September 8, 2015
Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence, Ave., S.W.
Washington, D.C. 20201

Re: CMS-1631-P: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Via: http://www.regulations.gov

Dear CMS Acting Administrator Slavitt:
The National Coalition for Hospice and Palliative Care (Coalition) appreciates the opportunity to submit comments in regards to the FY16 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, published in the Federal Register, July 15, 2015. Our Coalition welcomes the opportunity to provide input on the proposed changes to the Physician Fee Schedule published by the Center for Medicare and Medicaid Services (CMS). The Coalition is composed of the leading national hospice and palliative care organizations dedicated to advancing care of patients and families living with serious and life-limiting conditions. The organizations that form the Coalition represent more than 4,000 physicians, 11,000 nurses, 5,000 professional chaplains, 5,000 social workers, 1,600 palliative care programs, and over 5,300 hospice programs and related personnel, caring for millions of Medicare beneficiaries with serious illness and those at the end of life. Our combined membership represents the interdisciplinary hospice and palliative care team which is patient and family-centered.

Our Coalition comments focus primarily on the proposed positive changes in Medicare policy to cover and reimburse for advance care planning (ACP) services CPT codes 99497 and 99498. We thank CMS for the recognition that providing this critical health care service is a separate and
identifiable service which contributes to the overall health and well-being of Medicare beneficiaries. The Coalition encourages CMS to move forward with implementation and reimbursement of these critically important services.

Advance Care Planning Services (ACP): The Coalition strongly supports Medicare coverage and reimbursement of the critical need for beneficiary access to appropriate advance care planning services. According to the IOM Report: Dying in America: Improving Quality and Honoring Preferences Near the End of Life, September 2014, National Academy Press, for millions of Americans, advance care planning conversations should be “an essential component of quality care”. However, these conversations are now limited in frequency, in part due to the lack of reimbursement for this service. Advance care planning discussions and related planning activities between a qualified health care provider and the patient and family should lead to shared decision-making based on the patient’s values and preferences. The aim of these conversations is “to develop a coherent care plan that meets the patient’s goals, values and preferences.”  

CMS has proposed reimbursement for the following two services:

- CPT code 99497 (Advance care planning including the explanation and discussion of advance care directives 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.
- Add-on CPT code 99498 (Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure)).

Coalition Recommendations: The Coalition strongly supports CMS providing Medicare coverage and reimbursement for the above services as approved by the CPT Editorial Panel and the AMA-RUC.

Timing of ACP Services: CMS states that the ACP services should be reported when “the described service is reasonable and necessary for the diagnosis or treatment of illness or injury.” CMS seeks comment on whether payment for ACP is appropriate in other circumstances, such as at the beneficiary’s discretion or at the time of the annual wellness visit.

Coalition Recommendation: The Coalition strongly supports permitting ACP conversations at the request of the Medicare beneficiary, at any point during an illness or treatment trajectory, and/or when the Medicare beneficiary wants to consider future health care scenarios such as potential incapacitation.

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1 Institute of Medicine, Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life, September 2014.
Advance Care Planning is very often not a single conversation, but a process in which conversations are had in multiple stages, sometimes over the course of many years, and during varying states of health. In fact, the Institute of Medicine, *Dying in America*, recommended that all individuals regardless of age or health condition be able to access ACP services throughout their lives, and that reimbursement policy should encourage such access.\(^2\) The Coalition believes it would be unwise of CMS to limit reimbursement of these codes to specific disease states, illness trajectories, or service frequency. All Medicare beneficiaries who can benefit from ACP, delivered in accordance with these codes, should receive these valuable services.

Qualified Health Professionals: While the Coalition recognizes that ACP services reimbursed through the MPFS can be provided only by physicians or qualified health professionals such as nurse practitioners and physician assistants among others, we recommend that CMS consider future mechanisms to reimburse other members of the health care team that often initiate and conduct ACP discussions with patients and families. Many social workers, chaplains, and nurses who do not currently qualify to bill Medicare directly are trained and skilled to deliver ACP in the context of team-based care, and should be reimbursed for this valuable service.

We again thank CMS for the critical first step of supporting physicians and qualified health providers to provide ACP services. We do believe, however, that many Medicare beneficiaries would also benefit from ACP delivered by other skilled clinicians such as social workers, chaplains and nurses who would not be eligible to bill under this proposal—a growing number of health systems use these professionals to provide high quality ACP services. We would welcome the opportunity to work with CMS and other key stakeholders to develop innovative reimbursement models that support and promote this team-based approach.

Electronic Health Record: The Coalition is supportive of changing the electronic health record (EHR) to safely and securely document a patient’s advance care plans and preferences for goals and settings of care. We encourages CMS to work within the Administration, its various partner agencies and external organizations in the wider health IT field to determine how best to approach this technical problem. The Coalition supports efforts to make advance care planning a meaningful and universal component in the EHR.

Establishing Separate Payment for Collaborative Care:

The Coalition is very supportive of CMS’s efforts to enhance Medicare fee for service by supporting collaborative care services that can help seriously ill beneficiaries maintain function and independence as long as possible.

Research now demonstrates that palliative care provided collaboratively with usual care can improve patient quality of life, mood and even survival for patients with non-small cell lung cancer, while decreasing intensity hospitalization and use of intensive care at the very end of life.

\(^2\) Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, September 2014.
These results are currently being replicated in a number of other life-limiting illnesses, and demonstrate the significant opportunity to improve care for Medicare beneficiaries by establishing separate payment for collaborative care, including palliative care.

As a result, the Coalition urges CMS to consider several principles when developing separate payment for collaborative care:

- Many collaborative care services do not include a face-to-face visit with patient or family, but involve significant communication between health care providers which should be valued;
- The intensity of collaborative care will vary with individual patient medical condition and needs, any may not follow established time frames for global periods, CCM, or TCM. Payment then should include the requisite flexibility to address these uncertainties;
- The target population for this service should be those at highest risk for complications (including re-hospitalization), which maps closely to the patient populations for most palliative care providers.

The Coalition commends CMS for recognizing the need to ensure that Medicare beneficiaries with multiple chronic conditions receive better coordinated care and is seeking to cover and reimburse evidence based collaborative care models.

Chronic Care Management and Transitional Care Management:

In 2013, CMS implemented a separate payment for transitional care management (TCM) services, and in 2015 implemented a separate payment for chronic care management (CCM) services. In the preamble, CMS notes that there are more extensive requirements for TCM and CCM services compared to other evaluation and management services, and questions whether these requirements are impeding the ability to provide these services to beneficiaries.

The Coalition appreciates CMS’ recognition that the TCM and CCM codes have more extensive requirements than other evaluation and management services. We are concerned that these additional requirements hinder a provider’s willingness to engage in TCM and CCM services, which can help to ensure that a beneficiary’s care is coordinated across multiple providers and settings of care. Research has demonstrated that good care management can help avoid costly trips to the emergency room, hospital admissions or readmissions. Thus, the widespread use of these codes has the potential to improve quality of care while reducing health care expenditures.

However, we have received feedback from a number of providers that the CCM codes are not suitable when coordinating care for more complex patients. We encourage CMS to establish a separate code for complex chronic care management that recognizes the differences in the scope of services required for this patient population, as well as the type and intensity of

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physician supervision and the type and intensity of clinical staff resources required to perform complex chronic care management. At a minimum, we urge CMS to immediately begin payment on existing complex chronic care management codes (99487 and 99489), until a group of stakeholders can develop a more robust framework.

We thank CMS for consideration of our Coalition comments and recommendations as you draft and implement the final rule. Please do not hesitate to contact us if we can provide any further assistance or information. If you have any questions, or if you would like to discuss our comments in more detail with experts from our Coalition, please contact Amy Melnick, MPA, Executive Director, National Coalition for Hospice and Palliative Care, amym@nationalcoalitionhpc.org or 202.306.3590.

Sincerely,

Amy Melnick, MPA
Executive Director
National Coalition for Hospice and Palliative Care

MEMBER ORGANIZATIONS IN THE NATIONAL COALITION FOR HOSPICE AND PALLIATIVE CARE

American Academy of Hospice and Palliative Care (AAHPM)
Association of Professional Chaplains (APC)
Center to Advance Palliative Care (CAPC)
Health Care Chaplaincy Network (HCCN)
Hospice and Palliative Care Nurses Association (HPNA)
National Hospice and Palliative Care Organization (NHPCO)
National Palliative Care Research Center (NPCRC)
Social Work Hospice and Palliative Network (SWPHN)