National
Alliance for
Caregiving

Cancer
Caregiving
COLLABORATIVE

September 12, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1828-P, P.O. Box 8013
Baltimore, MD 21244-8013

RE: CMS-1832-P: Medicare and Medicaid Programs; CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program

Dear Dr. Oz:

On behalf of the Cancer Caregiving Collaborative, thank you for the opportunity to provide comments on Medicare and Medicaid Programs: Calendar Year 2026 Payment Policies Under the Physician Fee Schedule and Other Changes ("Proposed Rule").

The Cancer Caregiving Collaborative is an initiative of the National Alliance for Caregiving, representing those who care for an estimated 18 million cancer survivors[i] in the United States, a number projected to increase to 26 million by 2040. Recent estimates from the Caregiving in the U.S. 2025 report indicate that, out of the growing number of America's caregivers, over 4 million people are caring for someone whose cancer is the primary reason they need care.[ii]

The Collaborative is a multi-phase, cross-sector initiative that works to address the unmet needs of cancer caregivers through two priorities: healthcare integration and financial health. Last year, we were encouraged by and supported CMS's leadership in the CY2025 Physician Fee Schedule to expand caregiver supports and offer new opportunities for caregiver training services (CTS) via telehealth.

As described in the CY2026 Proposed Rule, we support CMS's decision to permanently add CTS services to the Medicare Telehealth Services list. We applaud CMS's ongoing strategy to support health-related needs, including mental and behavioral health, which can improve outcomes for people with cancer and their family caregivers. Additionally, we have provided our perspectives on provisions of the RFI on Prevention and Management of Chronic Disease as it relates to families who are managing cancer as a chronic disease.

From the perspective of the millions of Americans who are living with cancer and their family caregivers, we offer the following public comments for your information and review.

I. We support the inclusion of Caregiver Training Services (CTS) as a permanent, reimbursable service provided as a Medicare Telehealth Service because telehealth offers a safe, effective, equitable, and cost-efficient means of delivering cancer care.

The CY2025 MPFS offered provisional approval for the delivery of CTS via telehealth, including CPT Codes 97550, 97551, 97552, 96202, and 96203.[iii] The CY2026 MPFS proposes permanent inclusion of CTS and other caregiver supports as a covered Medicare Telehealth Service, including:[iv]

- 96161 – Caregiver health risk assessment.
- 96202 and 96203 – Behavioral health interventions for caregivers.
- 97550 and 97551 – Caregiver training.
- 97552 – Group caregiver training.

In addition, psychological and behavioral codes offer support for cancer caregivers by improving their ability to provide care to cancer survivors. For example, consider the existing CPT Codes 90846 and 90847 for family counseling (both with and without the patient present). In some models of caregiver support, particularly where the caregiver is a Medicare beneficiary, these types of codes can be helpful to providers offering support.

The RUSH Caring for Caregivers program[v] can serve as a use case for utilizing mental health supports to enhance the health of cancer survivors by improving health system outcomes and reducing institutional costs. Initial data from the RUSH model demonstrated an association between supporting caregivers and improved health outcomes for older adults, including a reduction in the average number of inpatient days, average number of inpatient stays, and emergency department visits.[vi]

For cancer caregivers enrolled in the Medicare program, mental and behavioral health supports can improve resilience and support improved relationships with the cancer survivor in their care. The RUSH model resulted in reduced caregiver burden, depression, and anxiety. These benefits continued for more than three months after the intervention.

As innovators continue to develop new programs, such as the RUSH model, Medicare codes like these can facilitate the development and expansion of new, more efficient models of care.

We believe these programs will be utilized and effective because telehealth offers a safe, cost-efficient means of supporting people with cancer and their family caregivers, reducing financial toxicity associated with cancer caregiving. The National Cancer Institute has noted that telehealth can save people and caregivers living with cancer “time, travel, and money.”[vii] For example, individuals under the age of 65 who used telehealth for cancer care saved approximately $147 to $186 per visit in out-of-pocket costs. These savings resulted from not having to travel to appointments and avoiding the potential “loss of productivity” from missing work for travel.[viii]

People living with cancer across diverse demographic backgrounds have reported that telehealth visits are “preferred” or even “superior” to in-person visits once technological barriers have been addressed. The convenience and time savings of telemedicine improved the patient experience.[ix] The federal government has also recognized that using telehealth to provide cancer care is a Best Practice, offering a comprehensive guide for providers via Telehealth.HHS.gov.[x]

Telehealth can reduce health disparities across populations, including families living in rural areas, throughout the oncological journey from screening to treatment, survivorship, and in non-clinical wrap-around services such as caregiving supports. Researchers estimate that by 2030, cancer rates among older adults will increase 67%, affecting more than 2.3 million people in the United States.[xi]

As the rates of cancer in older adults increase, caregivers (typically adult children or spouses) will be more likely to have to balance work and care responsibilities. Programs like telehealth can help reduce the burden on cancer caregivers by preventing lost time and productivity due to travel and in-person appointments. An October 2024 report[xii] from Memorial Sloan Kettering Cancer Center identified how well-designed telehealth programs can promote more equitable cancer care and treatment.

Leading, effective models of caregiver interventions rely on telehealth to deliver support to family caregivers. A multisite, randomized controlled trial found that people with cancer who received early palliative care via video visits reported quality-of-life scores equivalent to those assigned to in-person palliative care.[xiii,xiv] For caregivers of people with chronic disease, clinical trials have found that telehealth is effective in providing caregiver interventions that improve the health and wellness of caregivers, ultimately providing downstream benefits to the person in their care.[xv]

Disease-specific studies have also found that delivering caregiver training services remotely can be an effective way to support cancer caregivers. For example, caregivers of patients with high-grade glioma reported improvement in their self-efficacy up to six weeks after the intervention.[xvi] Mobile applications have also shown promise as a means to deliver caregiver interventions.[xvii]

While telehealth should not be used as a replacement for in-person care, it can be beneficial in improving access across state lines, equalizing care provided in rural and urban areas, and facilitating the transition from specialty care to primary care for cancer survivors.

Finally, we respectfully ask CMS to consider simplifying the billing process for CTS reimbursement. Some providers, including occupational therapists and other allied health professionals, have found that the existing billing process for CTS codes does not align with the billing codes of other therapies. We echo the comments of the American Occupational Therapy Association (AOTA) and family caregiving coalitions such as the Act on RAISE Coalition to clarify the coding practice for CTS reimbursement.

While not addressed in the CY2026 fee schedule, the CY2025 final rule[xviii] contradicts other guidance from CMS on billing for timed services. As stated in the 2025 final rule, CTS are treated as “most other timed services” with the full-time listing required in the code descriptor. Yet, most current coding practices report timed CPT codes at 50% of the code descriptor time plus one (1) minute. This approach to coding more closely aligns with the services provided by therapists and other allied professionals, as identified in case studies from RUSH and Northwell Health.[xix]

Considerations for the Ongoing Implementation of Caregiver Training Services

As providers continue to recognize and include family caregivers as members of the care team who surround the cancer survivor, we respectfully ask that CMS consider removing additional hurdles to implementation. Echoing comments from the Act on RAISE Coalition, CMS could clarify either in the CY2026 Final Rule or the CY2027 Proposed Rule how CTS can be fully utilized as a means to reduce institutional care costs. In particular, we ask CMS to:

- Expand the list of qualified providers of CTS to facilitate a patient’s functional performance to include auxiliary personnel identified in operating under general supervision of and billing incident-to a Medicare provider or nonphysician practitioner.

- Provide clarification on CTS standards, or reference existing leading caregiver training programs, to ensure high-quality training.
- 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.
- Evaluate whether existing reimbursement rates adequately incentivize providers to include caregivers in patient care plans and evaluate whether the existing co-pay requirements for CTS and CHI/PIN hinder accessibility to these critical services for patients and their caregivers.
- Update time-based billing requirements for CHI/PIN 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 30-minute threshold as reflected for CTS and other services.
- Consider and support 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 support for patients and their caregivers inherent in both CTS and services to address unmet upstream drivers of health.

These changes will amplify the impact of CTS and allow providers to work more closely with the unpaid friends and family members who provide the backbone of long-term care to patient communities, including cancer survivors.

II. We applaud CMS's ongoing strategy to support health-related needs, including mental and behavioral health, which can improve outcomes for people with cancer and their family caregivers.

Cancer caregivers often face emotional and behavioral stressors from caregiving that threaten their mental health and well-being. Managing the psychological distress of cancer caregiving is critical to improving quality of life and promoting family resilience.[xx] Researchers have developed a distress screening measure for cancer caregivers to ensure that referrals to mental health services align with the caregiver's needs.[xxi] Emerging models that integrate cancer caregivers into healthcare delivery at RUSH and Northwell have relied on the delivery of mental and behavioral health services, including leveraging the expertise of allied health professionals such as clinical social workers and marriage and family therapists.[xxii]

As proposed, the addition of a new telehealth service under CPT Code 90849 allows health systems to expand multiple-family group psychotherapy, potentially creating opportunities for new cancer caregiving support groups to address these needs.[xxiii] These services can be particularly crucial in providing family caregiver group support in rural settings or areas where in-person services are not available. CMS should also consider the importance of counseling and peer support that can be delivered telephonically for areas that lack internet access. These services can strengthen the ability of a cancer caregiver to provide care to a Medicare beneficiary, as well as support the health needs of Medicare beneficiaries who themselves are also cancer caregivers.

Additionally, clarifying how a provider may use CHI and PIN services can increase the efficacy of these services. Under the proposed rule, clinical social workers (CSWs), marriage and family therapists

(MFTs), and mental health therapists (MHTs) can bill community health integration (CHI) and Principal Illness Navigation (PIN) services only when they are providing direct services. For patients who are Medicare beneficiaries, we encourage CMS to provide wrap-around services that include the family caregiver, which can be billed under CHI and PIN. This aligns with CMS's continued support for community health integration (CHI), principal illness navigation (PIN), and principal illness navigation-peer support (PIN-PS), including efforts to reimburse medical providers for the labor required to provide social and healthcare to patients with unmet needs.

Where the Medicare beneficiary is also a caregiver for someone with cancer, we request that CMS clarify whether a formal mental health diagnosis is required before providers can bill CHI and PIN codes for related labor. Many cancer caregivers may be experiencing a mental health crisis without the formal diagnosis of depression, anxiety, or other behavioral health issues. CMS should expand the billing category when CHI and PIN are warranted based on the needs of the cancer survivor.

III. We appreciate the opportunity to respond to the Request for Information (RFI) on the Prevention and Management of Chronic Disease, as many cancer caregivers provide ongoing care to cancer survivors as their disease progresses from acute to chronic illness and recovery.

As medical technology and innovation continue to improve, cancer survivors and their family caregivers are often in the role of managing cancer as a chronic disease.[xxiv] Likewise, HHS Secretary Robert F. Kennedy Jr.'s leadership through the "Make America Healthy Again" strategy identifies cancer as a chronic condition affecting children.[xxv] Given this framework, we have provided responses below to the RFI on the Prevention and Management of Chronic Disease from the perspective of cancer survivors and their family caregivers who manage cancer as a chronic condition.

By identifying strategies to improve the prevention and management of chronic diseases, CMS has an opportunity to continue aligning with intra-agency efforts, such as the National Strategy to Support Caregivers.[xxvi] Under the bipartisan, multi-stakeholder goals, Goal 2 focuses on the integration of family caregivers into systems of care as described in the two desired outcomes below:

- Outcome 2.1: Family caregivers are recognized as essential partners in the care teams of the person(s) to whom they are providing support; and
- Outcome 2.3: Where appropriate, family caregivers are included and considered in the development of care recipients' plans of care across a range of settings and circumstances.

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

Cancer puts significant strain on families, and providing resources to support cancer caregivers can alleviate that strain by addressing the root causes that interfere with the management of chronic disease. The administrative burdens facing many cancer families, particularly with health insurance, disrupt the upstream drivers of health by delaying diagnosis, access to care, and treatment. For example, a national study from Cancer*Care* found that current utilization management practices make it harder for people to receive the care their doctor has prescribed, even when health insurance ultimately approves and pays for the prescribed treatment.[xxvii] Services such as patient navigation, which ease the administrative strain of care coordination, are key to reducing access barriers.

RFI: Are there current services being performed to address social isolation and loneliness of persons with Medicare, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? If so, what evidence has supported these services, and what do these services entail? What services have been delivered by Medicare providers or community-based organizations, including area agencies on aging and other local aging and disability organizations? What has been the impact?

Caregiver supports can mitigate the psychological impact of cancer caregiving and reduce the isolation and stress facing families who manage chronic cancer care. Many cancer caregivers face loneliness and isolation that harm their health and well-being.[xxviii] Because there are currently limited interventions to address loneliness in families who are managing cancer, CMS should consider how to incentivize new and innovative programs that can better support survivors and their caregivers.[xxix] This includes family-based counseling and resilience-promoting programs, which can improve the relationship between the caregiver and the cancer survivor and provide additional capacity to family units to engage socially.

RFI: Should CMS consider creating separate coding and payment for intensive lifestyle interventions, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set, and how should these interventions be prioritized? If so, what evidence has supported these services, and what do the services entail? How would additional coding and payment be substantively different from coding and payment for Intensive Behavioral Therapy?

The Medicare hospice benefit, and more broadly, a palliative care approach to managing advanced illness, can improve healthcare outcomes for cancer survivors and their family caregivers. Notably, palliative care provides specialized team-based medical care for people living with a serious illness that addresses not only the physical symptoms of disease but also the social, emotional, and spiritual stressors that cancer survivors and their family caregivers may face.

There is ample evidence that palliative care – delivered regardless of the stage of illness or prognosis – significantly improves the quality of life for both patients and caregivers, while reducing unnecessary healthcare spending.[xxx] In fact, some existing studies have shown that palliative care can extend survival.[xxxi] Under Medicare's Accountable Care Organizations (ACO) and Oncology Care models, palliative care has even been shown to save $5,400 - $12,500 for every beneficiary receiving those services.[xxxii]

Therefore, we recommend that CMS encourage palliative care consultations and co-management for Medicare beneficiaries whose chronic illness is potentially life-limiting, and whose lifestyle and function is impaired due to this illness. Metastatic cancer and heart failure are two areas where significant improvements in quality of life and cost reductions are possible, and where professional clinical guidelines recommend the inclusion of specialty palliative care services.[xxxiii] Likewise, learnings from other initiatives may be useful in improving the efficacy of chronic care management under the Medicare physician fee schedule: for example, under Medicare Advantage, Special Supplemental Benefits for the Chronically Ill (SSBCI) providers can offer LTSS-type services such as adult day health, in-home personal care, and support for caregivers, such as respite.[xxxiv]

RFI: Are there current services being performed that improve physical activity, where the time and resources to perform the services are not adequately captured by the current physician fee schedule code set? How should CMS consider provider assessment of physical activity, exercise prescription, supervised exercise programs, and referral, given the accelerating use of wearable devices and advances in remote monitoring technology?

Family caregivers often play a key role in addressing gaps in physical therapy during cancer recovery, which can provide more "humanized care."[xxxv] Caregivers are essential partners in helping cancer survivors exercise and build physical strength through clinically tested programs, such as Exercising Together.[xxxvi] In a systematic review of dyadic interventions, exercise programs that include both the caregiver and the older adult improved the caregiver's psychosocial health, which in turn enables them to be better equipped as care partners.[xxxvii] Caregiver training services (CTS), if made available to providers to offer instruction on dyadic exercise and physical activity, could provide new strategies to help cancer patients in recovery and improve the health of their caregivers.

RFI: Should CMS consider creating separate coding and payment for medically-tailored meals, as an incident-to service performed under the general supervision of a billing practitioner? If so, what would be the appropriate description of such a service, and under what patient circumstances (that is, after discharge from a hospital)? Do community-based organizations providing medically tailored meals currently employ a physician, nurse practitioner, physician assistant, or other practitioner who could both bill Medicare and supervise a medically-tailored meal service? Should CMS consider allowing billing providers to refer to community-based organizations to deliver and ensure quality of medically-tailored meals while under general supervision (please see § 410.26(a)(3) for further information about general supervision) of the referring billing provider? If CMS were to create separate coding and payment for medically-tailored meals, how should CMS ensure the integrity of the service being delivered?

Caregivers who support someone living with a chronic illness often provide care in home- and community-based settings. Many caregivers support diet and medical nutrition to improve cancer recovery. Groups like the American Cancer Society have even created resources to prepare healthy meals, such as online recipes and tailored cookbooks.[xxxviii] Some innovators have even applied caregiver training services (CTS) in the Medicare Program to provide training on nutrition and meal planning.[xxxix] Expanding the availability of these programs and increasing awareness of how CTS can be used to meet the nutritional goals of Medicare beneficiaries could expand the reach of medically-tailored meals programs. Caregivers, in addition to the professional medical providers named above, can be key partners in supporting better nutrition and overall health when receiving targeted training and support.

RFI: The Administration for Community Living (ACL) has defined evidence-based programs, which have demonstrated impact in effectively treating chronic disease, preventing disease, and helping older adults and people with disabilities to adopt healthy behaviors, improve their health status, reduce disability and injury, and reduce their use of hospital services and emergency room visits. In addition to programs impacting chronic disease management and prevention, there are evidence-based health programs that address older adult falls, mental health, physical activity, and more. Fifty-six State units on aging that work with over 600 area agencies on aging (AAAs) and their networks of service providers receive formula grants from ACL to administer programs, but the need exceeds available federal funding. Are there certain existing or new Physician Fee Schedule codes

and payment, or Innovation Center Models, that could better support practitioner provision of successful interventions through partnerships between health care entities, AAAs, community care hubs, and other local aging and disability organizations? If so, please provide specific examples.

Like others with family care responsibilities, cancer caregivers of older adults or adults with disabilities rely on the aging and disability network for support and to help manage the care of their loved one in home- and community-based settings. Innovators within the CMS Innovation Center have opportunities to better integrate caregivers into the aging and disability systems, as described in a June 2025 paper by the National Alliance for Caregiving.[xl] Recommendations included:

- Developing a comprehensive caregiver support comparison framework that evaluates and compares demonstration models based on their caregiver support components to inform the uptake of caregiver support interventions, such as respite care.
- Developing and testing demonstration models that expand eligibility criteria for home health benefits to better serve beneficiaries and their family caregivers and evaluate the impact of increased access to home health on healthcare utilization, cost outcomes, caregiver burden, and patient experience, with particular attention to beneficiaries managing chronic, complex, or serious conditions.
- Piloting self-direction pathways that allow Medicare beneficiaries to retain and compensate family caregivers for in-home health support.

Existing CMMI models, such as the Oncology Care Model,[xli] could be more effective by incorporating and supporting family caregivers within their structure. When partnered with initiatives such as CTS and family behavioral supports, the current evidence-based models used in the aging network could better support a whole-person, family-centered approach.

IV. Thank You and Contact Information

Thank you for your ongoing support and leadership. We are available to you as you consider this Proposed Rule and other policies that impact cancer survivors and the friend and family caregivers who support them.

If you need to reach us, please contact Yadira Montoya, M.S.P.H, Programs Director, at yadira@caregiving.org or (202) 918-1038.

Sincerely,

Academy of Oncology Nurse & Patient Navigators

Cancer Support Community

Cancer*Care*

Cancer Nation (formerly the National Coalition for Cancer Survivorship)

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* Affiliations of individuals are for identification purposes only and do not necessarily represent the endorsement of affiliated institutions

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[i] As defined by the National Cancer Institute, a “cancer survivor” is defined as, “one who remains alive and continues to function during and after overcoming a serious hardship or life-threatening disease. In cancer, a person is considered to be a survivor from the time of diagnosis until the end of life.” See NCI Dictionary of Cancer Terms at https://www.cancer.gov/publications/dictionaries/cancer-terms/def/survivor, last accessed July 31, 2025.

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