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
80 Fed. Reg. 41686 (July 15, 2015)

Dear Acting Administrator Slavitt:

We are writing collectively as members of the Patient Quality of Life Coalition, a group of over 30 organizations dedicated to advancing the interests of patients and families facing serious illness. Members represent patients, health professionals, and health care systems. One of the key priorities of the Coalition is to improve patient access to palliative care. Palliative care is specialized medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by a specially-trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

Palliative care teams provide a great range of services, including comprehensive pain and symptom management, communication with patients and their families about goals of care, education of family members and caretakers on what to expect and what to do if crises arise, activation of practical and social supports, and enhanced communication and coordination with other providers. Such services result in the avoidance of high cost care, improve patient quality of life, and result in fewer crises requiring acute care. Individuals whose care is managed by palliative care professionals have reduced hospitalizations or re-hospitalizations.[1]

The Coalition appreciates the opportunity to provide comments on the proposed changes to the Medicare Physician Fee Schedule for calendar year 2016. We offer the following recommendations with respect to specific policy proposals:

E. Improving Payment Accuracy for Primary Care and Care Management Services

2. Establishing Separate Payment for Collaborative Care

In the preamble, CMS recognizes that care management for Medicare beneficiaries with multiple chronic conditions, particularly complicated diseases or acute conditions often requires extensive

[1] For example, a 2008 study of eight diverse hospitals showed that palliative care consultations resulted in adjusted net savings of $1,696 in direct costs per admission and $279 in direct costs per day, including significant

discussion, information-sharing and planning between a primary care physician and a specialist. 80 Fed. Reg. at 41710. In CY 2014, four CPT codes (99446-99449) were created that describe interprofessional telephone/internet consultative services. CMS currently does not make separate payment for these services. In the preamble, CMS notes that it is considering how to improve the accuracy of payments for care coordination, particularly for patients requiring more extensive care, and requests comments on how Medicare might accurately account for the resource costs of a more robust interpersonal consultation.

A core component of quality palliative care is communication – communication with patient, family, and other loved ones, communication with all involved primary care, and specialty providers; communication with community services such as food services, transportation, home care agencies, hospice, and long term care facilities. Such communication is the dominant activity in palliative care, much of it telephonic and electronic, occurring between and during face to face visits.

We consider it appropriate to provide payment for these services, as this will encourage providers to more diligently communicate with other treating providers. It is important for a physician to speak to another treating provider when a patient with multiple or serious diagnoses has a change in health status, or is transitioning to a new setting. We recommend that when a provider bills at a 4 or 5 level of complexity, and/ or when a clinician has billed one of the time extender codes (99356 or 99357), this should indicate that it would be appropriate to bill for collaborate care services as well. The documentation requirements should include the nature of the change in status or transition, and language to support that a conversation between providers happened. Valuation of these codes should be similar to the time extender codes that CMS has already valued.

3. CCM and TCM Services

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 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 services provided under the TCM and CCM codes require 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 help to ensure that a beneficiary's care is coordinated across multiple providers and settings of care. CMS should also consider increasing the amount of the reimbursement to be more in line with the services that are being provided. Increased value in the reimbursement could encourage more providers to utilize these codes. Research has demonstrated that good care management can help avoid costly trips to the emergency room, hospital admissions or readmissions.[2] Thus, the widespread use of these codes has the potential to improve quality of care while reducing health care expenditures.

---

[2] Silow-Carroll S, Edwards JN, Lashbrook A. Reducing Hospital Readmissions: Lessons from Top-Performing Hospitals. *Commonwealth Fund* April 2011, available at http://www.commonwealthfund.org/~/media/files/publications/case-study/2011/apr/1473_silowcarroll_readmissions_synthesis_web_version.pdf.

At the same time, the current CCM codes target a patient who can be managed according to disease-specific clinical guidelines and are not really appropriate when coordinating care for more complex patients. These sickest Medicare beneficiaries are patients who cannot or should not be treated using standardized guidelines. 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 physician supervision and the type and intensity of clinical staff resources required to perform complex chronic care management.

I. Valuation of Specific Codes

6. CY 2016 Valuation of Specific Codes

c. Advance Care Planning Services

In CY 2015, the CPT Editorial Panel created two new codes describing advance care planning (ACP) 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)).

In the CY 2015 Medicare Physician Fee Schedule final rule, CMS assigned these codes a status indicator of "I" (not valid for Medicare purposes). CMS now seeks comment on whether payment for advance care planning is needed and what types of incentives this proposal creates. CMS notes that the ACP services should be reported when "the described service is reasonable and necessary for the diagnosis or treatment of illness or injury." Section 1862(a)(1)(A) of the Act. CMS also seeks comment on whether payment for ACP is appropriate in other circumstances, such as an optional element at the beneficiary's discretion at the time of the annual wellness visit.

The Coalition applauds CMS for considering reimbursement for the advance care planning codes. We strongly urge CMS to assign a status indicator "A", Active code beginning in CY 2016. Advance care planning allows providers and their patients (and their families and/or caregivers) to discuss and make known the patients' treatment preferences. Unfortunately, most Medicare beneficiaries do not have an advance care plan in their medical record. According to a recent study funded by the Agency for Health Care Research and Quality (AHRQ) only 12 percent of Medicare beneficiaries have developed an advance care plan in conjunction with their medical provider.[3] Oftentimes, medical professionals are

[3] Teno J, Lynn J, Wenger N, et al. Advance directives for seriously-ill hospitalized patients: effectiveness with the Patient Self-Determination Act and the SUPPORT intervention. *J Am Geriatr Soc* 1997;45:500-7.

not involved in the planning process, and they may be unaware of the existence of such plans,[4] reducing the likelihood that the patient's preferences will be carried out.

Conclusion

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the Medicare Physician Fee Schedule proposed rule. If you have any questions, please contact Keysha Brooks-Coley with the Patient Quality of Life Coalition, at 202-661-5720 or Keysha.Brooks-Coley@cancer.org.

Sincerely,

American Cancer Society Cancer Action Network

American Heart Association | American Stroke Association

American Psychosocial Oncology Society

Catholic Health Association of the United States

Center to Advance Palliative Care

Coalition for Supportive Care of Kidney Patients

Colon Cancer Alliance

Motion Picture & Television Fund

National Association of ACOs

Oncology Nursing Society

Partnership for Palliative Care

Supportive Care Coalition

Trinity Health

Visiting Nurse Associations of America

[4] Virmani J, Schneiderman LJ, Kaplan RM. Relationship of advance directives to physician-patient communication. *Arch Intern Med* 1994;154:909-13.