C+TAC
COALITION TO TRANSFORM ADVANCED CARE

September 6, 2022

Meena Seshamani, M.D., PhD.
Director, Medicare
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Baltimore, MD 21244-8016

Dear Dr. Seshamani,

Re: Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on the sections of this proposed rule regarding their effect on those living with serious illness.

C-TAC is a national non-partisan, not-for-profit coalition dedicated to ensuring that all those living with serious illness, especially the sickest and most vulnerable, receive comprehensive, high- quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 170 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for serious illness in the U.S.

C-TAC defines serious illness 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 family caregivers. This definition has been widely adopted, including by the National Committee for Quality Assurance (NCQA) and the National Quality Forum (NQF). There are also health equity issues with this population as, per a 2021 Commonwealth report on racial and ethnic health equity, communities of color are more likely to die from treatable conditions and are also at higher risk for many chronic health conditions. The lack of access to health insurance and primary care mean many are diagnosed only at a late or end-stage of illness, when disease-modifying treatment is typically no longer effective. Those from historically disadvantaged communities who also have serious illness also experience poorer care and access.

Chronic Pain Management and Treatment (CPM) Bundles

We support the proposed new CPM bundles as pain features in multiple serious illnesses such as diabetes, arthritis, sickle cell disease, fibromyalgia, and many musculoskeletal conditions. We therefore appreciate the proposed rule's recognition of the complexity of chronic pain management and the need for more integrated, on-going care there. This is also a health equity issue since evidence shows inequities in pain experience and care in communities of color. Our hope is that these CPM bundles will help promote interdisciplinary team care for chronic pain as there are often psychosocial, social risk factor, and emotional/existential aspects of living with chronic pain that affect function and quality of life. Here are our responses to specific aspect about the CPM bundles:

- Monthly payment and time-based codes- We support the concept of a monthly fee and feel the initial 30-minute and subsequent 15-minute time-based intervals are appropriate for the interactions these bundles cover.

- Validated pain scale- We agree these scales can be helpful but only if they are personalized to the individual living with pain. Evidence confirms people may not always report pain exactly in line with a validated scale but it is still possible to identify their goals despite that. It is also important to monitor function and quality of life in addition to scores on pain scales since these are also affected by chronic pain and amenable to holistic pain management. We would also suggest use of the newly endorsed NQF patient-reported measure, "Patients' Experience of Receiving Desired Help for Pain" since this addresses a different aspect of pain management beyond a pain scale.

- Person-centered care plan-We strongly support that the bundles will also require the development of and/or revisions to a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes. This is not only key for those living with chronic pain but for anyone with a serious illness and perhaps these elements can become required for other types of care for this population.

- Communication and care coordination- This is another important aspect of these bundles as many with chronic pain have not had good care coordination nor communication in the past. Even more important, evidence shows many with chronic pain, especially those from communities of color, have low trust in the health care system based on previous discrimination and poor treatment or follow up.

- Telehealth- We agree with the initial face-to-face assessment as proposed and believe some or most subsequent interactions can likely be done via telehealth since physical examination may be less necessary at that point. However, this should always be with the agreement of the patient as some are more comfortable with face-to-face interactions.

- Acute pain- We believe many of the aspects of these bundles would also relate to the management of acute pain, especially the focus on the person's goals and function, and suggest that CMS first gain experience with this approach for chronic pain and then consider applying it to acute pain management.

- Referral to other services- We strongly support referrals and recommendations for chronic pain management and feel that palliative care and other interdisciplinary approaches are a way to address the psychosocial, emotional, and even existential aspects of chronic pain. Many living with serious illness who have chronic pain could benefit from an approach that addresses all these aspects.

- Incident to- We believe that members of an interdisciplinary team working together on holistic management of chronic pain could provide care and that incident to billing could facilitate such team-based care. Clinicians such as nurses, social workers, pharmacists, and chaplains could be very helpful to address aspects of chronic pain so as to better manage it.

- Collaboration with other providers/clinicians- We see this as linked to the idea of referrals and recommendations and, again, feel that services like palliative care could help with chronic pain management, especially for those who have pain from serious illness. Social workers could certainly help with assessment of social risk factors and help make referrals to community-based services that may be needed to improve the safety and quality of life for these patients. Community health workers could be another group that could help support patients with social risk factors or other needs.

- Additional suggestion- Caregiver participation for those with cognitive or communication issues- We would suggest that the CPM bundles include the participation of family caregivers for those patients with chronic pain and cognitive or communication issues. Indeed, family members are often directly affected by the person's pain and can help in making its perception better or worse.

New Coding and Payment for General Behavioral Health Integration (BHI) billed by Clinical Psychologists (CPs) and Clinical Social Workers (CSWs)

As supporters of interdisciplinary care, we are in favor of this proposed change. Clinical psychologists and social workers can play an important role in providing behavioral health services and we appreciate the proposed new G code to facilitate that. We have no comment on whether this proposed value accurately reflects the resource costs involved in furnishing these models of care, or whether additional coding may be needed, and would encourage CMS to monitor this once the new codes are in use. This work is resource-intensive and so needs to be adequately reimbursed.

Request for Information: Medicare Part B Payment for Services Involving Community Health

Workers (CHWs)
We strongly support the use of CHWs as our members confirm they are very useful members of teams caring for those with serious illness. (One calls them "community hope workers.") There is an evolving body of evidence showing that CHWs can improve patient outcomes and provide valuable and needed support. Even more important, many community health workers come from the local community and so are a wonderful resource to deliver culturally appropriate and more equitable care. C-TAC advocates for their use in models for those with serious illness and encourages Medicare to explore ways to further support and promote this role.

Request for Information: Medicare Potentially Underutilized Services
We appreciate the opportunity to discuss high-value underutilized services. To add to the list in the proposed rule, we would suggest the following:

- Advance care planning (ACP)- Although the evidence for ACP is heterogeneous, a 2018 review found that it "improved end-of-life communication, documentation of care preferences, dying in preferred place, and health care savings." Other data on billing shows that use of the ACP CPT codes is still very low so this is clearly an underutilized service. Given that, ACP should be made a required activity in all Medicare programs and tracked by the current NQF measure along with a newly endorsed one, Patients' Experience of Feeling Heard and Understood.

- Palliative care- Evidence consistently shows that palliative care during serious illness improves quality of life, reduces caregiver and clinician burden, and reduces avoidable utilization and spending. It is also underutilized and so should be included in Medicare programs and integrated into routine care for serious illness as a way to truly deliver person-centered care.

- Hospice- While just under half, 47.8%, of Medicare decedents received hospice in 2020, the other half did not. Usage is also much lower among communities of color ranging from only 33-36%. This is unfortunate since evidence shows shifting to hospice care earlier can reduce unnecessary spending as people come to grips with their prognosis and the ineffectiveness of further disease-modifying treatment. The Center for Innovation's successful Medicare Care Choices Model (MCCM) showed that concurrent hospice and disease-modifying treatment yielded overall savings but was too small a sample for national expansion. We hope that the current Medicare Advantage Value-based Insurance Design, MA VBID, will provide more data on the benefits of hospice for that population. In the meantime, we would recommend requiring measurement of both referral to hospice and when before death such referral occurs for all Medicare programs.

- In-home services- We would also suggest consideration of how providing in-home care workers, non-skilled care, and even non-medical care could reduce unnecessary spending by helping to keep people cared for at home. We realize this is likely beyond

Medicare's statutory authority but our members who provide these services regularly confirm their benefits.

There are several barriers to the services above and one is payment. The reimbursement for ACP has not increased since the CPT codes were introduced in 2016 and they can only be billed by physicians, nurse practitioners, and physician assistants. C-TAC is working with Congress on legislation to add social workers to these codes. There is no payment for palliative care as fee-for-service does not pay for the full interdisciplinary team nor for much of the holistic care that is provided. The Medicare Hospice Benefit does not pay for concurrent hospice and disease-modifying care, despite data from MCCM and private payers that that is actually cost efficient. C-TAC is working with payers and CMMI to see how some of these payment issues might be addressed through value-based and other models.

Advancing Equity in the Medicare Shared Savings Program

We support the proposed changes with the goal of advancing equity. We know that value-based contracting, while a better way to promote good care and value than fee-for-service, can be difficult to participate in for providers from under-resourced communities. This issue was acknowledged along with recommendations by CMS about implicit bias in some of the CMMI models. This rules proposal to provide upfront investment via advance shared savings payments and a health equity payment adjustment will help those providers in marginalized communities invest in the necessary IT systems to track performance and the reporting mechanisms to handle the financial risk of the MSSP program.

We also recommend CMS collaborate more closely with the Administration for Community Living (ACL) and the Area Agencies on Aging as that infrastructure is already present in communities across the country and could help with social needs beyond what Medicare can cover. These are also local organizations who know their communities and so could assist ACOs in addressing and meeting any identified social needs.

Going beyond the proposed rule, we encourage waivers and other allowances for providers in rural areas with a low volume of patients to build the infrastructure either individually or in collaboration with other providers over time so that beneficiaries from these communities can benefit from value-based care. We also encourage CMS to consider "providers" more broadly, to encompass community-based organizations like faith-based organizations that often play a central role in serving individuals with serious illnesses. Many of these providers, some of which are C-TAC members, reflect lack of familiarity with value-based contracting models and we suggest additional steps to engage non-traditional "SDOH" organizations within programs like MSSP.

Addition of New Consumer Assessment of Healthcare Providers and Systems (CAHPS) for the Merit-based Incentive Payment System (MIPS) Survey Questions - Request for Information

We support revising the CAHPS to gather more and better information on beneficiary

experience. One concern is that the response rate to CAHPS continues to decline and so we would encourage CMS to also seek ways to increase participation or find other ways to gather this important information, especially among groups who have experienced historical health care disparities and who may not feel that their opinions are truly valued.

Regarding possible questions to add, we agree it would be good to ask about whether the care received was unfair or insensitive. We are aware of palliative care programs that are already asking patients if they were treated differently during a past clinical encounter and have heard anecdotes about the rich conversation such questions can prompt. We also agree that a general question about cost or the financial implications of care should be added as this is the public's top concern about health care. However, an accompanying question about whether the person got help with any financial issues might also be helpful. Finally, we would suggest also exploring the experience of the family caregiver since this may shed important light on the patient's care experience.

Group A: New MVPs Proposed for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

We are pleased to see that advance care planning has been added to this list and would encourage CMS to consider expanding its use beyond just those with cancer. Surely the foundation of person-centered care is engaging the person themself in the process of discussing and developing their plan of care.

Other comment: Incorrect proposed exclusion from several measures

We were alarmed to see the proposed new exclusion of those receiving palliative care from measures A.4.*Kidney care* (page 1647), D.19 *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan* (page 1945), and D.51 *Depression Remission at Twelve Months* (page 1982) as these are all inappropriate. Palliative care seems to be being equated here with hospice, which is incorrect. Excluding those on hospice, who are at the end of life, is appropriate while those receiving palliative care could live for years longer.

The Center to Advance Palliative Care defines palliative care as:

- *Palliative care is specialized medical care for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.*
- *Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support.*
- *Palliative care is based on the needs of the patient, not on the patient's prognosis. This care is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment."*

Therefore, since palliative care is appropriate at any point in a serious illness and can be provided along with any curative, disease-modifying treatment, people receiving those services should still be assessed for kidney health, BMI, or depression when appropriate. **Please remove this exclusion as it perpetuates the harmful misconception that palliative care and hospice are the same thing when they are not.**

(We would note that excluding those on palliative care from the Improvement activity IA_PSPA_6, *Consultation of the prescription drug monitoring program* on page 2033, is also debatable. These patients may be on opioids managed by the palliative care team and so consulting a PDMP is not inappropriate as a safeguard. However, this exclusion is in line with the CDC's 2016 Guideline for Prescribing Opioids for Chronic Pain and the Part D Opioid Overutilization program which both exclude those receiving palliative care. We would be happy to discuss this further if that would be of help.)

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at mgrant@thectac.org.

Sincerely,

Marian Grant

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