

December 30, 2014

SUBMITTED ELECTRONICALLY VIA
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Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1612-FC
P.O. Box 8013
Baltimore, MD 21244-8013

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015

Dear Administrator Tavenner,

The undersigned medical specialty societies urge the Centers for Medicare and Medicaid Services (CMS) to recognize and make separate payment for the new Current Procedural Terminology (CPT) codes for advance care planning (ACP) for CY 2016.

As you know, the CPT Editorial Panel developed two new codes to describe complex ACP services for CY 2015.

- 99497: Advance care planning including the explanation and discussion of advance directive such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate); and
- 99498: Advanced care planning including the explanation and discussion of advance directive such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes.

CMS has assigned a physician fee schedule status indicator of "I" (Not valid for Medicare purposes. Medicare uses another code for the reporting and payment of these services.) We recommend that CMS start making separate payment for these codes in CY 2016 and that the payment be based on the physician work and practice expenses inputs recommended by the American Medical Association/Specialty Society Relative Value Update Committee (RUC). We also request that CMS take these actions through notice and comment rulemaking.

ACP is a comprehensive, ongoing, patient-centered communication between patients, their surrogates and their health care providers to discuss and document their future health care choices. In providing these complex, vitally important services to their patients, our members know that understanding patients' values, treatment preferences, and care goals in the context of a serious illness is an essential element of high-quality care because it allows clinicians to align the care provided with what is most important to the patient. These services not only support patient choice regarding end-of-life care, but enhance quality of life throughout the illness trajectory, even if death is not an imminent outcome.

Research shows that ACP conversations significantly improve outcomes including increased likelihood of understanding and compliance with patient wishes,¹ fewer hospitalizations,² less intensive treatments,³ more hospice use,⁴ and increased likelihood of a person dying in their preferred location.⁵ From a psychological perspective, ACP is associated with higher satisfaction with the quality of care for patients,⁶ as well as less risk of stress, anxiety and depression in surrogates⁷ and surviving relatives.⁸ Finally, emerging data shows that ACP reduces the cost of end of life care⁹ without increasing mortality.¹⁰ In fact, in one

1 See Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ*. 2010;340:c1345 (patients who received ACP and died within 6 months were more likely to have their wishes known and followed (86% vs. 30%); Silveira MJ, Kim SY, Langa KM. Advance directives and outcomes of surrogate decision making before death. *N ENGL J MED*. April 1, 2010; 362(13): 1211-1218; Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*. Oct 8 2008;300(14):1665-1673; Hammes BJ, Rooney BL. Death and end-of-life planning in one midwestern community. *ARCH INTERN MED*. Feb 23 1998;158(4):383-390.

2 See Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ*. 2010;340:c1345; Teno JM, Gruneir A, Schwartz Z, Nanda A, Wetle T. Association between advance directives and quality of end-of-life care: a national study. *J AM GERIATR SOC*. Feb 2007;55(2):189-194; Molloy DW, Guyatt GH, Russo R, et al. Systematic implementation of an advance directive program in nursing homes: a randomized controlled trial. *JAMA*. Mar 15 2000;283(11):1437-1444.

3 See Teno JM, Gruneir A, Schwartz Z, Nanda A, Wetle T. Association between advance directives and quality of end-of-life care: a national study. *J AM GERIATR SOC*. Feb 2007;55(2):189-194.

4 See Teno JM, Gruneir A, Schwartz Z, Nanda A, Wetle T. Association between advance directives and quality of end-of-life care: a national study. *J AM GERIATR SOC*. Feb 2007;55(2):189-194.

5 See Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ*. 2010;340:c1345; Molloy DW, Guyatt GH, Russo R, et al. Systematic implementation of an advance directive program in nursing homes: a randomized controlled trial. *JAMA*. Mar 15 2000;283(11):1437-1444.

6 See Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ*. 2010;340:c1345; Molloy DW, Guyatt GH, Russo R, et al. Systematic implementation of an advance directive program in nursing homes: a randomized controlled trial. *JAMA*. Mar 15 2000;283(11):1437-1444.

7 Wendler D, Rid A. Systemic review: the effect on surrogates of making treatment decisions for others. *ANN INTERN MED*. 2008;149(12):336-346.

8 See Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomised controlled trial. *BMJ*. 2010;340:c1345; Wright AA, Zhang B, Ray A, et al. Associations between end-of-life discussions, patient mental health, medical care near death, and caregiver bereavement adjustment. *JAMA*. Oct 8 2008;300(14):1665-1673.

9 See Zhang B, Wright AA, Huskamp HA, et al. Health care costs in the last week of life: associations with end-of-life conversations. *ARCH INTERN MED*. Mar 9 2009;169(5):480-488; Teno JM, Gruneir A, Schwartz Z, Nanda A, Wetle T. Association between advance directives and quality of end-of-life care: a national study. *J AM GERIATR SOC*. Feb 2007;55(2):189-194.

10 See Zhang B, Wright AA, Huskamp HA, et al. Health care costs in the last week of life: associations with end-of-life conversations. *ARCH INTERN MED*. Mar 9 2009;169(5):480-488.

prospective randomized, controlled clinical trial, relative to patients receiving usual care, patients receiving palliative care in addition to usual care were shown to have a 25% longer survival.¹¹

ACP has become the standard of care and consensus regarding the importance and value of these services is widespread. Both the Centers for Disease Control and Prevention (CDC)¹² and Institute of Medicine (IOM) have advocated for increased use of ACP. For instance, a recent IOM report, “Dying in America,” recommends that standards for clinician-patient communication and ACP be developed that are measurable, actionable, and evidence-based. The report states that “payers and health care delivery organizations should adopt these standards and their supporting processes, and integrate them into assessments, care plans and the reporting of health care quality.”¹³ Numerous physician medical associations, whose members treat the patient populations that most benefit from ACP, have ongoing efforts to promote and encourage ACP as a standard of care.¹⁴ Last year, The American Bar Association’s Commission on Law and Aging Director testified in support of ACP before the Department of Health and Human Services’ Health Information Technology Policy Committee.

CMS has also recognized ACP as a standard of high quality care. In the 2015 Physician Fee Schedule, the Agency selected PQRS 047 (Advance Care Plan) as one of the 19 “broadly applicable” individual quality cross-cutting measures that eligible professionals will need to report for the Physician Quality Reporting System (PQRS).¹⁵ This NQF-endorsed measure describes the percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. In proposing this measure, CMS noted that the development of a care plan was applicable to most elderly patients in

11 Temel JS, Greer JA, Muzikanski A, et al. Early palliative care for patients with metastatic non-small lung cancer. *N ENGL J MED*. 2010;363(8):733-742.

12 CDC’s Healthy Aging Program, Give Peace of Mind: Advance Care Planning (March 3, 2014), *available at* <http://www.cdc.gov/aging/advancecareplanning/>.

13 Institute of Medicine, Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life (September 17, 2014), *available at* <http://www.iom.edu/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>.

14 The AMA’s Code of Medical Ethics includes a section devoted to ACP. The American Society of Clinical Oncology has published a number of resources on ACP. The American Academy of Family Physicians (AAFP) passed a resolution at its 2014 Congress of Delegates promoting the implementation of centralized registries for advanced directives, durable power of attorney for health care, physician orders for scope of treatment (POLST), and do not resuscitate orders. *JAMA Internal Medicine* recently published an article describing the value of and best practices for ACP, which was undertaken as part of the American College of Physicians (ACP) High Value Care Initiative and subsequently endorsed by the High Value Task Force.

15 Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015, 79 Fed. Reg. 40318, 40395 (July 11, 2014).

various inpatient/outpatient settings.¹⁶ We understand that commenters universally agreed that this measure was appropriately classified as cross-cutting.¹⁷

Unfortunately, not enough patients are receiving these services. At a recent large national meeting of primary care physicians, an audience poll found that most physicians acknowledged the importance of advance directives. However, most report that they do not routinely address ACP. Primary care providers and subspecialists who commonly deal with serious, complex illnesses often cite time constraints as a barrier to providing ACP.¹⁸ The unfortunate result is that often a patient's illness is extremely advanced by the time the patient and their family seriously consider or prepare for that possibility, and physicians with whom they have no prior relationship end up discussing end-of-life care in the emergency department or after admission to the hospital. Although guidelines recommend that initial discussions of goals of care and end-of-life preferences should occur when the patient is relatively stable,¹⁹ the majority (55%) of first discussions in a study of cancer patients took place in the inpatient setting.²⁰ In a large, population-based prospective cohort study of patients with metastatic lung and colorectal cancer, the first conversation about end-of-life care took place an average of 33 days before death.²¹

Moreover, Medicare reimbursement not only serves to promote these important services for beneficiaries but, without separate codes, CMS and other stakeholders are unable to track these services to look at utilization, outcomes, and which specialties are performing ACP services and where. This tracking is important for the widespread adoption of these services.

Our members view CMS' recognition of these codes as an important acknowledgement that quality of care can be dramatically improved when patients and their physicians work through end-of-life care issues so that patients receive their preferred care. Payment for these codes by Medicare would appropriately recognize the importance, and need for, ACP.

We urge CMS to recognize and make separate payments for these codes. We stand ready to work with CMS to educate our members on how the codes should be used in order to improve care for Medicare beneficiaries.

16 79 Fed. Reg. at 40407 Table 21 (July 11, 2014).

17 79 Fed. Reg. at 67802 Table 52 (November 13, 2014).

18 See, e.g., Ramsaroop, SE, Reid MC, Adelman RD. Completing an advance directive in the primary care setting: what do we need for success? *J AM GERIATR SOC.* 2007;55(2):277-283.

19 See Quill TE. Perspectives on care at the close of life: initiating end-of-life discussions with seriously ill patients: addressing the "elephant in the room." *JAMA.* 2000;284(19):2502-3507.

20 Mack JV, Cronin A, Taback N, et al. End-of-life care discussions among patients with advanced cancer: a cohort study. *ANN INTERN MED.* 2012;156(3): 204-210.

21 Mack JW, Cronin A, Keating NL, et al. Associations between end-of-life discussion characteristics and care received near death: a prospective cohort study. *J CLIN ONCOL.* 2012;30(35):4387-4395.

Thank you for considering our comments. If you would like to discuss this matter further, please contact Paul Rudolf at paul.rudolf@aporter.com or 202-942-6426.

Sincerely,

- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Academy of Family Physicians
- American Academy of Home Care Medicine
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American College of Emergency Physicians
- American College of Physicians
- American Geriatrics Society
- American Osteopathic Association
- American Society for Blood and Marrow Transplantation
- American Thoracic Society