Act on RAISE

September 12, 2025

The Honorable Dr. Mehmet Oz, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1832-P
P.O. Box 8016
Baltimore, MD 21244-8016

Submitted electronically via http://www.regulations.gov.

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 Act on RAISE Campaign (AOR, the Campaign), we appreciate the opportunity to comment on the CY 2026 Physician Fee Schedule (PFS) proposed rule (CMS-1832-P). The Act on RAISE Campaign, hosted by the National Alliance for Caregiving, brings together more than 120 stakeholder organizations representing caregiving, aging, disability, and patient advocacy stakeholders across the caregiving continuum.

Campaign partners share the common goal of strengthening our nation's first-ever National Strategy to Support Family Caregivers (National Strategy) and advocate to implement and strengthen the National Strategy, which directly impacts the one in four Americans who make up our nation's community of unpaid family caregivers. These 63 million family caregivers, who often go unrecognized, form the backbone of our long-term care system. It is these families and families of choice, who help older adults, people with disabilities, and people with serious illness manage their health and wellness.[1]

We appreciate that the CY 2026 Medicare PFS proposed rule preserves recently implemented policy and payment opportunities included in the 2024 and 2025 Medicare Physician Fee Schedules final rules that advance systemic changes to recognize and honor the vital role family caregivers serve as part of healthcare teams. In a rapidly changing federal funding and healthcare policy environment, fee-for-service Medicare is increasingly important in supporting family caregivers and their essential role serving millions of older adults, people with disabilities, and individuals with complex illness and care needs.

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[1] AARP and National Alliance for Caregiving. *Caregiving in the US 2025*. Washington, DC: AARP. July 24, 2025. https://doi.org/10.26419/ppi.00373.001

The population of older adults, who make up 90 percent of Medicare beneficiaries,[2] is growing at an historic rate,[3] and this growth increases the demands placed on family caregivers. According to *Caregiving in the US 2025*,[4] a joint report of the National Alliance for Caregiving (NAC) and AARP, between 2015 and 2025, the number of family caregivers increased by twenty million to 63 million American, and the ratio of available caregivers to those who need care—is declining.[5] The Act on RAISE campaign urges the CMS—and especially the Center for Medicare—to identify additional opportunities to do more to support this growing community as these challenges will become more acute with demographics shifts and recent federal policy changes and dramatic funding cuts impacting Medicaid and Medicare programs and the health of millions of enrollees.

We look forward to working with CMS to ensure that Medicare policy continues to align with the goals outlined in the National Strategy including, but not limited to Goal 2 to "advance partnerships and engagement with family caregivers."[6] In particular, we appreciate that the Center for Medicare through the PFS maintains caregiver training services, which will support the outcomes identified within Goal 2, including:

- Outcome 2.1: Family caregivers are recognized as essential partners in the care teams of the person(s) to whom they are providing support; and
- Outcome 2.3: Where appropriate, family caregivers are included and considered in the development of care recipients' plans of care across a range of settings and circumstances.

In light of these increasing challenges and ongoing opportunities for improvements to federal supports for family caregivers, the undersigned members of the Act on RAISE Campaign ***offer comments and considerations pertaining to CTS other critical issues as CMS finalizes the CY 2026 Medicare Physician Fee Schedule.***

AOR's input incorporates policy updates and recommendations regarding:

I. Designating Caregiver Training Services as "permanent" services available on the Medicare Telehealth Services List

II. Ensuring that CTS codes are coded and billed following the same coding guidance as other timed CPT codes used and understood by physical and occupational therapists

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[2] https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment#:~:text=68.8M,With%20Medicare%20Part%20D%20Coverage

[3] Population Research Bureau. *Fact Sheet: Aging in the U.S. January 2024*. *https://www.prb.org/resources/fact-sheet-aging-in-the-united-states/*.

[4] *ibid 1*.

[5] AARP Public Policy Institute. *The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers*. August 2013. https://www.aarp.org/content/dam/aarp/research/public_policy_institute/ltc/2013/baby-boom-and-the-growing-care-gap-insight-AARP-ppi-ltc.pdf

[6] National Strategy to Support Family Caregivers, Goal 2 (pgs. 41-51). https://acl.gov/sites/default/files/RAISE_SGRG/NatlStrategyToSupportFamilyCaregivers-2.pdf

III. Responding to the Request for Information included in the proposed rule seeking input about how CMS can improve support for prevention and management of chronic disease

IV. Eliminating the Social Determinants of Health (SDOH) Risk Assessment code (HCPCS code G0136) and updating the term SDOH to "upstream driver(s)" of health

V. Adding psychiatric diagnostic evaluation and Health Behavior Assessment Intervention (HBAI) to the list of qualifying visits for Community Health Integration services

VI. Elevating important policy opportunities to improve supports and services for family caregivers reflected in Campaign comment letters in response to the CY 2025 and CY 2024 proposed Medicare Physician Fee Schedules

I. Designating Caregiver Training Services as "permanent" services available on the Medicare Telehealth Services List

While we recognize that there were few substantive changes to payment policies and procedures governing CTS outlined in the CY 2026 draft PFS, we appreciate that CMS has proposed adding currently provisional CTS codes to the list of permanently available telehealth services. We support CMS's proposal to "revise the 5-step review process for reviewing requests to the Medicare Telehealth Services List" by removing Step 4 and Step 5. We agree that retaining Steps 1 through 3 will simplify the telehealth services list, address confusion about the evidence-base necessary to justify clinical efficacy, and allow practitioners to exercise their professional judgment about specific telehealth service delivery.

We support the proposed rule's update to designate that "all services listed or added on the Medicare Telehealth Services List would be considered included on a permanent basis" (90 FR 32388), and believe that this proposal to designate CTS as permanently available for telehealth services will allow providers to implement CTS more broadly and build an evidence base. *However, we echo our previous comments that unless additional resources are dedicated to the technical assistance needed to ease provider adoption, the availability of CTS services— whether provided in-person or remotely—will continue to lag amidst the growing need.*

Making CTS permanently available via telehealth will be especially important for the 20 percent of family caregivers that live in rural settings[7] who often contend with significant barriers to accessing healthcare and support services. According to a 2024 Joint Economic Committee (JEC) Report, 9 out of 10 rural counties face a shortage of primary care physicians,[8] and a March 2025 Health Resources and Services Administration (HRSA) report estimates that nearly two-thirds of rural areas were designated as Health

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[7] *ibid 1*.

[8] Joint Economic Committee. *Addressing rural health worker shortages will improve population health and create job opportunities*. January 2024. https://www.jec.senate.gov/public/_cache/files/79ef2a7d-1ec7-450e-ba5a-d5c14ad865ed/jec-issue-brief-on-rural-health-worker-shortages.pdf

Professional Shortage Areas (HPSA).[9] This scarcity of healthcare resources places an added hardship on rural caregivers, who must often travel long distances for medical appointments. These factors, combined with the higher prevalence of chronic conditions in rural populations, underscore the critical need for targeted support and telehealth resources for rural caregivers.

II. Ensuring that CTS codes are coded and billed following the same coding guidance as other timed CPT codes used and understood by physical and occupational therapists

While not reflected in the proposed CY 2026 Medicare PFS, we strongly urge CMS to rectify a contradictory statement included in the CY 2025 PFS which states that "*Caregiver training services are treated the same as most other timed services, and the full-time listed in the code descriptor is required*". Current coding practice, as directed by the AMA CPT Editorial Panel, directs coding to follow the Medicare 8-minute rule[10] or the AMA Midpoint rule for timed services. Both of these rules reflect a policy of reporting timed CPT codes once the service has reached 50% of the code descriptor time plus 1 minute.

Based on standard coding guidance, CMS's response reflected in the CY 2025 Medicare PFS final rule that, "*Caregiver training services are treated the same as most other timed services, and the full-time listed in the code descriptor is required,*"[11] is contradictory because most other timed-services do not require the full-time listed in the code descriptor in order to bill.

Campaign members echo recommendations from the American Occupational Therapy Association (AOTA) and other advocates urging CMS to require CTS to be coded and billed following the same coding guidance as other timed CPT codes used and understood by providers. Providers have expressed hesitancy in providing CTS and have further reported significant confusion with practitioner understanding of this specific policy that deviates from how the rest of the services the practitioners provide are billed. AOR and others have heard from providers that this contradictory policy is directly hindering beneficiary access to medically necessary CTS.

III. Responding to the Request for Information included in the proposed rule seeking input about how CMS can improve support for prevention and management of chronic disease

We appreciate the Request for Information included in the proposed rule seeking input to better understand how CMS can enhance support for the prevention and management of chronic disease. (90 FR 32507) In considering recommendations and resulting policy changes, we urge CMS to consider the vital role that family caregivers play in preventing and managing chronic disease for Medicare beneficiaries, and the impact that chronic

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[9] Bureau of Health Workforce. *Designated Health Professional Shortage Areas Statistics*. March 2025. https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport.

[10] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r2121cp.pdf

[11] https://www.federalregister.gov/d/2024-25382/p-1004

disease has on overall caregiver health and capacity to provide adequate support to care recipients.

Chronic disease directly impacts caregivers and care recipients

Family caregivers provide an estimated $600 billion in uncompensated care while serving as essential partners to both patients and healthcare providers.[12] Despite their critical role, research shows that one in four caregivers struggles to maintain their own health. According to a 2024 CDC report, family caregivers experience a higher disease burden across numerous health risk factors than non-caregivers.[13] These risk factors include smoking, heavy or binge drinking, physical inactivity, poor self-rated health, mental distress, diagnosed depression, physical distress, heart disease, stroke, chronic obstructive pulmonary disease, arthritis, diabetes, obesity, diagnosed asthma, one or more chronic physical health conditions, having no health coverage, and inability to see a doctor because of cost. Caregivers were also at higher risk of social isolation or disconnection than non-caregivers.

This reality affects general caregiver well-being and compromises the quality of care they can provide for their loved ones. In response to the RFI about how CMS can improve support for prevention and management of chronic disease, we urge CMS to understand that to truly modernize American healthcare and create better options for patients, we must recognize and support family caregivers.

CMS serves a key role in aligning health and community services to better support family caregivers and care recipients

We commend CMS for recognizing that a myriad of evidence-based and evidence-informed (EB/I) programs, often funded and/or administered through the Administration for Community Living (ACL), *"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."* We appreciate that CMS calls out that the 56 State Units on Aging, more than 600 Area Agencies on Aging, and the networks of tens of thousands of service providers that have a history of coordinating and delivery these critical services, but that, *"the needs exceed available* [discretionary] *federal funding."* CMS asks, *"Are there certain existing or new Physician Fee Schedule codes and payment, or Innovation Center Models* [CMMI], *which 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?"* (90 FR 32508)

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[12] Susan C. Reinhard, Selena Caldera, Ari Houser, Rita B. Choula. AARP. Valuing the Invaluable: 2023 Update Strengthening Supports for Family Caregivers. Washington, DC: AARP Public Policy Institute. March 2023. https://doi.org/10.26419/ppi.00082.008

[13] Centers for Disease Control and Prevention. *Changes in Health Indicators Among Caregivers — United States, 2015–2016 to 2021–2022*. August 2024. https://www.cdc.gov/mmwr/volumes/73/wr/pdfs/mm7334a2-H.pdf.

The Act on RAISE Campaign believes that there are numerous opportunities for CMS to better support improved partnerships between community and clinical entities. While we echo many of the recommendations and examples included in the Partnership to Align Social Care letter regarding overall opportunities for improved alignment through payment policy updates, we also encourage CMS to consider payment strategies and innovation models that aim to improve caregiver health and to address the chronic conditions of care recipients. Despite their essential role, caregivers are rarely seen as part of the care team. They are often excluded from care planning discussions, discharge instructions, and quality improvement processes. This lack of visibility undermines both caregiver and patient outcomes. A National Academies report emphasized the need for formal caregiver inclusion in care teams and reimbursement structures.

There are a number of existing and potential innovation models and opportunities that CMS could consider for implementation and expansion. In a June 2025 report from the Act on RAISE Campaign and the National Alliance for Caregiving, we encourage CMMI to integrate family caregivers across all innovation center models. This opportunity is especially important for patients and families navigating serious—often chronic—illnesses, for whom family caregivers represent an underutilized resource that significantly impacts both cost and quality outcomes.[14] We are eager to work with CMMI to ensure that caregivers are systematically integrated across demonstration models and recognized as essential partners in care delivery. In particular, we encourage CMMI to:

- Develop 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, across demonstration models.
- Develop and test 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.
- Pilot self-direction pathways that allow Medicare beneficiaries to retain and compensate family caregivers for in-home health support.

Additionally, we urge CMS to consider how allowing for evidence-based and evidence-informed programs can be scaled to be reimbursable as a Medicare Part B benefit. For example, the GUIDE (Guiding an Improved Dementia Experience) Model, launched by the CMS Center for Medicare and Medicaid Innovation (CMMI) 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. This model demonstrates how payment systems can be redesigned to formally incorporate caregivers, offering a blueprint for expanding this approach to other populations with serious illness, complex care needs, and chronic conditions. By providing dedicated funding for caregiver

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[14] 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

support services, GUIDE validates the essential role of family caregivers and creates a sustainable framework for their inclusion in care delivery.

We also recommend that CMS consider expanding fee-for-service specialty care models, including Kidney Care Choices, Oncology Care Model, and the Transforming Episode Accountability Model (TEAM). By definition, these models focus on subpopulations experiencing a specific clinical and/or chronic illness. However, CMS should consider opportunities to expand successful specialty care models—or components of these models and incorporate caregiver training and support opportunities—to broader populations experiencing chronic/complex illness. For example, an August 2025 Health Affairs report[15] recommends incorporating GUIDE Model components into other demonstration center models and specialty care models to ensure that caregivers are considered and supported as an integral component of the patient care team. We support these recommendations, which also include expanding wrap around supports and informal training opportunities for caregivers through Medicare by expanding the Resources for Enhancing Alzheimer's Caregivers Health (REACH)[16] and GUIDE Models, and by recognizing family caregivers for specified services provided to Medicare beneficiaries with complex/chronic care needs and building in caregiver compensation into demonstration models.

Supporting family caregivers will promote goals outlined in the RFI regarding preventing and managing chronic disease

We appreciate that CMS requests details regarding opportunities for Medicare Part B to address the root causes of chronic disease, social isolation, improve physical activity, and offer other proven lifestyle interventions for Medicare beneficiaries. We encourage policy makers to reference the wide array of evidence-based and evidence-informed programs supported by ACL[17] and the Aging and Disability Network to effectively treat and prevent chronic disease, help older adults and people with disabilities to adopt healthy behaviors, improve population health, reduce disability and injury, and reduce the use of hospital services and emergency room visits. (90 FR 32508)

We also encourage CMS to recognize and consider opportunities to encourage payment pathways to support the array of EBP/I programs focusing on chronic disease self-management, falls prevention, physical activity, behavioral health, and nutrition, which are specifically designed to address the unique health and social needs of caregivers and their care recipients. According to the National Council on Aging (NCOA), between 2019 to 2024, over 14,000 caregivers participated in 32 types of chronic disease self-management education (CDSME) programs, making up nearly a quarter of all participants. CDSME programs have shown to improve participants' self-reported health,

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[15] Health Affairs Forefront. *A National Action Plan To Strengthen Support For Informal Caregivers*. August 2025. https://www.healthaffairs.org/content/forefront/national-action-plan-strengthen-support-informal-caregivers

[16] Resources for Enhancing Alzheimer's Caregiver Health (REACH) is a program for supporting caregivers of people with Alzheimer's disease and related dementias (ADRD). The program was developed as part of the REACH project, a large, multi-state randomized control study jointly funded by the National Institute of Nursing Research and the National Institute on Aging, designed to test promising interventions to enhance family caregiving for persons with dementia. https://acl.gov/sites/default/files/programs/2023-03/REACH_TwoPager_220331_Final.pdf

[17] https://acl.gov/programs/strengthening-aging-and-disability-networks/aging-and-disability-evidence-based-programs

reduce days of depression, and enhance overall quality of life, and lead to tangible outcomes like fewer emergency room visits, saving an average of $364 per person.[18]

Furthermore, EB/I programs focused specifically on improving caregiver skills, support, and engagement, including, but not limited to, Building Better Caregivers, Powerful Tools for Caregivers,[19] Caring for Carers (C4C),[20] Active Caregiving: Empowering Skills (ACES), Care of Persons with Dementia in their Environments (COPE), and IDEA! Behaviors & Alzheimer's[21] are proven effective, have high participation rates, and underscore the need for these valuable resources. CMS has an opportunity to support scaling these and other important interventions by offering access as a Medicare Part B benefit, and we look forward to working with policy makers to realize the full potential of widely available services to meet the needs.

IV. Eliminating the Social Determinants of Health (SDOH) Risk Assessment code (HCPCS code G0136) and updating the term SDOH to "upstream driver(s)" of health

As we have echoed in previous comments to CMS, we support the opportunities adopted under the Healthcare Common Procedure Coding System (HCPCS) codes that provide a pathway to reimburse a range of activities to address non-medical, social, and health-related needs of Medicare Part B beneficiaries. These codes, Community Health Integration (CHI), Principal Illness Navigation (PIN), and Principal Illness Navigation-Peer Support (PIN-PS) HCPCS codes advance opportunities to integrate health and social care to improve clinical outcomes by providing payment for the labor extended to support persons who have unmet community/social health-related needs or require case management or health navigation services to address complex health conditions.

Addressing these unmet needs supports both family caregivers of Medicare enrollees who have unmet needs and caregivers who are Medicare enrollees who may also have unmet needs. Because CHI, PIN, and PIN-PS services can be billed as incident-to services and provided by non-physician practitioners under the direct supervision of a physician or non-physician practitioner, they provide important opportunities to integrate clinical and community providers to address non-clinical health needs. We are grateful that CMS maintained these payment pathways in the draft CY 2026 PFS.

In the CY 2026 PFS, CMS proposes eliminating the stand-alone G code—also established in the CY 2024 final rule—describing a Social Determinants of Health (SDOH) Risk Assessment, G0136, as CMS believes, "that the resource costs described by HCPCS code G0136 are already accounted for in existing codes, including but not limited to E/M

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[18] 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/.

[19] Ibid 15.

[20] The Better Care Playbook. *The Caring for Caregivers Program: Practical Approaches for Improving Caregiver and Patient Outcomes*. June 2024. https://bettercareplaybook.org/resources/caring-caregivers-program-practical-approaches-improving-caregiver-and-patient-outcomes

[21] Benjamin Rose Institute. Best Programs for Caregiving Website Serves Professionals and Family Caregivers. https://institute.benrose.org/evidence-based-and-informed-programs/best-programs-for-caregiving/

visits.” While we do not directly oppose eliminating G0136, if doing so streamlines access to services to address unmet health-related and non-medical drivers of health, we request that CMS to work closely with stakeholders to ensure that the elimination of SDOH Risk Assessment services does not compromise the provider’s ability to identify and treat unmet needs. (90 FR 32510)

Similarly, we take note of the CMS proposal to *“replace the term “social determinants of health (SDOH)” with the term “upstream driver(s)”* [based on the justification that CMS has] *determined that the term “upstream driver(s)” is more comprehensive and includes a variety of factors that can impact the health of Medicare beneficiaries.”* CMS contends that, *“the term “upstream driver(s)” encompasses a wider range of root causes of the problems that practitioners are addressing through CHI services,”* and that, *“This type of whole-person care can better address the upstream drivers that affect patient behaviors (such as smoking, poor nutrition, low physical activity, substance misuse, etc.) or potential dietary, behavioral, medical, and environmental drivers to lessen the impacts of the problem(s) addressed in the initiating visit.”* (90 FR 32510 and 90 FR 32511)

We do not directly oppose this change and agree that the term “upstream drivers” could capture additional non-clinical drivers of health than previously used terms. However, we recommend that CMS work closely with providers and practitioners to avoid confusion regarding frequent terminology changes, and to ensure that these updates do not have unintended consequences that present unforeseen or new barriers for CHI/PIN implementation efforts or care.

V. Adding psychiatric diagnostic evaluation and Health Behavior Assessment Intervention (HBAI) to the list of qualifying visits for Community Health Integration services

As we have previously stated, the Campaign fully supports the opportunities to address upstream drivers of health through CHI, PIN, and PIN-PS services. We maintain that these services can both support caregivers who *are* Medicare enrollees with unmet needs and provide support for family *caregivers of* Medicare enrollees with unmet needs. We have identified ongoing barriers to implementation, which we shared with CMS in our comment letter responding to the CY 2025 proposed PFS, and we maintain that successful implementation of services to address patients’ unmet upstream drivers of health has the potential to alleviate burden on family caregivers.

While we are eager to continue to work with policymakers to continue to address additional barriers, we appreciate and support the CMS proposal to expand access to CHI services by allowing for CPT code 90791 (Psychiatric diagnostic evaluation) or the Health Behavior Assessment and Intervention (HBAI) services that CPT codes 96156, 96158, 96159, 96164, 96165, 96167, and 96168 (and any subsequent HBAI codes) to serve as initiating visits for CHI services delivered by clinical social workers (CHWs), Marriage and Family Therapists (MFTs), and Mental Health Therapists (MHTs). (90 FR 32510)

We appreciate that CMS has *"continued to analyze the uptake of CHI services and believe that these services may fit the need for additional initiating CHI visits, as utilization data is showing that CHI services are being used to address SDOH need(s) that significantly limit the practitioner's ability to diagnose or treat mental illness."*

VI. Elevating important policy opportunities to improve supports and services for family caregivers reflected in Campaign comment letters in response to the CY 2025 and CY 2024 proposed Medicare Physician Fee Schedules

Act on RAISE Campaign members appreciate that the proposed CY 2026 Medicare PFS provides an ongoing opportunity to identify, implement, and improve policies to support family caregivers and their care recipients and to improve health care outcomes.

While we recognize that CMS does not ask about opportunities to address ongoing CTS, CHI, PIN, and PIN-PS implementation barriers in the CY 2026 PFS draft, we would be remiss in not reiterating some of the specific recommendations shared in the Campaign's 2025 letter. Specifically, we encourage CMS to consider implementing the following updates in the final CY 2026 PFS, or seriously consider incorporating these updates into the CY 2027 PFS:

- Expand 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;
- Provide clarification on CTS standards, or reference existing leading caregiver training programs, to ensure high-quality training;
- 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 important services for patients and their caregivers;
- Update 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; and
- Consider and support the technical assistance and awareness building activities that would help providers and their partners to address barriers to implementation and fully realize the opportunity to improve supports for patients and their caregivers inherent in both CTS and services to address unmet upstream drivers of health.

Conclusion

The Act on RAISE Campaign recognizes and appreciates 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 CY 2026 PFS proposed rule. We look forward to continuing to collaborate with agency officials and other stakeholders to ensure family caregivers are valued and supported in their vital role with Medicare beneficiaries. If you have any questions about this submission, please contact Elaine Dalpiaz at elaine@caregiving.org.

Sincerely,

Act on RAISE Steering Committee and Campaign Partners

National Alliance for Caregiving
Aging Life Care Association
ALS Association
Alzheimer's Association
Alzheimer's Impact Movement
Association of California Caregiver Resource Centers
Benjamin Rose
California Coalition on Family Caregiving
Center for Caregiver Serenity
Center for Medicare Advocacy
Compassion & Choices
Diverse Elders Coalition
Easterseals, Inc.
Elizabeth Dole Foundation
Family Caregiver Alliance
Family Caregiver Center of New Mexico
Gerontological Society of America
Gimme A Break
Grantmakers In Aging
Justice in Aging
Lupus Foundation of America
Milwaukee County Commission on Aging
National Adult Day Services Association (NADSA)
National Council on Aging
North Carolina Caregiving Collaborative
One Family Foundation
Respite Care Association of Wisconsin (RCAW)
Riccio Pick Me Ups
RRF Foundation for Aging
The Association for Frontotemporal Degeneration
USAging
Village to Village Network
Well Spouse Association
Wisconsin Aging Advocacy Network
Wisconsin Family & Caregiver Support Alliance