Mehmet Oz, MD, MBA
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

September 14, 2026

Re: CMS-1848-P Medicare and Medicaid Programs; CY 2027 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Administrator Oz,

The Alzheimer's Association and the Alzheimer's Impact Movement (AIM) appreciate the opportunity to comment on the Calendar Year (CY) 2027 Physician Fee Schedule (PFS) proposed rule.

The Alzheimer's Association is the leading voluntary health organization in Alzheimer's care, support, and research. The Alzheimer's Impact Movement (AIM), a separately incorporated advocacy affiliate, is a nonpartisan, nonprofit organization and works to make Alzheimer's a national priority.

Today, there are an estimated 7.4 million Americans 65 and older living with clinically diagnosed Alzheimer's dementia, and that population may grow to 13.8 million by 2060.[1] Total payments in 2026 for all individuals living with Alzheimer's or other dementias are estimated at $409 billion with Medicare and Medicaid bearing $263 billion - 64 percent - of that figure.[2] Thus, we encourage the Centers for Medicare & Medicaid Services (CMS) to consider the following comments to improve care for this growing population of beneficiaries.

Payment for Medicare Telehealth Services

We fully support CMS's proposal to add HCPCS G-codes GACP1 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), first 20 minutes of clinical staff time with the patient, family member(s), surrogate, directed by a treating physician or other treating qualified health care professional), and GACP2 (Advance care planning, each additional 20 minutes).

Advance care planning is critical to persons affected by dementia. Although Medicare reimburses physicians for visits related to advance care planning, these visits rarely occur. In

[1] Alzheimer's Association. (2026). *2026 Alzheimer's Disease Facts and Figures.*
[2] Ibid.

2017, less than three percent of traditional Medicare beneficiaries had at least one claim for advance care planning. However, compared with individuals without newly diagnosed conditions, Medicare beneficiaries with newly diagnosed Alzheimer's were 1.3 times as likely to have one or more claims for advance care planning.[3] Additionally, racial and ethnic disparities in the completion of advance care planning in the last six months of life are concerning. One group of researchers found that the proportion of Black and Hispanic Medicare beneficiaries with dementia who had completed advance care planning was less than half that of White beneficiaries.[4] Making this service available via telehealth may improve access to and uptake of this underutilized benefit and enhance the quality of life of beneficiaries, their caregivers, and families.

We also urge CMS to pair this proposal with attention to how the requirements accompanying related dementia care services are operationalized. Telehealth is already an established modality for the service most closely adjacent to advance care planning for this population: CMS permanently added CPT code 99483 to the Medicare telehealth services list in the CY 2021 Physician Fee Schedule final rule (85 FR 84472). The practical barrier for persons living with dementia and their families is therefore not whether the service may be furnished remotely, but how its accompanying elements are applied — most notably the requirement that an independent historian be present during the visit. Care partners are frequently long-distance, employed, or otherwise unable to be physically co-located with the beneficiary at the time of the encounter. A rigid reading of "present" risks excluding precisely those families for whom remote care planning would be most valuable.

CMS sub-regulatory guidance already contemplates a degree of flexibility here, recognizing that assessments requiring the direct participation of a care partner may be completed prior to the clinical visit and furnished to the clinician for inclusion in care planning. We ask CMS to build on that guidance and confirm, in the final rule or accompanying manual instruction, that the independent historian requirement may be satisfied where (1) the care partner participates remotely from a separate location by audio-video or, where video is not feasible, by telephone; and (2) the required history and structured caregiver assessments are collected before the encounter and incorporated into the clinician's documentation. We further ask CMS to confirm that GACP1 and GACP2 may be furnished via telehealth and that family members and surrogate decision-makers may participate remotely, so that the new codes are usable by the same families the flexibility above is intended to reach.

Valuation of Specific Codes for CY 2027

Caregiver Training Services

The Alzheimer's Association and AIM deeply appreciate CMS's efforts to acknowledge and better support caregivers of beneficiaries, from their integration into the Guiding an Improved Dementia Experience (GUIDE) Model at the Center for Medicare and Medicaid Innovation to the series of caregiver training services (CTS) codes implemented in recent years.

Nearly half of all caregivers (48 percent)[3] who provide help to older adults do so for someone living with Alzheimer's or another dementia. Nearly 13 million Americans will provide unpaid

[3] Ibid.

care for people with Alzheimer's or other dementias in 2026, a contribution to the nation valued at more than $446 billion.[4]

Caregivers are critical to the daily health and well-being of individuals living with dementia: they assist with activities of daily living and instrumental activities of daily living; adhering to medication and treatment regimens and managing comorbidities; managing behavioral symptoms of the disease such as aggressive behavior, wandering, depressive mood, and agitation; finding and using community support services; addressing family issues related to caring for a relative with Alzheimer's disease or related dementias; and providing emotional support and a sense of security.

While many caregivers find this role rewarding, it can take an enormous toll: compared with caregivers of people without dementia, twice as many dementia caregivers indicate substantial emotional, financial, and physical difficulties. The prevalence of depression is higher among dementia caregivers (30 percent to 40 percent) than other caregivers and the prevalence of anxiety among dementia caregivers is 40 percent or more, which is higher than among caregivers of people with stroke (31 percent). Evidence also suggests that the stress of providing dementia care increases caregivers' susceptibility to disease and health complications.[5] For these reasons, caregiver training benefits both the beneficiary and the caregiver.

Therefore, we are concerned that CMS appears to be questioning the value of three of the most recent CTS codes, G0541, G0542, and G0543 (direct care strategies). While we appreciate CMS's diligence in making the payment system as efficient as possible, these codes are still new and, as is typical with new codes, utilization has been low. We refer CMS to AARP's 2026 "Exploring Utilization and Advancing Impact of Caregiver Training Services" brief on CTS code utilization and the challenges that the codes may face: awareness and understanding, coverage and reimbursement inconsistencies, and provider education on family caregiver integration, among others. The brief establishes steps to promote utilization, and the Alzheimer's Association and AIM would be pleased to collaborate with CMS to preserve, promote, and improve access to these services that have the potential for enormous impact on beneficiaries, caregivers, and the Medicare program.

Comment Solicitation on Payment for Physician-Patient Clinical Trial Discussions
While great therapeutic strides have been made in recent years, only two treatments are available that change the underlying biology of Alzheimer's and slow cognitive decline, and the treatments are only for people with mild cognitive impairment or mild dementia due to Alzheimer's. People with moderate or severe Alzheimer's dementia have no therapeutic options, save drugs to lessen symptoms. Furthermore, research advances have made it possible to detect Alzheimer's biomarkers in individuals without symptoms - which might be the most effective time to intervene - but they also have no therapeutic options today. The demand for clinical trial participants remains as important as ever.

We therefore strongly support the new code CMS is considering, which would reimburse physicians and other qualified health care professionals for time spent discussing clinical trial

[4] Ibid.
[5] Ibid.

options with patients, and we encourage CMS to establish it. CMS correctly identifies clinician time and administrative burden as the operative barrier to these conversations and correctly observes that the existing E/M code family does not recognize them as distinct elements. In Alzheimer's disease, that gap is especially consequential especially for more advanced individuals, because a well-conducted trial discussion is substantially more involved than a general counseling conversation: it routinely requires assessing decisional capacity; identifying and counseling a study partner, whose sustained participation most Alzheimer's protocols require; explaining biomarker or genetic testing that may condition eligibility and the disclosure implications that follow; describing monitoring requirements such as serial imaging; and working through the travel and caregiving logistics that determine whether participation is realistic for the family.

To ensure the code reaches the beneficiaries who need it most, we suggest CMS make three design choices. First, payment should be attached to the counseling service itself, without regard to whether the beneficiary ultimately enrolls in a clinical trial. Second, CMS should not require that the billing practitioner be an investigator on the trial discussed; doing so would confine the benefit to academic medical centers and Alzheimer's Disease Research Centers and exclude the community neurologists, geriatricians, and primary care practitioners who see the majority of Medicare beneficiaries with cognitive concerns. Third, the service should be available via telehealth, and a study partner or care partner should be permitted to participate remotely from a separate location (if required for the specific trial and/or patient visit) — Alzheimer's trial sites are geographically concentrated, and the beneficiaries for whom a trial discussion is most consequential are often those least able to travel.

The Alzheimer's Association would be pleased to support CMS in the implementation of such a code, including by educating providers and beneficiaries about our TrialMatch® program, which connects individuals living with cognitive impairment or dementia, caregivers, and healthy participants with current research studies.

Request for Information (RFI): Redesigning Primary Care to Make America Healthy Again
As more diagnosis, care and prevention of cognitive decline move into the primary care setting, we appreciate CMS reconsidering how to value primary care codes to better support high-value care and offer the following thoughts and recommendations.

Reconsidering Relative Primary Care Payment in the Medicare Physician Fee Schedule and the Care Management Code 'Family"
Given the longer-term and evolving care needs of persons living with mild cognitive impairment or dementia, we encourage CMS to ensure that any "two-track" or technology-enabled restructuring continues to adequately support complex, longitudinal dementia care and does not erode the codes people with dementia rely on.

We also reiterate our suggestion in our CY 2026 PFS comments that CMS consider removing the cognitive assessment module of the Annual Wellness Visit (AWV) and creating a separate billing code for it. In light of the recent development, approval, and coverage of treatments for Alzheimer's disease, early detection and diagnosis have never been more important. Creating a separately billable code to conduct routine, structured cognitive assessments will help to drive

earlier detection and diagnosis, leading to better outcomes for beneficiaries and caregivers. This new separately billable code would complement the existing CPT code 99483 by creating a clearer preventive brain health pathway upstream of it.

With regard to prevention and considering the evidence around lifestyle interventions discussed beginning on page 5 of these comments, CMS should also consider a new billing code for brain health prevention services, counseling, and/or advice.

Finally, few quality measures related to cognitive decline and dementia risk factors currently exist. While there are measures on control of hypertension, diabetes, and tobacco use, we note that no quality measures exist on obesity (except for children), exercise, sleep assessment, nutrition, or head injury. We recommend that CMS support the development and use of such preventive quality measures in primary care.

Payment Implications of Technology Enablement of Primary Care

While we see real promise in technology-enabled approaches to cognitive detection in the AWV, we encourage CMS to support evidence-based digital cognitive assessment tools while ensuring that payment and care delivery policies reflect the evidence regarding their appropriate use. Today, these tools can help make detection more consistent and support practices in cognitive workups, while clinical interpretation remains important to understanding results in the context of factors such as education, primary language, hearing, mood, and other patient-specific considerations. As these technologies continue to evolve, CMS should maintain flexibility to incorporate new evidence regarding their capabilities and appropriate role in care. We encourage CMS to ensure that its approach supports innovation while preserving appropriate clinical judgment and safeguards for patients.

Request for Information (RFI) on Community-based Palliative Care

The Alzheimer's Association and AIM appreciate CMS's continued efforts to advance access to and utilization of palliative care services, including its focus on expanding opportunities for beneficiaries, which includes people living with moderate-to-severe dementia, to receive these services. For people living with dementia, palliative care can be beneficial across a long disease course, well before any determination of terminal status, making access important throughout the progression of the disease rather than only at the end of life.

As we have in other recent comments, we urge CMS to pursue as many options as possible to strengthen palliative care outside of the hospice benefit. Researchers have found reductions in hospitalizations at the end of life for individuals receiving palliative care. For nursing home residents with moderate-to-severe dementia, those who received an initial palliative care consultation between one and six months before death had significantly fewer hospitalizations and emergency department visits in the last seven and 30 days of life compared with those who did not receive palliative care. Individuals with an initial palliative care consultation within one month of death also had significantly fewer hospitalizations in the last seven days of life compared with those who did not receive palliative care.[6] This type of care can have a significant impact on individuals' health and well-being and the system alike.

[6] Ibid.

We would welcome the opportunity to work with CMS to identify examples that reflect how our constituents experience and benefit from palliative care, and we support CMS's continued efforts in this area and encourage the agency to keep the needs of people living with dementia and their caregivers in mind as it advances them.

Request for Information (RFI) on Intensive Lifestyle Interventions to Slow Progression of Alzheimer's Disease

The Alzheimer's Association and AIM are deeply grateful to CMS for its acknowledgment of and interest in the emerging science of brain health and reducing the risk of cognitive decline through lifestyle interventions. This is a shared priority with the Alzheimer's Association, as evidenced by our funded studies and initiatives. Many of the following responses are based on the evidence base from the U.S. Study to Protect Brain Health through Lifestyle Intervention to Reduce Risk, known as U.S. POINTER.[7] U.S. POINTER found that healthy lifestyle changes - specifically a combined exercise, nutrition, cognitive training, and heart health monitoring program - can meaningfully protect brain health. This study is the first large-scale, randomized controlled clinical trial to demonstrate that an accessible and sustainable healthy lifestyle intervention can protect cognitive function in representative populations in communities across the United States. Cognitive scores improved in both study arms - a structured intervention and a self-guided intervention. The structured intervention, however, produced a statistically significantly greater rate of improvement in cognition than the self-guided intervention, which amounted to a cognitive age up to two years younger.

More recently, the promising results of the Latin American Initiative for Lifestyle Intervention to Prevent Cognitive Decline (LatAm-FINGERS)[8] reported findings that two culturally tailored lifestyle interventions (differing in terms of structure and accountability for the participants) improved memory, thinking, and overall cognitive function in older adults at risk of dementia across Latin American countries, with the strongest gains seen in participants receiving structured support and coaching. Participants in the structured arm showed 55 percent greater improvement on a composite measure of global cognition than those in the flexible arm.

- Given the discussion of the evidence to date on the effectiveness of intensive lifestyle interventions for CMS to pursue, we are particularly interested in demonstrations of cost-savings associated with these and other interventions. Please cite any evidence available in your discussion.

Although direct evidence of cost savings from dementia prevention interventions is limited, several studies have identified potential reductions in health care utilization and substantial downstream savings associated with reducing dementia risk factors and cognitive decline. At this year's Alzheimer's Association International Conference®, researchers from the University of

[7] Baker LD, Espeland MA, Whitmer RA, et al. Structured vs Self-Guided Multidomain Lifestyle Interventions for Global Cognitive Function: The US POINTER Randomized Clinical Trial. JAMA. 2025;334(8):681–691. doi:10.1001/jama.2025.12923

[8] Crivelli L, Suemoto C, Sosa A et al.
Multidomain lifestyle intervention for the prevention of cognitive decline in at-risk older adults in Latin America (LatAm-FINGERS): a single-blind, multicentre, randomised controlled trial
The Lancet, 2026; 408, 417-429

Southern California[9] determined that the improved cognition and reduced frailty are associated with better labor market outcomes and lower health care utilization, potentially resulting in billions in savings, although additional data and analysis is needed.

A 2022 model[10] of the potential cost-effectiveness of the Finnish Geriatric Intervention Study to Prevent Cognitive Impairment and Disability (FINGER) program[11] suggested that programs like FINGER have the potential to be cost-effective in preventing dementia.

While not related to an intervention, 2014[12] and 2021[13] modeling related to a reduction in risk factor prevalence at the population level indicates fewer projected cases of Alzheimer's. Although these assume causal links, one could infer that cost savings would result from fewer people with Alzheimer's. Finally, a 2014 study[14] estimated that a 10 percent reduction in the prevalence of various risk factors among baby boomers would save Medicare and Medicaid money over the life of the baby boomer cohort:

- A reduction in body mass index among overweight and obese individuals would save Medicare $6 billion and Medicaid $35 billion;
- A reduction in cardiovascular diseases would save Medicare $20 billion and Medicaid $17 billion;
- A reduction in diabetes would save Medicare $7 billion and Medicaid $1 billion; and
- A reduction in hypertension would save Medicare $12 billion and Medicaid $12 billion.

- Given the emerging role of biomarker diagnostic testing (for example, p-tau217, et. al) for AD/ADRD leading to early diagnosis, please provide any evidence supporting earlier detection and its role in supporting improving AD/ADRD care and any potential role in identifying eligibility for an intensive lifestyle intervention focused on AD/ADRD.

Evidence on earlier detection.

We note for CMS's consideration a recent analysis demonstrating increased use of biomarker testing in diagnosis and that the diagnosis stage has shifted slightly earlier, meaning that mild dementia accounted for a larger proportion of newly diagnosed patients where, prior to the

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[9] Chapel J et al. 2026 AAIC Presentation; publication in development.
[10] Wimo A, Handels R, Antikainen R, et al. Dementia prevention: The potential long-term cost-effectiveness of the FINGER prevention program. Alzheimer's Dement. 2023; 19: 999–1008. https://doi.org/10.1002/alz.12698
[11] Ngandu T, Lehtisalo J, Solomon A, et al. A 2 year multidomain intervention of diet, exercise, cognitive training, and vascular risk monitoring versus control to prevent cognitive decline in at-risk elderly people (FINGER): a randomised controlled trial. Lancet. 2015; 385: 2256-2263.
[12] Norton S, Matthews F, Barnes D et al.
Potential for primary prevention of Alzheimer's disease: an analysis of population-based data
The Lancet Neurology, 13, 788-794
[13] Advisory Council on Alzheimer's Research, Care, and Services Risk Reduction Subcommittee. 2021 Proposed Recommendations. https://aspe.hhs.gov/sites/default/files/2021-09/NAPA-2021-Risk-Reduction-Recommendations.pdf
[14] Pei-Jung Lin, Zhou Yang, Howard M. Fillit, Joshua T. Cohen, and Peter J. Neumann. Unintended Benefits: The Potential Economic Impact Of Addressing Risk Factors To Prevent Alzheimer's Disease. Health Affairs 2014 33:4, 547-554 10.1377/hlthaff.2013.1276

availability of these tests, more people were staged at diagnosis as moderate or severe.[15] This shift is allowing more individuals to gain access to treatments and to take advantage of non-pharmacological care - such as care planning, care coordination, and advance care planning - at a more meaningful point in the disease continuum. The window for intervention is wider still than diagnosis suggests: physiological changes marking the earliest stages of Alzheimer's disease can begin up to 20 years before measurable cognitive impairment, and an estimated 4.2 million Americans are living with MCI due to Alzheimer's in addition to the 7.4 million living with clinical Alzheimer's dementia.[n]

What beneficiaries want, and when.

The Alzheimer's Association's 2026 Special Report, *Brain Health in America: Understanding and Supporting Lifelong Cognitive Health*, surveyed a nationally representative sample of 3,829 U.S. adults age 40 and older through the University of Michigan National Poll on Healthy Aging.[n] It documents both strong demand for brain health guidance and a striking absence of it in clinical practice. Sixty-eight percent of respondents reported worry about developing Alzheimer's or another dementia, and 99 percent said brain health is at least as important as physical health - yet only 9 percent said they know a lot about how to maintain it. Two in three (66 percent) identified their health care provider as their preferred source of brain health information, and only 2 percent were not interested in receiving it from a provider at all. Despite this, only 14 percent reported ever having discussed maintaining brain health with a physician, and only 11 percent had discussed ways to reduce dementia risk.[n]

Most relevant to CMS's question, the survey asked when beneficiaries want these conversations to occur. Eighty-six percent said they want brain health education during an annual exam *regardless of whether they are experiencing memory issues*. Forty-one percent supported a conversation prompted by a cognitive screening showing memory and thinking problems. Only 19 percent identified a dementia diagnosis as the appropriate trigger. [n] Beneficiaries are asking for brain health guidance upstream of detection, not downstream of it.

Implications for ILI eligibility.

Biomarker testing has not been used to establish eligibility for the multidomain lifestyle trials conducted to date; FINGER, U.S. POINTER and LatAm-FINGERS enrolled on clinical and demographic risk criteria, and cognitive impairment was a U.S. POINTER exclusion. The *Special Report*'s findings reinforce that a biomarker-conditioned eligibility standard would be poorly matched to how beneficiaries actually engage with brain health. Notably, adults with a family history of Alzheimer's reported substantially higher worry about developing the disease (80 percent versus 57 percent) but their interest in a brain health lifestyle program was no greater than that of adults without a family history.[n] Elevated risk status, in other words, does not predict who will seek out or benefit from these programs - demand is broad-based. Conditioning eligibility on biomarker confirmation would narrow the benefit away from the population in which effectiveness has been demonstrated.

- What are the essential domains to address in a multi-domain intensive lifestyle intervention to reduce the risk of cognitive decline for older adults at risk for developing AD/ADRD that would be appropriate to include under Medicare?

As discussed above, U.S. POINTER domains included exercise, nutrition, cognitive training, and health monitoring (including cardiovascular and metabolic health) and LatAm-FINGERS domains included physical activity, healthy eating, cognitive training, and social engagement. Researchers from University of California, Davis and Wake Forest School of Medicine presented initial analysis of the U.S. POINTER data suggesting the combination of the intervention components was greater than any one individual component for its impact on cognition, and that the synergy is an important aspect of the intervention.[15]

- Should these interventions be made available as a one-time service (that is, to teach older adults how to make changes in their lifestyle to help reduce AD/ADRD risk) or on a recurring basis?

While education and information are important, U.S. POINTER and LatAm-FINGERS demonstrate that an ongoing intervention is more likely to generate success than a one-time service. The details of several repeated aspects of the U.S. POINTER intervention are discussed below. Both studies are continuing to follow participants to better understand and inform the long-term impact of lifestyle intervention on brain health and dementia risk.

- Should the eligibility for these services be restricted to beneficiaries with a diagnosis of mild cognitive impairment (MCI), or early-stage dementia? If so, how should this diagnosis be made or confirmed?

We note that both U.S. POINTER and LatAm-FINGERS studied and found positive impacts in at-risk populations, not individuals with MCI or early-stage dementia. Both studies have continued extensions where there is no active intervention, but continued health and cognitive assessments (annually). This data will likely inform this question in the future.

In considering interventions that could benefit people living with cognitive impairment, we refer CMS to Barnes, et al.[16] and their investigation into interventions that can support a high quality of life.

- Given that intensive lifestyle interventions (ILIs) are multi-domain, and likely include physical activity, nutrition, potentially additional domains such as sleep and stress management, who are the essential interdisciplinary team members that CMS should account for in developing appropriate resource costs for future services?

[15] Whitmer R et al. 2026 AAIC, paper in development.

[16] Barnes DE, Jiang F, Benjamin C, Lee JA, Sudore RL, Mehling WE, Chesney MA, Chao LL, Nicosia FM. Livestream, group movement program for people living with cognitive impairment and care partners: A randomized clinical trial. Alzheimers Dement (N Y). 2024 May 2;10(2):e12467. doi: 10.1002/trc2.12467. PMID: 38698931; PMCID: PMC11064212.

Specific to U.S. POINTER – but conceivably for any intensive lifestyle intervention – we highlight the need for trained brain health coaches or navigators to bridge the gap between traditional health care systems and the community-based organizations (CBOs) that actually administer most of the intervention activities. We note for CMS's consideration the findings by Johnson, et al.,[17] regarding community health workers' capability to serve as navigators in this context. The agency should carefully examine and anticipate these roles as it considers developing and/or implementing lifestyle interventions.

- How should supervision be determined for AD/ADRD ILI's? Is general supervision sufficient for ensuring clinical safety and oversight? Is direct supervision required?

The U.S. POINTER study included an intervention oversight committee that worked with the teams (1-2 people) delivering the interventions at each study site to help ensure fidelity, and the Association, with our collaborators at Wake Forest School of Medicine, is currently working to develop core support and training for those who will deliver interventions in the future. We would be pleased to share those materials with CMS.

A U.S. POINTER-type intervention is also not designed to be run out of a doctor's office; it is designed to be administered by a CBO or affiliate of some sort upon referral from a clinician, akin to the National Diabetes Prevention Program (NDPP). As in the NDPP, the best way to ensure oversight is to create a system where community programs are certified as being compliant with a proven intervention, such as U. S. POINTER, and then allow those CBOs to be eligible for Medicare reimbursement in this context. Such a certification process helps ensure quality control, and direct Medicare payments to CBOs gives CMS a greater degree of oversight and audit control. As the Centers for Disease Control and Prevention certifies the NDPP, CMS could serve in that capacity or designate a duly qualified private entity.

- What is the minimum frequency of sessions for an AD/ADRD ILI per week? What is the minimum number of weeks that will be necessary?

The participants in the structured arm of U.S. POINTER attended 38 facilitated team meetings over two years with structured intervention navigators and interventionists, and received activity plans that included aerobic (4 days per week, 30-35 minutes per session), resistance (2 days per week, 15-20 minutes per session), and flexibility (2 days per week, 10-15 minutes per session) training; guidelines for following the MIND diet; web-based cognitive training three times per week; and biannual review of abnormal laboratory results with reinforcement of intervention goals. However, this level of intensity may not be necessary or appropriate in a real-world setting. Implementation studies could help address this question. The dementia-specific carveout in MAHA ELEVATE is helpful, and CMS should consider funding additional implementation studies. These studies could also provide data on adherence to the intervention and a better understanding of the extent to which each component of POINTER contributes to the overall impact on cognition when delivered through a program (and not a trial).

[17] Johnson E, Lewis M, Nordyke A, Lee M, Roberts S, Gaugler JE, Borson S. Community health workers: developing roles in public health dementia efforts in the United States. Front Public Health. 2025 Jul 2;13:1616404. doi: 10.3389/fpubh.2025.1616404. PMID: 40672929; PMCID: PMC12263905.

- Should CMS require a future AD/ADRD ILI to be delivered in person? Can it be delivered virtually?

While implementation studies will provide evidence to speak to the most effective methods of delivery in communities, we note that Baker, et al.,[18] found that the COVID-19 pandemic required various adaptations to keep U.S. POINTER participants engaged and that those were ultimately successful in retaining 98 percent of those participants by the time the study restarted. There are many potential means of delivery, but adherence to reaching the behavioral change is key.

In conclusion, we and other stakeholders are following the longitudinal cohorts in U.S. POINTER and working to advance implementation studies. The results of these efforts will be critical to better understanding what may contribute to the prevention of cognitive decline. We look forward to sharing those with CMS as they become available.

Proposed Substantive Changes to Previously Finalized MIPS Quality Measures for the CY 2027 Performance Period/2029 MIPS Payment Year and Future Years

Finally, we note with gratitude CMS's proposal to amend the wording of the measure "Dementia: Education and Support of Caregivers for Patients with Dementia" by clarifying that the caregivers to be measured are not part of the licensed care team. This amendment further recognizes unpaid caregivers' essential role in patient care. We thank CMS and the American Academy of Neurology for this thoughtful update.

Thank you for the opportunity to comment. The Alzheimer's Association and AIM would be glad to serve as a resource to CMS as it considers these important issues and how they relate to individuals living with Alzheimer's and related dementias. Please contact Laura Thornhill, Director, Regulatory Affairs, at 202-638-7042 or lthornhill@alz-aim.org if you have questions or if we can be of additional assistance.

Sincerely,

Robert Egge
Chief Public Policy Officer, Alzheimer's Association
President, Alzheimer's Impact Movement

18 Baker LD, Espeland MA, Whitmer RA, Kivipelto M, Antkowiak S, Chavin M, Cleveland M, Correia S, Day CE, Elbein R, Farias ST, Gitelman DR, Graef S, Katula JA, Lambert K, Leng XI, Lovato L, Morris MC, Ngandu T, Papp KV, Pavlik V, Raman R, Robertson J, Rushing S, Salloway SP, Solomon A, Tangney CC, Ventrelle J, Williams BJ, Williamson JD, Wilmoth S, Wing RR, Woolard N, Yu M, Snyder HM, Carrillo MC; U.S. POINTER Study Group. U.S. POINTER: Lessons learned about delivery of a multi-domain lifestyle intervention during the COVID-19 pandemic. Alzheimers Dement. 2021 Dec;17(Suppl 10):e055289. doi: 10.1002/alz.055289. Epub 2021 Dec 31. PMCID: PMC9011466.