September 6, 2022

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 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [CMS-1770-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 CY 2023 Medicare Physician Fee Schedule (PFS) proposed rule. Specifically, herein we provide background on palliative care and feedback on the following CMS proposals:

- CY 2023 Conversion Factor
- Electronic Prescribing of Controlled Substances
- Telehealth
- Request for Information: Potentially Underutilized Services
- Split (or Shared) E/M Services

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.[1] 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 communication with health care providers, and enormous strains on family members or other caregivers.[2,3] By focusing on priorities that matter most to patients and their families, palliative care has

[1]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.
[2] 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.
[3] 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.

been shown to improve both quality of care and quality of life during and after treatment.[4,5] 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.[6] 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.[7] 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.[8] Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.[9]

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.[10]

The Coalition appreciates the opportunity to provide comments on the calendar year (CY) 2022 Medicare Physician Fee Schedule (PFS) proposed rule.

CY 2023 Conversion Factor

CMS proposes a CY 2023 PFS conversion factor of $33.08, which represents a decrease of $1.53 to the CY 2022 PFS conversion factor, or a little over 4 percent. This decrease is due to budget neutrality adjustments, as required by law, along with the expiration of the 3 percent PFS payment increase that Congress enacted for CY 2022 under the *Protecting Medicare and American Farmers from Sequester Cuts Act*.

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 2023. Given the clinical, access, and financial challenges raised by supply chain shortages, rising healthcare costs, record inflation, and the continuing COVID-19 public health emergency, the proposed conversion factor reduction could not come at a worse time. 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 specialized care, to relieve patient suffering and to provide coordination among the healthcare team.

---

[4] 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).
[5] Casarett D, et al., Do palliative consultations improve patient outcomes? 56 J Am Geriatric Soc'y 593, 597-98 (2008).
[6] 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.
[7] May P, et al. Palliative Care Teams' Cost-Saving Effect Is Larger For Cancer Patients With Higher Numbers Of Comorbidities. Health Affairs. January 2016.
[8] 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.
[9] 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.
[10] 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.

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.

Electronic Prescribing of Controlled Substances

Beginning in 2023, most physicians are required to electronically prescribe controlled substances covered under Medicare Part D. For 2023, CMS limited its compliance action to sending noncompliance letters to prescribers determined to be out of compliance with the electronic prescribing requirement. CMS notes the downstream consequences for Medicare beneficiaries who require Part D drugs in cases where their physicians have not yet adopted electronic prescribing. CMS also proposes to update its exception policy for physicians who write fewer than 100 scripts annually to make the determination based on the number of prescriptions issued in the current year, rather than the previous year.

Comment: We support CMS' proposal to extend, through 2024, the policy to limit compliance action to sending letters of noncompliance. While we understand the goals of requiring electronic prescribing for certain prescriptions, we share CMS' concerns regarding access to care for patients whose clinicians may not have adopted such systems. Palliative care patients in particular should not experience a lack of access to pain and other drugs which may be acutely necessary given their clinical condition.

Telehealth

CMS proposes to extend telehealth flexibilities for 151 days after the expiration of the PHE, consistent with Congressional action. These flexibilities include additional telehealth eligible practitioners, coverage of certain services otherwise not available via telehealth (via the telehealth code list), and waiver of certain originating site requirements. Further, after the 151 days after the expiration of the PHE, CMS would revert to paying the "facility" rate for telehealth services, noting that the facility rate best reflects practice expenses.

Comment: The Coalition supports CMS' efforts to expand the use of telehealth services and, specifically, to permit payment for certain telehealth services for 151 days beyond the public health emergency (PHE) in circumstances where clinically appropriate. However, we urge CMS to allow reimbursement for audio-only advance care planning codes (CPT codes 99497-99498) beyond the conclusion of the PHE, as these codes will remain vital to informed and comprehensive palliative care beyond the COVID-19 pandemic. We believe such action would provide access to 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.

Request for Information: Potentially Underutilized Services

CMS requests feedback on how the agency can improve access to high value, potentially underutilized services by Medicare beneficiaries. CMS notes that high value health services have been described as those services that provide the best possible health outcomes at the lowest possible cost. The Department states its belief that some high value Medicare services may be potentially underutilized by

beneficiaries and, in some cases, limited use of these kinds of services may occur disproportionately in underserved communities.

Comment: We urge CMS to evaluate how palliative care may fit within the agency's efforts to address potentially underutilized services. Care management is a high-value service for beneficiaries living with serious illness and continues to be underutilized. Both to improve patient and caregiver quality of life, as well as to improve efficiency of healthcare utilization, clinicians must spend time in holistic planning, coordinating information across providers, and helping families to understand and navigate treatments. To eliminate barriers to these much-needed services, we recommend that CMS pursue options to exclude advance care planning, chronic care management, principal care management, and complex chronic care management reimbursement from beneficiary cost-sharing requirements.

We must also note that palliative care – interdisciplinary care that addresses the symptoms and stresses of serious illness – offers very high value yet remains underutilized. To support increased utilization of palliative care, we recommend that specific payment models for ongoing palliative care management be created. Doing so will help ensure that this high-value service can be recognized and researched; furthermore, access will be greatly improved through sufficient payment. The PQLC has previously communicated with the agency regarding recommendations for payment models that would promote better access to palliative care, and we refer you to this previous communication.[11]

Split (or Shared) E/M Services

For CY 2023, CMS is proposing to delay the split (or shared) visits policy it previously finalized. Specifically, in CY 2023, as in CY 2022, the substantive portion of a visit may be met by any of the following elements: History; Performing a physical exam; Making a medical decision; Spending time (more than half of the total time spent by the practitioner who bills the visit). CMS states that clinicians who furnish split (or shared) visits will continue to have a choice of history, physical exam, or medical decision making, or more than half of the total practitioner time spent to define the substantive portion, instead of using total time to determine the substantive portion, until CY 2024.

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.

Conclusion

[11] PQLC Letters to CMS dated June 27, 2016: https://www.dropbox.com/s/knnll3e79r9nhw2/PQLC%20MACRA%20Comment%20Letter%2006272016_FINAL.pdf?dl=0 and September 10, 2018: https://www.dropbox.com/s/htx81e6n0g5hlpv/PQLC_PFS%20Comment%20Letter%20on%20CMS-1693-P-%20FINAL%2009102018.pdf?dl=0

On behalf of the PQLC, we thank you for the opportunity to comment on the proposed CY 2023 updates to the PFS. If you have any questions, please contact Stephanie Krenrich, Chair of the PQLC, at Stephanie.Krenrich@cancer.org.

Sincerely,

American Academy of Hospice and Palliative Medicine
American Cancer Society Cancer Action Network
Association for Clinical Oncology
Cancer Support Community
Catholic Health Association of the United States
Center to Advance Palliative Care
Coalition for Compassionate Care of California
National Brain Tumor Society
Oncology Nursing Society
Pediatric Palliative Care Coalition
Physician Assistants in Hospice and Palliative Medicine
ResolutionCare, a Vynca company