

September 13, 2021

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



**Re: Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to the Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements.**

Dear Administrator Brooks-LaSure:

We are writing collectively as members of the Patient Quality of Life Coalition, 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. Members represent patients and their caregivers, health professionals, and health care systems. One of the key priorities of the Coalition 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. 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 too often 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. 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. 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. 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. The American Heart Association and American Stroke Association have 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. Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.

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.

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

## **CY 2022 Conversion Factor**

To calculate the CY 2022 PFS conversion factor (CF), CMS took the CY 2021 conversion factor without the 1-year 3.75 percent increase provided by the Consolidated Appropriations Act of 2021 (CAA), and multiplied it by the budget neutrality adjustment. Taking those factors into consideration, CMS estimates the CY 2022 PFS CF to be \$33.58, which is approximately 3.75 percent lower than the CY 2021 CF of \$34.89.

Comment: Given the clinical, access and financial challenges raised by the ongoing COVID-19 pandemic, the proposed 3.75 reduction in the CF could not come at a worse time. Palliative care providers have stepped up throughout the public health crisis 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. 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. **While we understand that CMS' options may be limited by statutory constraints, we urge the Agency to identify a solution and not finalize the proposed CF reduction.**

## **Health Equity Data Collection**

CMS solicits feedback on how it might best collect data to better measure and analyze disparities across Medicare programs and policies. Specifically, CMS raises the prospect of developing reports that would provide insights into beneficiary demographics (e.g., gender identity and sexual orientation, race and ethnicity, dual program-eligibility, and geography). This data could be utilized by providers to advance efforts around health equity.

Comment: The Coalition supports CMS' goal of addressing health equity and, specifically, gaining a deeper understanding of where care gaps exist and may be addressed. In addition to racial and ethnic disparities, questions regarding gaps in access to care for rural and urban areas must be addressed in order to deliver equitable, comprehensive care to all Medicare beneficiaries. **We urge CMS to consider the role that palliative care can play in addressing systemic issues including gaps in care; for example, we know that public hospitals and hospitals in Southern states are less likely to have hospital-based palliative care teams, which impedes equitable access to palliative care. Additionally, a 2019 study<sup>1</sup> found that lower access to palliative care was due to receipt of care at minority-serving hospitals, rather than a pattern of bias within any particular hospital. These findings suggest that policy is needed to encourage palliative care presence at public and minority-serving hospitals.**

## **Expanding Telehealth For Behavioral and Mental Health Care**

CMS proposes to implement recent legislation which allows patients to access tele-mental health services. Specifically, Medicare beneficiaries in any geographic location and their home would be able to access telehealth for the diagnosis, evaluation, and treatment of mental health disorders. Further, CMS proposes to expand upon this policy by reimbursing Rural Health Clinics and Federally Qualified Health Centers (FQHCs) to include behavioral and mental health care furnished via telehealth.

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<sup>1</sup> Cole AP et. al. doi:10.1001/jamanetworkopen.2018.7633

Comment: The Coalition supports CMS' efforts to expand equitable access to telehealth services and, specifically, to permit payment for behavioral telehealth and mental telehealth services beyond the public health emergency (PHE) in clinically appropriate circumstances. We further **support the proposed rule to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023**. Many of those codes, especially the evaluation and management for hospital inpatient services, nursing facility services, home services, and even critical care services are commonly used by palliative care teams and enable access to palliative care specialists when a physical visit is not possible, or puts undue travel burdens on facilities, patients, and families. **Additionally, 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.** 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. We believe that continued reimbursement of advance care planning via audio-only modalities would provide access to patients who do not have internet or broadband services, allowing those patients to equitably receive quality care.

Finally, we urge the Agency to extend reimbursement of prolonged psychotherapy visit codes (CPT codes 99354-99355) conducted via audio-only beyond the PHE, as those codes are also widely used by palliative care providers to ensure comprehensive discussions and planning with patients in distress.

## Conclusion

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the proposed CY 2022 updates to the Medicare Physician Fee Schedule. If you have any questions, please contact Stephanie Krenrich, Chair of the Patient Quality of Life Coalition, at [Stephanie.Krenrich@cancer.org](mailto:Stephanie.Krenrich@cancer.org).

Sincerely,

American Academy of Hospice and Palliative Medicine  
American Cancer Society Cancer Action Network  
Cancer Support Community  
Catholic Health Association of the US  
Center to Advance Palliative Care  
Coalition for Compassionate Care of California  
Hospice and Palliative Nurses Association  
Motion Picture & Television Fund  
National Coalition for Hospice and Palliative Care  
National Patient Advocate Foundation  
Oncology Nursing Society  
Pediatric Palliative Care Coalition