



2005 Market Street, Suite 1700 215.575.9050 Phone
Philadelphia, PA 19103-7077 215.575.4939 Fax

901 E Street NW, 10th Floor 202.552.2000 Phone
Washington, DC 20004 202.552.2299 Fax
www.pewtrusts.org

September 8, 2015

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via regulations.gov

Re: RIN 0938-AS40: Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Thank you for the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed Physician Fee Schedule (PFS). Pew applauds CMS for including advance care planning (ACP) codes in the proposed rule for the Physician Fee Schedule; this change will allow Medicare to pay providers for engaging their patients in advance care planning discussions.

The Pew Charitable Trusts is an independent, non-profit research and public policy organization. The Trusts' project to improve end-of-life care advances policies that help people make informed decisions about their treatment preferences, improve the documentation of these preferences, and hold health care providers accountable for honoring patient wishes and delivering high-quality care. Additionally, the project highlights innovative ways of providing care to seriously ill people and their families as they near the end of their lives.

Pew supports the section of the PFS proposed rule that would establish Medicare coverage for voluntary advance care planning (ACP), thereby increasing access to this important service. Helping people articulate the kind of care they want near the end of life can help them—along with their relatives, community and caregivers—address some of the profound challenges they face at that time. Advance care planning supports patients and families in discussing and documenting care preferences, with the goal of ensuring that the care patients receive is aligned with their goals, values and preferences.

The recent Institute of Medicine (IOM) report, *“Dying in America,”* emphasizes advance care planning as an essential tool to improve the care of Americans near the end of life, yet numerous studies have demonstrated that even the sickest people rarely discuss their preferences regarding end-of-life care—the medical treatment received in their final weeks and months of life—with their loved ones or medical care team.¹ For example, a recent study of patients with advanced cancer found that only 27 percent of patients had discussed end-of-life issues with their oncologist, and most had never discussed pain management with any doctor.² A 2012 survey by the California Health Care Foundation found that more than three-quarters of respondents

wanted to talk to their doctors about their end-of-life care wishes, yet 90 percent said that a doctor had never asked them about those issues.³

Engaging patients in the important conversation about their preferences for end-of-life care is a critical tool for patient engagement and shared decision-making. ACP discussions empower patients to make decisions about their care, and articulate whether they want comfort care, full measures, or something in between. It helps people inform their caregivers and providers about their values and goals near the end of life so that these preferences can be taken into account should the patient not be able to speak for him or herself.

Research has shown that people often receive aggressive treatments in the intensive care unit and ultimately die in the hospital when they would have preferred to die in their own home. ACP conversations significantly improve outcomes for patients and ultimately family members, including: care that is consistent with patient wishes, fewer hospitalizations, more use of hospice, and an increased likelihood of people dying in their preferred location.^{4,5,6} When advance care planning conversations have not occurred, family members and caregivers are forced to guess at what their loved ones would want and often experience stress, guilt, and regret when they are not confident that they know their loved one's wishes.^{7,8}

One challenge to providing ACP services has been that Medicare has not reimbursed for advance care planning discussions. Doctors who voluntarily provided ACP discussions needed to fit them into other meetings with patients, where key caregivers might not be present. ACP discussions are delicate, can be time-consuming and should involve other members of a patient's community when possible. Encouraging a meaningful ACP discussion requires more than a few minutes at the end of a short medical appointment scheduled for another purpose. Providing reimbursement for sessions dedicated to ACP—as these codes do—will allow providers to have these essential conversations about wishes for end-of-life care in a sensitive and thorough manner.

CMS is seeking comment on whether payment for advance care planning is appropriate in circumstances other than at diagnosis or treatment of illness or injury. As articulated in "*Dying in America*", everyone should have the opportunity to participate actively in their health care decision making throughout their lives.⁹ ACP should begin as early as possible to provide a roadmap for any unexpected or serious health events. Accidents or sudden severe health conditions cannot be predicted. Waiting until the onset of an illness or injury may preclude the chance for beneficiaries to voice their preferences about the care they would want should they be unable to speak for themselves. We ask that CMS view it as "reasonable and necessary" for Medicare beneficiaries to initiate ACP discussions with their providers at the beneficiary's discretion and not have to wait until the onset of an illness or injury.

The CPT codes 99497 and 99498 have been given status indicators of "A," which leaves coverage to the discretion of Medicare Administrative Contractors (MACs). It will be important for all MACs to adopt these ACP codes so that Medicare beneficiaries nationwide have access to advance care planning.

In conclusion, Pew commends CMS for including ACP codes in the proposed rule for the Physician Fee Schedule. We strongly urge CMS to include these codes in the final rule and not

limit their use to the diagnosis or treatment of illness or injury. ACP is core to ensuring that beneficiaries receive the care they want should they become unable to make medical decisions for themselves. Additionally, documenting what an individual desires in an advance care plan eases the burden for family members during a very difficult time and enables providers to deliver the best possible desired medical care.

If you have any questions, or need further assistance, please do not hesitate to contact me at 202-540-6761 or jrising@pewtrusts.org.

Sincerely,



Josh Rising, MD
Director, Health Care Programs
The Pew Charitable Trusts

¹ Institute of Medicine, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life,” (Washington, DC: National Academies Press, 2014).

² Jennifer W. Mack et al., “End-of-Life Discussions Among Patients with Advanced Cancer: A Cohort Study,” *Annals of Internal Medicine* 153, no. 3 (2012): 4–5.

³ California HealthCare Foundation. “Final Chapter: Californians’ attitudes and experiences with death and dying,” (2012).

⁴ Karen M. Detering et al., “The Impact of Advance Care Planning on End-of-Life Care in Elderly Patients: Randomized Controlled Trial,” *BMJ* 340 (2010): 4–5.

⁵ Rhea A. Stein et al., “Randomized Controlled Trial of a Structured Intervention to Facilitate End-of-Life Decision Making in Patients with Advanced Cancer,” *Journal of Clinical Oncology* 31, no. 27 (2013): 3406.

⁶ Lauren H. Nicholas et al., “Regional Variation in the Association Between Advance Directives and End-of-Life Medicare Expenditures,” *Journal of the American Medical Association* 306, no. 13 (2011): 1451.

⁷ Maria J. Silveira, Scott Y. H. Kim, and Kenneth M. Langa, “Advance Directives and Outcomes of Surrogate Decision Making Before Death,” *New England Journal of Medicine* 362, no. 13 (2010): 1214 -1216.

⁸ David Wendler and Annette Rid, “Systematic Review: The Effect on Surrogates of Making Treatment Decisions for Others,” *Annals of Internal Medicine* 154, no. 5 (2011): 344.

⁹ Institute of Medicine, “Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life,” p.3-57.