[Insert Date]

The Honorable Chiquita Brooks-LaSure, Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1784-P

Mail Stop C4-26-05

7500 Security Boulevard

Baltimore, MD 21244-1850

*Submitted electronically via* [*http://www.regulations.gov*](http://www.regulations.gov)*.*

RE: CMS-1784-P: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies

Dear Administrator Brooks-LaSure:

My name is [Insert Name], an advocate for family caregivers, writing to comment on the CY 2024 Physician Fee Schedule Proposed Rules.

America’s unpaid family caregivers, who often go unrecognized, form the backbone of our long-term care system, as it is families and families of choice, who help older adults and people with disabilities or serious health care needs to manage their health and wellness.[[1]](#footnote-1)

**Aligning the proposed rule with the administration’s promises to improve supports for informal/unpaid caregivers**

I commend the Centers for Medicare and Medicaid Services (CMS) for including several historic proposals in the proposed rule that align with and promote opportunities to achieve core policy principles outlined in various administration initiatives to improve support for caregivers.

These important frameworks include, but are not limited to:

* + [Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers](https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/)
	+ [2022 National Strategy to Support Family Caregivers](https://acl.gov/CaregiverStrategy)
	+ [Cancer Moonshot](https://www.whitehouse.gov/cancermoonshot/)
	+ [Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government](https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/20/executive-order-advancing-racial-equity-and-support-for-underserved-communities-through-the-federal-government/)
	+ [HHS’s Strategic Approach to Addressing Social Determinants of Health to Advance Health Equity](https://aspe.hhs.gov/sites/default/files/documents/aabf48cbd391be21e5186eeae728ccd7/SDOH-Action-Plan-At-a-Glance.pdf)

I appreciate that CMS has incorporated proposals within the CY 2024 Physician Fee Schedule proposed rule intended to leverage existing agency authorities to: 1) boost the supply of education and long-term care and to provide support for family caregivers; 2) support family caregivers of beneficiaries of federal health care programs and services; 3) recognize and address systemic barriers to healthcare services and benefits for people of color and other underserved groups; and 4) help patients, families, and caregivers better navigate the caregiving experience. Overall, HHS and CMS serve a critical role in ensuring that the federal government achieves the ambitious, but essential, goals included in myriad national commitments to caregivers. The annually updated Physician Fee Schedule provides an ongoing opportunity to identify, implement, and improve policies to support caregivers.

**Caregivers are essential participants in a patient’s care team, but have historically been unrecognized and unsupported**

According to recent research conducted by the National Alliance for Caregiving (NAC) and AARP[[2]](#footnote-2), nearly six in 10 family caregivers assist with medical and nursing tasks such as injections, tube feedings and changing catheters. Unfortunately, according to the same report, fewer than three in 10 caregivers surveyed (29 percent) said they have had general conversations with health professionals, such as a doctor, nurse, or social worker, about their caregiving duties. Only 13 percent said a health care professional has asked what they need to take care of themselves.

Furthermore, only seven percent report receiving any training related to tasks they perform[[3]](#footnote-3). Black and Latino American caregivers (67 percent each) more often help with medical/nursing tasks than do White caregivers (52 percent). While four in 10 caregivers are in high-intensity caregiving situations (40 percent) the proportion of caregivers (31 percent) who reported difficulty in coordinating care among health care providers is growing[[4]](#footnote-4).

Demographics portend that absent significant and cross-cutting action from federal policy makers, these challenges will become more acute. The population of older adults—the majority of Medicare beneficiaries needing care—is growing at an historic rate, necessitating the support of increasing numbers of family caregivers. In fact, between 2015 and 2020, the number of unpaid family caregivers increased by more than 10 million, to 53 million family caregivers according to research from NAC and AARP. However, the ratio of available caregivers to those who need care is declining. Existing national programs to support caregivers are vital but insufficiently funded to meet the need. CMS leadership and engagement is crucial to national efforts aimed at shifting the trajectory of these statics. Bolstering access to training and support services for caregivers is an important piece of this puzzle, and I applaud the CMS for including the proposal to pay for caregiver training in the proposed rule. I strongly believe this is a critical step in recognizing the essential role that family caregivers play in safeguarding the health of American families.[[5]](#footnote-5)

***I offer the following comments in response to Caregiver Training Services (CTS) for consideration as CMS finalizes the CY 2024 Physician Fee Schedule:***

* Expand, align, and clarify the definition of caregiver to reflect existing federal programs and policies addressing caregivers and the caregiver/patient experience;
* Provide clarification on CTS standards or reference to existing leading CTS programs and services to ensure high-quality training;
* Permit CTS in more than one single session or more than once per year and allow alternative methods of CTS delivery, including via telehealth;
* Clarify and confirm that CTS will not serve as a substitute or replacement for Medicare-covered home health aide benefits under the law, but rather as additional services to increase a willing and able caregiver’s knowledge; and
* Consider expanding the list of qualified providers of CTS to facilitate a patient’s functional performance to include auxiliary personnel identified in Community Health Integration (CHI) services operating under general supervision of the Medicare provider or nonphysician practitioner (NPP).

***Furthermore, I appreciate and supports CMS’s consideration and inclusion of the following payment provisions within the proposed rule, which I believe will alleviate some burden of family/informal caregivers:***

* Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services); and
* Expansion of Health Behavior Assessment and Intervention (HBAI) services to clinical social workers (CSWs), marriage and family counselors (MFCs), and mental health counselors (MHCs).

**Expand/align the definition of caregiver to reflect existing federal programs and policies addressing caregivers and the caregiver/patient experience**

CMS proposes to define the term “caregiver” to include an “*individual who is assisting or acting as a proxy for a patient with an illness or condition of short or long term duration (not necessarily chronic or disabling); involved on an episodic, daily, or occasional basis in managing a patient's complex health care and assistive technology activities at home; and helping to navigate the patient's transitions between care settings.*” Furthermore, CMS lists examples including, “*patients with dementia, autism spectrum disorder, or individuals with other intellectual or cognitive disabilities, may require assistance with challenging behaviors in order to carry out a treatment plan, patients with mobility issues may need help with safe transfers in the home to avoid postoperative complications, patients with persistent delirium may require guidance with medication management, patients with certain degenerative conditions or those recovering from stroke may need assistance with feeding or swallowing*” as benefiting from involvement of the caregiver in the patient treatment plan. (Pg. 52323)

I appreciate CMS’s stated intent to maintain a broad definition of caregiver and provide examples of conditions with which CTS could be an essential component of a patient’s treatment plan. However, I encourage CMS to consider aligning the definition of caregiver with existing statues and administration priorities that define caregivers. For example, the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act (P.L. 115-119) defines the term “family caregiver” as “an adult family member or other individual who has a significant relationship with, and who provides a broad range of assistance to, an individual with a chronic or other health condition, disability, or functional limitation.”[[6]](#footnote-6)

This definition has been incorporated into administration priorities cited by CMS as informing CTS proposals, such as the National Strategy to Support Family Caregivers, which includes 350 federal and 150 state, local, and private actions outlined in the strategy to build a system to support family caregivers,[[7]](#footnote-7) and the Executive Order on Increasing Access to High-Quality Care and Supporting Caregivers.[[8]](#footnote-8) While I are generally supportive of the definition included in the proposed rule, I believe that CMS should reconsider if/how it aligns with existing federal policies and national priorities.

[Additionally, I urge CMS to provide clarification regarding the term “unpaid assistance” to a person with a chronic illness or disabling condition. A 2022 survey conducted by the Kaiser Family Foundation found that states reported that maintaining a workforce was the biggest challenge for home and community-based (HCBS) programs during the COVID-19 public health emergency. As a response, 39 states addressed workforce shortages by allowing family caregivers to be paid providers. Since the end of the public health emergency, 20 states have indicated that they plan to continue allowing caregivers to be paid through HCBS programs.[[9]](#footnote-9) However, these individuals are not part of the formally trained professional caregiving workforce. Therefore, I ask CMS to provide clarification regarding whether caregivers paid to provide care to supplement—but not supplant—the formal HCBS workforce would be eligible for CTS services. Furthermore, I encourage CMS to identify these caregivers as eligible for these services.](https://www.kff.org/policy-watch/ending-the-public-health-emergency-for-medicaid-home-and-community-based-services/)

I also encourage CMS to consider expanding references to conditions from which patients may benefit from CTS as part of an individual’s care plan to ensure that these examples adequately represent the experiences of patients and caregivers. While I appreciate that dementia is specifically called out as a qualifying behavioral health condition, I also submit that caregivers should be involved in developing and carrying out a treatment plan for patients living with serious illnesses such as cancer, heart failure, ESRD, rare conditions, transplant care, etc. People living with serious illness often have complex and skilled needs to which caregivers must attend, often without sufficient training, and I encourage CMS to recognize the importance of preparing caregivers for this work.

I appreciate that CMS seeks input on whether CTS are duplicative of existing federal benefits and programs. However, I strongly believe that the provision of these services through traditional Medicare *will not* create service redundances in relation to other federal or state programs. For example, The Older Americans Act (OAA) includes the National Family Caregiver Support Program (NFCSP)—the largest discretionary caregiver support program and which includes access to CTS—serves an estimated 800,000 caregivers annually. While these services and supports are vital, these services available to only a small percentage of the nation’s 53 million family caregivers. I urge CMS to focus on including and implementing high-quality accessible CTS via the final rule rather than consider if these essential services are duplicative.

**Provide clarification on CTS standards or reference existing leading CTS programs and services to ensure high-quality training**

Again, I commend CMS for the proposal to reimburse physicians, nurses, and other clinicians who provide training to caregivers for patients under an individualized treatment or therapy plan of care. I agree that both behavior management/modification

training for guardians/caregivers of patients with a mental or physical health diagnosis and caregiver training in strategies and techniques to facilitate the patient’s functional performance in either individual or group settings are an important and valuable addition to the CY 2024 PFS proposed rule. However, I encourage CMS to incorporate/require quality standards for training as part of either the final rule or in subsequent guidance.

**Permit CTS in more than one single session or more than once per year and consider allowing alternative methods of CTS delivery, including via telehealth**

I appreciate that CMS has asked for comment about, “*considering whether CTS would be reasonable and necessary when furnished to caregivers in more than one single session, or to (presumably the same) caregivers by the same practitioner for the same patient more*

*than once per year.*” (pg. 52324) I echo the statements of other caregiver advocates in noting that the needs of patients with complex illness evolve over time as their conditions change and/or they are diagnosed with additional illnesses. According to the 2020 Caregiving in the US report,[[10]](#footnote-10) nearly a quarter of family caregivers are caring for more than one individual, necessitating additional training and support. I also recognize that often there is more than one caregiver caring for a single patient. Therefore, I ask that CMS provide reimbursement for caregiver training as it corresponds to patient and caregiver needs, rather than setting a universal limit.

I appreciate that CMS proposes several new telehealth policies for CY 2024, including the temporary addition of health and well-being coaching services to the Medicare Telehealth Services List and the permanent addition of Social Determinants of Health Risk Assessments. I support the ongoing expansion of telehealth services, and I urge CMS to consider opportunities to provide appropriate CTS via telehealth upon implementation of the final rule.

Furthermore, I echo the importance of continuing to allow reimbursement for audio-only advance care planning activities beyond 2024. Given the importance of caregivers and families to advance care planning discussions, ensuring access for patients who do not have internet or broadband services promotes equity and enables end-of-life care that is consistent with patient and family goals and preferences.

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

Again, I appreciate and commend CMS for including payment for CTS in the proposed rule. However, I urge CMS to take the appropriate precautions to ensure that Home Health Agencies (HHAs) are aware that CTS are an inappropriate, inadequate, and illegal substitution or replacement for a Medicare-covered home health aide. I echo the concerns included in the Center for Medicare Advocacy 2023 response to the CMS request for information (RFI) about access to necessary home health aide services.[[11]](#footnote-11) For qualifying patients, Medicare law authorizes up to 28-35 hours per week of home health aide and nursing services in addition to therapies and medical social services.[[12]](#footnote-12) However, utilization of home health aide services has declined by 95 percent in the past two decades.[[13]](#footnote-13)

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

**Consider expanding the list of qualified providers of CTS to facilitate a patient’s functional performance to include auxiliary personnel identified in Community Health Integration (CHI) services operating under general supervision of the Medicare provider or nonphysician practitioner (NPP)**.

Caregivers are a vital participant in many patient care plans, and I appreciate that the proposed rule recognizes this too-long unsung contribution. However, there are existing caregiver support and training programs based in many communities and funded through federal programs such as the Older Americans Act, the Geriatric Workforce Enhancement Program, the Lifespan Respite Program, etc. I encourage CMS to enable Medicare providers to learn about and partner with these programs and providers as CTS curriculums are developed.

Specifically, I ask CMS to align the list of eligible CTS providers with those outlined under the provision of CHI services provided by auxiliary personnel. For example, I encourage CMS to consider including reference to Community Health Workers as eligible paraprofessionals that can implement CTS to facilitate the patient’s functional performance (Activities of Daily Living and Instrumental Activities of Daily Living) operating under general supervision of a Medicare provider or NPP. Furthermore, I urge CMS to include a definitive reference and inclusion of community-based organizations and community care hubs contracting as third-party organizations with eligible Medicare providers to deliver CTS services. I believe this inclusion would align with and complement our comments regarding CHI.

**Services Addressing Health-Related Social Needs (Community Health Integration Services, Social Determinants of Health Risk Assessment, and Principal Illness Navigation Services); and Expansion of Health Behavior Assessment and Intervention (HBAI) services**

As previously noted, I appreciate CMS taking the expansive step to recognize the distinct impact that Health-Related Social Needs (HRSNs) contributes to negative health outcomes and increased total cost of care, for beneficiaries. I generally supports the proposed codes for community health integration, social determinants of health risk assessment, and principal illness navigation services. I recognize that these are an important and forward-looking approach to create a pathway for providers to sustain the essential contribution that community health workers and community-based organizations/community care hubs provide in addressing HRSNs when implementing a whole person model of care. I agree that approaching patient needs from a whole person model of care also reduces the immense burdens that family caregivers face and look forward to working with other caregiver advocates to see that these services are effectively implemented and broadly available to beneficiaries.

Furthermore, I appreciate that the proposed rule aligns with the CMS Behavioral Health Strategy[[14]](#footnote-14) and ongoing efforts to support an emotional and mental well-being through behavioral health care. I agree with CMS that this rule contains some of the most important changes to improve access to behavioral health in Medicare in the program’s history by allowing clinical social workers, marriage and family therapists, and mental health counselors, including addiction counselors, to enroll in Medicare and bill for their services. Given that an estimated 13 million caregivers support adults with mental health conditions and substance use conditions,[[15]](#footnote-15) expanded access to HBAI services is a critical component to supporting caregivers. I would urge CMS to include these providers in the list of eligible providers for CHI and PIN services as well.

**Conclusion**

Thank you for your consideration of my comments. I appreciate CMS’s commitment to supporting and expanding access to critical caregiver training services and to advance coordinated community-based continuums of services and supports available through Medicare.

Sincerely,

[Insert Name]

1. AARP and National Alliance for Caregiving. Caregiving in the United States 2020. Washington, DC: AARP. May 2020. <https://doi.org/10.26419/ppi.00103.001> [↑](#footnote-ref-1)
2. <https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf> [↑](#footnote-ref-2)
3. Burgdorf J, Roth DL, Riffin C, Wolff JL. Factors Associated With Receipt of Training Among Caregivers of Older Adults. JAMA Intern Med. 2019;179(6):833–835. doi:10.1001/jamainternmed.2018.8694 [↑](#footnote-ref-3)
4. *Supra* at 2 [↑](#footnote-ref-4)
5. <https://www.caregiving.org/nac-applauds-proposed-medicare-rule-change-to-support-training-for-family-caregivers/> [↑](#footnote-ref-5)
6. <https://acl.gov/sites/default/files/about-acl/2018-10/PLAW-115publ119%20-%20RAISE.pdf> [↑](#footnote-ref-6)
7. Administration for Community Living, 2022 National Strategy to Support Family Caregivers. Developed by The Recognize, Assist, Include, Support, and Engage (RAISE) Act Family Caregiving Advisory Council & The Advisory Council to Support Grandparents Raising Grandchildren. (September 21, 2022) (Available at: <https://acl.gov/sites/default/files/RAISE_SGRG/NatlStrategyToSupportFamilyCaregivers.pdf>). [↑](#footnote-ref-7)
8. <https://www.whitehouse.gov/briefing-room/presidential-actions/2023/04/18/executive-order-on-increasing-access-to-high-quality-care-and-supporting-caregivers/> [↑](#footnote-ref-8)
9. <https://www.kff.org/policy-watch/ending-the-public-health-emergency-for-medicaid-home-and-community-based-services/> [↑](#footnote-ref-9)
10. *Supra* at 2 [↑](#footnote-ref-10)
11. <https://medicareadvocacy.org/wp-content/uploads/2023/08/Home-Health-Aides-2024-NPRM-RFI-Response.pdf> [↑](#footnote-ref-11)
12. 42 U.S.C. §1395x(m)(1)-(4). Receipt of skilled therapy can also trigger coverage for home health aides. [↑](#footnote-ref-12)
13. Federal Register 2023-14044.pdf (govinfo.gov), pages 43663, 43671. [↑](#footnote-ref-13)
14. <https://www.cms.gov/cms-behavioral-health-strategy> [↑](#footnote-ref-14)
15. *Supra* at 2 [↑](#footnote-ref-15)