



September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: CMS-1784-P – Medicare and Medicaid Program: Calendar Year 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment, etc.

Dear Administrator Brooks-LaSure:

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the opportunity to comment on the proposed Medicare Physician Fees Schedule and other payment policies for 2024. Our comments focus on proposals and changes that directly impact beneficiary access and affordability or provide support for family caregivers. In particular, we strongly support the steps the agency is taking that recognize the critical role family caregivers play in Medicare and the delivery of care for their loved ones.

Valuation of Specific Codes

Payment for Caregiving Training Services (CPT codes 96202, 96203, 9X015-9X017)

AARP strongly supports CMS' proposal to pay for caregiver training services (CTS). This proposal is a monumental step in acknowledging the essential role family caregivers play in Medicare and we strongly urge CMS to retain it in the final Calendar Year 2024 Medicare Physician Fee Schedule. We appreciate that, in response to public comments from [AARP](#) and others, CMS is embracing the opportunity to invest in the training of family caregivers and supporting their role in the delivery of care. Making CTS available through Medicare is important to ensure access to these critical services for caregivers who need them. Assuming CMS implements the CTS provisions, educating practitioners and consumers/caregivers about these codes will be important to help ensure their use and maximize the benefit to family caregivers, the Medicare beneficiaries they are supporting, and providers themselves.

Definition of a Caregiver

CMS notes that in its ongoing education and outreach work on the use of caregivers in assisting patients, it has "broadly defined a caregiver as a family member, friend, or neighbor who provides unpaid assistance to a person with a chronic illness or disabling condition." In the context of proposals for CTS services, CMS believes:

“a caregiver is 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. For purposes of CTS, we also are including a guardian in this definition when warranted. For CTS, when we say ‘caregiver’ we are also referring to guardians who for purposes of CTS, are the caregiver for minor children or other individuals who are not legally independent. In these circumstances, a caregiver is a layperson assisting the patient in carrying out a treatment plan that is established for the patient by the treating physician or practitioner and assists the patient with aspects of their care, including interventions or other activities directly related to a treatment plan established for the patient to address a diagnosed illness or injury.”

It is important for CMS to define “caregiver” broadly to acknowledge the variety of relationships that family caregivers (caregivers) may have with the person they are assisting, that more than one caregiver may be involved in supporting the individual and caregivers can take on different roles in doing so, the range of types of conditions or illnesses that may involve the assistance of a caregiver (i.e., an illness or condition of short or long-term duration that is not necessarily chronic or disabling), and the types of support or assistance that caregivers may provide. We appreciate CMS’ proposed definition of caregiver that addresses many of these facets to some extent. AARP also urges some additional improvements to the definition of caregiver to be more inclusive of caregivers who may assist Medicare beneficiaries and need the proposed CTS services.

While some caregivers may meet some, but not all, of the criteria in the proposed definition, they still need training to provide important assistance to the Medicare beneficiary. The definition should be flexible enough to allow for situations with multiple caregivers who may perform different roles or more than one caregiver performing similar roles at different times, often due to scheduling considerations, such as one caregiver assisting a beneficiary while another caregiver is working a full- or part-time job. The definition should be flexible enough to enable caregivers who need the training to receive it and more than one caregiver to be trained to assist a beneficiary. CMS notes later in the proposal that the treating physician or nonphysician practitioner (NPP) may provide training to more than one caregiver for a single patient.” We encourage that the definition of caregiver also more specifically acknowledge that more than one caregiver per person they are assisting can receive the CTS services. This is very important, given the array of caregiver relationships and roles. Related to the above points and CMS’ proposed definition, AARP urges CMS to adopt the following text modifications:

- “involved on an episodic, daily, or occasional basis in managing, assisting with, coordinating, or supporting a patient’s complex health care or assistive technology activities at home” -- this helps ensure that caregivers who are “assisting with, coordinating, or supporting” and not just “managing” one’s complex health care and assistive technology needs can receive CTS services and that individuals who may assist

with either complex health care or assistive technology needs (not just both) may receive training;

- “and may help to navigate the patient’s transitions between care settings” – this helps ensure that if one caregiver is helping more with the navigation of the individual’s transitions between settings, but another caregiver may be providing more of the hands-on care and need training but is not navigating the care transitions, that such caregiver could also receive the training.

AARP requests that CMS consider “at home” broadly to not mean just in an individual’s home or apartment, but also in other residential settings where a Medicare beneficiary may be living, such as assisted living and other settings, using transportation between places (including to medical appointments), and while the individual is out in the community. Caregivers may be assisting individuals in these locations and contexts. It is also important to clarify that family caregivers who are unpaid and paid should be able to receive CTS if they need them. Family caregivers who may be paid to provide care in a Medicaid self-direction program or directly by an individual, for example, may not have received training that they need to address an individual’s aspect of care or change in condition. We encourage consideration on an individual basis of a caregiver’s need for CTS services. Assessing an individual caregiver’s situation and needs through a culturally appropriate caregiver needs assessment would help better determine their need for CTS services. It is also important that receipt of CTS services is voluntary for the caregiver.

Patients Who Benefit from Care Involving Caregivers

CMS believes “that a patient-centered treatment plan should appropriately account for clinical circumstances where the treating practitioner believes the involvement of a caregiver is necessary to ensure a successful outcome for the patient and where, as appropriate, the patient agrees to caregiver involvement.” The consent of the patient to caregiver involvement is important. In addition, it is important that the caregiver voluntarily agrees to involvement in a person’s treatment plan. There are a range of situations in which the involvement of a caregiver in developing and carrying out a treatment plan may be appropriate. CMS gives some examples of conditions and circumstances or medical scenarios under which CTS may be reasonable and necessary to train a caregiver who assists in carrying out a treatment plan, but does not limit situations where CTS may be reasonable and necessary to the examples provided. This is important. Medicare coverage of CTS is vital to ensure caregiver access to these important supports for caregivers and Medicare beneficiaries.

Reasonable and Necessary CTS

AARP agrees with CMS that CTS could be reasonable and necessary when furnished based on an established individualized, patient-centered treatment plan or therapy plan of care accounting for the patient’s specific medical needs, including, but not limited to, the examples specified previously in this proposed rule.

CMS describes that, as provided in the code descriptors, “treating practitioners may train caregivers in a group setting with other caregivers who are involved in care for patients with similar needs for assistance to carry out a treatment plan. Training for all of the caregivers for the

patient could occur simultaneously, and the applicable CTS codes (CPT code 96202, 96203, and 9X017) would be billed once per beneficiary.” CMS seeks comment on this issue. Caregivers may benefit from training in a group setting. We appreciate the availability of this training option for family caregivers. It is important to ensure that any group setting for training can address culturally appropriate care and meet the needs of all caregivers participating in the training. Caregivers should also be able to ask questions and get answers about their specific needs in a group setting. At the same time, an assessment of a caregiver’s needs can help determine the type, amount, and level of training a caregiver may need and a caregiver’s ability to learn. A caregiver may need and benefit most from individual training that is more specific to their caregiving situation, needs, and person they are assisting, including culturally appropriate care. It is also important that individual training is considered and available, as needed, as in CPT codes 9X015 and 9X016.

CMS is 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 and are seeking comment on this. In both instances, AARP believes CTS can be reasonable and necessary. Caregiver training needs may only require one session at a point in time, or may be extensive or change over time, and require more than one session. A caregiver’s need for training may change based on an individual’s assessment, reassessment, or changes in an individual’s condition, needs, or treatment plan; a caregiver’s abilities or circumstances may change impacting the training they need; or a care setting may change. These are examples that may trigger the need for more than a single training session or training for the same caregivers by the same practitioner for the same patient more than once per year. There should be flexibility in the frequency of training, so that it can be adjusted based on the needs in a particular caregiving situation. Regardless of the frequency of training, a caregiver should be able to access training (i.e., CTS) in a timely manner once the need for training is identified. This is important for quality, outcomes, and the stress of the caregiver. Again, AARP notes CMS’ point that “the treating physician or NPP may provide training to more than one caregiver for a single patient.”

Further Specifics of CTS Proposals

For Calendar year 2024, CMS proposes to establish an active payment status for CPT codes 96202 and 96203 (caregiver behavior management/modification training services) and CPT codes 9X015, 9X016, and 9X017 (caregiver training services under a therapy plan of care established by a physical therapist [PT], occupational therapist [OT], speech language pathologist [SLP]). Per CMS, these codes allow treating practitioners to report the training furnished to a caregiver, in tandem with the diagnostic and treatment services furnished directly to the patient, in strategies and specific activities to assist the patient to carry out the treatment plan.

CMS proposes that payment may be made for CTS services when the treating practitioner identifies a need to involve and train one or more caregivers to assist the patient in carrying out a patient-centered treatment plan. A practitioner may not always identify a need for caregiver involvement and training when it exists or offer needed training. It will be important for practitioners to be aware of the role of caregivers in general, inquire about the presence of

caregivers in the case of a particular patient, and engage them. Talking to a caregiver is important to help identify a need for training and if it would be helpful to them, including through the use of a culturally inclusive assessment of a caregiver's needs. Caregivers may not know to ask for training, that they can ask, that they need it, or they may be hesitant to ask for help. Different caregivers may engage based on their availability, timing, expertise, and shared responsibilities with other caregivers. One question that arises is whether the identification of the need to involve and train one or more caregivers is part of the identified codes that CMS proposes payment for, or whether that is covered under other codes? It is important for practitioners to have a plan for how to identify the need for training. This also starts with identifying the caregivers, and including the caregiver(s) and their contact information in the patient's electronic health record.

AARP supports CMS' proposals that the treating practitioner must obtain the patient's (or representative's) consent for the caregiver to receive the CTS and that the identified need for CTS and the patient's (or representative's) consent for one or more specific caregivers to receive CTS must be documented in the patient's medical record. We also suggest documenting the caregiver's consent to receive CTS. In addition, we suggest that CMS consider situations when the patient is not able to give consent, such as if they have dementia, and if a caregiver is the patient's representative, they may give consent for CTS for themselves.

CMS is proposing to require the full 60 minutes of time to be performed in order to report CPT code 96202. A question that arises is whether CPT code 96202 can be billed in increments of less than 60 minutes, such as based on the training needs of the caregivers involved? CMS is interested in and seeking comment on how the clinician and caregiver interactions would typically occur, including when the practitioner is dealing with multiple caregivers and how often these services would be billed considering the established treatment plan involving caregivers for the typical patient. Clinician and caregiver actions are likely to typically occur through in-person or virtual interaction such as office or virtual visits, conversations, calls, e-mails, patient portal communications, and access to electronic health records. Sometimes one or more caregivers may be communicating with a clinician, such as one caregiver taking the lead in communicating with a clinician and sharing the information with other caregivers or different caregivers handling different aspects of care or its coordination with a clinician. We can expect variation in interactions by patient, family, and circumstances. Communication may occur with doctors, nurses, social workers, administrative staff, and other nonphysician practitioners. In terms of considering how often CTS would be billed, it is important to allow for flexibility and variation based on patient and caregivers' needs and changes in such needs and conditions. (See our comments above under "Reasonable and Necessary CTS.")

CMS notes that treating practitioners establishing treatment plans could include a physician; nonphysician practitioner such as a nurse practitioner, physician assistant, clinical nurse specialist, clinical psychologist; or a physical therapist, occupational therapist, or speech-language pathologist. We agree and suggest that nonphysician practitioners could also include at least social workers. Such physicians and nonphysician practitioners should be able to provide CTS.

AARP supports CMS' proposal to designate CPT codes 9X015, 9X016, and 9X017 as "sometimes therapy." Per CMS, this means that the services of these codes are always furnished under a therapy plan of care when provided by PTs, OTs, and SLPs; but, in cases where they are appropriately furnished by physicians and NPPs outside a therapy plan of care, where the services are not integral to a therapy plan of care, they can be furnished under a treatment plan by physicians and NPPs. We think this is an important point that expands the access and availability to CTS for caregivers.

The CPT codes for CTS that CMS proposes to pay for provide for face-to-face training. We understand this to mean in-person training. AARP believes it is important and there should be explicit access to in-person CTS for caregivers who receive it. For group trainings (assuming there is more flexibility for individual caregiver trainings), it would be helpful for practitioners to offer or pilot offering back-up sessions or secondary dates for caregivers who are unable to attend a group training session. We also suggest making available, especially as a supplement, access to virtual or video training specifically for caregivers for whom, due to caregiving or scheduling circumstances, it is difficult for them to leave the person they are assisting, such as someone with dementia, or attend training at specific times. AARP also notes the value of providing training directly in the home for caregivers and encourages the provision of such training when possible. We assume face-to-face training may include adjustments in the case of a public health emergency.

AARP notes that the CTS provided should be available in languages other than English, based on the languages spoken by the caregivers receiving training. CTS should also be culturally sensitive and account for the literacy level of participating caregivers.

In receiving CTS in an individual or group setting, caregivers should be able to ask questions and help confirm their understanding of the training. CMS could encourage the sharing of promising or best practices or good models in terms of providing CTS. One learning we share from the Caregiver, Advise, Record, Enable (CARE) Act state implementation around hospital discharge is that some health systems developed a primer on who family caregivers are and background on working with family caregivers and wove this into ongoing staff training on other topics. Those systems recognized that not everyone understands what family caregiving is.

Additional Implementation Considerations

In past consideration of using existing codes to pay for support for family caregivers, one of the barriers providers identified was weighing whether a small amount of reimbursement was worth the time it took to complete billing paperwork. Given changes in technology, this may not be as much of a factor, though payment is important to ensuring CTS are available to caregivers. Another barrier raised by providers was concern that use of a non-frequently used code could lead to higher audit rates, which also cut into their time. We note these for awareness and to help eliminate any deterrence for utilization of caregiver training services.

Assuming the proposed CTS provisions are finalized, AARP urges CMS to analyze utilization of the proposed CPT codes for CTS by both the practitioner and the consumer (including where services are provided, who provides them, and take-up rates including geographically, settings,

location, and if caregiver assessments are used), education regarding these codes for both the consumer and practitioner, and the impact on workflow in the practitioner office. A survey of caregivers who receive CTS could provide useful insights and learnings. It is helpful to assess and address up front the potential benefits and burden associated with providing as well as utilizing these services. We encourage CMS education efforts for practitioners and caregivers to help increase awareness of these services.

AARP strongly urges CMS to move forward with implementation of payment for CTS. We also note the proposed codes generally do not address training for medical/nursing tasks or medical procedures. We encourage CMS to reference where such training may be provided now or refer to other training sources. This is also another potential aspect of training for family caregivers for future CMS consideration. We also acknowledge that training for caregivers is one important support that caregivers need and that we are pleased CMS proposes to address, but it is not the only one. AARP will continue to advocate for greater support for family caregivers, whether education and training, saving caregivers time, providing paid leave, expanding options for caregivers to be paid for providing care, increasing access to respite, and more.

On a related note to CTS, AARP supports the inclusion of the proposed codes for CTS in the definition of primary care services for purposes of beneficiary assignment in support of the Shared Savings Program mission to give coordinated, high quality care to an accountable care organization's Medicare beneficiaries.

Principal Illness Navigation (PIN) Services

CMS is proposing payment for principal illness navigation (PIN) services focused on patients with a serious, high-risk illness who may not have social determinants of health needs. As family caregivers are often involved in assisting individuals with a serious high-risk illness, AARP strongly supports and urges CMS to retain in the final rule the inclusion of caregivers and family members in the PIN services provisions. In the person-centered assessment, we suggest that CMS include an assessment of caregiver needs, where appropriate. This would also assist with identifying or referring the caregiver or family, if applicable, to appropriate supportive services. We also support payment for PIN services in rural health centers and federally qualified health centers and the inclusion of the caregiver mention in Community Health Integration (CHI) Services. These provisions would increase important support for family caregivers and the people they are supporting.

Evaluation and Management (E/M) Codes

AARP supports the implementation of the Office/Outpatient E/M Visit Complexity Add-on (G2211). This code was slated to be implemented in 2021, but Congress delayed its implementation in order to make other payment adjustments during the public health emergency. Now that the moratorium has been lifted, usage of the code should not be further delayed. Consumers benefit when they have ability to build trust and comfort with their health care providers over time. The G2211 code reflects the time, intensity, and practice expenses needed to

meaningfully establish relationships with patients and address most of their health care needs with consistency and continuity, particularly for primary care providers. However, we urge CMS to waive cost-sharing for this E/M add-on code, just as we have urged CMS to waive cost-sharing for chronic care management and transitional care management codes. Medicare beneficiaries should not be subjected to coinsurance for services that happen behind the scenes or without their direct initiation and involvement.

Payment for Medicare Telehealth Services

The Centers for Medicare & Medicaid Services proposes to change the classification tiers of approved telehealth service codes from Category 1, 2, or 3 to either *Permanent* or *Provisional*. AARP supports the change in classification, as it will reduce confusion about coverage of specific services. Moreover, we approve of the five-step process for analyzing services to be added, removed, or changed from the Medicare Telehealth Services List. In particular, we support Step 5, which considers whether there is evidence of clinical benefit on par with the clinical benefit of the in-person service. Similar to what is currently done when assigning a code to Category 2, CMS proposes that if there is enough evidence to suggest that further study may demonstrate that the service provided via telehealth is a clinical benefit, it would assign the code a “provisional” status on the telehealth list. When the clinical benefit of a service provided via telehealth is clearly analogous to the clinical benefit of the service provided in person, CMS would assign the code a “permanent” status. We urge CMS, though, to provide a timeline for permanent approval. A service code should not remain “provisional” indefinitely – either there is enough evidence to support its continued usage at the time or there is not.

Separately, CMS seeks information on whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology should potentially be made permanent, including whether this should be allowed only for a subset of services. AARP supports making this flexibility permanent and available to all providers eligible to bill for telehealth services. The COVID-19 pandemic made clear the importance of telehealth for Medicare beneficiaries who were able to use the technology to access the care they needed, and primary care providers who were able to see their patients and to increase their patient load. Telehealth remains a helpful tool in addressing the nation’s shortage of primary care professionals by extending the reach of clinicians and increasing access points for beneficiaries. The use of real-time audio/video technology to meet direct supervision requirements further enhances the ability of clinicians to see patients.

Advancing Access to Behavioral Health

AARP advocated for legislation expanding the pool of providers eligible to bill Medicare for behavioral health and mental counseling as a crucial step forward in helping our older adults improve and sustain holistic health. We are pleased to see CMS implementing the expansion of providers who can receive reimbursement from Medicare for mental health professionals to

include Marriage and Family Therapists (MFT) and Behavioral Health Counselors (BHC). Increased access to MFTs and BHCs to provide care to patients will increase use of mental health services, improving outcomes and overall wellness.

AARP also supports CMS's proposal to allow addiction counselors to be considered mental health counselors. Millions of older adults suffer from substance abuse disorder, and only 11% reportedly received treatment for their condition,¹ and many report inadequate coverage of treatment by Medicare as a barrier to accessing care.

CMS additionally requests feedback on ways to expand access to and use of behavioral health services, particularly behavioral health integration (BHI). Currently, Medicare utilizes the Collaborative Care Model (CoCM) for BHI. Under the CoCM model, a psychiatric consultant provides regular reviews of patient diagnosis, treatment plans, status, adjustments for patients who aren't progressing, and referrals for psychiatric care when necessary. The consulting psychiatrist often has no direct contact with the patient unless a need for direct behavioral health care is clinically indicated by a patient. We suggest Medicare allow and reimburse primary care providers for models which expressly include behavioral health, such as the Primary Care Behavioral Health Model (PCBH). Under the PCBH model, for instance, licensed behavioral health practitioners are core members of the primary care team and have direct interactions with patients, allowing them to meet the needs of patients more accurately and effectively. Data collection has shown these models to be effective at fulfilling the "Quadruple Aims" of improved outcomes, reduced costs, and better experience for both patient and clinician.

Medicare Payment for Dental Services

AARP applauds CMS for further clarifying Medicare payment of medically necessary dental treatment services for beneficiaries with cancer. There is a close association between cancer and oral disease. Moreover, there is an inextricable relationship between immunosuppression related to chemotherapy and radiation cancer treatments, and the need for dental services before, during, and following treatment. The specific concern, especially for older adults, is that immunosuppression increases the potential for sepsis and risk for infections like mucositis, both of which increase the risk for morbidity and mortality. By clarifying that the provision of dental services is integral to the effectiveness of cancer treatment, CMS is helping ensure that more Medicare beneficiaries have successful outcomes. In this spirit, we urge CMS to further clarify that dental and oral services are integral to the success of treatments for other covered services which involve immunosuppression or treatment of conditions that have an increased risk of infection, such as cardiovascular disease and diabetes, respectively.

Prescription Drugs

¹ Parrish, William J.; et. al.; *Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers*; American Journal of Preventive Medicine, Volume 63, Issue 2, August 2022, Pages 225-232

Drugs and Biological Products Paid Under Medicare Part B

AARP strongly supports CMS' ongoing efforts to implement the Inflation Reduction Act by codifying provisions relating to Medicare Part B payments for certain biosimilar drugs and limitations on beneficiary out-of-pocket costs for certain Part B drugs. These changes will help support the availability and use of biosimilar products and ensure that Medicare beneficiaries benefit from the savings that were intended by the passage of the new law. Furthermore, AARP is a strong advocate of reducing drug costs for older adults. We supported the provision in the Infrastructure Investment and Jobs Act that requires drug companies to refund Medicare for leftover and discarded Part B drugs. We support CMS's ongoing efforts to implement this legislation by continuing to refine the process for manufacturers to provide a refund to CMS for certain discarded amounts from a single-dose container or single-use package drug. This will also help reduce waste and spending within the Medicare program by discouraging drug manufacturers from overfilling single-use containers.

Payment for Preventative Vaccine Administration Services

COVID-19 vaccinations and boosters have been effective tools in helping prevent the severe consequences of COVID-19, including high hospitalization rates. [As we have previously commented](#), in general, with regards to payment for administering Part B vaccines to Medicare beneficiaries, AARP believes that Medicare payments should be fair and encourage provision of necessary services. More specifically, AARP supports CMS' efforts to encourage the administration of COVID-19 vaccines in certain vulnerable beneficiaries' homes. It is important to vaccinate as many older Americans as possible against preventable diseases, including individuals who are homebound or face challenges that significantly reduce their ability to get vaccinated outside of the home. We continue to support CMS' interest and proposal to expand this option for other Part B preventative vaccines, including influenza, pneumococcal, and Hepatitis B.

Conclusion

Thank you for the opportunity to comment on the proposed rule. If you have any questions about our comments or need more information, please feel free to contact me or Andrew Scholnick of our Government Affairs staff at ascholnick@aarp.org.

Sincerely,



David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs