C-TAC
COALITION TO TRANSFORM ADVANCED CARE

April 22, 2020

The Honorable Alex Azar
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Dear Secretary Azar and Administrator Verma:

On behalf of the Coalition to Transform Advanced Care (C-TAC), thank you for your leadership during the unprecedented challenge our country is facing. As a not-for-profit, non-partisan coalition of diverse organizations dedicated to improving the quality of life for people living with serious illness and their families, C-TAC and our members work every day on behalf of those who are most vulnerable to death and the poor medical outcomes related to the COVID-19 virus.

C-TAC requests that any rules, regulations, or other policy interventions CMS or HHS takes in response to this emergency acknowledge, and, to the extent possible, directly address the unique burdens patients and families with serious illness and the healthcare providers that care for them will face due to COVID-19. People with serious illness are at high risk for COVID-19 complications[1]. Most cannot self-quarantine on their own without additional support. Those who develop COVID-19 and choose *not* to come to the hospital will need symptom management, medications, and support delivered to wherever they are. We are grateful that Administration leadership has routinely stressed the heightened risk to seniors with underlying chronic conditions,[2] and appreciate the many actions you already taken that have removed barriers to high-quality care for the seriously ill during this emergency. We urge you to continue to advance a coordinated, cross-agency strategy that removes the remaining barriers to the most timely and efficient delivery of appropriate care for COVID-19 patients, especially the ones who are seriously ill.

C-TAC also requests that the Administration's response to the ongoing crisis account for the disproportionate impact the virus and its worst outcomes are having on historically marginalized people of color, particularly those in the African American community[3]. Minority populations already have unequal access to high-quality palliative and serious illness services[4], and are at a greater risk for poor

[1] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/groups-at-higher-risk.html
[2] *Remarks by President Trump, Vice President Pence, and Members of the Coronavirus Task Force in Press Conference*, March 13, 2020
[3] Thebault R, Ba Tran A, Williams V. *The coronavirus is infecting and killing black Americans at an alarmingly high rate.* The Washington Post. Published online April7, 2020.
[4] Johnson KS. *Racial and ethnic disparities in palliative care*. J Palliat Med. 2013;16(11):1329–1334. doi:10.1089/jpm.2013.9468

clinical and psychological outcomes related to end-of-life care[5]. Your response should be informed by a transparent and comprehensive data collection effort that accurately reports on data on patients' race and ethnicity as they relate to all aspects of COVID-19, its impacts, and the healthcare system's response. This monitoring should include data on infection rates, mortality, testing, hospitalizations, patient comorbidities, and place of death.

In line with the above general recommendations, C-TAC proposes the following specific priority areas:

Advance care planning (ACP)- We urge you to promote advance care planning to ensure that care will be in line with patient's personal goals and values. If there ever was a time when Americans needed to designate a health care agent to speak for them if they became acutely ill, and to share their wishes for future treatment with that agent and their healthcare providers, it is now. This is especially true for the minority populations being disproportionately impacted by COVID-19, as rates of advance care planning among these groups are historically low[6] Specifically:

- Allow advance care planning conversations that were included in the expanded telehealth flexibilities to be carried out using audio-only technologies while remaining billable under Medicare.
  - Equity-Many individuals faced with serious illness in this crisis are older and/or come from low-income communities and do not have access to technologies that would allow for both audio and visual capabilities, such as smartphones, that the current telehealth flexibilities require. Others may not have their smartphones with them in an emergency and might only have access to a land line instead, such as in a facility. We therefore ask that ACP conversations be eligible for audio-only telehealth capabilities, to ensure that all individuals have equal access to this vital process.
  - Precedent- The recent Interim Final Rule, *Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency* (CMS-1744-IFC), provides such an exemption[7] to the restriction on audio-only technology for the therapy and counseling portions of the weekly bundles furnished by opioid treatment programs (OTPs), and states that a major justification for this allowance is "*because interactive audio-video communication technology may not be available to all beneficiaries*". We ask that such an exemption be made now for advance care planning. We also appreciate the expanded availability of Medicare reimbursement for traditionally non-covered evaluation & management (E/M) services provided via an audio-only telephone during the emergency (CPT codes 98966-98968 and 99441-99443), and feel the same flexibility should be extended to the advance care planning codes classified as a "Medicare Telehealth" service.
- Waive patient cost-sharing and deductibility of Medicare Advance Care Planning services (CPT codes 99497 & 99498) or designate them as a preventative activity and waive any cost-sharing

[5] LoPresti, MA, Dement, F., & Gold, HT. *End-of-Life Care for People With Cancer From Ethnic Minority Groups: A Systematic Review*. American Journal of Hospice and Palliative Medicine. 2016; 33(3), 291–305. https://doi.org/10.1177/1049909114565658

[6] Garrido, M.M., Harrington, S.T. and Prigerson, H.G. (2014), *End-of-life treatment preferences: A key to reducing ethnic/racial disparities in advance care planning?*. Cancer, 120: 3981-3986. doi:10.1002/cncr.28970

[7] https://www.cms.gov/files/document/covid-final-ifc.pdf#page=101

and deductibility related to them. Given the current financial crisis accompanying the COVID-19 pandemic, even small charges are an issue for patients and could discourage them from participating in this important process.

- If possible, include clinical social workers, registered nurses, and certified hospital chaplains as eligible providers that are able to bill for Medicare Advance Care Planning services (CPT codes 99497 & 99498). This frees up advanced practice providers to do the work only they can do.
- Require the HHS Secretary to develop standards for including completed advance care planning documents within a patient's electronic health record.
- Encourage providers to create portable medical orders (e.g., POLST paradigm orders and pre-hospital DN(A)R orders) for the appropriate patient population to avoid subjecting them to unwanted and invasive medical interventions.
- Reconsider the *Flexibility in Patient Self Determination Act Requirements (Advance Directives)* waiver[8] which allows hospitals and CAHs to forgo providing information about their advance directive policies to patients.
    - While we support loosening administrative burdens on providers, to waive this activity in the midst of increasing admissions of seriously ill patients will not 'free up frontline' time and resources. Not having a clearly identified health care agent—a person authorized to participate in clinical decision making for individuals too sick to participate themselves—will result in time-consuming efforts during a clinical crisis following the admission.
    - Supporting families and loved ones to make decisions for admitted patients in a crisis will ultimately be time-consuming, especially when facilities are enforcing no or limited visitation.
    - This waiver risks increasing the emotional and moral distress felt by those clinicians who are placed in the position of decision-making without guidance from patients through their designated agent.

Telehealth- We are grateful for the recently announced flexibility and recommend these additional changes:

- Hospice & Home Health telehealth payment - Allow telehealth visits furnished by hospice and home health providers to count as in-person visits on claims for payment purposes.
- Guidance to Medicare Administrative Contractors (MACs) – provide operational guidance as soon as possible to the MACs to implement claims processing/billing requirements for expanded telehealth services to ensure timely and appropriate reimbursement.
- Private payers and state waivers- Encourage private payers and states to adopt similar telehealth waivers since state regulations may be more restrictive than federal ones in some states.

Access to needed medications- We will also need to ensure that there is sustained access to medications such as opioids, benzodiazepines, and other drugs that promote physical comfort for

[8] *COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers*. Updated April 15, 2020.

seriously ill and dying patients. We recommend loosening some of the opioid prescriber regulations to allow more providers to order adequate doses of these medications for patients near or at the end of life.

- Part D- Waive opioid restrictions to allow those with serious COVID-19 complications staying at home to receive "comfort packs[9]" including opioids for pain and shortness of breath. We must balance the risk of making such potentially vital medications available in this crisis with concerns about diversion and misuse.
- Request relaxation of some of the preclusions on using unused medications (e.g., opioids and sedatives)
- Relax regulations on medication disposal after death by hospices.

Access to personal protective equipment (PPE) for healthcare workers- We appreciate the disbursement of the first set of funds from the Public Health and Social Services Emergency Fund, and are grateful that hospice and other home-based providers in particular have been recipients of this initial wave of money, some of which is already being used to purchase needed PPE. As additional expected emergency funding becomes available that can be used to increase the supply of critical PPE such as isolation gowns, masks, and gloves, CMS and HHS should take steps to ensure that home and community-based providers of serious illness care, including hospice, palliative and home health providers, are included in the priority categories for any new funding disbursements. CMS should also disseminate further guidance to support home and community-based providers' ability to easily navigate the process by which they can access these materials.

Durable Medical Equipment (DME) and Oxygen- As one goal in this pandemic is to keep those who do not need to be hospitalized out of the hospital, we recommend removing all barriers/burdens to accessing DME and oxygen for initial requests and replacements. Oxygen, in particular, will need to be able to be ordered and delivered quickly for those with COVID-19 receiving care at home.

Medicare Advantage- Given that a third of Medicare beneficiaries are now enrolled in Medicare Advantage (MA)[10], it is important that changes be made there as well to address this crisis. Specifically, we recommend that MA should be required to comply with the Public Health Emergency guidelines regarding waivers.

C-TAC appreciates the opportunity to provide these recommendations. We will continue to monitor and analyze the outbreak as it unfolds and identify areas where we believe CMS and HHS can best support seriously ill patients, their families, and the providers who care for them. C-TAC and its members also stand ready to help the Administration in any way during this challenging situation.

Thank you again for your commitment and work on behalf of all Americans as we face this extraordinary challenge together. If C-TAC can be of any assistance to you at all, please do not hesitate to reach out to

[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118704/
[10] https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/

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Sincerely,

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