

September 11, 2023

Chiquita Brooks-LaSure  
Administrator  
Centers for Medicare & Medicaid Services  
US Department of Health & Human Services  
200 Independence Avenue SW  
Washington, DC 20543



**Re: Medicare and Medicaid Programs; CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Medicare Advantage; Medicare and Medicaid Provider and Supplier Enrollment Policies; and Basic Health Program [CMS-1784-P]**

Dear Administrator Brooks-LaSure:

We are writing collectively as members of the Patient Quality of Life Coalition (PQLC), a group of over 40 organizations dedicated to advancing the interests of patients and families facing serious illness, with the overarching goal of providing patients with serious illness greater access to palliative care services. PQLC members represent patients and their caregivers, health professionals, and health care systems. We appreciate the opportunity to provide our recommendations on the Calendar Year (CY) 2024 Medicare Physician Fee Schedule (PFS) proposed rule. Specifically, herein we provide background on palliative care and feedback on the following Centers for Medicare and Medicaid Services (CMS) proposals:

- CY 2024 Conversion Factor
- Caregiver Training
- Principal Illness Navigation Services
- Evaluation and Management (E/M) Services
- Behavioral Health
- Telehealth
- Heard and Understood in MIPS

## **Palliative Care**

One of the key priorities of the PQLC is to improve patient access to palliative care. Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis) and can be provided along with curative treatment.<sup>1</sup> The goal is to improve quality of life for both the patient and the family.

Studies show that without palliative care, patients with serious illnesses and their families receive poor-quality medical care that is characterized by inadequately treated symptoms, fragmented care, poor

---

<sup>1</sup>Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. J Clinical Oncol 2012; 30: 880-887.

communication with health care providers, and enormous strains on family members or other caregivers.<sup>2, 3</sup> By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve both quality of care and quality of life during and after treatment.<sup>4, 5</sup> In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly after diagnosis even lived longer than those who did not receive palliative care.<sup>6</sup> Another study found that the receipt of a palliative care consultation within two days of admission was associated with 22 percent lower costs for patients with certain comorbid conditions.<sup>7</sup> The American Heart Association has stated that palliative care can be a helpful complement to current care practices and can improve quality of life for stroke patients, caregivers, and providers.<sup>8</sup> Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.<sup>9</sup>

Yet, despite the demonstrated benefits of palliative care, there remain millions of Americans who are unable to access such services. Many of these people are included in the five percent of patients who account for approximately 60 percent of all health care spending – those with multiple chronic conditions and functional limitations who have persistent high costs.<sup>10</sup>

## **CY 2024 Conversion Factor**

CMS proposes a CY 2024 PFS conversion factor of \$32.75, which represents a decrease of \$1.14 to the CY 2023 PFS conversion factor, or nearly 3 and a half percent.

**Comment: While we understand that CMS' options may be limited by statutory constraints, we urge the Agency to work with Congress to avert reductions to PFS payments for CY 2024.** Clinicians cannot withstand annual payment cuts, the impact of which is compounded by workforce shortages, the high costs of goods, and mounting interest rates. Palliative care providers have stepped up throughout the uncertainty of the last several years to care for those Medicare beneficiaries who are most in need of

---

<sup>2</sup> Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004 Jan 7; 291(1):88-93.

<sup>3</sup> Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly*. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

<sup>4</sup> Delgado-Guay MO, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 115(2) *Cancer* 437-45 (2009).

<sup>5</sup> Casarett D, et al., Do palliative consultations improve patient outcomes? 56 *J Am Geriatric Soc'y* 593, 597-98 (2008).

<sup>6</sup> Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med*. 2010;363:733-742.

<sup>7</sup> May P, et al. Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. *Health Affairs*. January 2016.

<sup>8</sup> Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association

<http://circ.ahajournals.org/content/early/2016/08/08/CIR.0000000000000438> Aug 16.

<sup>9</sup> Agency for Healthcare Research and Quality: System-integrated program coordinates care for people with advanced illness, leading to greater use of hospice services, lower utilization and costs, and high satisfaction. [www.innovations.ahrq.gov/content.aspx?id=3370](http://www.innovations.ahrq.gov/content.aspx?id=3370).

<sup>10</sup> IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life*. Washington, DC: The National Academies Press.

specialized care, to relieve patient suffering, and to provide coordination among the healthcare team. Access to palliative care continues to be a stumbling block across our healthcare system, and cuts to reimbursement for such services do not advance patients' ability to access these life-enriching services.

## **Caregiver Training**

CMS proposes to reimburse physicians, nurses, and other clinicians who provide training to patient caregivers for patients under an individualized treatment or therapy plan of care. Specifically, CMS would 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 PT, OT, SLP). CMS provides a list of physical and behavioral conditions for which it might be appropriate to directly involve the caregiver in developing and carrying out a treatment plan.

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." (Pg. 222 of the pre-publication copy.)

CMS is also considering whether caregiver training services 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. CMS notes that the treating physician or NPP may provide training to more than one caregiver for a single patient.

**Comment: We strongly support CMS' proposal to provide clinician reimbursement for caregiver training services, and urge CMS to permit such services in more than one single session and/or more than once per year.** In addition to the physical and behavioral health conditions that CMS listed, we also submit that caregivers should be involved in developing and carrying out a treatment plan for patients living with serious illnesses such as heart failure, COPD, cancer, ESRD, etc. People living with serious illness often have complex and skilled needs to which caregivers must attend, often without sufficient training. This proposal would help prepare caregivers for this work. However, we note that the needs of these patients evolve over time as their conditions change and/or they are diagnosed with additional illnesses. Additionally, as CMS notes, there often is more than one caregiver caring for the patient. Therefore, we ask that CMS provide reimbursement for caregiver training as it corresponds to patient and caregiver need, rather than setting a universal limit.

Beyond that, we believe that CMS' definition of caregiver is broad enough to encompass caregivers who typically care for palliative care patients. We appreciate CMS' creative approach to provide

reimbursement for and incentivize these services, as caregivers hold an important role in managing palliative care patients' conditions and improving their quality of life.

## **Principal Illness Navigation Services**

CMS notes research showing the benefits of patient navigation services for patients experiencing cancer and other high-risk, serious illnesses, and its effectiveness in engaging non-white populations in health care services. CMS proposes to allow principal illness navigation services to be furnished following an initiating E/M visit addressing a high-risk condition/illness/disease, provided that certain characteristics are met. CMS states that examples of such high-risk conditions /illness/disease include, but are not limited to, cancer, chronic obstructive pulmonary disease, congestive heart failure, dementia, HIV/AIDS, severe mental illness, and substance use disorder. CMS requests comment on patient consent, and notes that the agency may not waive patient cost sharing for such services, if provided.

**Comment: We support CMS' recognition of principal illness navigation services and proposal to reimburse for them.** Palliative care patients often need additional supports beyond clinical care, and the principal illness navigation services that CMS proposes via new G-codes would provide avenues for such patients to better access community-based services, transportation, and the overall healthcare system. We also support this proposal as navigation services may help more patients who need palliative care receive clinically-appropriate referrals for such services. We do believe that patients should consent to the provision of such services prior to initiation, however, as serious illnesses and conditions can be costly and transparency regarding all costs is optimal; We also urge the Agency to continue to evaluate palliative care-specific supports, as our patient mix requires unique navigation and coordination services that are not fully accounted for by CMS' principal illness navigation services proposal. We also note that CMS may wish to further clarify how principal illness navigation services are different than chronic care management training services to avoid provider confusion.

## **Split (or Shared) E/M Services**

For CY 2024, CMS is proposing to delay the split (or shared) visits policy it previously finalized. That is, CMS is proposing to delay the implementation of their definition of the "substantive portion" as more than half of the total time through at least December 31, 2024. Instead, CMS is proposing to maintain the current definition of substantive portion for CY 2024 that allows for use of either one of the three key components (history, exam, or MDM) or more than half of the total time spent to determine who bills the visit.

**Comment: We support further delay of this policy. As CMS continues to evaluate its E/M policy, we encourage the agency to align with E/M level selection policies – that is, to allow clinicians to choose between time and medical decision making – to determine which practitioner performs the substantive portion of the visit.** Such an approach recognizes that time can be a meaningful determinant of the care furnished to patients, while also acknowledging the value of medical expertise that may be required to direct the course of a patient's treatment, including for services like palliative care that may involve complex medical decision making.

## **Behavioral Health**

Section 4121 of the *Consolidated Appropriations Act of 2023* (CAA) permits Medicare Part B coverage and payment under the PFS for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs) when billed by these professionals. CMS is proposing to allow MFTs and MHCs to enroll in Medicare after the CY 2024 PFS final rule is published, and to bill Medicare for services starting January 1, 2024, consistent with statute.

**Comment: We support CMS' implementation of the requirement that MFT and MHC services be eligible for reimbursement under Medicare Part B.** Palliative care patients and their families can often benefit from mental health and family therapy; undergoing a serious illness is a significant challenge for all members of the family, and can have innumerable impacts on both the patient and their family members. Palliative care patients' mental health and family relationship status can exacerbate or aid their clinical condition, and we fully support CMS' efforts to embrace a whole-patient care model through this proposal.

## **Telehealth**

CMS proposes a number of 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 to the same list. CMS also proposes a refined process to analyze requests received for addition of services to the Medicare Telehealth Services List, and outlines a determination process regarding whether such requested services should be added permanently or provisionally.

CMS also outlines its implementation of several CAA-required policies, including: 1) allowance of the provision of telehealth services in any place where the beneficiary is located, including in the home; 2) permitting certain clinicians (e.g., occupational therapists) continued to be reimbursed for telehealth services; 3) a delay of the in-person requirement for certain mental telehealth services; and others. Lastly, CMS proposes to continue to define "direct supervision" to permit the presence and immediate availability of the supervising practitioner through real-time audio and video interactive telecommunications through December 31, 2024.

**Comment: The Coalition supports CMS' efforts to expand the use of telehealth.** We also urge CMS to continue to allow reimbursement for audio-only advance care planning codes (CPT codes 99497-99498) beyond 2024, as these codes remain vital to informed and comprehensive palliative care. Permitting audio-only for these services allows access for patients who do not have internet or broadband services, or whose service is unreliable, allowing those patients and their families to equitably participate in the important process of ensuring they receive care that is consistent with their goals and preferences. Advance care planning can be done via phone, as it is essentially a conversation between the provider, the patient, and the patient's family members or surrogates.

## **"Heard and Understood" in the MIPS Quality Measure Set**

CMS proposes to include Ambulatory Palliative Care Patients' Experience of Feeling Heard and Understood (Heard and Understood) to the Merit-based Incentive Payment System (MIPS) quality

measure set. CMS specifies that this patient-reported outcome measure “...would fill a gap in the current quality measure inventory for patients receiving palliative care” and notes that it “...captures the patient’s voice and experience of care by assessing communication and shared decision making with their clinician.”

**Comment: We support and thank CMS for the inclusion of this important measure in MIPS, and we further recommend that CMS include this measure in relevant MIPS Value Pathways.** The Heard and Understood measure is the result of several years of leadership and partnership between CMS, the American Academy of Hospice and Palliative Medicine, the National Coalition for Hospice and Palliative Care, and RAND International. This rigorously tested measure holds clinicians accountable for ensuring that they understand what matters most to patients and their caregivers, and is a critical component of developing patient-centered care plans. As such, we believe it is important to include this measure in relevant MIPS Value Pathways (e.g., any that currently include the advance care planning measure), which will support a continuing focus on palliative care as the MIPS program evolves. Furthermore, while this measure has been tested in palliative care programs, the concept of patients feeling heard and understood should not be limited to this patient population. As such, we encourage CMS to consider inclusion of this measure concept in other quality reporting programs that address care for patients with serious illness.

## **Conclusion**

On behalf of the PQLC, we thank you for the opportunity to comment on the proposed CY 2024 updates to the PFS. If you have any questions, please contact Dan Smith, acting Chair of the PQLC, at [dan.smith@advocacysmiths.com](mailto:dan.smith@advocacysmiths.com).

Sincerely,

[LIST OF PQLC SIGNING ORGANIZATIONS]