CAREGIVER NATION COALITION

NATIONAL ALLIANCE FOR CAREGIVING

September 14, 2026

Administrator Mehmet Oz
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1848-P
7500 Security Boulevard
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 (CMS-1848-P; RIN 0938-AV82; 91 FR 43842, July 16, 2026)

Dear Administrator:

On behalf of the National Alliance for Caregiving (NAC) and the undersigned organizations, thank you for the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule, *Medicare and Medicaid Programs; CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies* (CMS-1848-P). NAC is a nonprofit coalition dedicated to advancing family caregiving through research, innovation, and advocacy. We work on behalf of an estimated 63 million family caregivers across the United States — individuals who provide unpaid care and support to a family member, partner, or friend managing a chronic condition, disability, serious illness, or the challenges of aging (National Alliance for Caregiving & AARP, Caregiving in the U.S. 2025, July 2025).

This letter reflects input gathered from across NAC's broader caregiving constituency, including our Caregiver Nation Coalition (CNC), a coalition that unites partners across aging, disability, patient advocacy, and caregiving sectors to drive meaningful policy change for America's 63 million family caregivers. While several of the provisions below were first surfaced through the Coalition's review, the comments and recommendations in this letter are offered from the perspective of family caregivers broadly, regardless of the specific condition, illness, or diagnosis they are helping to manage.

We appreciate that this proposed rule touches on several provisions of direct and significant importance to family caregivers, including caregiver training services, advance care planning, care management for the seriously ill, and community-based palliative care. Our comments below are organized around those provisions in the order they appear in the discussion that follows, beginning with the four issues we consider most consequential to family caregivers this cycle.

Provisions CNC Fully Supports

The CNC commends CMS for proposing the following two provisions, both of which directly recognize and support the essential role of caregivers.

- The proposed clarification to quality measure Q288, "Dementia: Education and Support of Caregivers for Patients with Dementia," specifying that the required caregiver education and support apply to caregivers who are not part of the licensed care team.

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- The proposed addition of caregiver training codes — CPT 96202–96203, CPT 97550–97552, and HCPCS G0539–G0540 and G0541–G0543 — to the list of codes used to attribute Medicare beneficiaries to ACOs, effective performance year 2027.

I. Caregiver Training Services (CTS): Preserve Distinct Valuation and Resolve Implementation Gaps

In the CY 2025 Physician Fee Schedule final rule, CMS finalized three G-codes for direct, one-on-one, patient-absent caregiver training in disease-specific management techniques such as wound care, pressure-ulcer prevention, and infection control: G0541 (initial 30 minutes), G0542 (each additional 15 minutes, an add-on to G0541), and G0543 (group caregiver training involving multiple caregiver sets). In this year's proposed rule, CMS is soliciting comment, under its review of potentially misvalued services, on whether the resource costs associated with these codes are accurately captured by this coding, or whether that resource use is already reflected in the valuation of other Physician Fee Schedule services, such as E/M visits.

CTS Codes Are Not Duplicative of E/M Services

CNC emphasizes that **CTS direct care codes do not duplicate E/M services and are not misvalued.** CTS codes reimburse the time a clinician spends training a family caregiver to safely perform a disease-management task for their loved one — a service furnished to the caregiver, often without the patient present. E/M services, by contrast, are built around the documentation and assessment of the patient by a physician or non-physician practitioner. These are fundamentally different clinical activities, and CMS's own description of E/M services supports this distinction.

Several allied health associations have independently reached the same conclusion, which CNC echoes. Folding CTS into E/M valuation would not simplify billing; it would misprice the service by measuring it against an encounter it does not resemble. Three structural mismatches make E/M an inappropriate home for this work. First, E/M valuation presumes the beneficiary is present and is built around the practitioner's assessment and documentation of that beneficiary, whereas CTS is furnished to the caregiver and is frequently delivered patient-absent by design. Second, a meaningful share of the disciplines that furnish CTS — including occupational therapists, physical therapists, and speech-language pathologists — have no E/M billing option at all, so an E/M-based valuation would offer them no pathway to bill for training they are already qualified and expected to provide. Lastly, absorbing CTS into E/M would render caregiver training invisible in claims data, eliminating CMS's own ability to measure utilization, evaluate impact, or identify where need is going unmet. A 2026 report documenting caregiver training needs across the Medicare beneficiary's journey — from acute and post-acute care through chronic disease management and advanced illness — demonstrates that the need CTS addresses is distinct and persistent, rather than a duplication of work already captured in existing billable services[1].

Low Utilization Reflects a Gap in Awareness, Not a Gap in Need

We strongly encourage CMS to pursue increased visibility for CTS rather than consolidation with E/M codes, including through an educational campaign designed to expand provider awareness of

[1] AARP Public Policy Institute, *Exploring Utilization and Advancing Impact of Caregiver Training Services* (Apr. 29, 2026), https://doi.org/10.26419/ppi.00407.001.

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these services. Despite robust evidence documenting both the need for these services and their positive impact on caregivers and the beneficiaries they support, a substantial proportion of providers remain unaware that CTS is available for billing. The same analysis cited above on early CTS adoption, drawing on Medicare claims data, stakeholder interviews, and a practitioner roundtable, found that utilization to date has been limited in the pattern typical of newly established billing codes, and that stakeholders remain unfamiliar with how CTS is implemented and applied.[2] That analysis identified clear guidance and communication as one of five conditions necessary for adoption, alongside open access, aligned incentives, integrated infrastructure, and provider capacity. Feedback gathered from clinicians and health and social service providers is consistent with those findings: providers report that they would adopt the codes upon learning of their existence, and payer adoption tends to follow provider uptake. Low utilization therefore reflects a gap in awareness rather than an absence of clinical need.

Revaluation at This Stage Would Be Premature

CTS codes first became available in 2024. Revisiting their valuation at this juncture — prior to the maturation of the billing infrastructure and provider education that any newly introduced code requires — would be premature. At minimum, CNC requests that CTS be afforded the same implementation runway that CMS extends to other newly introduced services before any modification to its valuation is considered.

Expand the List of Qualified CTS Providers

Relatedly, CNC implores CMS to expand the list of qualified CTS providers to include auxiliary personnel operating under general supervision and billing incident-to — consistent with the flexibility CMS has proposed elsewhere in this same rule for health and well-being coaching services (see Section VI below). Certain clinician types, registered nurses (RNs) in particular, are currently unable to conduct this training, putting the onus predominantly on physicians and NPPs to furnish CTS. RNs are uniquely positioned to conduct this training, given the immense overlap of RNs skillsets and the clinical responsibilities of caregivers in the home.

CTS's Reach Extends Well Beyond Older Adults

CNC also cautions CMS against underestimating the reach of these codes. Although CTS is billed here under Medicare, the underlying caregiver training services are not limited to older adults; the same family of codes is used to train caregivers of children and of adults of all ages living with disability or serious illness. A valuation change made in the Physician Fee Schedule would therefore ripple well beyond the Medicare population, into pediatric and other settings where the caregiver being trained is often a parent.

A Growing Caregiving Infrastructure Depends on These Codes

These codes are also load-bearing for the caregiving workforce still being built around them. Clinicians who supervise students in caregiver-facing disciplines rely on CTS to bill for that work, and at least one university-affiliated caregiver clinic preparing to open this fall has built its operating model on these codes. Health systems standing up dedicated caregiver support programs describe

[2] Ibid

CTS as a critical tool among the very few available to them. CTS is a low-cost, high-leverage way to build caregiving capacity and to meet needs CMS has itself already recognized. Withdrawing it now would remove one of the few tools available and would run counter to this Administration's stated commitment to supporting family caregivers.

Outstanding Technical and Operational Questions

Separate from the valuation question addressed above, CNC asks CMS to use this rulemaking cycle to resolve several outstanding technical and operational questions that have carried over from prior comment cycles. These are implementation matters rather than objections to the codes themselves, but each currently creates friction for practices attempting to bill CTS:

- Clarify CTS training standards, or reference existing evidence-based caregiver-training curricula that satisfy them.
- Evaluate cost-sharing and copay treatment for CTS alongside Chronic Care Management, Community Health Integration, and Principal Illness Navigation services.
- Align the Community Health Integration/Principal Illness Navigation 60-minute monthly billing threshold with the 30-minute threshold used for CTS, to reduce administrative complexity for practices billing both.
- Resolve the timed-service billing contradiction identified in the CY 2025 final rule, where CTS is coded using the convention applied to "most other timed services" for full-unit billing, while the common industry practice bills at 50 percent of the code's time plus one minute — CMS should clarify which standard governs.

CNC urges CMS to use this rulemaking cycle to resolve the implementation questions above rather than leaving them unaddressed for another year.

II. Request for Information on Community-Based Palliative Care: Six Recommendations for Needs-Based Eligibility

CNC appreciates CMS's Request for Information (RFI) on developing community-based palliative care services, building on a related RFI in the FY 2027 Hospice proposed rule. CMS points to its own Innovation Center synthesis of palliative care model tests from 2012 through 2021, which found that comprehensive approaches — including interdisciplinary teams, home visits, and shared decision-making — improved outcomes for beneficiaries. CMS asks, among other things, whether eligibility for a future palliative or supportive care benefit should require a certified terminal prognosis or instead rest on a broader definition tied to functional decline or impact on activities of daily living, and whether eligibility should separately account for caregiver strain. CNC offers six recommendations in response.

1. **CMS should frame eligibility around a comprehensive, needs-based assessment rather than a fixed prognostic category.** "Serious illness" and "palliative care" are not interchangeable terms. Serious illness spans a spectrum — individuals who will stabilize or recover, individuals whose illness will progress toward hospice, and individuals who move between these trajectories over time — while palliative care is defined by need rather than by a fixed point on that spectrum. Defining the benefit around a prognostic category risks producing yet another segmented, siloed model of care.

2. **CMS should pair eligibility with a separate, separately payable comprehensive assessment, and situate caregiver strain within it.** That assessment should span pain and symptom-related distress, functional status, cognitive status, medication risk, emotional and spiritual distress, social risk factors, and the preparedness and strain of the family caregiver supporting the beneficiary — not a prognosis requirement, and not a single-domain screen. Caregiver strain belongs within that assessment as one essential component among several, rather than as a standalone eligibility trigger. Functional decline in a beneficiary very often directly drives caregiver strain, but caregiver strain also independently signals unmet need that an assessment of the patient alone will miss, which is precisely why it belongs inside a comprehensive instrument rather than outside one.

3. **CMS should define what a comprehensive assessment must cover rather than mandate a single assessment tool.** Validated instruments already exist across each of these domains — typically several per domain — and no instrument is universally applicable across settings, conditions, and care models. CMS should instead permit alignment across existing validated options. CNC further recommends that the type of assessment be matched to the intervention it is meant to inform: evaluating a caregiver's candidacy for hands-on training calls for a preparedness measure, while evaluating a caregiver for behavioral health calls for a validated psychological instrument. A single mandated tool cannot serve both purposes well.

4. **CMS should weigh practicality alongside validity and keep documentation proportionate to the decision it supports.** Several of the most widely cited caregiver burden instruments are long and difficult for caregivers to complete in the middle of an active caregiving episode. A documentation requirement built around them would exclude the very families it is meant to reach. Relatedly, because what a caregiver must be prepared for depends entirely on the intervention at hand, burden alone is often not the most useful construct to measure. CNC encourages CMS to recognize caregiver knowledge and readiness — preparedness — as a measurable construct alongside burden and strain.

5. **CMS should design eligibility and documentation standards to accommodate fluctuating caregiving intensity.** Caregiving intensity is rarely static. Caregiving burden for a family member typically fluctuates with treatment cycles, disease progression, and periods of acute crisis. Eligibility and documentation standards should be flexible enough to capture that reality rather than assume caregiver strain is a fixed determination.

6. **CMS should use this RFI to move toward a more coherent benefit design, drawing on the evidence its own models have produced.** There is currently no freestanding federal palliative care benefit under Medicare. Palliative care is billed through a patchwork of Part B codes across multiple disciplines, with no unified benefit comparable to the Medicare hospice benefit. While a wholly new standalone benefit would likely require statutory authority from Congress, CMS can continue building the evidentiary and administrative groundwork using the authority it already has. Its own evidence supports doing so. The CMS Innovation Center's synthesis found that certain interventions and care model structures - which could also serve as an ideal setting for palliative care services - can "reduce caregiver burden" and "increase beneficiary and caregiver satisfaction," with caregivers

benefiting particularly from improved symptom management, psychosocial and spiritual support, and help with shared decision-making. The Medicare Care Choices Model (MCCM) reduced Medicare spending, significantly reduced emergency department visits and hospitalizations, and achieved 96 percent caregiver willingness to recommend the model. CNC urges CMS to treat MCCM's structure as a scalable template for a future community-based palliative care benefit.

III. The Future of Care Management Services: Embed Caregiver Assessment and Support as Required Elements

CMS is reconsidering the future of care management services that form the basis for payment adequacy for important between-visit care, in addition to E/M services for outpatient or home visits. CMS acknowledges that care for the seriously ill involves interdisciplinary care teams and requires even greater coordination and between-visit care than typical primary care services, and asks how care management requirements for seriously ill beneficiaries should be differentiated from other Medicare beneficiaries, and what essential service elements a future benefit must include. CMS's own illustrative list names continuity with a designated team member, access to timely clinical support, **comprehensive symptom and caregiver assessment**, electronic care plans, coordination with treating physicians, **patient/caregiver education**, and timely follow-up after an emergency department visit or hospital discharge and asks what other elements should — or should not — be included.

CNC strongly supports CMS's inclusion of comprehensive symptom and caregiver assessment, and patient/caregiver education as named candidate elements. This is precisely the kind of caregiver-inclusive benefit design NAC has long urged CMS to adopt, and we ask CMS to finalize both elements as **required**, not optional, components of any care management benefit built for seriously ill beneficiaries.

There is also a practical, cost case for treating these elements as required. A growing evidence base links the involvement of family caregivers in care planning and discharge preparation to reduced reutilization of health services, including fewer avoidable hospital readmissions.[3] Building caregiver assessment and caregiver education into the required elements of a care management benefit is therefore not only responsive to how care for the seriously ill actually works day to day — it is consistent with the total-cost-of-care objectives CMS pursues elsewhere in this rule.

CNC recommends CMS go further in three respects as it finalizes this framework:

- **Assess caregiver capacity, not only patient symptoms.** A seriously ill beneficiary's care plan is only as sustainable as the caregiver supporting it. If caregiver capacity and strain are not routinely assessed alongside patient symptoms and documented in the care plan, care plans risk failing at exactly the moments — crisis, transition, decline — when they matter most.
- **Define "continuity with a designated team member" to include continuity with the family caregiver, not only the patient.** Family caregivers are frequently the primary point of contact for care coordination, medication management, and symptom reporting for

[3] Juleen Rodakowski et al., *Caregiver Integration During Discharge Planning for Older Adults to Reduce Resource Use: A Metaanalysis*, 65 J. Am. Geriatrics Soc'y 1748 (2017), https://doi.org/10.1111/jgs.14873.

beneficiaries who cannot manage these tasks independently. A designated team member requirement that only contemplates continuity with the patient will not reflect how care for the seriously ill actually functions day to day.

- **Build hospital-to-home transition requirements on the evidence base underlying the Caregiver Advise, Record, Enable (CARE) Act,** now enacted in a large majority of states, which requires hospitals to identify a patient's family caregiver, notify that caregiver before discharge, and instruct the caregiver on the medical tasks they will need to perform at home. CNC urges CMS to treat CARE Act-aligned discharge practices as a floor for what "timely follow-up after ED visit/discharge" should require under this benefit.

CNC also recommends that CMS explicitly permit validated caregiver assessment tools as an allowable component of the electronic care plan, so caregiver status is documented and tracked over time alongside patient status rather than captured only informally or not at all. CNC would welcome the opportunity to share relevant evidence-based caregiver assessment tools and patient/caregiver education program research with CMS as this policy is finalized.

Finally, CNC asks CMS to clarify how this redesign will interact with the existing Chronic Care Management, Principal Care Management, and Advanced Primary Care Management codes, as well as the related Request for Information CMS has issued on defining complexity tiers for a potential future capitated or hybrid primary care payment model. CNC requests that the caregiver-related elements identified through this RFI be carried through consistently into whatever billing structure ultimately implements them.

IV. New Advance Care Planning (ACP) Billing Codes — GACP1 and GACP2: Support for Team-Based Billing and Explicit Family Recognition

Since Advance Care Planning (ACP) codes were introduced in 2016, they have been billable only by the physician or non-physician practitioner (NPP) personally — even though CMS has long acknowledged that the whole care team is typically involved in furnishing ACP, through "incident to" billing. This mismatch has created confusion in claims about who is actually delivering ACP conversations in practice.

For CY 2027, CMS proposes two new G-codes — GACP1, for the first 20 minutes of clinical staff time spent on ACP conversations, and GACP2, for each additional 20 minutes — to separately and explicitly value clinical staff time on ACP, while the existing 99497/99498 codes would be understood to reflect only time the billing practitioner personally spends. The new codes would require direct supervision of the clinical staff member by the billing physician or NPP, and the work must still be "incident to" a service the billing practitioner is personally managing. CMS proposes adding both codes to the Medicare Telehealth Services List and requests comment on the appropriate care-team structure and how "incident to" rules should apply. Notably, the proposed code descriptors explicitly include *"the patient, family member(s), surrogate"* — meaning family involvement in ACP conversations is recognized as billable clinical staff time under this proposal, not only physician time.

CNC supports finalizing GACP1 and GACP2. This is a substantive and positive step giving CMS, and providers, an accurate and granular way to reflect who is actually furnishing ACP care, and it creates a clearer billing pathway for the team-based, often nurse- or social-worker-led conversations that characterize high-quality ACP as it is typically practiced today.

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CNC specifically supports the explicit inclusion of "family member(s)" and "surrogate" in the proposed code descriptors, and urges CMS to retain and reinforce that language in the final rule. ACP conversations for beneficiaries who lack full decision-making capacity — or who simply want their family to be involved — routinely include family caregivers as active participants, not passive observers. The billing code descriptor should reflect that reality without ambiguity.

CNC further encourages CMS to apply the same reasoning to Caregiver Training Services. The recognition embedded in this proposal — that trained clinical staff, rather than only the billing physician or non-physician practitioner, can appropriately furnish structured, protocol-driven conversations with patients and their families — applies with equal force to caregiver training. As discussed in Section I above, CTS is currently limited to a narrow set of qualified providers, and extending comparable, appropriately supervised flexibility to CTS would meaningfully expand access to caregiver training without altering the clinical standard of the service.

V. MIPS Improvement Activities: Support New ACP Activity, Preserve Visibility of Caregiver Engagement in IA_CC_9

CMS proposes a new Merit-based Incentive Payment System (MIPS) improvement activity, IA_AHW_XX, *"Advance Care Planning Conversations to Support Patient Wellness and Care Preferences,"* which would allow MIPS-eligible clinicians to *"engage patients and caregivers"* in structured advance care planning and end-of-life discussions, documenting goals of care and reassessing as needs change. CNC supports and encourages CMS to finalize this activity, which explicitly names caregivers as intended participants — a concrete example of the kind of caregiver-inclusive MIPS design CNC would like to see reflected more broadly across the program.

Separately, CMS proposes to remove IA_BE_15, *"Engagement of Patients, Family, and Caregivers in Developing a Plan of Care,"* as a standalone improvement activity, folding its elements into IA_CC_9, *"Implementation of practices/processes for developing regular individual care plans."* IA_CC_9's revised description would highlight *"creating and regularly updating individualized care plans for at-risk patients in collaboration with the patient and their family or caregivers,"* emphasizing alignment with the patient's goals and priorities. CMS's stated rationale is that IA_BE_15 substantially overlaps with IA_CC_9. This change applies to the master MIPS Improvement Activities Inventory, the removal cascades through dozens of MIPS Value Pathway (MVP) appendices across specialties.

We are concerned, however, that removing IA_BE_15 as a standalone, explicitly named activity reduces the visibility of family and caregiver engagement as a distinct MIPS priority, even though its substance is nominally preserved within IA_CC_9. IA_BE_15 was one of the few MIPS activities that named "family" and "caregivers" directly in its title, and that visibility shapes how clinicians, electronic health record vendors, and MVP developers prioritize caregiver engagement.

CNC requests that CMS retain explicit, prominent reference to "family or caregivers" in IA_CC_9's final description as proposed and confirm that a clinician who is already engaging family caregivers in care planning will not lose all pathways to MIPS credit for that caregiver-engagement work. If IA_CC_9's documentation requirements create a materially higher bar than IA_BE_15 did on its own, CMS should consider a transition period or alternative credit pathway.

VI. Health and Well-Being Coaching: Support Finalization and Broader Application of the Supervision Flexibility

CMS proposes national payment and conditions of payment for individual and group health and well-being coaching services (CPT 0591T–0593T). CMS proposes that these services generally be performed under direct supervision of the billing practitioner, but proposes a certification pathway allowing non-clinical "auxiliary personnel" — certified health coaches — to furnish these services if credentialed through the National Board for Health & Wellness Coaching, the National Commission for Health Education Credentialing's Certified Health Education Specialist standard, the American Holistic Nurses Credentialing Certified Nurse Coach standard, or training through an evidence-based program funded under the Older Americans Act and overseen by the Administration for Community Living (ACL). CMS further proposes that coaches employed by community-based organizations (CBOs) may operate under general, rather than direct, supervision if they meet the same certification standards, and asks whether these Category III CPT codes should be converted to HCPCS G-codes for CY 2027.

1. **CMS should finalize coding and payment for health and well-being coaching, including the certification pathway recognizing ACL-overseen, Older Americans Act-funded programs.** This pathway reflects exactly the kind of integration between Medicare billing and the aging and disability service network that NAC has long recommended. The proposal is relevant to family caregivers in two respects: caregivers who are themselves Medicare beneficiaries may directly benefit from coaching services, and to the extent coaching reduces the day-to-day self-management burden on beneficiaries with chronic conditions, it can meaningfully ease the burden carried by the family caregivers supporting them.

2. **CMS should treat the general supervision, CBO-based certification pathway as a template for other caregiver-facing services rather than a one-off exception.** The reasoning CMS applies here — that trained non-physician staff, including those affiliated with community-based organizations, can safely and effectively deliver structured, protocol-driven services — applies directly to Caregiver Training Services and, as discussed in Section IV above, to Advance Care Planning conversations. CNC encourages CMS to extend comparable, appropriately safeguarded flexibility to those services in future rulemaking.

3. **On the Category III CPT-to-G-code question, CMS should prioritize payment stability and administrative simplicity.** CNC has no strong preference between retaining the Category III CPT codes and converting them to HCPCS G-codes. Our concern is that coaching services remain a reliable, billable option for beneficiaries and their caregivers, and CMS should select whichever approach best secures that outcome.

Conclusion

The Caregiver Nation Coalition thanks CMS again for the opportunity to comment on this proposed rule and for its continued attention to the needs of family caregivers across several distinct provisions this cycle. We would welcome the opportunity to serve as a resource to CMS as these policies are finalized, including by sharing the caregiver assessment tools and patient/caregiver education program research referenced in Section III above.

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For questions, please contact us through Blaire Bryant, Vice President of Policy and Advocacy at Blaire@caregiving.org.

Sincerely,

National Alliance for Caregiving
Aging Life Care Association
Alliance for Aging Research
ALS Association
Alzheimer's Association
Alzheimer's Impact Movement
American Association on Health and Disability
American Nurses Association
American Society on Aging
Association of California Caregiver Resource Centers
Association for Frontotemporal Degeneration (AFTD)
California Coalition on Family Caregiving
Caregiver Wisdom
Caring Across Generations
Center for Caregiver Serenity
Diverse Elders Coalition (DEC)
Easterseals, Inc.
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Grantmakers In Aging
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