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Author manuscript

*Mayo Clin Proc.* Author manuscript; available in PMC 2021 April 01.

Published in final edited form as:

*Mayo Clin Proc.* 2020 April ; 95(4): 653–657. doi:10.1016/j.mayocp.2019.12.017.

## Ethical Considerations About Clinician Reimbursement for Advance Care Planning

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### Introduction

The Centers for Medicare and Medicaid Services (CMS) introduced two Current Procedural Terminology (CPT) codes that allow clinicians to bill for time spent discussing advance care planning (ACP) effective January 1, 2016. As defined by Sudore et al, advance care planning is “a process that supports adults at any age or stage of health in understanding and sharing their personal values, life goals, and preferences regarding future medical care...[with] the goal. that people receive medical care that is consistent with their values, goals, and preferences during serious and chronic illness.”<sup>1</sup> Proponents applauded this new policy as a method to incentivize ACP potentially increasing the uptake of ACP, thereby improving the delivery of medical care that aligns with the patients’ goals, values, and preferences.<sup>2</sup> The purpose of this manuscript is to examine the 2016 reimbursement policy through the lens of the ethical principles at stake: beneficence, autonomy, justice by considering conflict of interest, quality not quantity of CPT coding, and potential disparities that may occur.

### Background

Following several years of deliberation, CMS approved two CPT codes for ACP in January 2016. CPT code 99497 allows clinicians to be reimbursed \$80–86 for the first 30 minutes of a face-to-face conversation with patients and/or surrogates related to advance care planning. CPT code 99498 allows clinicians to be reimbursed \$75 for each subsequent 30-minute increment in time. Physicians, nurse practitioners, or physician assistants of any specialty may use these codes to bill for ACP. Additionally, clinicians can bill for conversations in

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**Conflict of Interest:** Drs. Amelia Barwise, Erin DeMartino and Wilson have no conflict of interest. Dr. Sharp has a conflict of interest due to his editorial responsibilities within *The Compass* journal.

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outpatient, inpatient, or nursing home settings, provided that these discussions take place in-person. CMS also expects that certain activities be documented in the patient's medical record, including: total time of discussion in minutes, that the patient or surrogate was given an opportunity to decline the discussion, who was involved in the discussion, some detail about what was discussed, spiritual factors, understanding of illness and why specific decisions were reached, and whether an advance directive was completed.<sup>3</sup> For billing purposes, it is not a requirement that the patient or surrogate complete an advance directive.

Many medical and surgical professional organizations supported the introduction of these new CPT codes.<sup>4-6</sup> The American College of Physicians has described ACP conversations as "the standard of care."<sup>7</sup> A letter of support for the CPT codes from the American Academy of Hospice and Palliative Medicine to the Secretary of Health and Human Services signed by 66 medical and health associations stated that "published, peer-reviewed research shows that ACP leads to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression, and lost productivity." ACP is particularly important for Medicare beneficiaries because many have multiple chronic illnesses, receive care at home from family and other caregivers, and their children and other family members are often involved in making medical decisions."<sup>4,8</sup> These codes were intended to benefit patients and families by improving access to ACP conversations and increasing occurrence of conversations, as clinicians will be allowed to charge for the time spent discussing ACP. In this way the codes were intended to reduce uncertainty and "reliev[e] families with the emotional and financial burden of costly end-of-life care."<sup>9</sup>

## Ethical Tensions

Despite widespread support for these new CPT codes, there are several potential ethical tensions surrounding the use of the CPT codes, their positive and negative impact on patients and the public and whether they can meaningfully improve goal concordant care during serious or chronic illness. For example, although many physician organizations maintain that billing for ACP promotes patient autonomy others worry that these changes could compromise patient interests or beneficence by incentivizing the completion of documents that limit patient care potentially without the benefit of in-depth discussions of goals of care at the end of life. This would violate the principal of non-maleficence.

## Conflict of Interest

Conflict of interest is defined as occurring when a person's private interests conflict with his/her official responsibilities in a position of trust (Merriam Webster definition). Opponents of the CPT codes argue that physicians and healthcare systems may inappropriately over-engage in ACP for the purposes of financial reimbursement. Financial incentives may lead clinicians to conduct non-beneficial or even potentially harmful ACP conversations. Such non-beneficial conversations may take place under several circumstances: 1) by clinicians who are unqualified to conduct such conversations, 2) by clinicians at inappropriate times, or 3) by clinicians at an unnecessary high frequency. ACP and advance directive completion can be nuanced. Many contextual factors and conversation components can significantly influence patient treatment preferences.

Evidence suggests that patients welcome ACP discussions with their clinicians and want to know their clinician is comfortable talking about death and dying.<sup>10</sup> Patients are not compelled to complete advance directive documentation during these billed visits. In certain cases these conversations may lead to advance directive completion or more specific decisions regarding treatments that a patient wishes to pursue or decline. In this way ACP discussions foster autonomy provided they are used properly.

However specialists may be highly qualified to conduct necessary and beneficial ACP conversation about specific, anticipated decisions for a chronic, progressive condition. In fact, disease-specific advance directives, such as those for amyotrophic lateral sclerosis, are lauded for precisely this reason.<sup>12</sup> In addition, many specialists may also act as primary care physicians for a group of patients—and such specialists may be optimally poised to engage in ACP with such patients. While clinicians from a variety of specialties, including primary care, have utilized the CPT codes for ACP, it should be specifically noted that palliative care specialists, have seen the highest uptake in 2016 and 2017.<sup>13</sup>

In a recently published study by Auriemma et al, 90% of surveyed adults supported programs promoting ACP.<sup>16</sup> Lay population participants were presented with hypothetical mechanisms to incentivize ACP, including payments dispersed directly to patients, insurance coverage contingent on completion of an advance directive, and different physician reimbursement structures. The physician reimbursement structures garnered the lowest support from subjects, with only 23% of those surveyed supporting physician reimbursement versus 58% supporting patient reimbursement for completing an advance directive. Financial incentives can help patients overcome an up-front unpleasant activity (of contemplating death) in exchange for a future health benefit, much as they have been shown to increase weight loss and encourage smoking cessation.<sup>14-17</sup>

Financial incentives can help patients overcome an up-front unpleasant activity (of contemplating death) in exchange for a future health benefit, much as they have been shown to increase weight loss and encourage smoking cessation.<sup>14-17</sup> If we consider the financial incentives from a justice perspective, one could argue that prioritizing patients for reimbursement would have been a more effective and fairer strategy to encourage uptake of ACP. Furthermore it would negate concerns about conflict of interest for clinicians jeopardizing beneficence and give precedence to patient autonomy. It is unclear if patients would be eager to participate in ACP conversations (and how the ACP conversations might change) if patients knew a priori that their clinician would be billing for and receiving reimbursement for such conversations.

### Quality not Quantity

There is general agreement that promoting ACP conversations can benefit patients<sup>18</sup> However, measures of quality and clinical impact of encounters reimbursed for ACP remain elusive.<sup>2,19</sup> To protect patient autonomy, patients must have a clear understanding of likely treatment decisions and options they might face as well as the potential clinical contexts in which they could receive them.<sup>20</sup> It may be hard for patients to imagine diverse situations and account for all possibilities in an advance directive therefore ACP discussions that do

not focus on specifics are helpful.<sup>12</sup> Patients must have the opportunity to ask questions and express concerns during discussions.

There is always a potential risk that poor quality ACP discussions could mislead patients into accepting care that is not concordant with their personal values and goals, or, conversely, declining interventions that they may desire under certain circumstances. For example patients might inadvertently articulate they would never want to be on a ventilator when a time limited trial of life sustaining treatment would be a medically acceptable option that aligns with the patient's values. While these limitations have been inherent in ACP since its inception, the new CPT codes, with resultant increase in the number of potentially poor quality ACP conversations, have the potential of making under-informed decision making more prevalent.

Whereas metrics exist for assessing procedural performance (example: postoperative infection data, length of stay, readmission rates, redo rates), no analogous metrics exist for evaluation of ACP on the individual level, let alone the population level. The introduction of billing codes alone is insufficient to ensure that high-quality care preference conversations are occurring and are available for future reference in decisions about end-of-life care, whether in an AD or in a clinical note, therefore it is critical suitable metrics be developed and deployed.

To improve the quality of ACP conversations we must continue to emphasize clinician training and develop best practice standards.<sup>21</sup> Navigating ACP discussions requires not only knowledge of the potential interventions and morbidity that patients may experience but sensitivity and an ability to invite open discussion about personal goals and values. Many clinicians report little or no training in these skills and may feel underprepared to engage in ACP with their patients.<sup>3,22</sup>

### **Effect on Disparities**

Minority communities and vulnerable populations generally have lower rates of ACP completion for a variety of reasons including cultural and faith-based beliefs about end-of-life care as well as mistrust of the healthcare system and clinicians.<sup>23,24</sup> There is a substantial body of literature that demonstrates that minority groups cost less during most of lifespan but cost more at end of life, presumably because they may fear discrimination or bias is motivating recommendations to withdraw or reduce care. Clinician reimbursement for advance care planning could be viewed by these populations as incentivizing conversations to limit the care that members of these communities receive. Conversations with minority patients, especially those with limited English proficiency or low health literacy, also may require more time and sensitivity to cultural beliefs and practices—two things that clinicians may lack. Some may argue that incremental recognition and compensation for these conversations is better than none. However one could contend that investing in this mechanism to improve goal concordance at end-of-life ignores the inherent and glaring differences in ACP acceptability, and uptake. Indeed, when Pelland et al analyzed uptake of advance care planning CPT coding among Medicare beneficiaries in New England, they found Hispanic and Asian patients had a lower odds ratio of having had an eligible visit.<sup>25</sup>

## Conclusion

While ACP does tend to influence end of life care, it has many limitations.<sup>18</sup> Furthermore there are multiple other systemic and organizational factors that may influence the effectiveness of the CPT codes on ACP discussions. Although the introduction of CPT codes to encourage ACP discussions between clinicians and patients represents an important step in recognition and remuneration for ACP, this policy change, and its implications for clinical practice, warrant ongoing scrutiny, and systematic study. Public opinion supports direction of financial incentives for ACP to patients over clinicians.<sup>16</sup> As a profession we must sensitively acknowledge and mitigate the potential conflict inherent in receiving reimbursement for advance care planning; the public, and particularly members of underserved populations, may justifiably view this fee structure with skepticism. Because of the sensitivities surrounding ACP, use of these billing codes to augment a clinic's revenue stream would be particularly egregious and erosive of public trust.

Despite these worries, a far more positive, and likely, consequence of incentivizing ACP through billing codes, would be increased patient engagement in ACP. While the modest reimbursement rates may be insufficient to motivate health systems to encourage ACP discussions, the continuing low rates do not necessarily reflect a lack of ACP conversations, but billing practices.<sup>13,25</sup> The modest increase in use of codes may reflect remuneration for ACP that was already occurring, or may be motivating conversations that would not otherwise have occurred.<sup>25</sup> Monitoring the billing practices of providers, the rates of AD completion, as well as metrics more closely aligned with patient-centered outcomes such as quality of death and dying, will help guide future policy interventions.

## Acknowledgements:

The authors would like to acknowledge Susan Curtis, MLS for her assistance.

Funding: This study was supported by CTSA Grant Number TL1 TR002380 from the National Center for Advancing Translational Science (NCATS). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the NIH.

## Abbreviations:

<b>ACP</b>	advance care planning
<b>CPT</b>	current procedural terminology

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