



December 30, 2014

Marilyn B. Tavenner Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: File Code CMS – 1612-FC. 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 American Academy of Home Care Medicine (Academy) appreciates the opportunity to provide our comments regarding the Centers for Medicare and Medicaid Services' (CMS) 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

The Academy represents those physicians and non-physician providers who are caring for some of Medicare's sickest and most costly beneficiaries—those with multiple chronic conditions who are home-limited due to illness and disability. To improve Medicare physician fee schedule payment policy and for consideration for 2015 rulemaking the Academy provides the comments in this letter that are first summarized below. The Academy:

- Supports and thanks CMS for establishing the Chronic Care Management (CCM) Code (CPT 99490), as a first step toward payment for the care management services for beneficiaries with multiple chronic conditions, with particular regard to the extensive non face to face services rendered. We provide recommendations to make a difference in care for the sickest and costliest beneficiaries and for an increased opportunity to reduce Medicare cost. We also recommend that CMS provide interpretive guidance for CCM that the time of non-clinically trained staff that is rendering CCM service be counted toward the monthly twenty minute requirement.
- Supports the establishment of two codes for Advanced Care Planning services and respectfully requests that CMS recognize and provide distinct payment for the codes under the Medicare Fee Schedule.

- Supports the CMS' proposal to add codes to the list of covered Medicare Telehealth services. We also recommend that CMS interpret the home, assisted living facility and group home places of services as office setting to improve care, reduce cost and for regulatory consistency.
- Supports CMS' efforts to develop value based payment policies that reward results such as initiated in the Value Based Payment Modifier program. However, we are concerned that absent additional attention to risk adjustment particularly that associated with the sickest Medicare beneficiaries that providers caring for these sickest and highest cost beneficiaries could be unduly penalized under the VBPM and we offer solutions.
- Recommend that CMS review its policy regarding participation in MSSP programs based on tax identification numbers (TINs) and recommend consideration of use of national provider identification numbers (NPIs).
- Recommend that CMS develop policy to recognize nurse practitioners and physician assistants for direct beneficiary attribution in the MSSP programs.
- Recommend that as CMS expands state sponsored "Dual Programs" that existing PCP relationships with home limited populations be protected and that CMS shared savings program beneficiaries be excluded from dual contract attribution.

Our detailed recommendations follow.

## **1) Chronic Care Management Services**

### *A. Coverage and Payment for Chronic Care Management (CCM) Services is a Good First Step to Address the Care and Cost of Medicare Beneficiaries*

We commend CMS for recognizing the importance of care management services to the care of Medicare beneficiaries. Specifically, the Academy commends CMS for its decision to cover and pay for the non face to face aspects of care management.

We believe that CCM represents two (2) important developments:

CCM coverage and payment reflects CMS' recognition of the importance of care management services to Medicare beneficiaries and begins to pay for some of the work and expense of this service.

Second, by paying for CCM, the service helps practices as intended to start to transform to advanced practice models in the care of the chronically ill and more costly Medicare beneficiaries.

### *B. While Beneficial CCM Does Not Address the Greatest Need, Which is to Impact the Cost and Care of the Most Expensive Medicare Beneficiaries*

However, we are concerned that CMS also recognize the need to pay for services that are required for the more costly and also the costliest of Medicare beneficiaries. CCM will help in a most general way the two thirds of Medicare beneficiaries who explain 93% of Medicare cost.

However, CCM does not address the needs of the top 5% of Medicare beneficiaries who represent 43% of Medicare cost. Medicare, through coverage and payment and enhanced population-based targeting should more effectively and precisely impact the cost of care for Medicare's sickest and most complex beneficiaries. Medicare can do this in two ways:

1. *Adopt the CPT code 99487 accepted by CMS to recognize the additional work, time and resources devoted to caring for the more complex costly Medicare beneficiaries.*

We believe that coverage and payment for this code would represent a more comprehensive and meaningful effort to address the care and cost of Medicare beneficiaries whose care including non face to face time is significantly more than 20 minutes a month. The primary reason is that patient definition is the key for determining how much care management is required, and at what expense. "Two or more chronic conditions" includes many patients who are not very ill and do not require material care management, let alone care coordination and thus present less opportunity for material Medicare savings.

Additionally, coverage and payment for CPT code 99487 would give Medicare providers an incentive to increase the numbers of beneficiaries meeting the code criteria. While again, CCM represents a good start for the reasons mentioned above, we do not believe the coverage and level of payment will adequately encourage providers to render more service than they are currently rendering.

2. *Develop a complex care management and payment model for the sickest most costly Medicare beneficiaries. This model would include standards and outcome measures.*

Fortunately, a model exists upon which to establish this complex care management service. Independence at Home (IAH) is a model that targets the multimorbid and most expensive Medicare beneficiaries and is now being evaluated within CMMI.

We believe that IAH standards and measures or those similar to IAH could be used as the criteria to describe the beneficiary population and to pay for the increased work and expense required for the care of the sickest costliest beneficiaries (well described in the Medicare Chronic Condition Sourcebook).

We have learned through the work of those involved with ACOs and through the literature, that services organized around typical Medicare conditions and coordination alone are not sufficient to address the care and cost needs of this complex multimorbid population.

Rather, additional interventions and services that address social, financial and legal issues are also required. These services are not currently covered in the Medicare program and this is why an all-inclusive model needs to be developed that encompasses the costs of such services. Again, IAH serves as a model. We also believe that the alternative payment model should become a required feature of the Medicare program outside of traditional fee for service.

An IAH-like model would provide more service than distinct CPT codes describe. In contrast to the beneficiaries who would receive CPT code services, the sickest and most costly 5% of Medicare beneficiaries have many more concurrent chronic conditions that in turn have a significant impact on morbidity/mortality, and they nearly always need ADL and IADL assistance.

This is objectively reflected by way of HCC scores where the HCC scores of those that would meet the criteria for CCM (HCC range of 1.5-2.0) are lower than the HCC scores of the sickest most costly Medicare beneficiaries (3.0-3.2). In fact, at least one of three Medicare beneficiaries receiving a housecall would meet the eligibility criteria for Independence at Home (IAH) and IAH eligible beneficiaries have been found in a cohort population study to have an average HCC of 3.3.4. We have also learned that services that truly impact care and Medicare cost for this population require practice transition from reactive to proactive that is more extensive and also more expensive to achieve than will be supported through standalone CPT services.

As discussed further below in our comments on the Value Base Payment Modifier, the Academy could provide CMS the guidance it needs to create a payment model that takes into account the multimorbid status of this population. This would also include the additional personnel and technological costs, and stimulate policy changes to expanded range options, such as intravenous therapies in the home and waiver of the 3-day stay for access to institutional skilled care, that would be fully appropriate in this context.

*CCM and Transitional Care Management (TCM) Services Furnished Incident to a Physician's Service under General Physician Supervision*

We appreciate CMS finalized provisions to count clinical staff time furnished incident to a physician's service under general (versus direct) physician supervision and regardless of whether such services are rendered through employment or other basis.

We also commend your proposal to apply this policy to TCM services and agree that TCM is similar in kind in that much of the service for TCM as well as CCM is non-face to face.

CMS can expand the benefits of CCM by counting the time of provider administrative staff that render CCM services as time toward satisfying the 20 minutes required each month.

We request that CMS provide guidance that Part B practice administrative staff time when rendering CCM service can count toward the 20 minutes required under the CCM code.

Many mobile practices that are members of the Academy provide care management that meets the exact meaning of the elements of service for the CCM. These services are rendered effectively and efficiently through administrative staff. These administrative personnel do not have direct patient contact nor render clinical services as is understood by the traditional meaning of the Part B incident to provisions. As a result, they are not required to be clinically licensed, to have completed paraprofessional training or have obtained such designation. However, they do render service that is "incident to" providers rendering the CCM code. Moreover, they already provide CCM with great effect given their training by the practice and experience rendering CCM services.

While these staff members do not possess clinical paraprofessional designation they have rendered chronic care management prior to its coverage by Medicare. Their services have contributed to the triple aim of quality care, patient satisfaction and reduced cost. CMS, absent this requested guidance would inadvertently hinder beneficiary access to these important services, stymie the development and transformation of team based models of care, and penalizing practices that have and hired and trained staff effective in delivering the elements of CCM incident to a provider.

Such guidance to the Medicare Administrative Contractors and to the provider community will greatly help to support the development of collaborative and innovative care models that contribute to the Triple Aim and to practice transformation.

## **2) Request for Coverage and Payment for Advance Care Planning**

CMS in the Final Rule requests comment on its decision to recognize two new codes to describe complex ACP services for CY 2015.

The codes are:

- 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.

We support this decision to establish the codes and respectfully request that CMS recognize and provide distinct payment for the ACP codes for the reasons discussed below. The Academy is also among the many professional association signatories to a letter from the American Geriatric Society requesting this coverage and payment. We have attached that letter as an addendum to these comments.

## **3) Medicare Telehealth Services for the Physician Fee Schedule – Request that Home and Assisted Living Facility Sites of Service be Included as Office Setting for Telehealth**

We support the CMS expansion of coverage for the following services when rendered under Telehealth.

- Psychotherapy services CPT codes 90845, 90846 and 90847.
- Prolonged service office CPT codes 99354 and 99355.
- Annual wellness visit HCPCS codes G0438 and G0439.

We appreciate the rationale for adding coverage for these services as well as the rationale for the coverage of Telehealth in general. We also believe that Medicare could utilize the benefits of Telehealth in a more substantive and consistent manner to support the Triple Aim.

## Request that Home, Assisted Living Facility and Group Home Locations be Interpreted as Office Setting for Telehealth

We request that CMS provide guidance to the Medicare Administrative Contractors and to the provider community that the home (12) assisted living facility (13) and group home (14) sites of service be interpreted as office settings for the purpose of Telehealth. This would provide needed consistency with Medicare Part B coverage and payment for the home and domiciliary sites of service “in lieu of” an office setting for the home limited population.

The underpinning for the Part B coverage of home care medicine is based on the requirement that the home visit be “in lieu of” an office visit and the medical necessity for the home visit be documented each encounter. This coverage provides access to millions who otherwise would not obtain treatment until their clinical condition had further deteriorated to the point where hospitalization is required. Such deterioration in condition is not the threshold for beneficiaries who are able to receive service in an office setting. As a result, beneficiaries receive needed timely care and Medicare avoids cost through the coverage and payment for services rendered in the home. Home care medicine has a growing evidence base in the VA, in the Medicare program through Medicare Advantage plans and this evidence base is being further established now through housecall services within ACOs and in the Independence at Home Demonstration.

We understand that the statutory designation of originating sites is within the purview of Congress. However, we believe that just as home limited beneficiaries are able to access needed Part B services in their place of residence and are not denied Medicare Part B services due to their difficulty in leaving the home through CMS “in lieu of” guidance and medical necessity requirements that CMS would be able to use the same existing authority to find the home to be “in lieu of” (approved) office setting for the purpose of Telehealth coverage.

The positive result of such guidance would be to increase access to the most isolated, dependent beneficiaries who are in need of primary and specialty medical care. The increase in access will improve quality and reduce burden and stress on beneficiaries and caregivers, enhance quality of care and satisfaction by improving the timeliness of care and reduce cost to the beneficiaries and to CMS. This express regulatory guidance would eliminate another barrier to equal access to Medicare Part B benefits for these home limited beneficiaries.

Expressly adding these locations as approved originating sites will also produce the benefit of regulatory consistency in that “housecalls” are covered “in lieu of an office visit” when specified medical necessity requirements are met. And this consistency is all the more important for those beneficiaries who are otherwise eligible for Telehealth services.

The practical basis for this request is that the Academy is aware of situations where beneficiaries are hundreds of miles, and many hours away from the care that they require. At the same time the beneficiary may be homebound by Medicare Part A standards, home limited and thus eligible for Medicare Part B housecalls as discussed above, or both.

Just to note, we propose there would be no specialty limitation in the rendering of Telehealth services whose site of origination was the home or domiciliary location. The primary care provider or specialist who rendered the service would be paid for the covered service. The geographic and technical requirements for Telehealth coverage would apply and coverage would continue for the list of approved Medicare services as promulgated.

#### 4) Value Based Payment Modifier

We support the development of additional means to support and assess value in the Medicare program. As such, we support the Value Based Payment Modifier program to encourage value based care.

We also support the changes in the Final Rule to reduce from 4 x in the Proposed Rule to 2 x in the Final Rule the amount of bonus or penalty as the VBPM program gets underway for practices less than 10 providers. We appreciate moving NPs and PAs into Step One of attribution to a practice. We also appreciate the delay of adding individual non-physician providers until 2018.

However, as we commented in prior years we have significant concern that an emerging evidence base supports that Part B providers who treat the sickest of Medicare beneficiaries may be unintentionally disadvantaged and penalized by the VBPM unless 1) applicable measures are developed for the high cost multimorbid population and until 2) risk adjustment methods are developed that fully take into account the health and social status of beneficiaries, particularly the sickest, highest cost beneficiaries. We also appreciate that CMS will be reviewing the recommendation of the NQF as relates to the incorporation of SES of beneficiaries into measures.

This is critically important as we have learned that Medicare beneficiaries receiving care in their residence (home and domiciliary) have HCC scores that are the highest of Medicare sites of service and programs (higher than office based practice, higher than Medicare Advantage and higher than PACE). In fact, at least one of 3 Medicare beneficiaries receiving a housecall would meet the eligibility criteria for Independence at Home (IAH) and IAH eligible beneficiaries have been found in a cohort population study to have an average HCC of 3.3.4. These beneficiaries also have as a cohort of Medicare beneficiaries SES attributes that influence and increase their actual cost of care. Accordingly, such SES attributes should be incorporated into cost measures.

We also believe based on analysis of a Medicare 5% sample, that the proposed bonus of one percent for those providers with HCC scores in the top 25% within their specialty would be inadequate. Such providers, by focus of practice (location and services), are more likely than others in their taxonomy who are office or clinic based, to have 20 beneficiaries or more in their practice who have an attributable index admission or episode during the year.

In fact, it is often the case that beneficiaries enter housecall practices as a result of an index admission or have an index admission during their length of stay with the practice. Thus, the nature of the housecall practice itself will result in inordinate cost. This likelihood is also reflected in the admissions rate information in the Chart Book. Additionally, cost associated with an admission, despite the best efforts of proactive practices, is not within the sole control or determination of the home care medicine provider or practice.

What are the problem areas on which we want to work with CMS?

- PQRS Measures: many are not relevant to the high cost multimorbid population, and some may even harm patients;
- Specialty designation: while some primary care providers who serve this population are office or clinic based, many are mobile providers making house calls or seeing patients in facilities such as nursing homes. Beneficiaries seen by mobile providers or in nursing homes are much sicker and most often more costly than those in offices.

Yet the comparison group is the office-based physician.

- HCC scoring: as MedPAC and others have pointed out, current HCC scoring methodologies badly under-represent the costs of the high need, high cost population
- Frailty factors: The current VBPM program uses the standard MA risk adjustment model, without any of the modifications made for frail elders such as is the case in the PACE model (inclusion of dementia HCCs, use of a frailty adjuster, use of an enhanced county rate benchmark).

CMS staff with whom we have discussed concerns suggested we review the Quality Resource and Use Reports (QRUR) for Academy members to confirm existence of the problems after application of the VBPM risk adjustment methodology. Our review confirms that programs that are cost effective housecall practices (including those that appear to be “high performers” in the Independence at Home demonstration), were classified as “low quality/high cost” on the QRUR reports. This confirms our concern that as structured the VBPM program will penalize the practices and providers that are in reality producing the highest triple aim benefit for Medicare as compared to other practices and to providers in one’s specialty.

Based on this concern and QRUR validation we are seeking grant funding to conduct analysis to share with you that this problem with the methodology and impact on the field of home care medicine (and others that treat sick patients in non office settings) is real and will in time harm beneficiary access to care, add to beneficiary stress and trauma, and increase Medicare cost due to the lack of the motivated workforce needed to provide service to the most isolated and costliest cohort of Medicare beneficiaries. This analysis will expand on that conducted and shared with CMS CMMI staff regarding the Independence at Home program that reflects underestimate of expense that is similarly based on the MA risk adjustment model.

With this population we’ve shown that the PACE model with FFS county benchmarks, but with the PACE frailty adjuster, predicts costs that are at least 18% below what is observed (and the PACE model is more appropriate for a home-limited population than the standard HCC model CMS is using for VBPM). We’ve also shown that use of the PACE benchmarks significantly improves, but doesn’t completely eliminate, a downward bias in expected to observed costs.

We believe the end result of this analysis will be that comparison within one’s own specialty with existing (MA) risk adjustment is inadequate for payment policy and payment adjustment, and that Part B providers treating house call beneficiaries (and those similarly treating the sickest beneficiaries in alternative sites of service), will need to be considered as a separate class or strata for VBPM calculations and adjustments.

Moreover, this analysis would inform payment models for the costliest and sickest beneficiaries in other Medicare initiative and programs. We look forward to sharing the results of this analysis with you and we would be pleased to answer any questions in the interim.

## **5) Participation in Multiple Shared Savings Programs**

Home based primary care providers generally serve relatively large geographies and diverse populations (20-30+ mile radius). Serving multiple health systems is not uncommon; utilizing numerous hospitals and health systems in an urban community setting is the norm for house call practices across the country. Participation in MSSP Programs based on tax ID numbers (TINS) as opposed to provider NPI’s has proved to be an obstacle to expanding participation in MSSP’s across the country.

In the final rule and re-iterated in the 2015 PFS, CMS has stated that TINS are more stable and provide CMS with necessary controls; whereas, NPI's create operational complexity. We fail to see the operational burden and respectfully request CMS find a solution to exclusivity provisions inherent in a TIN methodology.

#### **6) MSSP ACO Patient Attribution Model for the Nurse Practitioners and Physician Assistant Community of Providers**

With the expansion of primary care services anticipated under the ACA and the Advanced Practice Models of Medical Home (PCMH) and Independence At Home (IAH) the medical practice community has embraced the Nurse Practitioner (NP) and Physician Assistant (PA) as key members in the delivery of primary care services. However, the MSSP ACO Patient Attribution Model fails to recognize the role the NP/PA serves in providing direct patient care. Since IAH has provided for direct patient attribution to an identified NP/PA, the MSSP ACO and Pioneer ACO Models should provide the same accommodation.

Our suggestion would provide that any provider NPI aligned with an ACO or other CMS shared savings program would recognize "the preponderance of evaluation and management services provided to a Medicare beneficiary for the purposes of attribution to an MSSP." Like taxonomy and primary care E/M codes would suffice to identify the PCP Provider.

#### **7) Home Based Primary Care for America's Dual Eligible Population**

We are compelled to request CMS address issues surrounding assignment of Medicare/Medicaid Beneficiaries in state sponsored "Dual Programs". Existing shared savings programs (ACO's and IAH) and home based primary care providers (FFS) are being forced out of the cost effective care of the chronically ill. We respectfully request that CMS, when developing the three-way agreements on state sponsored dual programs, provide that existing PCP relationships with home limited populations be protected and that CMS shared savings programs beneficiaries be excluded from dual contract attribution.

We appreciate the opportunity to comment and we would be pleased to answer any questions.

Sincerely,



Robert Sowislo  
Chair, Public Policy Committee

## Addendum

December 30, 2014

SUBMITTED ELECTRONICALLY VIA  
<http://www.regulations.gov>

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 "1" (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,<sup>1</sup> fewer hospitalizations,<sup>2</sup> less intensive treatments,<sup>3</sup> more hospice use,<sup>4</sup> and increased likelihood of a person dying in their preferred location.<sup>5</sup> From a psychological perspective, ACP is associated with higher satisfaction with the quality of care for patients,<sup>6</sup> as well as less risk of stress, anxiety and depression in surrogates<sup>7</sup> and surviving relatives.<sup>8</sup> Finally, emerging data shows that ACP reduces the cost of end of life care<sup>9</sup> without increasing mortality.<sup>10</sup> In fact, in one 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.<sup>11</sup>

---

<sup>1</sup> See Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomized 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.

<sup>2</sup> See Detering KM, Hancock AD, Reade MC, Silvester W. The impact of advance care planning on end of life care in elderly patients: randomized 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.

<sup>3</sup> 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.

<sup>4</sup> 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.

<sup>5</sup> 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.

<sup>6</sup> 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.

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

<sup>8</sup> 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.

<sup>9</sup> 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.

<sup>10</sup> 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.

<sup>11</sup> 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.

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)<sup>12</sup> 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.”<sup>13</sup> 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.<sup>14</sup> 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).<sup>15</sup> 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 various inpatient/outpatient settings.<sup>16</sup> We understand that commenters universally agreed that this measure was appropriately classified as cross-cutting.<sup>17</sup>

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.<sup>18</sup> The unfortunate result is that often a patient’s illness is

---

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

<sup>13</sup> 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>.

<sup>14</sup> 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.

<sup>15</sup> 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).

<sup>16</sup> 79 Fed. Reg. at 40407 Table 21 (July 11, 2014).

<sup>17</sup> 79 Fed. Reg. at 67802 Table 52 (November 13, 2014).

<sup>18</sup> 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.

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,<sup>19</sup> the majority (55%) of first discussions in a study of cancer patients took place in the inpatient setting.<sup>20</sup> 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.<sup>21</sup>

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.

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 Society for Blood and Marrow Transplantation
- American Thoracic Society

---

<sup>19</sup> 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.

<sup>20</sup> 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.

<sup>21</sup> 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.

