

April 13, 2026

The Honorable Shelley Moore Capito, Chair
The Honorable Tammy Baldwin, Ranking Member
Subcommittee on Labor, Health and Human Services, Education and Related Agencies
Committee on Appropriations
United States Senate
Washington, D.C. 20510

Dear Chair Capito and Ranking Member Baldwin,

On behalf of 15 national aging, health, family caregiver and bone health organizations, we are writing to express our sincere thanks for your longstanding efforts on behalf of the more than 50 million Americans who have or are at risk of osteoporosis and to request the Subcommittee's continued attention to the crisis in bone health and osteoporosis as you consider fiscal year 2027 appropriations for the Department of Health and Human Services. As you know, one in two women and one in four men over the age of 50 will suffer a bone fracture in their lifetime due to the chronic disease osteoporosis. In 2018 alone, approximately 1.8 million Medicare beneficiaries—70 percent of them women—experienced about 2.1 million osteoporotic fractures.

The breadth and scale of the impact of fractures tied to osteoporosis is stunning:

- 30% of those who suffer hip fractures die within a year.
- 42,000 patients institutionalized in nursing homes within three years.
- 23% of opioid-naïve hip fracture patients became chronic opioid users after surgery.
- Without reforms, total annual cost among Medicare beneficiaries will grow from \$57 billion in 2018 to over \$95 billion in 2040, as our population ages.

Our investments in research have given us the tools to reduce the rate of fractures and lower costs, but few Medicare beneficiaries receive them:

- Only 20% of hip fracture patients receive medication proven to greatly reduce the risk of a second fracture, compared to 95% of heart attack patients receive medication to prevent another heart attack.
- Only 8% (and only 5% of Black Americans) are even screened for osteoporosis within 6 months of an initial fracture.
- Few Medicare beneficiaries receive evidence-based post-fracture care demonstrated to greatly reduce repeat fractures and costs.

While lowering the costs associated with many debilitating conditions requires additional research, new breakthrough treatments and/or expensive legislative mandates, this can be

done for osteoporosis right now through simple administrative action. A broad coalition of health professional and patient advocacy organizations has worked to develop, in consultation with CMS, a care coordination payment mechanism that assures beneficiaries who suffer an osteoporotic fracture get the evidence-based post-fracture care they need to help reduce their risk for a preventable but all-too common second fracture. We have been greatly disappointed that CMS did not act on our recommendations or the Subcommittee's report language by including new G-codes in its 2026 Medicare physician payment updates.

We greatly appreciate the Subcommittee including report language on this in its FY26 report, but because CMS has not yet acted, we respectfully request the Subcommittee include language in its FY2027 report (specific language is attached) calling on CMS to adopt changes to improve post-fracture care, including promptly providing guidance to providers on how to best use existing Medicare codes to bill for this care while new regulations are finalized.

Medicare has implemented similar payment reforms to improve outcomes in conditions like opioid use disorder and pain management. Independent auditing firm Milliman found that reducing just 20 percent of repeat/secondary fractures would save up to \$1.1 billion in Medicare fee-for-service spending alone over 3 years.

Thank you so much for your attention to this very important and growing health crisis. We would be happy to answer any questions you may have. Please contact Claire Gill, CEO of the Bone Health and Osteoporosis Foundation at (703) 647-3025 or cgill@bonehealthandosteoporosis.org.

Sincerely,
Bone Health and Osteoporosis Foundation
Alliance for Aging Research
Alliance for Women's Health and Prevention
Caregiver Action Network
Celiac Disease Foundation
Global Healthy Living Foundation
HealthyWomen
National Alliance for Caregiving
National Asian Pacific Center on Aging
National Council on Aging
National Menopause Foundation
National Spine Health Foundation
Obesity Action Coalition
Society for Women's Health Research
TOUCH, The Black Breast Cancer Alliance

cc: The Honorable Susan Collins, Chair, Committee on Appropriations
The Honorable Patty Murray, Ranking Member, Committee on Appropriations

(Center for Medicare and Medicaid Services; Program Operations)

Reducing Costly Osteoporotic Fractures. The Committee remains concerned that every year 1.8 million older Americans suffer over 2 million bone fractures related to osteoporosis at estimated national cost of over \$57 billion and that most are not getting the evidence based post fracture care proven to reduce costly and preventable secondary fractures. The Committee included language about this in its FY26 report and again calls on CMS to establish a clear payment mechanism for evidence-based post-fracture care that has been shown to reduce the rates of costly secondary fractures through improved screening, treatment initiation and adherence, patient and caregiver education and counseling, and comprehensive falls prevention strategies. *The Committee also directs CMS to work with professional societies and patient organizations to promptly publish a [Medicare Learning Network Matters](#) article detailing how providers can use existing Medicare codes to bill for such evidence-based post-fracture care.*

Background:

Up to 2.1 million osteoporotic bone fractures were suffered by approximately 1.8 million Medicare beneficiaries in 2016. That is more than the number of heart attacks, strokes or new breast cancer cases. The total annual cost for osteoporotic fractures among Medicare beneficiaries was \$57 billion in 2018 and without reforms is expected to grow to over \$95 billion in 2040, as our population ages. Those who suffer a first fracture are at very high risk of another fracture. Yet, most are not getting the follow-up care proven to reduce subsequent fractures because Medicare payment codes do not incentivize its use. Leading health systems have successfully employed models of coordinated post-fracture care and successfully reduced the rate of secondary (repeat) fractures and lowered costs.

These secondary fracture prevention models (sometimes called fracture liaison service) have been in operation for more than 20 years in leading health systems in the U.S. and in countries around the world. A [demonstration by the VA](#) also found this coordinated post-fracture care improved care and reduced fractures and costs. These models are typically headed by a nurse coordinator who utilizes established protocols to ensure that individuals who suffer a fracture are identified and a care plan is established and implemented to assure receipt of appropriate screening, treatment and patient and caregiver education and counseling. Many models have incorporated a pharmacist in the care coordination team to enable prompt resolution of patient concerns related to prescribed medications and improved medication adherence. A population registry of fracture patients is typically established as well as a process and timeline for patient assessment and follow-up care. In addition to managing osteoporosis, where appropriate, these programs will refer patients to fall prevention services.

Numerous studies have demonstrated the effectiveness of model post-fracture care. For example, Kaiser Permanente demonstrated that its program reduced the expected hip fracture rate by over 40% (since 1998). If implemented nationally, Kaiser estimates a similar effort could reduce the number of hip fractures by over 100,000 and save over \$5 billion/year. A recent meta-analysis of 159 publications evaluating their impact found that patients receiving care

from a model post fracture program had higher rates of bone density testing (48.0% vs 23.5%), treatment initiation (38.0% vs 17.2%) and greater adherence to treatment (57.0% vs 34.1%).

Medicare payment codes do not clearly capture many of the costs associated with providing this model post-fracture care. That is why all the leading professional societies and patient organizations have worked over the past 5 years to develop a set of unique Medicare G codes that effectively capture these services. The codes would incentivize many more health professionals and systems to adapt this model of care. In addition, inquiries by leading patient organizations have found that many providers are discouraged from billing for components of model post-fracture care using existing codes for fear of spurring costly and time-consuming Medicare audits. Therefore, as CMS works on finalizing new G codes for this care it should work with professional societies and patient organizations to promptly publish a [Medicare Learning Network Matters](#) article detailing how providers can use existing Medicare codes to bill for such evidence-based post-fracture care.