



September 6, 2016

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-1654-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY2017; Proposed Rule
81 Fed. Reg. 46162 (July 15, 2016)

Dear Acting Administrator Slavitt:

We are writing collectively as members of the Patient Quality of Life Coalition, a group of over 40 organizations dedicated to advancing the interests of patients and families facing serious illness, with the overarching goal of providing patients with serious illness greater access to palliative care services. 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. Palliative care is appropriate at any age and any stage in a serious illness (ideally made available to patients with serious illnesses upon diagnosis)¹ and can be provided along with curative treatment. The goal is to improve quality of life for both the patient and the family.

Studies show that without palliative care, patients with serious illness and their families receive poor-quality medical care that is characterized by inadequately treated symptoms, fragmented care, poor communication with health care providers, and enormous strains on family members or other caregivers.^{2,3} By focusing on priorities that matter most to patients and their families, palliative care has been shown to improve both quality of care and quality of life during and after treatment.^{4,5} In one study, patients with metastatic non-small-cell lung cancer who received palliative care services shortly

¹ Smith, TJ, Temin S, Alesi ER, Abernathy AP, Balboni TA, Basch EM, Ferrell BR, Loscalzo M, Meier DE, Paice JA, Peppercorn JM, Somerfield M, Stovall E, Von Roenn JH. American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care Into Standard Oncology Care. *J Clinical Oncol* 2012; 30: 880-887.

² Teno JM, Clarridge BR, Casey V, Welch LC, Wetle T, Shield R, Mor V. Family perspectives on end-of-life care at the last place of care. *JAMA*. 2004 Jan 7; 291(1):88-93.

³ Meier DE. Increased Access to Palliative Care and Hospice Services: Opportunities to Improve Value in Health Care. *The Milbank Quarterly*. 2011;89(3):343-380. doi:10.1111/j.1468-0009.2011.00632.x.

⁴ Delgado-Guay MO, et al. Symptom distress, interventions, and outcomes of intensive care unit cancer patients referred to a palliative care consult team, 115(2) *Cancer* 437-45 (2009).

⁵ Casarett D, et al., Do palliative consultations improve patient outcomes? 56 *J Am Geriatric Soc'y* 593, 597-98 (2008).

after diagnosis even lived longer than those who did not receive palliative care.⁶ The American Heart Association / American Stroke Association have stated that palliative care can be a helpful complement to current care practices and can improve quality of life for cardiovascular disease and stroke patients, caregivers, and providers.⁷ Furthermore, palliative care results in fewer crises, reducing hospital utilization and resulting in overall cost savings.⁸

Yet despite the demonstrated benefits of palliative care, there remain millions of Americans who do not access such services. Many of these people are included in the five percent of patients who account for approximately 60 percent of all health care spending – those with multiple chronic conditions and functional limitations who have persistent high costs.⁹ While the Coalition appreciates the steps the Centers for Medicare and Medicaid Services (CMS) has taken in recent years to improve patients' access to specific palliative care services (e.g., providing reimbursement for advance care planning codes 99497 and 99498 in the calendar year (CY) 2016 Physician Fee Schedule), additional work remains.

The Coalition appreciates the opportunity to provide comments on the proposed changes to the Medicare Physician Fee Schedule (PFS) for CY 2017. We offer the following recommendations with respect to specific policy proposals:

C. Medicare Telehealth Services

3. Submitted Requests to Add Services to the List of Telehealth Services for CY 2017

Advance care planning (ACP) allows providers and their patients (and their families and/or caregivers) to discuss and make known the patients' treatment preferences. CMS proposes to add the two ACP codes (99497 and 99498) to the list of Medicare telehealth services beginning in CY 2017 on a category 1 basis.

The Coalition supports this proposal, as it has the potential to expand access to important services for seriously ill beneficiaries living in rural and underserved areas, as well as patient surrogates who may live at a distance and are unable to be physically present to engage in these important services. That being said, we urge CMS to monitor both the uptake and provision of these services in the first implementation year. Conducting meaningful face-to-face ACP discussions can be very difficult; conducting these conversations remotely, without the benefit of being able to see the patient and/or family fully and respond to their non-verbal cues, could increase the difficulty, and possibly result in negative outcomes. Therefore, we suggest that CMS monitor the implementation of these codes for any unintended consequences.

⁶ Temel JS, Greer JA, Muzikansky A, et al. Early palliative care for patients with metastatic non-small-cell lung cancer. *N Engl J Med.* 2010;363:733-742.

⁷ Palliative Care and Cardiovascular Disease and Stroke: A Policy Statement From the American Heart Association/American Stroke Association
<http://circ.ahajournals.org/content/early/2016/08/08/CIR.0000000000000438> Aug 16.

⁸ Agency for Healthcare Research and Quality: System-integrated program coordinates care for people with advanced illness, leading to greater use of hospice services, lower utilization and costs, and high satisfaction. www.innovations.ahrq.gov/content.aspx?id=3370.

⁹ IOM (Institute of Medicine). 2014. *Dying in America: Improving quality and honoring individual preferences near the end of life.* Washington, DC: The National Academies Press.

E. Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

2. Non-Face-to-Face Prolonged Evaluation & Management (E/M) Services

CMS proposes to recognize CPT codes 99358 (Prolonged evaluation and management service before and/or after direct patient care, first hour) and 99359 (Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes) for separate payment under the PFS beginning in CY 2017. Acknowledging that these services can look similar to other E/M and care management services, CMS specifies that the time cannot be counted more than once towards the provision of CPT codes 99358 or 99359 or any other PFS service. Furthermore, CMS proposes to require the services to be furnished on the same day by the same physician or other billing practitioner as the companion E/M code.

The Coalition supports CMS' recognition of the need to provide reimbursement for non-face-to-face, prolonged E/M services. A core component of palliative care is care coordination for beneficiaries, which can often happen outside the presence of the beneficiary. At the same time, we recognize that this non-face-to-face communication may not necessarily occur on the same day as the companion E/M code – particularly if the E/M visit occurred at the end of a providers' normal workday or required additional research, the non-face-to-face E/M activity may occur on the following business day. Thus, we encourage CMS to clarify that in such instances the codes do not have to be furnished on the same day.

4. Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM Services)

In light of stakeholder feedback, CMS is proposing several changes in the payment rules for chronic care management (CCM) services. CMS is proposing to more appropriately recognize and pay for the following additional CPT codes:

- CPT code 99487 – Complex chronic care management services, with the following required elements:
 - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
 - Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
 - Establishment or substantial revision of a comprehensive care plan;
 - Moderate or high complexity medical decision making;
 - 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
- CPT code 99489 – Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (list separately in addition to code for primary procedure).

CMS proposes to allow CPT codes 99487, 99489, and 99490 to only be used once per service period (calendar month) and only by the single practitioner who assumes the care management role with a particular beneficiary for the service period.

In general, the Coalition appreciates CMS' desire to eliminate burdensome and/or redundant requirements for billing the following complex CCM services. We have remained concerned that the extensive requirements hinder a provider's willingness to engage in CCM services, which ensure that a beneficiary's care is coordinated across multiple providers and settings of care. By making the following changes, CMS will increase the likelihood that clinicians will provide these services to patients with serious illness.

a. Initiating Visit

CMS is not proposing any change to the kinds of visits that can qualify as initiating CCM visits. However, they are proposing to require the initiating visit only for new patients or patients not seen within one year instead of for all beneficiaries receiving CCM services. CMS is also proposing a new add-on G-code that would be billable for beneficiaries who require extensive face-to-face assessment and care planning by the billing practitioner (as opposed to clinical staff), through the add-on code to the initiating visit, GPPP7.¹⁰

The Coalition supports this change, as it will allow clinicians who provide CCM services to exercise their clinical judgment as to whether it is necessary to schedule a face-to-face visit with existing patients they have seen recently. We agree that an initiating visit should be required at the start of CCM services. Subsequent visits should not be required at specific intervals. However, we would urge CMS to clarify that if a beneficiary has not received any E/M services (including CCM services) in over a year, then an initiating visit to re-establish the care plan and ensure that complex CCM services are necessary and provided appropriately should be required. We are also pleased that CMS is proposing an add-on payment (CPT code GPPP7) for beneficiaries who require an extensive face-to-face encounter.

At the same time, we note that in some instances (for example, a cancer diagnosis) a beneficiary may have a recurrence of illness that may occur within the 12-month period after which the initiating visit has already occurred. In such instances, the beneficiary will require substantive face-to-face assessment and the visit should be considered another initiating visit and billed accordingly. We recommend that CMS clarify that a qualifying event – such as a disease recurrence – should be exempt from the 12-month billing limitation.

b. 24/7 Access to Care and Continuity of Care

CMS' proposed revisions to this requirement include: 1) removing the requirement that all clinicians providing after-hours care must have access to the electronic care plan; 2) clarifying that 24/7 access must be available for "urgent" needs and not just "urgent chronic care needs"; and 3) expanding 24/7 access to caregivers, as well as patients.

The Coalition supports CMS' revisions, particularly clarifying that the after-hours services need not be limited to issues concerning the beneficiaries' chronic condition(s), and expanding access to caregivers. We have some concerns about removing the requirement that clinicians providing after-hours care have access to the beneficiaries' electronic care plan, since a well-constructed care plan is critical to ensuring that care is aligned with the patients' expressed goals and wishes. However, we recognize that

¹⁰ GPPP7 (Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service).

electronic health record (EHR) interoperability continues to be a problem for some providers, particularly small practices, and thus suggest that CMS may want to consider delaying this requirement for small practices.

c. Electronic Care Plan

CMS proposes not to require individuals providing the beneficiary with the required 24/7 access to care for urgent needs to have access to the care plan as a condition of CCM payment. CMS proposes to change the CCM service element to require timely electronic sharing of care plan information within and outside the billing practice, but not necessarily on a 24/7 basis, and to allow transmission of the care plan by fax.

The electronic care plan is a document ideally developed as the result of a thoughtful and meaningful conversation between providers and the beneficiary. This plan should represent the beneficiary's intent regarding their care. While we recognize the complexities with the requirements that the electronic care plan be accessible via 24/7 access, we are concerned that the preamble proposes to replace the 24/7 requirement with "timely" sharing of this document. It is unclear from the preamble what is meant by "timely" sharing and we urge CMS to clarify. We urge CMS to provide further clarification on what is meant by the term "timely", including whether the standard would differ depending on the size of the practice.

In addition, while we recognize that historically fax transmission has been an acceptable means of transmission of health care information, in today's electronic era we do not believe that reliance on fax transmission is a preferred alternative. Absent justification from CMS as to why fax transmission in this instance should be permitted, we urge the Agency to reconsider this portion of its proposal.

d. Beneficiary Consent

CMS proposes to simplify the current beneficiary consent process by leaving it up to the practitioner and the beneficiary to determine the best way to establish consent. CMS would still require practitioners to inform the beneficiary of the required information (e.g., the availability of CCM services; the fact that only one practitioner can furnish and be paid for these services during a calendar month; and the beneficiary has the right to stop the CCM services at any time of the month). CMS proposes to allow the practitioner to document in the beneficiary's medical record that this information was explained and note whether the beneficiary accepted or declined CCM services without having to obtain a written agreement.

The Coalition appreciates CMS' attempt to provide flexibility to providers and beneficiaries regarding how beneficiary consent is provided. However, we are concerned that absent additional direction from CMS, some providers may simply "check the box" that beneficiary consent has been provided without participating in a meaningful conversation with the beneficiary to obtain her consent. This is particularly important given that the beneficiary is assessed cost-sharing related to CCM services.

5. *Assessment and Care Planning for Patients With Cognitive Impairment*

CMS is proposing a G-code that would provide separate payment to recognize the work of a physician or other appropriate billing practitioner in assessing and creating a care plan for beneficiaries with

cognitive impairment, GPPP6.¹¹ CMS also proposes the add-on code must be furnished by the physician (or other appropriate billing practitioner) and could not be billed on the same day as other enumerated E/M services. CMS proposes the following as required service elements:

- Cognition-focused evaluation including pertinent history and examination.
- Medical decision making of moderate or high complexity (defined by the E/M guidelines).
- Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity.
- Use of standardized instruments to stage dementia.
- Medication reconciliation and review for high-risk medications, if applicable.
- Evaluation of neuropsychiatric and behavioral symptoms, including depression, including use of standardized treatment(s).
- Evaluation of safety (for example, home), including motor vehicle operation, if applicable.
- Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks.
- Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference.
- Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (for example, adult day programs, support groups); care plan shared with the patient and/or caregiver with initial education and support.

The Coalition applauds CMS for proposing an add-on payment for the development of a care plan for cognitively-impaired beneficiaries. Developing a care plan for individuals with cognitive impairments can be a time-consuming – yet no less important – process.

We are particularly pleased that CMS recognizes the value of ACP and palliative care services by including them as required service elements of GPPP6. However, it is important to clarify that true palliative care encompasses a range of services, including in-depth pain and symptom management, expert communication (of which ACP is a part), and care coordination. Thus, we recommend that CMS separate the advanced care planning and palliative care needs into two separate service elements. We recommend that this service element be broken out into the following two parts:

- Advance care planning, if applicable and consistent with beneficiary preference.
- Addressing symptoms and stressors, consistent with beneficiary preference.

We note that care plans for cognitively-impaired individuals may be more likely to be amended and/or changed based on the cognitive impairments of the beneficiary, particularly if the beneficiary's impairment is the result of a degenerative condition. Thus, we suggest that CMS reconsider its proposal to provide the add-on payment on a temporary basis.

Conclusion

¹¹ GPPP6 (Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, in office or other outpatient care setting or home or domiciliary or rest home).

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the proposed rule implementing the CY 2017 Medicare Physician Fee Schedule. If you have any questions, please contact Keysha Brooks-Coley, Executive Director of the Patient Quality of Life Coalition, at 202-661-5720 or Keysha.Brooks-Coley@cancer.org.

Sincerely,

Alzheimer's Association
American Academy of Hospice and Palliative Medicine
American Cancer Society Cancer Action Network
American Heart Association / American Stroke Association
Association of Oncology Social Work
Center to Advance Palliative Care
Colon Cancer Alliance
Motion Picture and Television Fund
National Coalition for Hospice and Palliative Care
National Palliative Care Research Center
Oncology Nursing Society
Pediatric Palliative Care Coalition
Supportive Care Coalition