

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 National Alliance for Caregiving (NAC), we would like to thank the Administration for its continued leadership in supporting the individuals and families who provide unpaid care to aging adults and people with disabilities. In his first term, President Trump signed into law landmark legislation to support family caregivers, including the VA Mission Act of 2018 ([P.L. 115-118](#)) which expanded supports to military and veteran caregivers, and the RAISE Family Caregivers Act of 2018 ([P.L. 115-119](#)), which established a National Strategy to Support Caregivers within the Administration of Community Living at HHS.

As advocates for the more than 63 million family caregivers who provide care, we have been actively involved in the implementation of the RAISE Family Caregivers Act and the corresponding [National Strategy to Support Family Caregivers](#). This strategy, much like the strategy of the current Administration, prioritizes the need to improve efficiency across government. Under the bipartisan, multi-stakeholder strategy, Goal 2 focuses on integrating family caregivers into care systems. This goal, among others, envisions a healthcare system where family caregivers are recognized as essential partners in the care teams (Outcome 2.1) and where caregivers are included and considered in the development of care recipients' plans of care across a range of settings and circumstances (Outcome 2.3).

It is against this backdrop that we offer public comments on the Proposed CY 2026 Physician Fee Schedule (PFS) (CMS-1832-P) ("Proposed Rule"). **We respectfully offer the following comments:**

- I. CMS should continue to support and expand the Caregiver Training Services (CTS) program as an effective, evidence-based strategy to improve the efficiency of home- and community-based care and provide**

guidance and clarification on the billing processes for CTS to avoid inefficiencies and increase awareness of the incentive to include family caregivers.

- II. In response to the RFI on the Prevention and Management of Chronic Disease, we urge CMS to continue to recognize family caregivers as valued members of the healthcare team who can improve the delivery of care in home and community-based settings.**

Understanding the Scope and Reach of America’s Family Caregivers

More than 63 million Americans are providing ongoing, complex care to older adults and people with disabilities, a reality we uncovered in a recent national study with AARP surveying over 7,000 people.¹ The prevalence of caregiving continues to increase as America ages, reflecting the growing need for long-term care support.

Table 1. Estimated Number of Family Caregivers and Prevalence of Family Caregiving by Age of Care Recipient, Trend 2015–2025

Types of Care Recipients	2015	2020	2025
Total Family Caregivers (of adults or children with medical conditions or disabilities)	43.5 million <i>(prevalance: 18.2%)</i>	53.0 million <i>(prevalance: 21.3% ↑)</i>	63.0 million <i>(prevalance: 24.0% ↑)</i>
Family Caregivers of Adults Age 18+	39.8 million <i>(prevalance: 16.6%)</i>	47.9 million <i>(prevalance: 19.2% ↑)</i>	59.0 million <i>(prevalance: 22.5% ↑)</i>

↑↓ Significantly higher or lower than prior wave.

The average caregiver is 51 years old, and 1 in 5 caregivers (22%) are themselves age 65 or older, making them eligible for the Medicare program. Those receiving care are 70 years old on average, with growing needs for help with long-term physical conditions, memory problems, or emotional and mental health issues.

Most family caregivers help with a variety of activities, including medical and nursing tasks such as managing wound care, giving injections, or other similar nursing tasks (55%). Only 22% of caregivers conducting these tasks receive training, despite the reality that 96% of caregivers who do receive training report that it has helped them to be better prepared to care.

Likewise, academic research has shown that providing caregiver training can have positive effects both on the health of the caregiver and on the outcomes of those in their care. The U.S. Department of Veterans Affairs has relied on this model extensively since the 2010 creation of the VA Caregiver Support Program.² In fact, the current program uses several

¹ National Alliance for Caregiving and AARP. Caregiving in the US (July 2025). <https://www.caregivingintheus.org/>; full report at https://www.caregivingintheus.org/wp-content/uploads/2025/07/caregiving-in-us-2025.doi_10.26419-2fppi.00373.001.pdf.

² See https://www.caregiver.va.gov/Publications_Resources_Topic.asp.

evidence-based training programs for those caring for wounded warriors, including Building Better Caregivers, Caregivers FIRST, and other tailored skills-building programs to help caregivers support the care plan of the Veterans in their care.

CMS's groundbreaking work to implement CTS as a reimbursable service in the CY2025 year poses significant opportunities to reduce health care costs, both for Medicare beneficiaries who are caregivers and need support and those who are caring for a Medicare beneficiary and may be able to provide better care at home and in the community. Trends in implementing CTS billing codes have revealed multiple use cases that can relieve some of the existing pressures on the health care system, from cancer and oncology settings³ to physical rehab⁴ and even nutrition.⁵

I. CMS should continue to support and expand the Caregiver Training Services (CTS) program as an effective, evidence-based strategy to improve the efficiency of home- and community-based care and provide guidance and clarification on the billing processes for CTS to avoid inefficiencies and increase awareness of the incentive to include family caregivers.

The CY2025 MPFS offered provisional approval for the delivery of CTS via telehealth, including CPT Codes 97550, 97551, 97552, 96202, and 96203.⁶ The CY2026 MPFS proposes permanent inclusion of CTS and other caregiver supports as a covered Medicare Telehealth Service, including:⁷

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

These services offer an incredible resource for families, including those who live in rural areas that may have significant barriers to instruction on how to provide care at home or in settings far from institutional healthcare providers. Likewise, telehealth-delivered services

³ National Alliance for Caregiving. (2025). Trends in Innovation: Implementing and Refining Caregiving Training Services in Medicare. June 2025. https://www.caregiving.org/wp-content/uploads/2025/07/NAC_CancerCollab_CTS-Medicare_v4.pdf.

⁴ Griffin, J. M., Smiley, A., Kaufman, B. G., & Fields, B. (2025). Reimbursement Opportunities for Caregiver Training in Rehabilitation: Using New CMS Training Service Codes. Archives of physical medicine and rehabilitation, 106(8), 1279–1284. <https://doi.org/10.1016/j.apmr.2025.03.047>.

⁵ Raj, M., Khan, N., & Resendez, J. Caregiver Nutrition Training Services: Optimizing the 2024 Medicare Physician Fee Schedule to Meet Caregiver Needs (July 2025). Journal of the Academy of Nutrition and Dietetics, 125(7), 869 – 874. [https://www.jandonline.org/article/S2212-2672\(24\)00920-1/fulltext](https://www.jandonline.org/article/S2212-2672(24)00920-1/fulltext).

⁶ See Medicare and Medicaid Programs; 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; and Medicare Overpayments, 89 Fed. Reg. 97710 (Dec. 9, 2024), <https://www.federalregister.gov/d/2024-25382/p-1015>.

⁷ See CMS-1832-P Regulation Supporting Documentation (“Downloads”), CY 2026 PFS Proposed Rule List of Telehealth Services (July 16, 2025), <https://www.cms.gov/medicare/payment/fee-schedules/physician/federal-regulation-notice/cms-1832-p>.

have been shown in some cases to be as effective as those delivered in person.⁸ Telehealth can also reduce the out-of-pocket cost to the patient and their caregiver, allowing for the delivery of information while reducing time off work or travel expenses.⁹

As promising as the early data is, CMS should consider issues that have arisen with the implementation of CTS, which may reduce the effectiveness of this service. These include:

- Clarifying whether telephonic services also qualify for CTS reimbursement, as some rural areas and other hard-to-reach populations may not have access to the internet needed for telehealth delivery.
- Clarifying the billing requirements with respect to the Medicare 8-minute rule or the AMA Midpoint rule for timed services, which allows billing for timed CPT codes once the services have reached 50% of the code descriptor time plus 1 minute. Aligning CTS billing to other billing practices will improve implementation and integration with billing systems.
- Updating 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.
- Expanding the list of qualified providers of CTS to facilitate a patient's functional performance to include auxiliary personnel identified in operating under the general supervision of and billing incident-to a Medicare provider or nonphysician practitioner.
- 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.
- Supporting technical assistance and awareness-building activities that would help providers and their partners to address barriers to

⁸ Doshi SD, Charvadeh YK, Seier K, et al. Perspectives on Telemedicine Visits Reported by Patients With Cancer. *JAMA Netw Open*. 2024;7(11):e2445363. doi:10.1001/jamanetworkopen.2024.45363. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2826208>.

⁹ Patel KB, Turner K, Alishahi Tabriz A, et al (2023). Estimated Indirect Cost Savings of Using Telehealth Among Nonelderly Patients With Cancer. *JAMA Netw Open*. 2023;6(1):e2250211. doi:10.1001/jamanetworkopen.2022.50211. <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2800164>.

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.

As CMS continues to implement CTS, we are available for further dialogue about how to maximize the efficiency and impact of this program and the integration of family caregivers into models of healthcare delivery in general.

II. In response to the RFI on the Prevention and Management of Chronic Disease, we urge CMS to continue to recognize family caregivers as valued members of the healthcare team who can improve the delivery of care in home and community-based settings.

We support the comments of our colleagues from the Cancer Caregiving Collaborative and the Act on RAISE Coalition with respect to the RFI on the Prevention and Management of Chronic Disease. Additionally, we offer two further perspectives on the role of family caregivers in preventing and managing chronic diseases.

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.

In the Proposed Rule, CMS notes the terminology change for services related to “social determinants of health (SDOH)” to a more holistic “upstream drivers of health” with respect to community health integration services and other community-based care models.¹⁰ Notably, the Proposed Rule states the need to emphasize “whole-person care,” which addresses the upstream drivers that affect patient behaviors, such as smoking, poor nutrition, low physical activity, substance misuse, etc., and/or potential dietary, behavioral, medical, and environmental drivers.

Notably, almost all of these drivers of health behaviors are intimately related to how an individual interacts within their family unit. For example, poor mental health among family caregivers can be a predictor of mortality among patients with neurodegenerative disease.¹¹ Conversely, a positive caregiving relationship and a well-supported caregiver can improve cognitive health, according to an analysis of the National Health and Aging Trends Survey and the National Study of Caregiving.¹² When adequately supported and included in care models, family caregivers can be a positive force to address the root cause of disease

¹⁰ <https://www.federalregister.gov/d/2025-13271/p-820>.

¹¹ S.J. Lwi, B.Q. Ford, J.J. Casey, B.L. Miller, & R.W. Levenson, Poor caregiver mental health predicts mortality of patients with neurodegenerative disease, *Proc. Natl. Acad. Sci. U.S.A.* 114 (28) 7319-7324, <https://doi.org/10.1073/pnas.1701597114> (2017).

¹² Wennberg, A. M., Anderson, L. R., Cagnin, A., Chen-Edinboro, L. P., & Pini, L. (2023). How both positive and burdensome caregiver experiences are associated with care recipient cognitive performance: Evidence from the National Health and Aging Trends Study and National Study of Caregiving. *Frontiers in public health*, 11, 1130099. <https://doi.org/10.3389/fpubh.2023.1130099>.

and can reinforce healthy family habits that allow individuals to better manage their chronic care needs.

Because of this interrelationship, we continue to support opportunities under the Healthcare Common Procedure Coding System (HCPCS) to reimburse labor related to non-medical, social, and health-related needs of Medicare Part B beneficiaries. Community Health Integration (CHI), Principal Illness Navigation (PIN), and Principal Illness Navigation-Peer Support (PIN-PS) HCPCS codes are necessary to provide wrap-around services to individuals and their caregivers, addressing the root causes of chronic illness.

As existing rules allow CHI, PIN, and PIN-PS services to be billed as incident-to services and provided by non-physician practitioners, there are opportunities to better integrate clinical and community providers with person- and family-centered models of care. This includes clarifying how these types of incentives work with CTS and other family support incentives as described above, and providing technical assistance to allow providers to more effectively implement CHI, PIN, and PIN-PS services to address the root cause of chronic disease.

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.

There are few formal programs within the federal government to support family caregivers. Two of the largest programs – although still small in scope and not sufficient to meet the needs of 65 million Americans – are the [National Family Caregiver Support Program](#) and the [Lifespan Respite Program](#). These programs provide grant funding to states and communities, offering a broad range of support services to caregivers of adults with disabilities and aging adults. The NFCSP offers local and state-based information to allow family caregivers to utilize services already available near them, such as:

- information to caregivers about available services.
- assistance to caregivers in gaining access to the services.
- individual counseling, organization of support groups, and caregiver training.
- respite care; and
- supplemental services, on a limited basis.

As mentioned in the RFI, the “need exceeds available funding,” and the most recently available data on the NFCSP indicates only 700,000 caregivers received services (2014), less than 1% of America’s estimated family caregivers.

In identifying how CMS can improve the management of chronic disease by working more closely with the aging network, we could encourage innovators to better integrate caregivers into the aging and disability systems, as described in a June 2025 paper by the National Alliance for Caregiving.¹³ Key strategies include:

- 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.

These strategies would allow CMS to build on existing evidence-based models identified and tested under the other areas of CMS, such as CMMI and ACL. Examples of evidence-based programs include:

- [The GUIDE \(Guiding an Improved Dementia Experience\) Model](#) (CMMI), which explicitly recognizes and compensates care partners (caregivers) as integral members of the dementia care team, providing them with training, respite services, and a 24/7 support line.
- [The Expanded Home Health Value-Based Purchasing Model](#) (CMMI), which includes training modules for family and caregiver engagement, assessment, teaching, and guidance, in addition to capturing data about caregivers within the OASIS reporting system.

¹³ National Alliance for Caregiving and Act on RAISE Campaign. Strengthening the National Strategy to Support Family Caregivers: A Medicare Policy Framework. June 2025. https://www.caregiving.org/wp-content/uploads/2025/06/NAC-AOR-Medicare-Policy-Brief_June-2025.pdf.

- Fee-for-service specialty care models from CMMI, such as [Kidney Care Choices](#), [Oncology Care Model](#), and [Transforming Episode Accountability Model \(TEAM\)](#), which focus on subpopulations experiencing a specific clinical and/or chronic illness.
- [The Chronic Disease Self-Management Program](#) (ACL), which served over 14,000 caregivers between 2019 and 2024, resulted in improved participants' self-reported health, reduced days of depression, and enhanced overall quality of life. The program has also led to improved outcomes like fewer emergency room visits, saving an average of \$364 per person.¹⁴
- Programs developed through ACL such as [Powerful Tools for Caregivers](#).
- Programs in use at the U.S. Department of Veterans Affairs caregiver programs such as [Building Better Caregivers](#).
- Programs developed through public-private partnerships or academic centers, such as [Caring for Carers \(C4C\) at RUSH](#), and [Care of Older Persons in their Environment \(COPE\) at Drexel](#).

Finally, we encourage CMS to continue to engage with the [Council](#), which leads the development of the National Strategy to Support Family Caregivers and works to improve alignment of public, private, and government initiatives that support family caregivers. The federal advisory council is charged with making recommendations to the Secretary of HHS and provides insights from people with lived experience, subject-matter experts, and government officials. Likewise, the [RAISE Act Family Caregiver Resource and Dissemination Centers](#) supported by the John A. Hartford Foundation and the National Academy of State Health Policy offer resources and recommendations to support state and federal policymakers. These existing, bipartisan, consensus-based resources can provide key insights to federal regulators as you work to address the needs of people and families who are managing chronic disease.

Thank you for your consideration of these comments and the opportunity to provide feedback from the caregivers who support our long-term care system. Should you have questions, please don't hesitate to contact me at the information below.

Sincerely,



Jason Resendez
President & CEO
National Alliance for Caregiving

¹⁴ National Council on Aging. *How to Engage Caregivers in Evidence-Based Programs*. September 2025. <https://www.ncoa.org/article/how-to-engage-caregivers-in-evidence-based-programs/>.