NATIONAL ALLIANCE FOR CAREGIVING
Making Caregiving More Sustainable, Dignified, and Equitable

September 9, 2024

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services Department of Health and Human Services
Attention: CMS-1784-P Mail Stop C4-26-05 7500 Security Boulevard
Baltimore, MD 21244-1850

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

**RE: CMS-1807-P: CY 2025 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Prescription Drug Inflation Rebate Program**

Dear Administrator Brooks-LaSure:

On behalf of the National Alliance for Caregiving, we appreciate the opportunity to comment on the CY 2025 Physician Fee Schedule (PFS) proposed rule (CMS-1807-P).
The National Alliance for Caregiving (NAC) is a national system change organization focused on building health, wealth, and equity for family caregivers through research, cross-sector partnerships, and advocacy. We envision a society that values, supports, and empowers our nation's 53 million family caregivers to thrive at home, work, and life. Family caregivers form the backbone of our healthcare system and economy, yet often go unrecognized. These dedicated individuals provide vital support to relatives, chosen family, and friends as they navigate aging, serious illness, and disability.[1]

The CY2025 Medicare PFS proposed rule continues to advance systemic changes that recognize and honor the vital role of family caregivers within healthcare teams. The proposed rule builds off advances made in the FY2024 PFS final rule, and we applaud CMS for its role in advancing vital cross-cutting action from federal policymakers to mitigate the growing challenges facing family caregivers. The proposed rule also provides an ongoing opportunity to identify, implement, and improve policies to support caregivers in support of these outcomes. CMS serves a critical role in ensuring that the federal government achieves the ambitious, but essential, goals included in myriad national commitments to caregivers.

As the population of older adults grows at an historic rate, this growth increases the demands placed on family caregivers. According to Caregiving in the US, a joint report of the National Alliance for Caregiving (NAC) and AARP, between 2015 and 2020, the number of unpaid family caregivers increased by more than ten million, to fifty-three million family caregivers—and the ratio of available caregivers to those who need care—is declining.[2] In addition, family caregivers provide an estimated $600 billion worth of care for people navigating serious illness, disability,

and aging,[3] policies and actions that make caregiving more equitable, sustainable, and dignified will benefit the Medicare and Medicaid programs and positively affect the health of these beneficiaries. As CMS considers comments in response to the CY2025 Medicare PFS proposed rule, we urge the agency to boldly pursue opportunities to strengthen and broaden supports for a growing caregiving community.

**The National Alliance for Caregiving appreciates the context in which CMS has proposed changes for CTS and other critical services affecting millions of family caregivers, and we offer the following comments in response to changes proposed for CTS in the CY 2025 Physician Fee Schedule:**

1. Establish new coding and payment opportunities for caregiver training services for direct care services and supports that include specific clinical skills aimed at enabling caregivers to provide hands-on treatment, complication mitigation, infection care, and patient monitoring;
2. Provisionally add CTS to the Medicare Telehealth Services List;
3. Establish a new coding and payment allowance for caregiver behavior management and modification training for caregiver(s) of an individual patient; and
4. Allow for verbal consent for CTS.

In addition, we appreciate the opportunity to respond to the agency's request for information regarding services addressing health-related social needs (HRSN) including Community Health Integration (CHI) and Principal Illness Navigation (PIN) services (PIN). Ensuring successful implementation of services to address patients' HRSNs has the potential to alleviate burden on family caregivers.

1. **Establishing new coding and payment opportunities for caregiver training for direct care services and supports**

According to the most recent and industry-standard research conducted by NAC and AARP,[4] six in ten family caregivers assist with medical and nursing tasks such as injections, tube feedings, and changing catheters. Unfortunately, according to the same report, fewer than three in ten caregivers surveyed (29 percent) said they have had general conversations with health professionals, such as a doctor, nurse, or social worker, about their caregiving duties. Only 13 percent said a healthcare professional has asked what they need to take care of themselves.

Furthermore, only seven percent report receiving any training related to tasks they perform.[5] Black and Latino American caregivers (67 percent each) more often help with medical/nursing tasks than do White caregivers (52 percent). While four in ten caregivers are in high-intensity caregiving situations, the proportion of caregivers (31 percent) who reported difficulty in coordinating care among healthcare providers is growing.[6]

We commend CMS for proposing training supports for caregivers who are providing care requiring medi2cal and clinical skills including hands-on treatment, patient monitoring, and reducing complications as described in HCPCS Code GCTD1, HCPCS Code GCTD2, and HCPCS Code GCTD3.

We agree that expanding available caregiver training services beyond functional skills and behavior management/modification to include training for the sixty percent of family caregivers who are assisting with direct-care management—such as wound care and dressing and

infection control—will contribute to improved patient safety and support treatment goals. This is especially important for family caregivers managing complex chronic diseases, serious illnesses, and disabilities such as cancer, transplant-related conditions, and dementia.

2. **Provisionally adding CTS to the Medicare Telehealth Services List**

We applaud CMS for heeding recommendations to add CTS to the list of available telehealth services in CY 2025. While we understand that there is limited current evidence justifying permanent inclusion on the list of available telehealth services, we agree that provisionally adding these services will allow providers to implement CTS more broadly and build that evidence base.

We hope provisionally adding these services will support the ongoing work of researchers to better understand and document the instrumental role of caregivers in supporting patients at home and in their communities. Fostering research is particularly important as practitioners continue to develop and scale interventions to improve their training and support family caregivers, especially among caregivers from racial/ethnic, cultural, economic, and linguistically diverse backgrounds, as well as providing opportunities for innovation into interventions that improve the caregiver's skills in providing direct care.[7]

We believe that including CTS on the list of available telehealth services will be particularly important for the 12 percent of family caregivers who live in rural settings.[8] These rural caregivers often contend with significant barriers to accessing healthcare and support services. A 2009 report from the Rural Health Research & Policy Centers found that 77 percent of rural counties are designated as Health Professional Shortage Areas, limiting access to both primary and specialized care.[9] This scarcity of healthcare resources places an added hardship on rural

caregivers, who must often travel long distances for medical appointments. These factors, combined with the higher prevalence of chronic conditions in rural populations, underscore the critical need for targeted support and telehealth resources for rural caregivers.

We also echo the comments offered by the Cancer Caregiving Collaborative in a separate letter that the provisional approval of CPT Code 97550 and CPT Code 97551 to provide caregiver training to support an individual's functional status in the home and community aligns with existing provider guidance offered by HHS to improve the delivery of care and will be especially important for caregivers of people living with cancer and other immunocompromising illnesses. Limiting exposure to in-person healthcare facilities can protect them from the risk of infections and other complications.

However, we caution that unless additional resources are dedicated to the technical assistance needed to ease provider adoption, the availability CTS services— whether provided in-person or remotely—will lag the growing need.

3. **Establishing a new coding and payment pathway for behavior management and modification training for caregiver(s) of an individual patient**

Again, we commend CMS for incorporating recommendations from—and considering the experiences of—patients and providers to ensure that caregiver training for behavior management and modification services are allowable in individual as well as group settings.

This important change recognizes the unique burdens faced by caregivers for individuals with mental illness and/or those with Alzheimer's Disease and Related Dementias (ADRD).

Caregiving for people struggling with mental health issues, cognitive decline, and/or other behavioral challenges can be especially difficult. Care recipients may demonstrate upsetting, confusing, and unpredictable behavior and choices, and/or refuse that support or be non-compliant with the treatment plans.

While we appreciate that CMS included group training for these caregivers in the CY2024 Medicare PFS, given the individual nature—and variability of—behavioral symptoms associated with mental illnesses and the outsized stigma of mental health challenges, applying a person-centered approach to caregiver training is particularly important. An estimated thirteen million caregivers support adults with mental health conditions and substance use conditions,[10] and expanded access to behavior management and modification training for caregiver(s) of an individual patient is important progress toward comprehensive caregiver support.[11]

4. **Allowing for verbal consent of the patient or representative for the provision of CTS**

Because caregiver training services are provided on behalf of the patient but without the patient present, we appreciate the intent of requiring that consent for CTS be documented in the patient's medical record included in the CY2024 PFS. However, we support the proposal in the CY2025 PFS allowing verbal consent from the patient or patient representative to administer CTS. We agree with CMS that this change would align consent requirements with other services paid for under the PFS that may be furnished without the patient present. We also believe that allowing for verbal consent will streamline the provision of CTS through telehealth.

**Responding to the request for information (RFI) about services to address health-related social needs**

In the CY2024 PFS, CMS took the expansive step to recognize the distinct effect that unaddressed individual HRSNs contribute to negative health outcomes and increased total cost of care for beneficiaries. NAC supported including a payment pathway for CHI and PIN services and social determinants of health (SDOH) risk assessment as an important and forward-looking approach to sustaining the essential contribution that community health workers (CHWs), community-based organizations (CBOs), and community care hubs (CCHs) provide in addressing HRSNs when implementing a whole-person model of care. We note that allowing patient HRSNs to be addressed can also reduce the immense burdens that family caregivers face.

We appreciate that CMS is issuing a broad RFI on the newly implemented CHI and PIN services to learn more about existing barriers and viable solutions to promote broader provider adoption of these critical supports. In response to the RFI, we encourage CMS to pay particular attention to comments submitted by the Partnership to Align Social Care.

Specifically, we encourage CMS to consider implementing updates in the CY2025 PFS that clarify that CCHs as well as CBOs can serve as employers for eligible auxiliary personnel; and update time-based billing requirements to align with those included for CTS. Currently CHI/PIN services require a 60-minute threshold each month to bill, which can serve as an impediment because the minimum threshold is too high. We support a lower threshold (20 or 30-minute

threshold) as reflected for CTS and other services. Lastly, we again echo the importance of supporting technical assistance activities that will enhance implementation of these new and milestone services that address the socio-economic factors contributing to patient and caregiver health outcomes.

**The National Alliance for Caregiving encourages CMS to consider addressing the following as it finalizes the proposed rule:**

1. Change the CTS benefit and the proposed Direct CTS benefit to allow a qualified healthcare provider to bill for all caregiver training services when rendered by trained auxiliary personnel as an incident to benefit, under general supervision;
2. Provide clarification on CTS standards, or reference existing leading caregiver training programs, to ensure high-quality training;
3. Clarify and confirm that CTS will not serve as a substitute for Medicare-covered home health aide benefits under the law, but rather as additional Medicare benefits to increase a willing and able caregiver's knowledge;
4. Ensure payment rates for CTS are adequate to incentivize implementation among providers and consider implications of co-pay requirements on widespread adoption; and
5. Clarify that providers may conduct a caregiver assessment and may offer subsequent CTS when reasonable and necessary regardless of the underlying diagnoses of the Medicare beneficiary who needs care.

**1. Change the CTS benefit and the proposed Direct CTS benefit to allow a qualified healthcare provider to bill for all caregiver training services when rendered by trained auxiliary personnel as an incident to benefit, under general supervision.**

Caregivers are vital participants in many patients' care plans, and we appreciate that the proposed rule again recognizes and respects this too-long unsung contribution through proposals to expand available CTS. However, we echo last year's comments noting that there are existing caregiver support and training programs based in communities and funded through federal programs such as the Older Americans Act, the Geriatric Workforce Enhancement Program, the Lifespan Respite Program, etc. We encourage CMS to enable Medicare providers to learn about and partner with these programs and providers as CTS curriculums are developed.

Currently, the original CTS benefit is difficult to implement because of structural barriers in the policy, which do not allow for the use of appropriately trained auxiliary personnel to provide CTS under general supervision as an incident to service. We anticipate the proposed Direct CTS will face the same barriers. The current benefit requires a provider to fit expanded caregiver training services into clinical settings, which is not necessarily conducive to the completion of extensive training required of caregivers.

Caregiver training programs are often provided under general supervision of a qualified healthcare provider but are not reimbursable because of the restriction on billing for CTS using auxiliary personnel as an incident to service provided under general supervision. We believe the adoption of essential caregiver training services would increase if CTS were permitted to be provided as an incident to service that can be provided by trained auxiliary personnel operating under general supervision. This change would also ensure that Registered Nurses (RNs) and Certified Nursing Assistants (CNAs) could deliver CTS, an omission that has been specifically identified as a barrier to adoption and implementation.

Furthermore, the current standard of practice dictates that caregiver training must incorporate the cultural beliefs and mores of targeted communities. Existing interventions have been effectively replicated to reflect the cultural diversity of the population served, which is essential to achieving health. Existing culturally relevant caregiver training programs are often delivered

through local, trusted, and appropriately trained community-based providers. Allowing CTS to be conducted as an incident to service under general supervision would expand access to existing, proven, culturally humble best-practice caregiver training programs.

We also urge CMS to include a definitive reference and inclusion of community-based organizations and community care hubs contracting as third-party organizations with eligible Medicare providers to deliver CTS services. We believe this inclusion would align with and complement our comments regarding CHI and PIN.

2. **Provide clarification on CTS standards, or reference existing leading caregiver training programs, to ensure high-quality training**

Again, we commend CMS for the proposal to reimburse physicians, nurses, and other clinicians who provide training to caregivers for patients under an individualized treatment or therapy plan of care. However, we again encourage CMS to consider referring to and/or encouraging providers to implement CTS programs that—at a minimum—encourage quality standards for CTS as part of the final rule or in subsequent guidance. There are multiple evidence-based or evidence-informed caregiver training programs that are funded by the U.S. Administration for Community Living (ACL), which could be leveraged to meet the growing need for caregiver training including:

- Powerful Tools for Caregivers (https://www.powerfultoolsforcaregivers.org)
- Savvy Caregiver® (https://savvycaregiver.com)

However, realizing the potential of scaling these programs to benefit caregivers will be possible only if CMS allows a qualified healthcare provider to bill for all caregiver training services when rendered by trained auxiliary personnel as an incident to benefit, under general supervision. NAC and our advocacy organization colleagues would welcome the opportunity to work with CMS to identify and implement existing evidence-based and evidence-informed caregiver training programs to ensure that caregivers receiving CTS are adequately equipped to provide safe and high-quality care to their care recipients.

3. **Clarify and confirm that CTS does not serve as a substitute or replacement for Medicare-covered home health aide benefits under the law, but rather as additional Medicare coverage to increase a willing and able caregiver's knowledge**

Again, we appreciate and commend CMS for including expanded service and payment opportunities for CTS in the proposed rule. However, we urge CMS to take the appropriate precautions to ensure that Home Health Agencies (HHAs) are aware that CTS are an inappropriate, inadequate, and illegal substitution or replacement for a Medicare-covered home health aide. We echo the concerns included in the Center for Medicare Advocacy 2023 response to the CMS request for information (RFI) about access to necessary home health aide services.[12] For qualifying patients, Medicare law authorizes up to 28-35 hours per week of

home health aide and nursing services in addition to therapies and medical social services.[13] However, utilization of home health aide services has declined by 95 percent in the past two decades.[14]

Increasingly, HHAs improperly require family caregivers to perform aide services or require a caregiver to be present as a condition of accepting a patient for services. These and other restrictions are rarely enforced, and we strongly urge CMS to ensure that the provision of CTS does not further erode already dwindling access to home health aide services for qualifying beneficiaries.

4. **Ensuring payment rates for CTS are adequate to incentivize implementation among providers and consider implications of co-pay requirements on widespread adoption.**

As providers consider whether to implement CTS, we encourage CMS to evaluate whether existing reimbursement rates adequately incentivize providers to include caregivers in patient care plans. NAC has heard members of the Act on RAISE Campaign and some state-based coalitions that current rates do not sufficiently incent implementation of CTS for many providers. Additionally, we have heard anecdotally that providers are also reticent to implement services that occur outside of the presence of the patient due to the co-pay requirements. Similarly, this is a barrier to implementation for CHI/PIN services that can also support caregivers. We realize that CMS does not have the regulatory authority to waive co-pay requirements for these services— and that most Medicare beneficiaries have additional insurance that covers co-pays.[15] However, we encourage CMS to evaluate whether the existing co-pay requirements for CTS and CHI/PIN hinder accessibility to these important services for patients and their caregivers.

5. **Clarify that providers may conduct a caregiver assessment and may offer subsequent CTS when reasonable and necessary regardless of the underlying diagnoses of the Medicare beneficiary who needs care.**

We support the approach of recognizing the caregiver's role as a partner in providing care and supporting the patient's care goals and the recognition that CTS may be necessary to ensure success of the patient's treatment plan. However, it is unclear from the Proposed Rule whether the assessment and CTS support would apply only in situations where "the patient cannot follow through with the treatment plan for themselves." While we appreciate that CTS is considered reasonable and necessary when directly relevant to the patient's treatment plan, the Proposed Rule also suggests that receiving CTS would not be reimbursable in medical treatment scenarios where the patient can "follow through with the care plan for themselves." This statement equates the ability to "ensure a successful treatment outcome" with the patient's self-autonomy. Caregiver support is complementary to, and does not supplant, the patient's own self-determination.

We believe the guardrails in the proposed rule—that each training activity is "clearly identified and documented in the treatment plan" and the exclusion of reimbursement for services provided under home health, at-home therapy, or DME services—are sufficient to prevent services duplication or abuse of the benefit. Therefore, we request that CMS clarify that caregiver assessment and caregiver training services may be offered regardless of the underlying disease state of the patient.

**Conclusion**

As agency leaders and policymakers finalize the CY2025 Medicare Physician Fee Schedule, we again urge CMS to consider the technical assistance and awareness building activities that would help providers and their partners to address barriers to implementation and fully realize the opportunity to improve supports for patients and their caregivers inherent in both CTS and services to address HRSNs.

We appreciate that some of these resources exist for providers in the 2024 Medicare Learning Network's® (MLN) Health Equity Services Booklet on the CY 2024 Physician Fee Schedule Final Rule.[16] However, we encourage CMS to continue to expand its educational efforts pertaining to recently implemented CTS and other services to address HRSNs.

Particularly, providers could benefit from information about these services through MLN online courses, fact sheets, webinars, and video tutorials through the MLN, as well as through email campaigns, social media outreach, provider conferences, and local workshops. We also ask that CMS consider consumer, beneficiary, and importantly auxiliary provider-facing educational materials that ensure that the public and community-based partners are also well-informed about these important policy changes. By implementing a multi-faceted educational strategy, CMS can ensure adequate alignment around, and understanding of, the full scope of reimbursement pathways leading to better utilization and outcomes.

Thank you for your consideration of NAC's comments. We appreciate 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. We look forward to continuing to collaborate with CMS to ensure family caregivers are valued and supported in their vital role. If you have any questions about this submission, please contact Michael Wittke at mike@caregiving.org.

Sincerely,

Jason Resendez
President & CEO
National Alliance for Caregiving