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September 14, 2026

The Honorable Mehmet Oz, MD, MBA
Administrator, Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services (HHS)
Attention: CMS-1848-P, 7500 Security Blvd
Baltimore, MD 21244

RE: 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[1]

Dear Dr. Oz:

Today's healthcare systems rely on cancer caregivers more than ever, as rates of cancer survivorship continue to rise. Roughly seven out of ten people diagnosed today will survive their initial five-year prognosis.[2] Improved public awareness, diagnostic testing, and biomedical innovations to treat cancer have saved lives and made it possible for people to envision a future that would not have been possible a generation ago.

With improved survivorship comes a growing need for healthcare providers to better support the friends and family who provide care to someone living with cancer. More than four million people support someone living with cancer, helping them with activities of daily living, medical/nursing tasks, and financial and psychosocial support.[3] Many caregivers are thrust into care activities without training or support.

As one caregiver recently shared, "I was taught how to feed my husband by hand through his feeding tube after we were discharged… It was a 60-second experience, and I learned on the way out the door."[4]

This Administration's efforts to include family caregivers in the delivery of healthcare support a more efficient, effective Medicare program that incorporates emerging technologies and innovative, new models of care.

As a multistakeholder coalition, the Cancer Caregiving Collaborative at the National Alliance for Caregiving is a multi-phase, cross-sector initiative working to address the unmet needs of cancer caregivers. With academic institutions, patient advocacy organizations, and biotech companies, the CCC represents the diverse and changing needs of America's cancer caregivers. Through this lens, the CCC respectfully offers the following comments on the CY2027 Medicare Physician Fee Schedule ("Proposed Rule").

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[1] 91 FR 43842 (July 16, 2026). https://www.federalregister.gov/documents/2026/07/16/2026-14327/medicare-and-medicaid-programs-cy-2027-payment-policies-under-the-physician-fee-schedule-and-other

[2] Siegel RL, Kratzer TB, Wagle NS, Sung H, Jemal A. Cancer statistics, 2026. CA: A Cancer Journal for Clinicians. 2026;76(1). doi:10.3322/caac.70043

[3] 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.

[4] National Alliance for Caregiving and CancerCare. Caregiving Without a Roadmap: Insights from Cancer Caregivers (February 2026). https://www.caregiving.org/wp-content/uploads/2026/02/NAC_CancerCare_ListeningSession-02.13.26.pdf.

1730 Rhode Island Ave. NW,
Suite 812
Washington, D.C., 20036

TEL 202-918-1013
EMAIL info@caregiving.org

I. Ongoing Implementation of Caregiver Training Services: We applaud the CMS's continued support for Caregiver Training Services (CTS), and we encourage CMS to simplify CTS billing for providers.

Since the implementation of Caregiver Training Services (CTS) codes in 2024, providers have used CTS to provide behavior management and functional performance training for family caregivers of Medicare beneficiaries. Under these codes, a wide variety of health care professionals can offer caregiver training, including physicians and nonphysician practitioners such as nurse practitioners, clinical nurse specialists, clinical psychologists, clinical social workers, marriage and family therapists, physical therapists, and occupational therapists, among others. The Cancer Caregiving Collaborative applauds the Administration's work to implement CTS codes, and to make them permanently available via telehealth in the CY2026 Final Rule.

Recent Medicare claims analysis from AARP's Public Policy Institute and ATI Advisory have revealed how these codes are used in practice.[5] From Q1 2024 through Q2 2025, Medicare paid 26,173 claims for CTS to approximately 9,622 beneficiaries. The type of provider who offers the training, and the location of the training itself, tends to vary by the type of training provided, as illustrated in the table below.

CTS Service Category	Typical Providers	Training Location
Functional Performance Training	Rehabilitation therapists (occupational therapists, physical therapists, speech-language pathologists), physicians, nurses	Private practices, patient's home, facilities, remote (telehealth)
Direct Care Strategies	Nurses, physicians	Private practices
Behavior Management	Social workers, psychologists	Private practices, patient's home

Opportunities exist under the current program to better align the caregiver's training to the underlying risk or health need of the Medicare patient. CMS clarified in the CY2025 rule that the Caregiver Health Risk Assessment (CHRA, CPT Code 96161), which assesses caregiver stress and well-being, can be used to identify caregiving training needs. The AARP/ATI claims analysis reveals, however, that there is a different provider base that provides CTS compared to the CHRA, and only 44 beneficiaries received both in the same year.

We believe that CMS can greatly improve the efficiency of CTS by educating Medicare providers on the program and how it can be used to improve patient health outcomes. Cancer caregivers provide a wide range of health-related care to people living with cancer, such as:

1. Assisting with hands-on and direct symptom management

[5] Cuozzo J, Choula R, AARP Public Policy Institute, Cromer T, Greer A, ATI Advisory. Exploring Utilization and Advancing Impact of Caregiver Training Services. April 2026. Accessed August 24, 2026. https://www.aarp.org/content/dam/aarp/ppi/topics/ltss/family-caregiving/exploring-utilization-and-advancing-impact-of-caregiver-training-services.doi.10.26419-2fppi.00407.001.pdf

2. Providing emotional support and motivation

3. Promoting preventative self-care and restorative behaviors

4. Serving as a symptom reporter, advocate, and information seeker.[6]

Assessment and training focused on the types of care that family caregivers provide would be a more effective way to supplement formal care provided by healthcare providers. While existing claims data is too early to show whether the CTS program reduces Medicare spending while improving overall care, research on caregiver training in general has shown that the more prepared a caregiver is to provide care, the less likely the patient will experience unplanned healthcare utilization or costs.[7]

CMS should evaluate whether the reimbursement is sufficient to allow health systems to fully engage in caregiver training. The AARP/ATI data cited above, for example, indicates that reimbursement for functional performance training greatly outpaced reimbursement for behavioral management or direct care strategies. For example, of the 7,063 claims paid in Q2 2025, 6,340 were for functional performance training compared to 381 for behavior management and 342 for direct care strategies.

The existing design of the CTS program may also benefit from closer alignment with how CTS are delivered in practice. CPT codes 97550 and 97551, for example, require a full 30 minutes of training without a patient, with an additional 15-minute increment before the service is reimbursed. Some health systems have indicated that this structure resulted in lost revenue, as the reimbursement rate relative to the 30-minute requirement forced them to shift the administration CTS services to lower-cost providers (such as changing the CTS provider from a physician to a speech therapist).[8]

a. CTS do not duplicate services provided under Evaluation/Management (E/M).

In the Proposed Rule, CMS has asked whether the resource costs associated with CTS are reflected in existing coding or already accounted for elsewhere in the PFS, such as E/M visits.[9] The services provided under CTS are distinct from other billable services and do not overlap with E/M reimbursement codes.

The American Occupational Therapy Association (AOTA) offers a perspective based on their work providing CTS.[10] Occupational therapists rely on CTS codes to provide caregiver education in the Medicare patient's home, including strategies that keep the patient safe and help avoid issues that could lead to unplanned hospitalizations. By design, this training is provided without a patient present and serves a "fundamentally different purpose" than E/M visits, which focus on patient evaluation and management. Many of the allied professionals who can bill for CTS codes under the existing program, such as OTs, cannot bill for E/M services.

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[6] Odom JN, Henderson NL, Padalkar TV, et al. Roles undertaken by family caregivers to help individuals with cancer manage symptoms: a qualitative study of caregivers, patients, and oncology clinicians. Support Care Cancer. 2026;34(3):255. Published 2026 Feb 27. doi:10.1007/s00520-026-10500-9.
[7] See, e.g., Poco LC, Malhotra C. More competent informal caregivers reduce advanced cancer patients' unplanned healthcare use and costs. Cancer Med. 2024;13(11):e7366. doi:10.1002/cam4.7366
[8] National Alliance for Caregiving. Trends in Innovation: Implementing and Refining Caregiver Training Services in Medicare. (June 2025). https://www.caregiving.org/wp-content/uploads/2025/07/NAC_CancerCollab_CTS-Medicare_v4.pdf
[9] https://www.federalregister.gov/d/2026-14327/p-661.
[10] Karr K, Parsons H. From payment to practice: What OT practitioners need to know about the 2027 Medicare Physician Fee Schedule Proposed Rule. July 17, 2026. Accessed August 24, 2026. https://www.aota.org/advocacy/advocacy-news/2026/what-ot-practitioners-need-to-know-about-the-2027-medicare-physician-fee-schedule-proposed-rule

b. Interdisciplinary healthcare providers support the continued, distinct use of CTS.

Finally, many interdisciplinary healthcare providers are using CTS and beginning to implement them as part of a whole-person approach to care. Occupational therapists, social workers, and psychological professionals have provided practice guidelines on implementing caregiver training services. As CMS works to improve care delivery and simplify unnecessary bureaucracy, CTS codes offer providers a way to work more effectively with friends and family caregivers, who often bridge gaps in care.

II. Response to RFI on Community-Based Palliative Care: We support CMS's effort to strengthen community-based palliative care, which helps family caregivers support people living with cancer at home and in their community.

We appreciate CMS's leadership in recognizing that community-based palliative care offers benefits to Medicare beneficiaries separate and apart from the Medicare hospice benefit. In many cases, individuals with cancer and their families navigate medical uncertainty about the likelihood of surviving cancer and related health issues. Even where palliative care can be beneficial, patients and caregivers are often confused by the difference between hospice and palliative care.

For example, in a study of people with glioblastoma multiforme (GBM) and their caregivers, structured interview participants indicated that most rehabilitative, palliative, and hospice care services were underutilized or implemented too late to be effective.[11] One caregiver shared, "Once PT and OT came in there toward the end, I'm going, wow, how much easier would some of those things have been earlier on to know?" Another said, "Some of the tips and tricks…were so helpful. It just felt like they were a little late sometimes."

Caregivers also noted that the type of support they receive in an inpatient facility didn't always transfer to home- and community-based settings. As one person described, "They would show me how to get him from behind and lift him because we have a lift chair and that's instrumental in taking care of him. They would show us how to transfer him in bed to sitting up. But things in a real setting like this and do it, it just didn't work really that well for us. I mean the PT could do it, you know and stuff, but it was really hard."

These examples illustrate the benefit of offering more expansive, community-based palliative care in the settings where real people and families live every day.

a. Eligibility for Serious Illness Care

Research has routinely shown that estimated prognoses for people living with cancer are very often inaccurate.[12] Cancer caregiving often reflects this uncertainty, where caregiving strain can suddenly increase or decrease depending on how the cancer has progressed. We support an approach that would allow for expanded use of palliative care without requiring a terminal diagnosis or "certification of a likely life expectancy duration." Earlier, more effective implementation of palliative care would likely reduce unnecessary spending and utilization and ease the medical anxiety that accompanies an uncertain prognosis.

b. Eligibility of Palliative Services Based on Daily Function and Caregiver Strain

[11] Muasher-Kerwin C, Baumbach A, Liu Y, Hughes MC. "You sure feel like you're alone, kind of flailing away out there": Family caregiver perspectives of caring for an individual with glioblastoma multiforme. Palliative and Supportive Care. 2025;23:e62. doi:10.1017/S147895152500015X

[12] Higginson IJ, Costantini M. Accuracy of prognosis estimates by four palliative care teams: a prospective cohort study. BMC Palliat Care. 2002;1(1):1. doi:10.1186/1472-684x-1-1

CMS should consider a balanced approach that evaluates daily function and caregiver strain. As described in the Proposed Rule, programs such as the Medicare Care Choices Model (MCCM)[13] provide insight into which approaches may effectively align the patient's needs with caregiver support. Notably, the MCCM innovation project demonstrated that palliative care can "reduce caregiver burden" and "increase beneficiary and caregiver satisfaction." Family caregivers particularly benefited from better symptom management, psychosocial and spiritual support, referrals to community-based resources (such as caregiver education and support), and help with shared decision-making. From a systems standpoint, MCCM reduced Medicare spending, with significant reductions in unnecessary ED visits and hospitalizations, while also reporting high rates of caregiver satisfaction (96% of caregivers would recommend the model to friends and family).

Additionally, we echo the recommendations from the Center to Advance Palliative Care (CAPC). When evaluating access to palliative care, CMS should consider a population-based approach that addresses the heterogeneity of serious illness. Even within the same diagnosis, caregiver strain, knowledge, and readiness vary. Programs like MCCM may be rigid in application because they rely on prognosis to predict utilization. Notably, economic analysis of Medicare claims data comparing spending to mortality revealed that "death is highly unpredictable." A better approach would tailor palliative care access to the individual patient and family's needs.[14]

For caregivers who may be struggling with grief, guilt, and caregiver strain, palliative care can restore a caregiver's capacity to support someone living with cancer. We would ask that CMS avoid an overly restrictive definition of palliative care tied to overly prescriptive definitions of daily function and caregiver strain. Reflecting the reality of living with cancer, a more general approach that reflects existing models of care may be more effective at meeting CMS's goals.

c. Future of Care Management Services: Essential Service Elements

In the Proposed Rule, CMS asks about the essential service elements for the future of care management services.[15] The existing CHRA (CPT Code 96161) is foundational to assessing how a caregiver's stress and well-being can impact patient safety and health. However, CMS has opportunities to better align caregiver assessment with the needs of the Medicare patient and to provide patient and caregiver education that addresses the risk. For example, most states now require caregiver assessment and training during hospital-to-home transitions under AARP's state C.A.R.E. Act. This is an effective approach that should also be extended to oncology and cancer clinic settings, as people living with cancer may not be transitioning frequently between an acute care hospital and their homes. Continuity requires acknowledging and empowering the family caregiver who is at the bedside of the person with cancer, making it possible for them to fill in the gaps between providers, care plans, and health records as a person with cancer moves from setting to setting. For this reason, we ask CMS to preserve the importance of caregiver assessment, patient/caregiver education, and other caregiver-related elements within care management services for seriously ill Medicare beneficiaries.

III. Telehealth and Remote Technologies: We request that CMS continue to prioritize telehealth and remote monitoring technologies that help people and families living with cancer stay safe at home and avoid high-risk medical settings.

[13] Centers for Medicare & Medicaid Services, Innovation Center, Palliative Care Synthesis 2012–2021 (2022). https://www.cms.gov/priorities/innovation/data-and-reports/2022/palliative-care-synthesis-2012-2021

[14] Einav L, Finkelstein A, Mullainathan S, Obermeyer Z. Predictive modeling of U.S. health care spending in late life. Science. 2018;360(6396):1462-1465. doi:10.1126/science.aar5045

[15] https://www.federalregister.gov/d/2026-14327/p-958.

Telehealth and remote technologies offer a safe and effective means of supporting people with cancer and their family caregivers. As described by the National Cancer Institute, telehealth can save people and caregivers living with cancer "time, travel, and money."[16] The federal government currently recognizes telehealth as a Best Practice for providing cancer care and offers a comprehensive guide for providers via Telehealth.HHS.gov.[17] Telehealth offers many benefits for people with cancer and their caregivers, such as reducing travel time and expense and expanding access for patients who need to see specialists in rare or orphan diseases. From a public health standpoint, telehealth and remote monitoring technologies reduce germ exposure for immunocompromised people and can help prevent caregivers from unknowingly exposing the person they care for to infectious disease.

We thank the Administration for its role in expanding telehealth-delivered CTS services in the CY2026 rule and for it support in extending telehealth flexibilities beyond the COVID19 public health emergency.

In the current Proposed Rule, we likewise support efforts to offer telehealth-delivered coaching under CPT codes 0591T, 0592T, and 0593T. These services can benefit Medicare beneficiaries who are currently undergoing treatment for cancer and would benefit from specialized coaching on diet, exercise, and other healthy behaviors. Likewise, family caregivers of people with cancer who are themselves on Medicare would benefit from the additional support from health coaches to avoid issues that may jeopardize their ability to support the person with cancer.

The Proposed Rule additionally creates new restrictions on reimbursement for remote patient monitoring (RPM) and remote therapeutic monitoring (RTM). We ask CMS to consider how these programs might adversely impact people with cancer and their caregivers.

IV. Additional Considerations

a. ACP Conversation Reimbursement: **We support CMS's proposal to reimburse advance care planning conversations with patients and families through billing codes GACP1 and GACP2.**

We generally support CMS's effort to incentivize advance care planning conversations with the patient and their caregiver. We ask CMS to consider whether the new billing codes under GACP1 and GACP2 most effectively achieve this goal, as the codes as proposed would separately value clinical-staff time spent on advance care planning conversations. Because advance care planning conversations are often iterative and may happen with multiple members of the oncology team, such as a nurse and social worker, the billing structure should reflect the touchpoints in the patient and caregiver's cancer experience. Encouraging providers to explicitly name the family member or surrogate as caregivers for the purpose of advance care planning would also help to ensure that the patient's wishes and desires are met during serious illness.

Additionally, we echo concerns raised by our colleague organization, the Center to Advance Palliative Care, that while GACP1 and GACP2 will allow for billing for ACP conversations with a nurse or social worker, these new codes may undercut existing processes built around CPT codes 99497 and 99498, which allow teams to bill "incident to" a physician or advanced practice provider. Billing should reflect person- and family-centered practice, allowing families and patients time to adjust to the reality of living with advanced illness and planning for end-of-life.

[16] Winstead, E. Telehealth Can Save People with Cancer Time, Travel, and Money. Cancer Currents Blog. February 16, 2023. Retrieved July 31, 2025, from https://www.cancer.gov/news-events/cancer-currents-blog/2023/telehealth-cancer-care-saves-time-money.
[17] Telehealth.HHS.gov. Telehealth and cancer care. Best Practice Guides. Retrieved July 31, 2025, from https://telehealth.hhs.gov/providers/best-practice-guides/telehealth-and-cancer-care.

b. Caregiver Supports Under ACO Shared Savings: We request that CMS continue to encourage accountable care organizations (ACOs) to offer caregiver support services.

We appreciate CMS's current insights on implementing the ACO Shared Savings program and ask for additional clarification on how these programs are currently used for family caregivers. Given that shared savings, whether prepaid or earned, can be used for family caregiver supports, we ask that CMS explore education for ACOs on how to implement these services, as they can result in better health outcomes at lower system costs. ACOs may be more likely to implement caregiver support services if CMS adopts a caregiver-related quality measure similar to those proposed under MIPS and other CMS-led programs. If possible, CMS should evaluate the impact that eliminating prepaid shared savings will have on existing caregiver programs and provide more comprehensive education on the role of ACOs in supporting families.

c. Advanced Primary Care Management and MIPS Value Pathways: We support the proposal to include a new MIPS activity for ACP conversations to support patient wellness and care preferences.

We support a MIPS Value Pathway reporting for providers who offer care management services for seriously ill beneficiaries under the proposed MIPS activity, "Advance Care Planning Conversations to Support Patient Wellness and Care Preferences." As described in the rule,[18] this activity would "allow MIPS-eligible clinicians to engage patients and caregivers in advance care planning and end-of-life discussions using structured communication tools while documenting goals of care, symptom management, and patient priorities." Notably, the proposal would also ask clinicians to update care preferences or changes as needed, including regular reassessments of the patient's goals and clinical status.

We appreciate the activity's requirement to use a standardized communication tool, such as the Serious Illness Conversation Guide and Practitioner Orders for Life-Sustaining Treatment (POLST). We agree with the rationale that engaging patients and their families in structured end-of-life care planning can help control symptoms, improve patient and caregiver well-being, reduce unnecessary hospitalization, and support better care coordination.

V. Thank You and Contact Information

Thank you for the opportunity to provide feedback on the CY2027 Proposed Rule and for your ongoing leadership. We stand ready to provide additional insight, research, and feedback as you work toward the Final Rule and its implementation.

Please feel free to contact us through Yadira Montoya, M.S.P.H, Health Programs Senior Director, at yadira@caregiving.org or (202) 918-1038.

Sincerely,

[18] https://www.federalregister.gov/d/2026-14327/p-3238