August 14, 2015


Dear CMS Administrator,

The Health Service System of the City and County of San Francisco administers health benefits for over 113,000 employees, retirees and their families. We welcome the opportunity to comment upon Proposed Rule CMS – 1631 – P, Section 6c, “Advance Care Planning Services.” Each of the paragraphs we refer to are labeled 80 FR 41773. We write in support of the addition of the two new CPT codes to allow for the billing of time spent with patients discussing the critical matters of end-of-life care and advance directives. Below we outline the reasons for our support.

**Patient and family satisfaction with care:**

When patients fill out advance directives and make their wishes regarding end-of-life care explicit, health care providers are able to honor patients’ stated preferences instead of subjecting them to treatments that they might not want. Citing a study conducted by Johns Hopkins School of Medicine, *The New York Times* reports that many cancer patients don’t receive the care they want at the end of their lives. Patients who had had discussions about end-of-life care with their doctors and had living wills in place were most likely to avoid having unwanted treatments imposed upon them.1 More than 80% of patients say that they wish to avoid hospitalization and intensive care during the terminal phase of illness,2 and aggressive medical treatments near the end of life are negatively associated with quality of life.3 However, doctors are likely to default to the provision of extreme, life-prolonging measures—no matter their cost or their impact on the patient’s quality of life—in the absence of an advance directive that instructs otherwise.4

Advance directives have also been shown to reduce the suffering of family members and caregivers at the end of their loved ones’ lives. Empirical research shows that advance directives are positively associated with a number of benefits for family members of dying patients. These benefits include satisfaction with patients’ quality of death and patients’ quality of care leading up to death, and lower levels of stress,

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anxiety, and depression after the loss of their loved one. Family members of deceased patients who had an advance directive are likely to report fewer concerns with physician communication than family members of decedents who did not have advance directives. In the absence of an advance directive, family members of a patient who has become incapacitated to the point where they can no longer speak for themselves may face excruciating decisions based upon speculations about what their loved one might have wanted. Medical professionals argue that the severity of the distress families face in these situations can be alleviated by proactively having conversations about the end of life.

Cost savings:
In addition to increasing the likelihood of patient and family member satisfaction, advance directives are also positively associated with a reduction in end-of-life care costs. Multiple studies have demonstrated that patients who complete advance directives often indicate that they would like to receive less care, or less extreme life-prolonging measures at the end of their lives. As a result, patients with advance directives tend to incur significantly lower health care expenditures in the last months of their lives.

La Cross, Wisconsin serves as an instructive case study to this effect. The concerted efforts of Bud Hammes, a medical ethicist at the Gunderson Health System, led to discussions about advance directives becoming so routine within medical appointments that 96% of those who die in La Cross have advance directives (or similar documentation), which is higher than national averages. In keeping with broader trends, La Cross residents who completed advance directives typically opted for less care or less extreme care at life’s end. Because of this, La Cross spends less on health care for patients at the end of their lives than any other place in the United States, according to the Dartmouth Health Atlas.

In order for Medicare to be sustainable, it is essential to continuously find ways to both reduce costs and to enhance the quality of care and patient satisfaction. Given that more than 25% of Medicare dollars are allocated to care for patients in their last year of life, policy interventions targeting end-of-life care have the potential to effect significant

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9 Ibid.
financial change. We believe that compensating doctors for having conversations with Medicare patients and their families/caregivers about advance directives and end-of-life care will help both reduce the cost and improve the quality of end-of-life care.

Payment and incentives for end-of-life conversations:

We believe that payment to physicians and other qualified providers for their time spent discussing end-of-life care with patients is essential. The editors of Scientific American put it plainly: "Physicians will help more with end-of-life planning when government and private insurers reimburse them for their time." In other words, not providing payment for conversations about end-of-life care effectively dis-incentivizes doctors from having such conversations. Just as patients who need palliative care are sometimes denied these services because health care providers cannot be reimbursed for their provision, it is reasonable to assume that without assurance of timely reimbursement for services rendered, physicians will be reluctant—at best—to devote time to discussions about end-of-life care.

Moreover, creating payment codes for discussions about advance directives and end-of-life care is an important symbolic move that legitimizes these sorts of conversations and affirms their status as an essential component of person-centered health care. Averring that such conversations are essential without supporting them with appropriate remuneration for the time that health care providers invest in them sends a contradictory message about their importance.

We believe there is a need for clarification about the nature of the conversations or services that can be billed to CPT codes 99497 and 99498. We suggest that the Rule specify that only conversations between health care providers and patients and their families/caregivers are eligible for reimbursement. Group information sessions concerning end-of-life care matters or similar activities or offerings should not be eligible for reimbursement.

Training for health care providers to engage in end-of-life conversations:

We agree with the observers of medicine and medical education who argue that doctors will require additional training in order to be prepared to engage in end-of-life care discussions. In a recent study of doctors’ perceptions of barriers to having effective end-of-life conversations with patients, 85.7% of doctors studied stated that conducting

end-of-life conversations with patients is “very challenging.” This is hardly surprising, given that death and dying are generally considered sensitive or difficult subjects under most circumstances. But beyond these more familiar challenges, the study revealed 6 types of barriers that doctors experience when considering or attempting conversations about end-of-life care with their patients:

1. Language and medical interpretation issues.
2. Patient/family religious and spiritual beliefs about death and dying.
3. Doctors’ ignorance of patients’ cultural beliefs, values, and practices.
4. Cultural differences in truth handling and decision making.
5. Patient/family’s limited health literacy.
6. Patient/family’s mistrust of doctors and the health care system.

These trends will persist as the population of the United States becomes increasingly culturally and linguistically diverse. Training for conversations about end-of-life care should be required and should include consideration of these – and other – challenges, and should be taken as seriously as training for performing any other complex procedure.

**Specifying which providers can be reimbursed for conversations about end-of-life care:**

As it is written, the Proposed Rule refers to end-of-life care conversations being conducted by “the physician or other qualified health professional,” implying that health care providers other than physicians may be reimbursed for these services. We believe that health care providers other than physicians should be eligible to use these CPT codes. Enabling nurse practitioners, physicians’ assistants, nurses, and social workers to have these conversations with patients and their loved ones would give these professionals opportunities to do more of the work that is within their scopes of practice, and help even out the distribution of labor among health care providers. We must remember that a perennial problem within medical practice and medical education is that of too much to do and too little time. Making conversations about end-of-life care routine creates work to be done, and while it may be appropriate for doctors to be responsible for these conversations some of the time, they need not be all of the time.

**Timing of advance care planning and reimbursement:**

We believe that payment for advance care planning is appropriate under any circumstances within a provider-patient encounter, including but not limited to the context of annual wellness visits. Put differently, we do not believe that

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17 Ibid.
reimbursement for end-of-life care conversations should be restricted to circumstances in which a patient's health is declining.

A one-size-fits-all "ideal time" for advance care planning is likely to be elusive at best. Some research indicates that it is possible for discussions about advance care to occur "too early": patients who are healthy and make hypothetic, abstract decisions about end-of-life care tend to request more aggressive care than patients who are faced with an immediate serious illness. On the other hand, research also shows that advance care decisions that are made "too late"—for instance, when a patient is in the final stages of a terminal illness—tend to be rushed and focused on specific life-sustaining procedures, without sufficient attention to the patient's overall values and priorities. The solution, some argue, is for clinicians to be attuned to the prognoses of their patients in order to better identify the "just right" opportunities for end-of-life care planning.

We believe that although the goal of finding the "right time" for discussions about end-of-life care may be well-intentioned, it misses the more important points. By definition, advance directives must be completed in advance of circumstances that render patients unable to speak for themselves, and it is not always possible to predict when these conditions might arise. Even individuals who are in excellent health may be suddenly incapacitated by a serious unforeseeable accident.

Thus, we take the position that discussions about advance care should occur early and regularly. We should anticipate that making decisions about end-of-life care will be a multi-step, ongoing process that will usually involve more than one conversation between health care provider and patient. Even outside of the context of a diagnosis of terminal illness, patients may need to have multiple conversations with their health care provider in order to gain a thorough understanding of their options and the implications thereof. Simply gaining familiarity with the relevant medical terminology may take time, not to mention thinking and talking through priorities, values, and beliefs.

The process of identifying, articulating, and documenting a patient's wishes for the care they will receive at the end of their life should come to be regarded as an aspect of preventive services, rather than a set of concerns that arise in the context of life-threatening illness or marked physical/mental decline. Having discussions about end-of-life care well in advance of a crisis allows plenty of opportunity for the achievement of clarity and understanding; revisiting advance directives regularly allows for changes to be made as circumstances evolve. While policies concerning the use of these CPT codes should be restrictive enough to prevent fraud, they also need to be flexible enough to accommodate the reality that end-of-life

20 Ibid.
21 Ibid.
planning is likely to be an iterative process—recognizing that investments into end-of-life planning may yield substantial returns in the form of money saved on end-of-life healthcare costs.

**Broader implications:**

Death is a taboo, discomfort-provoking subject in the medical profession and American society more generally. Compensating providers for engaging in end-of-life care conversations may constitute a small but significant step towards de-stigmatizing discussions about the end of life, and recognizing death as a normal component of the life course.

Thank you for your time and consideration of our comments.

Sincerely yours on behalf of the San Francisco Health Service Board,

Catherine Dodd, Ph.D., R.N.
Director, San Francisco Health Service System