Center to Advance Palliative Care
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July, 2024

The Honorable Sheldon Whitehouse
United States Senate
530 Hart Senate Office Bldg
Washington, DC 20510

The Honorable Bill Cassidy
United States Senate
455 Dirksen Senate Office Bldg
Washington, DC 20510

Via electronic submission to *physician_payment@cassidy.senate.gov*

RE: Request for Information: Pay PCPs Act (S. 4338)

Dear Senator Whitehouse and Senator Cassidy:

Thank you for the opportunity to provide input on elements of the Pay PCPs Act. We applaud your recognition of the need for dramatic payment change, at scale, for primary and preventive services. We are writing to urge you to include co-management palliative care in the Pay PCPs Act, and to structure the hybrid payment and quality measures to ensure high-quality care for all beneficiaries living with a serious illness.

The Center to Advance Palliative Care (CAPC) is a national organization dedicated to ensuring that all persons living with serious illness have access to high-quality, equitable care that addresses their symptoms and stresses, including access to specialty palliative care services. Palliative care specifically refers to specialized medical care for people living with a serious illness, focused on providing relief from the symptoms and stress of the illness. It is an *added* layer of support, working in partnership with other providers and can be provided along with curative treatment. A strong and consistent evidence base indicates that palliative improves quality of life, reduces caregiver and clinician burden, and avoids preventable and unnecessary services. Strong collaborative palliative care models exist for patients with dementia, cardiovascular illnesses, and cancer.

While primary care is foundational for every patient in the health care system, there is a subset of patients living with serious illness for whom a special kind of expertise is needed to optimize quality of life and health care decision-making. While palliative care is typically associated with late-stage illness, its benefits are most fully realized when provided early on – ideally at the point of diagnosis of a serious illness. Proactive palliative care can help those living with serious illness avoid unnecessary suffering by:

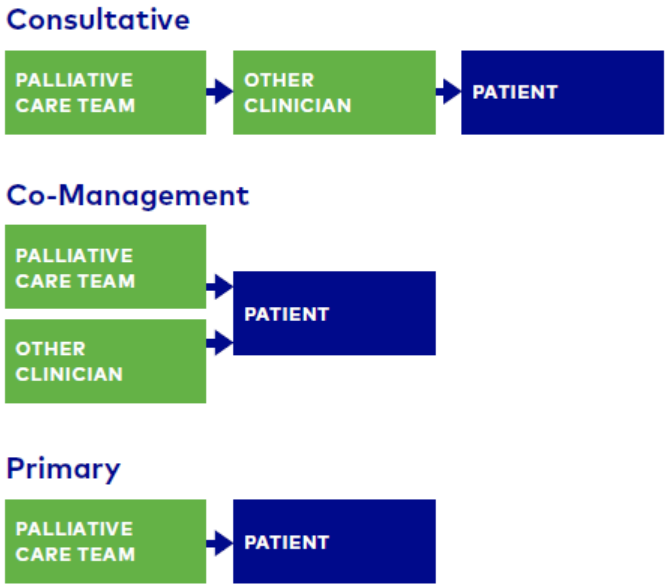
1. Helping them (and their caregivers) understand what to expect throughout the course of their illness – providing "anticipatory guidance" that supports person-centered decision-making
2. Conducting a comprehensive assessment to identify areas of strength and where additional support might be needed across physical symptoms, psychological distress, social needs, spiritual needs, and caregiver burden
3. Developing a plan of care to manage these comprehensive needs, often mitigating acute exacerbations and crises and dramatically reducing avoidable utilization.

In all these respects, palliative care is "preventive" care, focusing on anticipating and potentially avoiding suffering. Indeed, the Centers for Medicare and Medicaid Services (CMS) recently approved a State Plan Amendment for Hawaii that adds community palliative care as a preventive service within the Medicaid program (SPA TN 22-0013).

From this vantage point, we urge you to include palliative care clinicians as an essential component of primary care for the subset of the U.S. population living with serious illness.

Identifying the Primary Care Provider

In palliative care, there are three commonly used models of clinical responsibility: consultative, primary, and co-management.



- The consultative model typically includes a specific request from a primary clinician for palliative care expertise on a focused issue, such as treatment decision-making or managing side effects. The palliative care team makes recommendations to the primary, but does not manage any care directly. This model is not relevant to the proposed hybrid payment approach.
- The **primary care model** has the palliative care team assuming primary responsibility for a patient's comprehensive health care needs, taking over this role from the referring clinician. Responsibility includes both palliative and non-palliative issues, and is commonly delivered in the home setting, In this model, we would expect to see the relationship demonstrated through claims (e.g., billing for the plurality of E&M and/or relevant care management codes), and do not foresee a need for further adjustments.
- The co-management model has the palliative care team collaborating with the primary team, collaboratively creating and managing a care plan that benefits from the expertise of both teams.

Because of its significant impact on the "quintuple aim" and the proven inadequacy of current Medicare payment methods for community-based palliative care, **we strongly recommend that for a subset of beneficiaries, the legislation should allow for both a traditional primary care provider AND the palliative care provider to receive payment under the proposed hybrid model**.

In terms of identifying the correct sub-set of beneficiaries, CAPC recommends the following diagnostic codes be used:

Condition	ICD-10 Codes
Cancer	C00-C14, C15-C26, C30-C39, C40-C41, C45-C49, C50-C50, C51-C58, C60-C63, C64-C68, C69-C72, C73-C75, C76-C80, C7A-C7A, C7B-C7B, C81-C96, D00-D09, D10-D36, D37-D48
Heart Disease	I09.81, I11.0, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, J80, J81.1

Chronic Obstructive Pulmonary Disease and Other Respiratory	J43.0, J43.1, J43.2, J43.8, J68.4, J84.10, J84.111, J84.112, J84.17, J96.10, J96.11, J96.12, J96.20, J96.21, J96.22, J969.0, J969.1, J969.2, J98.2, J98.3
Dementias	A81.00, A81.01, A81.09, F03.91, F03.911, F03.918, F03.92, F03.93, F03.94, F03.B0, F03.B11, F03.B18, F03.B2, F03.B3, F03.B4, F03.C0, F03.C11, F03.C18, F03.C2, F03.C3, F03.C4, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83
Renal Disease	I12.0, I13.0, I13.11, I13.2, N18.3, N18.30, N18.31, N18.32, N18.4, N18.5, N18.6, N18.9, N19, N28.0
Other	Z51.5, Z74.1-9, Z99

In terms of identifying palliative care providers, this can be done via the PECOS code 17 (Hospice and Palliative Care). We suggest that anyone with that specialty be allowed to participate in the hybrid payment model as a second primary care provider.

Proposed Quality Measures

We agree with the categories of quality measures currently proposed for the hybrid payment. For additional consideration, these three specific quality measures will incentivize appropriate collaborations with palliative care, as well as attention to high-quality communications and pain/symptom management, areas that broadly drive quality care and cost-effectiveness:

Concept	Measure	Type
Patient-reported Experience of Serious Illness Care	Feeling Heard and Understood https://p4qm.org/measures/3665	Patient-reported experience of care
Prevention and Treatment of Symptoms	Getting the Help Wanted for Pain https://p4qm.org/measures/3666	Patient-reported experience of care
Timely and Appropriate Use of Hospice Care	Proportion of Patients who Died who Were Admitted to Hospice for 3 Days or More EOM – 2	Utilization outcome

The first two measures are the result of several years of work between CMS, the American Academy of Hospice and Palliative Medicine, RAND International and the National Coalition for Hospice and Palliative Care. The third is currently used in the CMS Innovation Center's Medicare payment model for oncology care.

Additional Services

We support the four types of services that the legislation includes in the hybrid payments, and appreciate the inclusion of office-based evaluation and management visits, regardless of modality, which can help to bring needed primary and palliative care services to under-served areas.

In addition, we suggest that the hybrid payment – for all primary care providers, not just the palliative care specialists – include these services:

- Comprehensive assessment and initial care planning, medical home program (HCPCS code S0280). We further suggest that participating providers be required to assess needs in each of these domains: physical, psychological, social needs, spiritual, and caregiver burden. For those providers delivering care in the home, a home safety assessment should also be required.
    - Comprehensive assessment and care planning for cognitive impairment (CPT 99483) should be included in the hybrid payment as well. Additional analysis would be needed to determine if these funds should be included for all patients or a sub-set of patients; however we caution that, given that dementia is often under-diagnosed, a documented ICD-10 would be insufficient to limit the payment.
- Caregiver training services (CPTs 97550, 97551, 97552, 96202, and 96203). Although many Medicare beneficiaries rely on informal caregivers, the inclusion of these services would be especially important for the population living with serious illness.
- Advance care planning (CPTs 99497, 99498).
- Ensure that the hybrid payment based on care management services be inclusion of chronic care management (99490, 99439, 99491, and 99437)), complex chronic care management (99487, 99489), transitional care management (99495, 99496) and principal care management (99424, 99425, 99426, and 99427)

Incorporating payment for these services into primary care hybrid payments will help ensure that clinicians will have the resources they need to spend time on meaningful assessment, communication, and care planning with both patients and their caregivers.

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Thank you for the opportunity to submit these comments. Please do not hesitate to contact me or Stacie Sinclair, Associate Director for Policy (stacie.sinclair@mssm.edu), if we can provider further assistance.

Sincerely,

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