



October 5, 2020

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1734-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies [CMS-1734-P]

Dear Administrator Verma:

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 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) 2021 Medicare Physician Fee Schedule (PFS) proposed rule.

Evaluation & Management (E/M) Visits

In the CY 2020 PFS final rule, for the office/ outpatient E/M visit code set (CPT codes 99201-99215), CMS finalized a policy to generally adopt the new coding, prefatory language, and interpretive guidance framework issued by the AMA's CPT Editorial Panel earlier that year, as well as to increase valuation of these services consistent with recommendations from the AMA RVS Update Committee. In this CY 2021 PFS proposed rule, CMS affirms that the previously finalized E/M policy will be effective January 1, 2021. Separately, to comply with statutory budget neutrality rules and offset the E/M and other payment changes, CMS proposes a CY 2021 conversion factor (CF) of 32.2605, which represents an RVU budget neutrality adjustment of -10.61 percent (0.8939) relative to the CY 2020 CF.

Comment: **The Coalition greatly appreciates the benefits that the planned E/M coding, documentation, and payment changes will have on the delivery of palliative care, and strongly urges CMS to proceed with these changes as scheduled.** As CMS and other stakeholders explore potential options for mitigating the impacts of statutory budget neutrality adjustments, we urge the Agency to stay the course with the planned 2021 E/M changes. Palliative care providers have prepared for these changes by adjusting their administrative, electronic, and training systems, and modifying E/M documentation, coding, or payment at this late stage would be extremely disruptive. Furthermore, the increased valuation will better reflect the resources required to furnish high-quality palliative care to patients with serious illness.

Audio-Only Visits

CMS seeks comment regarding the continuation of payment for audio-only visits. The Agency previously established separate payment for audio-only telephone E/M services in its March 2020 COVID-19 interim final rule with comment (IFC), and expanded upon that policy in its May 2020 COVID-19 IFC and blanket waivers to allow for audio-only provision of a number of telehealth services that had previously only been reimbursable if provided via a two-way, interactive audio and video telecommunications system. CMS notes in the preamble of the proposed CY2021 PFS that it is unable, absent statutory authority, to waive the requirement that telehealth services be furnished using an interactive telecommunications system that includes two-way, audio visual communication technology and, therefore, cannot widely reimburse for audio-only telehealth visits outside the circumstances of the public health emergency (PHE). At the same time, CMS acknowledges that that the need for audio-only interaction could remain.

Comment: The Coalition supports CMS' efforts to expand the use of telehealth services and, specifically, to permit payment for audio-only telehealth services beyond the PHE in circumstances where clinically appropriate, such as advance care planning. **Specifically, 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. Additionally, 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 patient care. Finally, we urge the Agency to extend reimbursement of prolonged visit codes (CPT codes 99354-99355) conducted via audio-only, as those codes are also widely used by palliative care providers to ensure comprehensive discussions and planning with patients.

Conclusion

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the proposed updates to the Quality Payment Program. If you have any questions, please contact Keysha Brooks-Coley, Executive Director of the Patient Quality of Life Coalition, at 202-661-5720 or Keysha.Brooks-Coley@cancer.org.

Sincerely,

American Academy of Hospice and Palliative Medicine
American Association of Colleges of Nursing
American Cancer Society Cancer Action Network
Association of Professional Chaplains
Cancer Support Community
Center to Advance Palliative Care
Children's National Hospital
Coalition for Compassionate Care of California
GO2 Foundation for Lung Cancer
Health Care Chaplaincy Network
Hospice and Palliative Nurses Association
Motion Picture & Television Fund
National Coalition for Hospice and Palliative Care
National Hospice and Palliative Care Organization
National Palliative Care Research Center
National Patient Advocate Foundation
Oncology Nursing Society
Pediatric Palliative Care Coalition
Physician Assistants in Hospice and Palliative Medicine
ResolutionCare Network
Society of Pain and Palliative Care Pharmacists
Supportive Care Coalition
Trinity Health