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 Hospice and Palliative Care Organization (NHPCO) 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. NHPCO is the largest membership organization representing the entire spectrum of not for profit and for profit hospice and palliative care programs and professionals in the United States. We represent over 4,000 hospice locations and more than 70,000 hospice professionals in the United States, caring for the vast majority of the nation’s hospice patients. The organization is committed to improving end-of-life care and expanding access to hospice care with the goal of creating an environment in which individuals and families facing serious illness, death, and grief will experience the best that humankind can offer.

**Advance Care Planning Services**

One of the key goals of hospice care is providing patients with end of life care that is consistent with their wishes, goals and values, so NHPCO has long been an advocate of ensuring that individuals engage in advance care planning, in discussion with their health care providers and loved ones. However, helping individuals think through these issues, understand their options and articulate their desires is time consuming, and lack of reimbursement for these efforts has been an impediment. NHPCO strongly supports Medicare coverage for advance care planning and the availability of these services for Medicare beneficiaries. The IOM Report: *Dying in America:*
Improving Quality and Honoring Preferences Near the End of Life, September, 2014, National Academy Press, references how important advance care planning conversations are for millions of Americans, and how few are having them currently, including those already facing serious illness. The IOM report states that these conversations should be “an essential component of quality care,” with the aim 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)).

NHPCO Recommendations: NHPCO strongly supports the implementation of these two CPT codes by CMS, providing reimbursement for these services as approved by the CPT Editorial Panel and the AMA-RUC. We also ask CMS to make clear that completion of a particular form, such as an advance directive, during the advance care planning visit is not a prerequisite to billing for the service. Beneficiaries may want to initiate a discussion of advance care planning with their health care provider before they are ready to document their wishes on a standard form.

By paying separately for these important services, we believe CMS will greatly increase the number of Medicare beneficiaries who are able to discuss and document with their health care providers their treatment goals and wishes in the event of incapacity or a serious illness. We urge CMS to finalize its proposal to pay for these codes beginning in CY 2016.

**Timing of ACP Services:** CMS notes that ACP services could be reported when “the described service is reasonable and necessary for the diagnosis or treatment of illness or injury”, but seeks comment on whether payment for ACP is appropriate in other circumstances as well, such as an optional element at the beneficiary’s discretion, or at the time of the annual wellness visit. ACP often is not completed in a single visit or conversation – it may be a process in which the conversations occur in multiple stages and during varying states of health, and individuals’ goals and wishes may evolve and change over time. In fact, the Institute of Medicine, *Dying in America*, recommended that all

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1 Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, September 2014.
NHPCO Recommendation: NHPCO believes that advance care planning discussions, including planning for future events, goals of care, plans for treatment and the outcomes of treatment. and the completion of advance care planning documents should be done as desired by, and indicated for, the individual beneficiary, and would be appropriate at the Welcome to Medicare visit, an annual wellness visit, as well as when more serious illness presents itself.

Qualified Health Professionals: As with other Evaluation and Management codes, CPT codes 99497 and 99498 may be used only by physicians or “other qualified health professionals”, such as nurse practitioners, clinical nurse specialists, certified nurse midwives, and physician assistants. In the hospice and palliative care context other members of the interdisciplinary team may have the opportunity to initiate and guide conversations with patients about their goals of care and their wishes, and may be key participants in the care planning process, outside the context of a physician office visit. In fact, many of these conversations may involve non-clinical decision making on the part of the patients and families and such professionals are uniquely equipped to provide this broader range of expertise.

NHPCO recommends that CMS recognize the important role of other members of the interdisciplinary team for their expertise and training in having advance care planning conversations, and look for ways to recognize the role of these team members, such as social workers, when ACP services are provided in settings outside the traditional physician office visit.

Establishing Separate Payment for Collaborative Care

NHPCO is very supportive of CMS’s efforts to strengthen the care and management of services for Medicare beneficiaries with multiple chronic conditions. Palliative care specialists are often involved in the collaborative effort required to fully provide the care needed for these patients.

NHPCO commends CMS for recognizing the need for, and value of, collaborative care for patients with complex needs and supports the development of a CMMI model to test various ways to implement a collaborative approach to care, as well as the consideration of technology to aid in communication and coordination between primary care providers and specialists.

Care Management Services

NHPCO is very appreciative of CMS’s efforts to recognize and provide separate payment for care management services, including Transitional Care Management and, more recently, Chronic Care

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Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, September 2014.
Management. However, NHPCO shares the concern expressed by others that the documentation requirements and administrative burdens imposed on providers in order to bill these codes are an impediment. We ask CMS to work with stakeholders to identify ways to simplify and streamline the requirements for reporting these codes, while still addressing CMS’s concerns. Research has shown that good care management can save money through fewer E.R. visits and fewer hospitalizations and readmissions.

NHPCO urges CMS to continue evaluating the role of care management in providing high quality care to beneficiaries, particularly those with complex care needs, and those who often cycle in and out of different care settings. These are some of the most costly and complicated beneficiaries to care for, and NHPCO urges CMS to recognize the CPT codes for reporting Complex Chronic Care Management Services, and to provide separate payment for these codes. The beneficiaries who need these services often end up as hospice patients, and we understand the complexity of their care needs, and the time it takes to provide and coordinate it.

Physicians Employed by Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) Serving as a Hospice Patient’s Attending Physician

Hospice providers serving Medicare beneficiaries in areas served by Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs) have encountered a significant barrier to care after recent regulatory clarifications. In addition, hospices who serve frail and dying Medicare beneficiaries in rural areas where RHC or FQHC practitioners are the only health care professionals in the area are increasingly concerned about the limitations that these regulatory requirements present.

Medicare requirements for beneficiaries electing the Medicare hospice benefit: Patients who elect their Medicare hospice benefit are required to choose an attending physician or NP, who will continue to provide attending physician services in collaboration with the hospice interdisciplinary team, specified in the patient rights section of the Medicare hospice conditions of participation. (42 C.F.R. 418.52(c)(4).) Patients in rural areas often have only RHC physicians and physician extenders available for their care.

RHC/FQHC requirements for beneficiaries electing their hospice benefit: Medicare Benefit Policy Manual, Chapter 13 states that “RHCs and FQHCs are not authorized under the statute to be hospice attending practitioners.” NHPCO has identified the statutory issue and is working on a legislative fix to this problem to ensure that hospice patients can name a RHC or FQHC physician as their attending physician.

NHPCO requests CMS support as legislation is drafted to allow RHC or FQHC physicians to serve as a hospice patient’s attending physician, so that residents in some rural or frontier areas are able to access their Medicare hospice benefit.
NHPCO stands ready to discuss our comments for further clarification and to work with CMS in whatever ways possible as the final rule is implemented. Thank you for the opportunity to comment.

Sincerely,

J. Donald Schumacher, PsyD
President and CEO