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June 14, 2024

The Honorable Ron Wyden
Chairman
Senate Finance Committee
Washington, DC 20510

The Honorable Michael Crapo
Ranking Member
Senate Finance Committee
Washington, DC 20510

RE: Comments on "Bolstering Chronic Care through Physician Payment" white paper

Dear Chairman Wyden and Ranking Member Crapo:

On behalf of the members of the American Academy of Hospice and Palliative Medicine (AAHPM), we would like to thank you for the bipartisan work to bolster chronic care through Medicare physician payment reforms.

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our more than 5,200 members also include nurses, social workers, spiritual care providers, pharmacists, and other health professionals deeply committed to improving quality of life for the expanding and diverse population of patients facing serious illness or multiple chronic conditions, as well as their families and caregivers. Together, we strive to advance the field and ensure that patients across all communities and geographies have timely access to high-quality, equitable palliative and hospice care. For more than 30 years, AAHPM has been dedicated to advancing the discipline of Hospice and Palliative Medicine through professional education and training, development of a specialist workforce, support for clinical practice standards, research, and public policy.

BACKGROUND

Palliative care is an interdisciplinary model of care aimed at preventing and treating the debilitating effects of serious and chronic illness, such as cancer, cardiac disease, respiratory disease, kidney failure, Alzheimer's disease, acquired immunodeficiency syndrome (AIDS), Amyotrophic Lateral Sclerosis (ALS), and Multiple Sclerosis (MS). It can be provided from the time of diagnosis and involves the relief of pain and other symptoms that cause discomfort, such as shortness of breath and unrelenting nausea.

Palliative care is patient- and family-centered—it focuses on matching treatment to achievable patient goals to maximize quality of life. In practice, this involves detailed and skilled communication with patients and families to elicit goals and preferences; expert assessment and management of physical, psychological, and other sources of suffering; and coordination of care across the multiple settings (e.g., hospital, post-acute care, ambulatory clinics, home) that patients traverse throughout the course of a serious illness. Palliative care can be offered alongside life-prolonging and curative therapies for individuals living with serious illness. Hospice is care specially designed for those nearing the end of life.

CHRONIC CARE BENEFITS IN MEDICARE FFS

Our comments focus on the following questions related to supporting chronic care benefits in Medicare fee-for-service (FFS) found on page 21 of the white paper:

1. *Which services provide the most value in reducing downstream health care costs and improving outcomes for the chronically ill?*
2. *What other benefit-related policies should the Committee consider to improve chronic care in Medicare FFS?*

Need for Increased Access to Community-Based Palliative Care

For patients with serious and chronic illness, palliative care delivered through interdisciplinary teams can not only help to relieve pain and other distressing symptoms but also address patients' psychosocial and spiritual needs and improve their capacity to contend with the stresses associated with their illness. Palliative care also can improve patient and caregiver outcomes, including through improved care coordination and reduced utilization of high-cost interventions that are inconsistent with patients' goals and preferences. Current payment systems pose numerous barriers that limit palliative care teams' ability to receive adequate reimbursement for providing comprehensive palliative care services – and therefore limit patients' ability to receive high-quality palliative care.

AAHPM has sought to address this gap through advocacy for a robust Medicare alternative payment model (APM) that would offer payment for palliative care services and enable palliative care teams to take on cost and quality accountability for patients with serious illness. In the fall of 2017, AAHPM submitted a model proposal to the Physician-Focused Payment Model Technical Advisory Committee

(PTAC) called *Patient and Caregiver Support for Serious Illness (PACSSI)*. Following PTAC's recommendation to the Secretary of the Department of Health and Human Services (HHS) for limited-scale testing of the PACSSI model, AAHPM – along with additional stakeholders – worked to inform the Centers for Medicare and Medicaid (CMS) Innovation Center on critical elements of a community-based palliative care model that should be tested in a demonstration project. The subsequent announcement of the Serious Illness Population (SIP) component under the Innovation Center's Primary Care First (PCF) model in April 2019 appeared to be a first step for making community-based palliative care services available to Medicare patients with serious illness on a pilot basis, including in conjunction with the delivery of advanced primary care services for certain qualifying practices. However, in November 2021, CMS announced it would not move forward with the SIP component of the PCF model, unraveling years of investment and preparation by stakeholders seeking to participate in the SIP component and putting the brakes on the most advanced effort to date to test community-based palliative care services in the traditional Medicare program.

AAHPM continues to believe that increased coverage for and access to community-based, team-based palliative care services is necessary to support patients with serious illness and multiple chronic conditions. **We therefore urge lawmakers to prioritize access to palliative care for patients with serious illness and multiple chronic conditions, including through new APMs that connect patients with serious illness to community-based palliative care services.**

According to the CMS Innovation Center authorizing statute, the HHS Secretary can only expand models that have demonstrated cost savings or neutrality on initial testing, regardless of the magnitude of quality of life or experience of care benefits that they may provide. This requirement results in an overemphasis of cost saving over enhanced quality in the determination of high-value care and discourages the testing of models of services like palliative care which may require initial investments and result in delayed cost savings. AAHPM believes that there must be a willingness to conduct long-term tests of palliative care models that may not initially appear to reduce or maintain costs. As the Committee works to strengthen the Medicare program, **AAHPM urges you to ensure support for innovative payment models that make investments in high-value services like palliative care, even if cost savings for such models may be initially unclear.**

MEDICARE PHYSICIAN FEE SCHEDULE POLICIES

Our comments focus on the following question related to addressing Medicare payment update adequacy and sustainability found on page 14 of the white paper:

1. *As an alternative to the current-law updates, how should the CF be updated to provide greater certainty for clinicians moving forward, including in light of inflationary dynamics?*

And the following question related to budget neutrality adjustments to the conversation factor found on page 16 of the white paper:

2. *Should the Committee consider additional parameters to align the statute's budget-neutrality provisions with the goal of maintaining fiscal integrity, as well as to avert or mitigate substantial payment fluctuations and volatility resulting from regulatory policy changes?*

AAHPM appreciates your concerns related to the adequacy and sustainability of the Medicare Physician Fee Schedule (MPFS). **AAHPM is deeply troubled by the continuous erosion of payment for Medicare physician services,** as demonstrated by the reduction in the MPFS conversion factor for the last four years. This trend devalues the role that physicians play in promoting the health and well-being of Medicare beneficiaries year over year. It also fails to adequately compensate physicians for the costs that they incur, as annual payment updates do not account for inflation in practice expense costs. Given this disparity between negative payment growth rates and positive cost growth rates, it is no wonder that the nation's healthcare system is seeing greater rates of consolidation and physician employment in large group practices as insufficient payments threaten practice sustainability, and ultimately the availability and quality of care furnished to Medicare beneficiaries.

AAHPM recognizes that the limitations on conversion factor (CF) growth stem from structural problems with the statutory formulas for updating payments under the Medicare Physician Fee Schedule (MPFS), including the fact that payment updates are not tied to any indicators of inflation – unlike updates received for almost every other Medicare payment system – and that changes in relative value units (RVUs) are subject to budget neutrality adjustments. Especially as CMS has sought to balance out PFS payments to place greater emphasis on cognitive services in recent years – a change that AAHPM has supported – the outsized budget neutrality adjustments have been particularly damaging to physician payment rates and have furthermore undercut much of the gains for cognitive specialties that the RVU changes have been intended to produce.

Together with the American Medical Association and more than a hundred other specialty societies and state medical associations, AAHPM endorsed a set of characteristics of a rational Medicare payment system, which provides a framework for future payment reform that should ensure financial stability and predictability, promote value-based care, and safeguard access to high-quality care. AAHPM continues to stand by that framework and supports fundamental reform in how Medicare physician payment updates are made. AAHPM therefore urges the Committee to work with CMS and medical societies to achieve broad reforms consistent with the above goals for the long term.

EVALUATION AND MANAGEMENT (E/M) VISITS

Our comments focus on the following question related to ensuring accuracy of values within the PFS found on page 22 of the white paper:

1. *What structural improvements, if any, would help to bolster program integrity, reliability, and accuracy in CMS's RVU and rate-setting processes?*

AAHPM recognizes that E/M services have historically been undervalued and that there have been numerous other coding and payment deficiencies – for example related to care management and communication technology-based services – that have been addressed over the years. AAHPM appreciates the steps CMS has taken in this regard – including to improve coverage and payment for cognitive services – as the consequences of inaccurate or inappropriate coding and valuation can be substantial. For example, under previous E/M documentation guidelines, medically necessary services were regularly denied due to technical documentation shortcomings that did not detract from the comprehensiveness or quality of care delivered. More broadly, however, inaccurate or inappropriate coding and valuation results in a system where services furnished do not align with desired outcomes, on one hand leading to waste for overvalued services and on the other resulting in underutilization and lack of access to undervalued or undefined services that can have significant impacts on patients' health and well-being.

Our members see this dynamic play out regularly with respect to the delivery of community-based palliative care services. AAHPM has regularly highlighted the lack of access to palliative care services for patients who do not elect the hospice benefit, which we believe is a result of current payment policies under the MPFS that have restricted payment that supports team-based care. Without appropriate payment, palliative care teams may not have the resources to fully support patients and families contending with serious illness; likewise, hospitals and health systems may divert resources away from palliative care programs and instead focus on delivery of high-revenue procedures. Ultimately, patients with serious illness and their caregivers are the ones who suffer, without adequate support to manage their treatment plans, navigate complex health systems, access available social supports, and more.

AAHPM therefore appreciates the role that CMS has played in driving more appropriate coverage and payment for services, particularly by highlighting where gaps exist or where revaluation is needed. However, we also value the role of the CPT Editorial Panel and the Relative Value Scale Update Committee (RUC) to refine CMS' policies, as we have seen, for example with transitional care management and chronic care management services. Indeed, we believe that the CPT and RUC processes are critical for ensuring that coding and valuation are physician- led processes that rely on the experience and expertise of professionals furnishing the services. We also appreciate how these processes result in data-driven recommendations. Therefore, we encourage policymakers to continue to identify opportunities for improvement in coding and valuation, and then to work with the physician community via the CPT and RUC processes to refine final policies.

ENSURING CONTINUED ACCESS TO TELEHEALTH

We thank the Committee for its bipartisan leadership to ensure continued access to telehealth services and appreciate the discussion on pages 22-24 of the white paper. The extension of telehealth flexibilities through 2024 has been very important to ensure sustained access to care after the end of the COVID-19 public health emergency. However, we believe that **permanent expansion of telehealth flexibilities is needed to support care for patients with serious illness who experience numerous challenges accessing in-person care,** including as a result of mobility

and/or cognitive limitations; pain, frailty, or medical instability; reliance on caregivers to assist with transportation; and more. In particular, we believe the statutory geographic location and originating site restrictions that limit the availability of Medicare telehealth services are outdated and do not reflect the current needs and technological capabilities to safely, effectively, and efficiently deliver care – not to mention patients' and providers' preferences for receiving and delivering care with minimal burden. AAHPM therefore urges the Committee to **permanently eliminate the geographic and originating site restrictions** on Medicare telehealth services such that patients can continue to receive these services on an ongoing basis, regardless of their location across the country.

We also urge the Committee to **provide ongoing coverage of audio-only services when two-way audio-visual technology is not available**, including for audio-only E/M services and audio- only advance care planning services. Use of audio-only services has enabled patients with serious illness to maintain access to medically necessary care that could be furnished in a clinically appropriate manner via audio-only telecommunications technology, as determined by treating physicians, rather than forgoing care. Indeed, audio-only E/M and advance care planning services – when needed to accommodate lack of video communications – have enabled patients with serious illness to receive more timely and efficient care – for example, to hold discussions about goals of care, treatment options, values, and preferences; to allow for assessment of disease progression and symptoms; and to facilitate prescribing of medication and counseling services. Moreover, we note that older people and those in rural and under-resourced areas who are harmed by structural disadvantages such as limited options for connectivity would be the most likely to benefit. Thus, enabling ongoing audio-only telehealth services on a permanent basis would advance health equity goals.

AAHPM also urges the Committee to **extend the use of telehealth to conduct a face-to-face (F2F) encounter prior to recertification of eligibility for hospice care**. As background, for the first benefit period (up to 90 days), the patient's chosen attending physician and either the hospice medical director or hospice team physician provides the certification of terminal illness. For the second benefit period (up to 90 days), only the hospice medical director or hospice team physician can provide the certification. For the third and subsequent benefit periods (up to 60 days), a F2F visit is required before certification. The F2F visit can be provided by a physician or nurse practitioner employed by the hospice who attests that they shared the information with the certifying physician. Only the hospice medical director or hospice team physician can provide the certification of terminal illness.

In response to the COVID-19 public health emergency, Congress allowed the F2F encounter to be furnished via telehealth. However, this flexibility, like other telehealth flexibilities, is set to expire at the end of 2024.

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Thank you again for your efforts to modernize clinician payment and improve chronic care in Medicare FFS. If you have any questions or need additional information, please reach out to Wendy Chill, Director, Health Policy and Government Relations at wchill@aahpm.org or 847-375-6744.

Sincerely,

Vicki Jackson, MD
President, American Academy of Hospice and Palliative Medicine