[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-1807-P: 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**

Dear Administrator Brooks-LaSure:

My name is [Insert Name], an advocate for family caregivers, writing to comment on the CY 2025 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 illness.[[1]](#footnote-2)

The CY2025 Medicare PFS proposed rule continues to advance important changes that recognize and honor the vital role of family caregivers within healthcare teams and aligns with the National Strategy.

***[As a caregiver, care recipient, caregiver advocate], I support the following proposed rule policy changes to:***

1. Add direct-care services to the list of allowable caregiver training services.
2. Provisionally add CTS to the Medicare Telehealth Services List;
3. Allow caregivers to be trained individually on behavior management and modification for an individual patient; and
4. Allow for verbal consent for CTS.

In addition, I appreciate that CMS is asking for input regarding how to improve supports to address health-related social needs (HRSN) including Community Health Integration (CHI) and Principal Illness Navigation (PIN) services (PIN). Meeting patients’ HRSNs needs has the potential to alleviate burden on family caregivers.

1. **Establishing new coding and payment opportunities for caregiver training for direct care services and supports**

According to the most recent and industry standard research conducted by NAC and AARP,[[2]](#footnote-3) six in ten 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 ten 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 healthcare 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-4) Black and Latino American caregivers (67 percent each) more often help with medical/nursing tasks than do White caregivers (52 percent). While four in ten caregivers are in high-intensity caregiving situations, the proportion of caregivers (31 percent) who reported difficulty in coordinating care among healthcare providers is growing.[[4]](#footnote-5)

I commend CMS for proposing training supports for caregivers who are providing care requiring medical and clinical skills including hands-on treatment, patient monitoring, and reducing complications. This is especially important for family caregivers managing complex chronic diseases, serious illnesses, and disabilities such as cancer, transplant-related conditions, and dementia.

1. **Provisionally adding CTS to the Medicare Telehealth Services List**

I applaud CMS for heeding recommendations to add CTS to the list of available telehealth services in CY 2025. While I understand that there is limited current evidence justifying permanent inclusion on the list of available telehealth services, I agree that provisionally adding these services will allow providers to implement CTS more broadly and build that evidence base.

I believe that including CTS on the list of available telehealth services will be particularly important for the 12 percent of family caregivers that live in rural settings.[[5]](#footnote-6) These rural ill caregivers often contend with significant barriers to accessing healthcare and support services. I also think that offering CTS via telehealth will be especially important for caregivers of people living with cancer and other immunocompromising illnesses. Limiting exposure to in-person healthcare facilities can protect them from the risk of infections and other complications.

1. **Establishing a new coding and payment pathway for behavior management and modification training for caregiver(s) of an individual patient**

Again, I commend CMS for incorporating recommendations from—and considering the experiences of—patients and providers to ensure that caregiver training for behavior management and modification services are allowable in individual as well as group settings. This important change recognizes the unique burdens faced by caregivers for individuals with mental illness and/or those with Alzheimer’s Disease and Related Dementias (ADRD).

Caregiving for people struggling with mental health issues, cognitive decline, and/or other behavioral challenges can be especially difficult. Care recipients may demonstrate upsetting, confusing, and unpredictable behavior and choices, and/or refuse that support or be non-compliant with the treatment plans.

1. **Allowing for verbal consent of the patient or representative for the provision of CTS**

Because caregiver training services are provided on behalf of the patient but without the patient present, I appreciate the intent of requiring that consent for CTS be documented in the patient’s medical record included in the CY2024 PFS. However, sometimes written documentation isn’t realistic, and I support the proposal in the CY2025 PFS allowing verbal consent from the patient or patient representative to administer CTS. I also believe that allowing for verbal consent will streamline the provision of CTS through telehealth.

**Responding to the request for information (RFI) about services to address health-related social needs**

In the CY2024 PFS, CMS took the expansive step to recognize the distinct effect that unaddressed individual HRSNs contribute to negative health outcomes and increased total cost of care for beneficiaries. Including these payment opportunities was an important and forward-looking approach to sustaining the essential contribution that community health workers (CHWs), community-based organizations (CBOs), and community care hubs (CCHs) provide in addressing HRSNs when implementing a whole-person model of care. I agree that allowing patient HRSNs to be addressed can also reduce the immense burdens that family caregivers face.

I appreciate that CMS is issuing a broad RFI on the newly implemented CHI and PIN services to learn more about existing barriers and viable solutions to promote broader provider adoption of these critical supports. In response to the RFI, I encourage CMS to pay particular attention to comments submitted from the [Partnership to Align Social Care.](http://www.partnership2asc.org)

I also think it’s very important that the agency focuses on opportunities to help Medicare providers enact these critical supports and services.

***[As a caregiver, care recipient, caregiver advocate], I encourage CMS to consider the addressing the following as it finalizes the proposed rule which will help to ensure that these services are implanted equitably for beneficiaries:***

1. Consider expanding the list of qualified providers of CTS to facilitate a patient’s functional performance to include auxiliary personnel identified in operating under general supervision of and billing incident-to a Medicare provider or nonphysician practitioner (NPP);
2. Provide clarification on CTS standards, or reference existing leading caregiver training programs, to ensure high-quality training;
3. 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; and
4. Ensure payment rates for CTS are adequate to incentivize implementation among providers and consider implications of co-pay requirements on wide-spread adoption

**[If you have thoughts about why these ongoing advocacy asks would be important, please include (note, these were included in last-year’s template letter, so personal experiences will be most effective here).]**

**Conclusion**

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 and the CY2025 PFS proposed rule and believe these are important steps to ensure family caregivers are valued and supported in their vital role with Medicare beneficiaries. Thank you for the opportunity to submit comments.

Sincerely,

**[Your 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-2)
2. [*Supra*](https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf) at 1 [↑](#footnote-ref-3)
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-4)
4. *Supra* at 1 [↑](#footnote-ref-5)
5. *Supra* at 1 [↑](#footnote-ref-6)