (AAAs) and Medicaid Managed Long-Term Care (MLTC) plans under New York's 1115 Waiver.

We submit these comments to directly address the Centers for Medicare and Medicaid Services' (CMS) *Request for Information (RFI) on Prevention and Management of Chronic Disease*. Each question is restated verbatim from the Proposed Rule, followed by our response with examples from Social Adult Day Services (SADS).

RFI Questions and Responses

Q1. How could we better support prevention and management, including self-management, of chronic disease?

Response:

SADS are uniquely positioned to support prevention and self-management of chronic disease because they combine daily social engagement with practical, trusted supports that extend far beyond what a physician can provide during brief visits.

1. Addressing Social Isolation as a Health Intervention
    - The *U.S. Surgeon General's Advisory on Social Connection* (2023) identifies social isolation as a health risk comparable to smoking and obesity, raising dementia risk by 50% and heart disease risk by 29%.
    - By engaging participants in daily structured activities, SADS reduce isolation, build peer support networks, and create consistent opportunities for positive behavior reinforcement. This social environment improves adherence to care plans and encourages healthier lifestyles.

2. Trusted Case Managers and Coordinators
    - SADS staff often serve as trusted navigators, helping older adults interpret physician instructions, manage follow-up tasks, and connect with community resources.
    - Because staff see participants multiple times per week, they can detect subtle changes in behavior, mood, or physical health that may signal complications, allowing for early intervention.

3. Appointment Scheduling and Reminders
    - Missed medical appointments are a leading cause of unmanaged chronic disease. SADS staff coordinate transportation, provide reminders, and ensure participants get to follow-up care.
    - Example: A participant with diabetes who consistently misses endocrinology visits is reminded by SADS staff, who also coordinate transportation and support medication reconciliation upon return.

4. Medication Support and Adherence
    - SADS provide medication reminders and supervision of self-administered medications, reducing errors that lead to complications.
    - Staff also monitor side effects and communicate with caregivers and providers, ensuring better adherence.

5. Daily Self-Management Supports
    - Programs reinforce disease management strategies like hydration and nutrition education.
    - Peer discussions normalize these practices and reduce stigma, improving confidence and compliance.

Example from New York:

In one New York program, participants with hypertension attend daily exercise sessions, receive reminders to take prescribed medications, and are encouraged to track blood pressure. Staff coordinate with the participant's MLTC care manager when concerning trends are observed. This coordinated support helps stabilize chronic conditions that would otherwise escalate to costly emergency care.

Recommendation to CMS:

To strengthen prevention and self-management, CMS should:

- Reimburse community-based services that reduce isolation and improve adherence.
- Recognize SADS staff as extensions of the care team for appointment reminders, medication adherence, and case coordination.
- Support bundled reimbursement codes for integrated supports that address both medical and social risk factors.

Q2. Are there certain services that address the root causes of disease, chronic disease management, or prevention, where the time and resources … are not adequately captured by the current physician fee schedule code set? If so, please provide specific examples.

Response:

Yes. SADS directly address root causes of chronic disease—particularly social isolation, poor nutrition, physical inactivity, and caregiver strain—yet the time, staffing, and infrastructure required for these services are not recognized or reimbursed under the current Physician Fee Schedule (PFS).

1. Addressing Social Isolation
    - The *U.S. Surgeon General's Advisory on Social Connection* (2023) warns that social isolation increases the risk of premature death by 29%, raises dementia risk by 50%, and increases stroke risk by 32%. Its health impact is comparable to smoking 15 cigarettes a day.
    - SADS reduce isolation by providing daily social engagement, structured peer activities, and trusted staff supervision. These are not episodic services, but continuous preventive interventions—a model CMS does not yet reimburse.
    - Example: Participants in SADS attend group discussions, games, and cultural activities that build friendships and restore a sense of belonging. Staff also check in on absent members, preventing prolonged isolation that exacerbates depression or chronic disease progression.

2. Nutrition Services
    - Poor diet and malnutrition are root drivers of chronic disease, but are not adequately reimbursed.
    - SADS provide daily meals, hydration reminders, and culturally tailored nutrition education. For example, a program serving Hispanic participants offers diabetes-friendly meal options while teaching culturally relevant cooking adaptations.

3. Physical Activity
    - SADS provide group exercise programs (yoga, tai chi, chair aerobics, walking groups) that improve mobility and reduce fall risk.
    - These programs require staff time, participant monitoring, and, in some cases, space and equipment—all unfunded under the current PFS and not available to

Medicare beneficiaries unless otherwise qualified under Medicaid or other programs for low-income recipients.

4. Case Management and Caregiver Support
    - SADS staff act as trusted coordinators, ensuring participants attend medical appointments, adhere to medications, and access community resources.
    - Caregiver education, respite, and counseling are provided to reduce caregiver burnout, a leading factor in nursing home placement. Yet these hours of staff coordination and training are not reimbursed by Medicare.

5. Transportation Coordination
    - Missed appointments are a root cause of poor chronic disease outcomes. SADS programs schedule rides, provide reminders, and often coordinate with MLTC plans or local AAAs to ensure participants arrive at appointments.
    - Example: A participant with heart failure who repeatedly missed cardiology follow-ups remained stable once SADS began coordinating transportation and appointment reminders.

Recommendation to CMS:

- Create new billing codes for services that address social determinants of health (SDOH)—such as socialization, nutrition, caregiver support, and transportation—when delivered by trusted community-based providers.
- Recognize that preventing isolation and addressing root causes requires ongoing, daily engagement, not short clinical encounters.
- Partner with states (like New York's AAA and MLTC networks) to scale these proven community services nationally.

Q3. Are there current services being performed to address social isolation and loneliness of persons with Medicare?

Response:

Yes. SADS are already being performed in New York and are proven to reduce social isolation and loneliness for older adults, including many Medicare beneficiaries.

1. Integration with Medicare and Medicaid
    - In New York, SADS are a covered benefit under Medicare-Medicaid integrated plans (dual-eligible plans) administered through MLTC. These programs demonstrate how SADS can be financed as part of a coordinated care model.
    - SADS are also part of New York's Expanded In-Home Services for the Elderly Program (EISEP), which targets low-income older adults who are not Medicaid-eligible, but still need structured support and respite.

2. Persistent Unmet Need
    - Despite their value, these services are underfunded. According to the New York State Comptroller's report, "Support for Aging New Yorkers" (2024), thousands of older adults remain on waiting lists for aging services each year, including adult day programs, congregate meals, and caregiver supports.
    - For example, the report highlights that over 16,000 older New Yorkers annually experience delays accessing services like meals, transportation, and adult day programs due to insufficient funding.

3. Program Activities that Reduce Isolation
   SADS programs directly reduce isolation by:
    - Providing group meals and daily structured activities that foster peer networks.
    - Offering companion calls and digital engagement (tablet programs, video chats) to connect with homebound participants.
    - Hosting cultural programming (music, language, art, intergenerational projects) that builds belonging across diverse communities.

4. Health Impact of Addressing Isolation
    - The *U.S. Surgeon General's Advisory on Social Connection* (2023) found that loneliness increases dementia risk by 50% and stroke risk by 32%, with health effects comparable to smoking 15 cigarettes a day.
    - By providing daily connection and trusted staff oversight, SADS mitigate these risks while also supporting chronic disease management (e.g., encouraging medication adherence, hydration, and healthy routines).

Recommendation to CMS:

- Recognize SADS as reimbursable interventions for social isolation and loneliness under Medicare, building on their inclusion in duals programs and EISEP.
- Establish Medicare billing codes for group social engagement, cultural programming, and technology-enabled connection provided in adult day settings.
- Ensure reimbursement allows scaling to meet current demand and reduce waiting lists, which disproportionately affect low-income and rural older adults.

Q4. Are there current services being performed that improve physical activity?

Response:

Yes. SADS provide daily opportunities for physical activity that improve cardiovascular health, mobility, and independence for older adults, including many Medicare beneficiaries.

1. Integration with Medicaid and Dual-Eligible Plans
    - In New York, SADS are recognized under Medicaid MLTC and Medicare-Medicaid dual-eligible plans, where physical activity programming is routinely offered as part of the service package.

- These programs demonstrate the feasibility and impact of funding physical activity through adult day services, but coverage is fragmented and not available under Medicare fee-for-service.

2. Types of Physical Activity Services Delivered
    - Evidence-Based Programs: *Matter of Balance* and *EnhanceFitness* classes improve balance, strength, and chronic condition management.
    - Group and Individual Activities: Walking clubs, chair yoga, and light aerobics tailored to participant mobility levels.
    - Functional Movement Support: Range-of-motion exercises, fall prevention drills, and assisted stretching.
    - Technology Integration: Some programs provide pedometers or integrate with wearable devices to track daily steps, heart rate, or activity levels.

3. Daily Monitoring and Reinforcement
    - Unlike physician-led care, SADS staff provide daily reinforcement of exercise and self-management routines, helping participants sustain progress and avoid setbacks.
    - Staff are trusted observers who can identify when a participant is at risk for falls, frailty, or decline, and can coordinate timely referrals to providers.

4. Unmet Demand and Waiting Lists
    - Despite proven outcomes, the New York State Comptroller's 2024 report highlights persistent waiting lists for community-based programs, including those offering physical activity and fall prevention.
    - Older adults who could benefit from structured exercise programs often cannot access them due to funding shortages and lack of Medicare reimbursement.

Example:

A participant enrolled in a New York dual-eligible plan attends a SADS program three days per week, where they engage in chair yoga and a structured *Matter of Balance* course. Staff track the participant's progress and communicate improvements to the MLTC care manager. This level of integrated, routine support prevents falls and maintains independence—yet the service has no direct Medicare payment pathway.

Recommendation to CMS:

- Create new codes for supervised physical activity programs offered by trusted community-based providers, including group classes and evidence-based falls prevention programs.
- Permit reimbursement for technology-enabled activity monitoring integrated with chronic care management.
- Build on the Medicaid and dual-eligible plan experience in New York to scale these proven interventions nationally, ensuring equitable access for Medicare-only beneficiaries.

Q5. Should CMS consider creating separate coding and payment for intensive lifestyle interventions?

Response:

Yes. SADS already deliver multi-component intensive lifestyle interventions that address the daily realities of chronic disease prevention and management. These go far beyond brief physician encounters, combining nutrition education, physical activity, medication adherence, behavioral support, and caregiver relief into one coordinated program.

1. Daily Multi-Component Interventions
    - Nutrition: Programs integrate cooking workshops, culturally tailored meals, and ongoing hydration reminders to improve diet quality and reduce malnutrition.
    - Physical Activity: Chair yoga, walking groups, and evidence-based falls prevention programs (*Matter of Balance*) reinforce healthy routines.
    - Medication Adherence: Staff provide reminders and observe self-administration, preventing errors and complications.
    - Behavioral Support: Staff use motivational interviewing techniques and peer support groups to reinforce positive changes in diet, exercise, and self-care.

2. Impact of Addressing Social Isolation
    - According to the *U.S. Surgeon General's Advisory on Social Connection* (2023), social isolation increases the risk of dementia by 50%, stroke by 32%, and premature death by 29%. Its health impact is comparable to smoking 15 cigarettes per day.
    - SADS reduce isolation through structured daily socialization, peer networks, and consistent staff oversight, creating an environment where lifestyle interventions are not only taught, but sustained.

3. Cost Savings Potential
    - By preventing falls, stabilizing chronic conditions, and reducing hospital readmissions, SADS produce downstream Medicare savings. For example, preventing one nursing home placement can save Medicare and Medicaid over $100,000 annually.
    - Programs that keep participants active and engaged reduce reliance on emergency care and institutionalization—interventions proven to be more cost-effective than post-acute treatment.

4. Unmet Need and Waiting Lists
    - The New York State Comptroller's report, "Support for Aging New Yorkers" (2024), highlights that over 16,000 older adults remain on waiting lists annually for community-based programs like adult day services, congregate meals, and transportation.
    - This demonstrates both the demand for intensive lifestyle interventions and the lack of sufficient reimbursement to meet current needs.

5. Caregiver Burden
    - Intensive lifestyle support is not limited to participants. Caregivers also benefit from respite, training, and counseling provided by SADS.
    - Evidence shows that unrelieved caregiver stress is a leading factor in premature nursing home placement, driving up Medicare and Medicaid costs. By sustaining caregivers, SADS extend the ability of families to provide home-based care, delaying or preventing institutionalization.

Example:

A participant with diabetes and hypertension attends a SADS program three days per week. They join a cooking workshop on low-sodium meals, participate in a chair aerobics class, receive daily medication reminders, and benefit from peer support. Staff also communicate with the participant's MLTC care manager to track blood pressure and glucose trends. Meanwhile, their spouse receives daily respite, reducing caregiver stress. This comprehensive support stabilizes chronic conditions and prevents costly emergency room use.

Recommendation to CMS:

- Establish separate coding and payment for intensive lifestyle interventions delivered in community-based settings such as SADS.
- Recognize the unique role of adult day services in sustaining long-term adherence by combining social connection, daily engagement, and caregiver support.
- Incorporate waiting list data and caregiver burden into payment policy, ensuring services are scaled to meet demand and reduce downstream Medicare costs.

Q9. Are there certain existing or new Physician Fee Schedule codes … to better support interventions through partnerships between health care entities and AAAs/community organizations?

Response:

Yes—SADS are natural partners for AAAs and MLTC plans. Programs already deliver Administration for Community Living (ACL)-funded evidence-based services (falls prevention, Chronic Disease Self-Management Program (CDSMP), nutrition).

Recommendation to CMS:

- Create bundled codes for community-delivered, evidence-based programs integrated with physician care plans.

Q10. In consideration that there are significantly more types of coding and payment that describe procedures in the physician fee schedule, please provide feedback regarding whether this detracts from the codes describing services that address underlying health behaviors, chronic disease management, and prevention.

Response:

Yes. The current PFS is heavily weighted toward procedure-based billing codes, which overshadows preventive, behavioral, and community-based interventions. This imbalance undervalues services that address the root causes of chronic disease, such as social isolation, malnutrition, inactivity, and caregiver strain.

1. Lessons from the GUIDE Model
    - CMS's *Guiding an Improved Dementia Experience (GUIDE) Model* recognizes that care coordination, caregiver support, and integration with community-based organizations (CBOs) are essential to improving outcomes and reducing costs for people with dementia.
    - The same principles apply to beneficiaries with multiple chronic diseases—they too need sustained engagement, navigation, and non-clinical supports that fall outside traditional procedure codes.
    - GUIDE demonstrates CMS's willingness to invest in non-procedural supports when evidence shows improved quality of life and cost savings. Expanding this logic to chronic disease prevention would align the PFS with CMS's innovation trajectory.

2. Impact on Beneficiaries with Multiple Chronic Conditions
    - Medicare beneficiaries with two or more chronic conditions account for the majority of Medicare spending, yet they often receive fragmented, episodic care focused on medical interventions rather than daily prevention.
    - SADS fill this gap by providing ongoing supervision, structured lifestyle interventions, and caregiver respite that stabilize chronic conditions and reduce hospitalizations.
    - Example: A participant with heart failure, diabetes, and arthritis attends SADS, where staff provide nutrition support, daily exercise, medication reminders, and social engagement. These interventions prevent falls, improve medication adherence, and reduce caregiver stress—outcomes not captured by current codes.

3. Unmet Demand and Waiting Lists
    - The New York State Comptroller's report (2024) highlights that over 16,000 older adults are on waiting lists annually for community-based programs like adult day services, nutrition, and transportation. This gap illustrates how undervaluing preventive services in the PFS leaves thousands without access to proven interventions.

4. Caregiver Burden
    - Like dementia caregivers supported under GUIDE, caregivers of individuals with multiple chronic diseases face high levels of stress and burnout, often leading to premature nursing home placement.
    - Supporting caregivers through respite and education, as SADS do, is critical to sustaining home- and community-based care and reducing long-term costs to Medicare and Medicaid.

Recommendation to CMS:

- Rebalance the PFS to elevate prevention, behavioral, and community-based codes, drawing on lessons from the GUIDE Model.
- Expand GUIDE-like supports (care coordination, respite, and integration with CBOs) beyond dementia care to beneficiaries with multiple chronic conditions.
- Recognize SADS as eligible billers for these supports, ensuring reimbursement for interventions that reduce hospitalizations, delay institutionalization, and provide measurable cost savings.

Q21. To what extent would new coding … support ACL programs?

Response:

Directly. ACL-funded programs (falls prevention, CDSMP) already embed motivational interviewing, but lack Medicare reimbursement. Codes would allow scaling and sustainability.

Caregiver Support and Respite

Family caregivers are the backbone of the long-term care system. Yet untrained or unsupported caregivers face high levels of stress, depression, and burnout, which often results in increased hospitalizations or premature institutionalization of the individuals they care for. Caregiver burden is a leading factor in decisions to place loved ones into nursing facilities, driving significant costs to both Medicare and Medicaid.

1. Scope of the Challenge
    - In New York, nearly 2.5 million residents provide unpaid family caregiving, representing billions of dollars in economic value.
    - Nationally, research shows that caregivers often experience worse health outcomes themselves, including higher rates of chronic disease, depression, and financial stress.
    - According to the New York State Comptroller's report (2024), demand for caregiver support services exceeds available funding, leaving families without adequate training or respite and creating long waiting lists for services like adult day programs, transportation, and nutrition supports.

2. Role of SADS
    - SADS reduce caregiver burden by providing structured daytime supervision, which allows caregivers to remain in the workforce, rest, or attend to their own health needs.
    - Programs also provide education and skills training to help caregivers manage medications, monitor symptoms, and provide safe daily support at home.
    - Staff frequently serve as trusted navigators, connecting caregivers to local resources, health care providers, and support groups.
    - By offering consistent respite and practical training, SADS extend the capacity of families to care for loved ones at home, delaying or preventing nursing home placement.

3. Evidence of Impact
    - Studies compiled by ARCH (2020) demonstrate that adult day services significantly reduce caregiver stress, depression, and feelings of isolation.
    - The RAISE National Strategy to Support Family Caregivers emphasizes caregiver education, respite coordination, and equitable access to supports as essential to sustaining home- and community-based care.
    - CMS's own GUIDE Model for dementia care affirms the value of caregiver supports—respite, navigation, and coaching—as cost-saving and quality-enhancing. The same principles apply to caregivers supporting loved ones with multiple chronic conditions, not just dementia.

4. Cost Savings
    - Preventing even a single nursing home placement can save Medicare and Medicaid more than $100,000 annually.
    - By reducing caregiver burnout and sustaining home- and community-based care, SADS generate measurable downstream savings while improving quality of life for both participants and their families.

<u>Example</u>:

A caregiver for a participant with heart failure and diabetes uses SADS three days per week. During program hours, the caregiver is able to work part-time and manage their own medical appointments. Meanwhile, SADS staff provide education on fluid management and medication reminders, reducing both participant hospitalizations and caregiver stress. Without respite, this caregiver would likely have been forced to seek nursing home placement.

<u>Recommendation to CMS</u>:

- Create new PFS codes for caregiver education, training, and respite coordination, modeled after supports in the GUIDE dementia program.
- Recognize SADS as eligible billers for caregiver interventions, reflecting their trusted role in supporting both participants and families.
- Scale funding to reduce waiting lists, ensuring equitable access to respite and education for caregivers of individuals with chronic disease.

Conclusion

SADS directly address CMS's priorities in the RFI. By reimbursing SADS under Medicare, CMS can:

- Prevent costly hospitalizations and institutionalization.
- Support caregivers and reduce burnout.
- Expand access to nutrition, activity, and social connection programs.
- Align Medicare payment with evidence-based, community-delivered interventions.

We urge CMS to establish distinct coding and reimbursement for SADS under the PFS, complementing, but not duplicating, Adult Day Health Care.

Respectfully submitted,

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NYSADSA