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and Palliative Medicine**  
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September 11, 2023

The Honorable Chiquita Brooks-LaSure  
Administrator, The Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20101

**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:

The National Coalition for Hospice and Palliative Care thanks the Centers for Medicare and Medicaid Services (CMS) for the opportunity to submit comments on the proposed rule to update payment policies for physicians and other qualified providers and to modify other Part B policies for calendar year (CY) 2024. The Coalition represents the thirteen leading professional organizations dedicated to advancing equitable access, delivery and quality of hospice and palliative care to all those who need it. Our Coalition represents the interdisciplinary workforce and programs that deliver serious illness care. This includes more than 5,000 physicians, 1,000 physician assistants, 11,000 nurses, 5,000 chaplains, 8,000 social workers, researchers, and pharmacists, along with over 1,800 palliative care programs and 5,300 hospices caring for millions of patients and families each year across the United States. We bring a broad, multidisciplinary perspective on serious illness care and the changes this proposed rule will have on the vulnerable population we serve.

The Coalition would like to thank CMS for its many innovative proposals in this year's Proposed Rule that represent an acknowledgement that beneficiaries with serious illness require additional training and services. Our comments and recommendations focus on the following CMS proposals:

- **Establishing Caregiver Training**
- **Covering Principal Illness Navigation Services**
- **Expanding Behavioral Health**
- **Expanding Telehealth Options**
- **Coding and Payment for Social Determinants of Health Risk Assessments**
- **Including "Heard and Understood Measure" in MIPS**
- **Reduction in Payment: Conversion Factor**

The Coalition however seeks additional clarification and guidance on many of the above proposals and is seeking specific written explanation and interpretation on CMS intent on implementing:

- Changes to behavioral health that implement section 4121 of Division FF of the Consolidated Appropriations Act of 2023 (CAA 2003) that establishes a new Medicare benefit category for the services of marriage and family therapists (MFTs) and mental health counselors (MHCs), especially as it relates to when MFTs and MHCs may be *included in the hospice interdisciplinary team*.

**Palliative Care:** Palliative care focuses on expert assessment and management of pain and other symptoms, assessment and support of caregiver needs, and coordination of care. Palliative care attends to the physical, functional, psychological, social, and spiritual needs of a patient with a serious illness. It is a person- and family-centered approach to care, providing people living with serious illness relief from the symptoms and stress of a serious illness. <sup>1</sup>

Serious illness is defined as “a health condition that carries a high risk of mortality and either negatively impacts a person’s daily function or quality of life or excessively strains their caregiver”. <sup>2</sup>

### **Caregiver Training**

For 2024, CMS is proposing payment to practitioners who train and involve caregivers in supporting patients with certain diseases or illnesses. These payments would cover caregiver training services by a physician, non-physician practitioner (NPP) or therapist under an individualized treatment plan.

CMS is also considering whether caregiver training services would be reasonable and necessary when provided to caregivers in more than one single session, or to 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.

### **Coalition Recommendation:**

New Caregiver Training: The Coalition strongly supports and commends CMS for recognizing a portion of the caregiver burden that could be alleviated by providing a mechanism for additional caregiver training through the Physician Fee Schedule (PFS). These training sessions will require additional staff time and resources, and these additional payments reflect that work. Annually, nearly 53 million people assist family members or other loved ones in maintaining health, quality of life, and independence due to aging, disability, or a chronic health condition, according to the Administration for Community Living (ACL)<sup>3</sup>. Receiving training can be critical to fulfilling the role of a caregiver as caregivers are increasingly being held responsible for more and more complex health care tasks. Delivering high quality palliative care includes providing these fundamental services – caregiver assessment, support, and education and are referenced in numerous domains in guidelines. We appreciate CMS’ innovative approach to provide reimbursement for and incentives for delivering these services.

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<sup>1</sup> National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018.

<https://www.nationalcoalitionhpc.org/ncp>.

<sup>2</sup> Kelley AS, Bollens-Lund E. Identifying the Population with Serious Illness: The "Denominator" Challenge. J Palliat Med. 2018 Mar;21(S2):S7-S16. doi: 10.1089/jpm.2017.0548. Epub 2017 Nov 10. PMID: 29125784; PMCID: PMC5756466.

<sup>3</sup> [https://acl.gov/sites/default/files/RAISE\\_SGRG/NatlStrategyToSupportFamilyCaregivers.pdf](https://acl.gov/sites/default/files/RAISE_SGRG/NatlStrategyToSupportFamilyCaregivers.pdf)

Frequency: We strongly recommend CMS think critically about the needs of seriously ill people and their caregivers and urge CMS to permit such caregiving training sessions to be reimbursed for more than one session and more than once per year. With appropriate documentation, caregiver training should be provided based on the needs of the patient and caregiver and not based on arbitrary limits.

Limited Conditions: The Coalition notes that CMS has only identified a limited list of physical and behavioral health conditions as examples to begin this new training payment. Many other patients with serious illnesses such as heart failure, COPD, cancer, ESRD, Post-COVID Conditions, among other serious illnesses, often have complex and skilled needs that caregivers are expected to address, often without this needed training. Therefore, we ask that CMS clarify that reimbursement for caregiver training can be based on patient and caregiver need, rather than on a limited set of conditions identified in the proposed rule.

### **Principal Illness Navigation (PIN) Services**

CMS is proposing two time-based HCPCS codes for the purpose of helping patients navigate their health care treatment for cancer and other high-risk, serious illnesses. CMS is proposing to pay for certified or trained auxiliary personnel incident to the supervision of the billing practitioner. This may be a patient navigator or certified peer specialist as part of the treatment plan for a serious, high-risk disease which is expected to last at least three months. Another key component of quality palliative care is the team developing, in partnership with the patient, family, and other providers, a care plan for social services and supports in alignment with the patient's condition, goals, social environment, culture, and setting to maximize patient and family coping and quality of life across all care settings. CMS is requesting comments on patient consent, and notes that the agency may not waive patient cost sharing for such services, if provided.

**Coalition Recommendation:** The Coalition commends and endorses CMS' effort and recognition that people with serious illness need increased access to supports and its proposals to reimburse for principal illness navigation (PIN) services. Countless surveys and articles have demonstrated that patients have difficulty navigating the health care system.<sup>4</sup>

#### Patient Need:

A key component of the interdisciplinary palliative care team is the ability to recognize and obtain needed additional services beyond clinical care for the seriously ill patient and their family and/or caregivers. PIN services could provide a needed bridge for these patients to better access community-based services, transportation, and the overall healthcare system. We recommend that a key component of PIN services would be to integrate referral to palliative care as appropriate.

Consent: A tenet of our Coalition is transparency in our operations and in health care generally. If there will be a patient charge or a co-pay, then patients should consent to receiving these services. CMS should consider waiving co-pays for these PIN services as co-pays may present serious barriers to access.

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<sup>4</sup> <https://time.com/6279937/us-health-care-system-attitudes/>

Clarification Needed: The Coalition notes there is a detailed explanation regarding the new time-based codes. However, further clarification is important to determine how these new PIN codes are distinct from chronic care management training services to avoid provider confusion.

Service Provision in Facility Settings: The Coalition notes that incident to services may only be furnished in noninstitutional settings. However, many academic medical centers and other facility-based provider types would also benefit from furnishing these services, particularly given that these facilities regularly house palliative care programs. We ask that CMS address this gap such that these services may be furnished in facility settings.

## **Behavioral Health**

Section 4121 of Division FF of the CAA 2023 establishes a new Medicare benefit category 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. Additionally, a related proposal modifies the requirements for the hospice Conditions of Participation (CoPs) to specify that the interdisciplinary group must include a social worker, MFT, or MHC.

**Coalition Recommendation:** The Coalition understands the proposed rule, when finalized, will create some of the most significant changes to promote access to behavioral health in the history of the Medicare program. These changes help close the access gap by expanding the behavioral health workforce and paying more accurately for behavioral health services. This is CMS's effort to implement the legislative requirement that MFT and MHC services be eligible for reimbursement under Medicare. Patients with serious illness can often benefit from mental health and family therapy and in fact, access to these services is a cornerstone of palliative care. "The palliative care interdisciplinary team (IDT) systematically addresses psychological and psychiatric aspects of care in the context of serious illness. The IDT conducts comprehensive developmentally and culturally sensitive mental status screenings of seriously ill patients. The social worker facilitates mental health assessment and treatment in all care settings, either directly, in consultation, or through referral."<sup>5</sup>

The Coalition supports CMS' efforts to broaden access to mental health services for the palliative care population.

Clarification needed for Hospice CoP's: As part of this implementing proposal, the hospice CoPs are amended to allow MFTs and MHCs to serve as members of the interdisciplinary group. Our Coalition is seeking additional guidance and clarification as the core members of the hospice interdisciplinary team currently includes the nurse (and other advanced practice providers), physician, social worker and chaplain. It appears that, section 1861(dd)(2)(B)(i)(III) of the Act was amended by 4121(b)(2) of the CAA, 2023 to require a hospice program to have an interdisciplinary team that includes *at least one social worker, MFT or MHC*. There are numerous published studies about the essential value of the social worker on the hospice IDG.<sup>6</sup> The Coalition strongly supports the continued role of the social worker on

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<sup>5</sup> National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018.

<https://www.nationalcoalitionhpc.org/ncp>.

<sup>6</sup> Role of the Hospice and Palliative Care Social Worker #390, Alyssa A. Middleton, Barbara A. Head, and Stacy S. Remke, Published Online:25 Mar 2020<https://doi.org/10.1089/jpm.2019.0698>

the hospice IDG. If these additional providers can also serve in an optional capacity (i.e., MFTs and MHCs are available to supplement the core IDG/IDT that continues to include social workers), the Coalition welcomes these changes. However, we are concerned that the new policy could lead to a decrease in hospice patients' access to social workers. We therefore encourage CMS to monitor for unintended consequences of this change, including related to hospice beneficiaries' social needs and access to community health services. We urge CMS to convene with legislators to determine the legislative intent of this specific change and also with the affected stakeholder community before finalizing any changes to the hospice IDG.

### **Telehealth Options**

CMS proposes several new telehealth policies for CY 2024, including the temporary addition of health and well-being coaching services to the Medicare Telehealth Services List and a refined process to analyze requests received for addition of services to the Medicare Telehealth Services List.

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 in the country, including in the home; 2) permitting certain clinicians (e.g., occupational therapists) to continue to be reimbursed for telehealth services; 3) delaying the in-person requirement for certain mental telehealth services; 4) permitting ongoing telehealth availability of specified services via audio-only communications technology; and others.

**Coalition Recommendation:** The Coalition strongly supports CMS' efforts to expand the use of telehealth options and to update the process for future decision making. Given the tremendous benefit telehealth has afforded patients with serious illness, we urge CMS to work with Congress to pursue legislative changes that would make the above telehealth flexibilities permanent.

**Advance Care Planning:** Consistent with our recommendation above, we particularly urge CMS to continue to allow reimbursement for audio-only advance care planning codes (CPT codes 99497-99498) beyond 2024, as these services are important for patients' hospice and palliative care. Permitting reimbursement for audio-only ACP services facilitates access for patients who do not have internet or reliable broadband services. This allows these patients and their families to equitably participate in important care planning services that will help ensure they receive care that is consistent with their goals and preferences. Advance care planning can be done via phone, as it is conducted through one or more conversations between the provider, the patient, and the patient's family members or surrogates.

### **Social Determinants of Health Risk (SDOH) Assessments**

As it relates to telehealth, CMS is proposing to add SDOH Risk Assessments to the Medicare Telehealth List and creating a separate payment code for SDOH risk assessments.

**Coalition Recommendation:** The Coalition strongly supports both of these SDOH proposals.

#### **Separate Payment Code for SDOH Risk Assessments**

CMS proposes adding a HCPCS code so that practitioners would be able to bill Medicare for administering a standardized, evidence-based SDOH risk assessment during certain E/M visits. We

concur with CMS that a SDOH assessment can help inform diagnoses, care planning, and care coordination, and many palliative care providers are knowledgeable, skilled and aware of how to incorporate these SDOH assessments into their practice.<sup>7</sup>

### **“Heard and Understood” in the Merit-based Incentive Payment System (MIPS) Quality Measure Set**

CMS proposes to include Ambulatory Palliative Care Patients’ Experience of Feeling Heard and Understood (Heard and Understood) in 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.”

**Recommendation:** We strongly support and thank CMS for the inclusion of this important measure in MIPS. This measure was developed, tested, and subsequently considered and approved by the Measures Application Partnership (MAP) as part of CMS’ pre-rulemaking process. Furthermore, we recommend that CMS include this measure in the below relevant MIPS Value Pathways. The Heard and Understood measure is the result of several years of work between CMS, the American Academy of Hospice and Palliative Medicine, RAND International and our Coalition.<sup>8</sup> The Coalition was a subrecipient of AAHPM’s CMS awarded cooperative grant (Cooperative Agreement #1V1CMS331639-01-00) and responsible for stakeholder engagement in the creation of this patient-reported outcome measure for palliative care. This measure holds clinicians accountable for ensuring that they understand what matters most to patients and their caregivers and can be a critical component in measuring patient-centered care. We recommend that CMS consider adding this quality measure to the following existing MVPs, which may be used by a range of physician specialties who care for patients with serious illness:

- Advancing Cancer Care MVP
- Advancing Care for Heart Disease MVP
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP
- Optimal Care for Kidney Health MVP
- Optimal Care for Patients with Episodic Neurological Conditions MVP
- Optimizing Chronic Disease Management MVP, or its successor, Value in Primary Care MVP
- Supportive Care for Neurodegenerative Conditions MVP

Although this measure was tested in palliative care programs, the concept of patients feeling heard and understood should be expanded to a wider 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. Studies show that seriously ill persons often report feeling silenced, ignored, and misunderstood in medical institutions.<sup>9</sup> Feeling heard and understood is a critical component of patient-centered decision-making, which reinforces dignity and is one of the key factors in patient-reported

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<sup>7</sup> Health Disparities in Palliative Care and Social Determinants of Health, Alma Y. Dixon, Cecilia R. Motschenbacher <https://doi.org/10.1093/med/9780197559321.003.0020>, Pages 239–246, Published: December 2021

<sup>8</sup> <https://www.nationalcoalitionhpc.org/qualitymeasures/>

<sup>9</sup> Frosch, D. L., May, S. G., Rendle, K. A., Tietbohl, C., & Elwyn, G. (2012). Authoritarian physicians and patients’ fear of being labeled ‘difficult’ among key obstacles to shared decision making. *Health Affairs*, 31(5), 1030-1038

quality care.<sup>10</sup> Systematically measuring this concept can promote more universal adoption of key practices of shared decision making and generalist palliative care.

This patient-reported outcome performance measure (PRO-PM) focuses on patient experience, which is a high priority area for the Merit-based Incentive Payment System (MIPS) and CMS' Meaningful Measures 2.0 initiative. Feeling Heard and Understood represents the first measure to focus on palliative care in physician's offices and clinics, which is often an important component of care for the patient populations captured by the aforementioned MVPs.

Embedding this measure within existing MVPs focused on serious illness would give any MVP participant the option to measure whether their patients' needs and preferences are also being met.

### **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 ½ percent.

**Recommendation:** The Coalition acknowledges that statute requires specified changes to the conversion factor for 2024, and that statutory budget neutrality requirements also apply. However, a reduction of the proposed magnitude after three previous years of payment reductions is untenable. With costs continuing to rise and health care [labor shortages](#) continuing to exacerbate, moving forward with these reductions and future payment uncertainties reduces providers' and patient's trust and confidence in the sustainability and quality of the US health care system.

This mission of our Coalition is to improve the equitable access and quality of palliative care – payment reductions of this magnitude act to reduce patients' ability to access these essential services. We join with nearly all health care organizations to express our concern about the impact of these reductions and encourage CMS to consider all short term and long-term alternatives to avert the proposed conversion factor reduction for 2024 and to reform the way in which Medicare physician payments are annually updated more broadly, including by working with Congress to achieve these goals.

Thank you for the opportunity to comment on the proposed CY 2024 updates to the PFS. If you and/or members of your staff have questions regarding our comments or are interested in speaking with Coalition leadership, please contact Amy Melnick, Executive Director, [amym@nationalcoalitionhpc.org](mailto:amym@nationalcoalitionhpc.org) or 202.306.3590.

Sincerely,

**American Academy of Hospice and Palliative Medicine**  
**Association of Professional Chaplains**  
**Health Care Chaplaincy Network**  
**Center to Advance Palliative Care**  
**Hospice Palliative Nurses Association**  
**National Association of Home Care & Hospice**

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<sup>10</sup> Gramling, R., et al., Feeling heard and understood: A patient-reported quality measure for the inpatient palliative care setting. *Journal of Pain and Symptom Management*, 2016. 51(2): pp. 150–154

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