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Advance Care Planning For Medicare Beneficiaries Increased Substantially, But Prevalence Remained Low

DOI: 10.1377/hlthaff.2020.01895
HEALTH AFFAIRS 40,
NO. 4 (2021): 613–621

ABSTRACT In 2016 fee-for-service Medicare began reimbursing physicians for advance care planning conversations with enrollees during outpatient visits and waived the copayment for advance care planning when it was part of the Medicare annual wellness visit. Advance care planning is intended to help providers treat patients in ways consistent with their wishes and may also reduce unnecessary health care use and spending. Examining fee-for-service Medicare claims, we found a substantial increase in outpatient advance care planning claims between 2016 and 2019, although prevalence remained below 7.5 percent for all patient subgroups analyzed. Roughly half of beneficiaries with advance care planning claims received the service at an annual wellness visit; the remainder received it at a different outpatient visit. Among those with claims, Black, Hispanic, and Medicaid dual-eligible patients and patients with comorbidities were less likely to have a claim at an annual wellness visit, largely because they have fewer such visits overall. Medicare's annual wellness visits offer the potential to expand enrollees' access to advance care planning at no expense to them, in advance of serious illness, and to populations less likely to undertake advance care planning generally.

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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 a goal to "help ensure that people receive medical care that is consistent with their values, goals and preferences during serious and chronic illness."[1] It presents an opportunity for health care providers to treat patients in ways consistent with their wishes and may also reduce unnecessary health care use and spending.[2–4]

Numerous studies have documented an association between advance care planning conversations and improved care concordance with patients' wishes,[5,6] lower rates of in-hospital deaths,[5,7] and higher rates of hospice use.[7,8] Increasing rates of advance care planning are widely recognized as an important focus of health system reform.[9] To that end, fee-for-service Medicare began reimbursing physicians and other qualified health care professionals for advance care planning conversations beginning January 2016. Fee-for-service Medicare covers these conversations conducted either as a stand-alone Part B service at any outpatient visit or as an optional element of an annual wellness visit—a comprehensive preventive health visit offered annually to all Part B enrollees without cost sharing. Although advance care planning billed as part of an annual wellness visit does not incur cost sharing, such planning billed outside of an annual wellness visit is subject to the standard 20 percent

coinsurance. Beneficiaries are not limited in the number of advance care planning claims billed to Medicare in a year. However, because Medicare covers only one annual wellness visit per year, beneficiaries can have no more than one advance care planning conversation billed at an annual wellness visit per year.

Several recent studies have evaluated advance care planning billing in fee-for-service Medicare but focus on a limited geography,[10] population,[11,12] or point in time.[13] These studies have found low uptake of advance care planning, with billing for it representing between less than 1 percent and 2.4 percent of beneficiaries[10–13] and with significant variation in claims by state.[10,13] Only one study—focused solely on Medicare beneficiaries in New England—analyzed the demographics of beneficiaries with advance care planning claims.[10] Consistent with survey data about advance care planning conversations, that study found that beneficiaries with such claims are more likely to be older, female, and White and to have chronic conditions and higher incomes. However, the New England study did not assess whether demographics differed by visit type (annual wellness visit or other).[10] This distinction is important, given that advance care planning at an annual wellness visit may represent preemptive planning, rather than a response to a new medical development, and is not subject to patient cost sharing.

We used fee-for-service Medicare claims to characterize the evolution of advance care planning claims over time, the type of visit (annual wellness visit or other) where billed services were rendered, and the demographic characteristics of patients with advance care planning claims across visit types. Our key contributions follow three research questions. First, how have rates of advance care planning claims changed over time? Second, how do these rates vary between claims provided as part of an annual wellness visit versus other outpatient visits? And third, what are the characteristics of beneficiaries with advance care planning claims across the two types of visits? Understanding these aspects of advance care planning billing provides valuable information about the scale and growth of such billing and the potential role in reducing racial and socioeconomic disparities in advance care planning conversations.

Study Data And Methods

We analyzed 100 percent of Medicare outpatient claims for beneficiaries continuously enrolled in fee-for-service Medicare each year between 2016 (when advance care planning coverage began) and 2019. Beneficiaries who died during the year were included. We considered all fee-for-service beneficiaries, including those younger than age sixty-five who qualify because of disability. This resulted in 133,234,642 beneficiary-year observations across the first four years. The authors had access to these data through the Centers for Medicare and Medicaid Services (CMS) Virtual Research Data Center under a data use agreement at the Leonard D. Schaeffer Center for Health Policy and Economics. The project was deemed exempt by the University of Southern California's Institutional Review Board.

ANNUAL WELLNESS VISITS We identified annual wellness visits using *Current Procedural Terminology* (CPT) codes G0438 and G0439, which capture initial and subsequent visits, respectively.

ADVANCE CARE PLANNING We identified advance care planning claims using CPT code 99497 for an initial thirty-minute advance care planning conversation in the Medicare Part B Outpatient and Carrier files. We did not count billing code 99498 because it represents extended time on a 99497 conversation rather than a unique service at a separate visit. We labeled billed advance care planning occurring on the same day as an annual wellness visit as "annual wellness visit–advance care planning." We labeled billed advance care planning that occurred at another type of outpatient visit as "non–annual wellness visit–advance care planning."

KEY COVARIATES To characterize which beneficiaries had an advance care planning claim and in which setting, we used Medicare Beneficiary Enrollment data to capture beneficiaries' age, race/ethnicity, sex, and dual eligibility for Medicare and Medicaid. We also used the Chronic Conditions Segment of the Master Beneficiary Summary File to capture whether beneficiaries had been newly diagnosed with the following conditions in the past twelve months: Alzheimer disease, acute myocardial infarction, breast cancer, colorectal cancer, endometrial cancer, lung cancer, prostate cancer, chronic obstructive pulmonary disease, diabetes, hip fracture, hypertension, ischemic heart disease, osteoarthritis or rheumatoid arthritis, and stroke or transient ischemic attack. We further created a count of the number of these conditions that beneficiaries were diagnosed with in the past twelve months.

ANALYSIS We used fee-for-service Medicare Part B claims to quantify the number of unique beneficiaries receiving visits with an advance care planning claim by month between 2016 and 2019 overall and the number that occurred at an annual wellness visit or at another outpatient visit. We then conducted an in-depth analysis of the characteristics of beneficiaries with claims in 2017. We choose 2017 to allow time

for providers to learn about advance care planning billing codes and because that was the last complete year of data we had from the Chronic Conditions Segment of the Master Beneficiary Summary File, which captures comorbid conditions. We compared beneficiaries' characteristics overall and according to visit type.

Finally, we estimated logistic regression models to parse out the independent relationship between patients' demographic and health characteristics and the likelihood of a 2017 advance care planning claim, overall and by visit type. Our models controlled for age groups (younger than 65, 75–84, and 85 and older relative to ages 65–74), patient race/ethnicity (Black, Asian, Hispanic, and other relative to White), sex, dual eligibility status, state of residence, and indicators for each of the newly diagnosed comorbidities.

LIMITATIONS This was the first study to use national claims data to analyze the demographics of beneficiaries billed for advance care planning in the outpatient setting. Although the large sample and national coverage are an advantage, our data did not capture the content or quality of advance care planning conversations.

Although our focus was on advance care planning claims in the outpatient setting, these codes can be billed by qualified providers in any setting. Thus, our data did not capture conversations billed as inpatient, in other institutional settings (for example, skilled nursing facilities), or at home.

Our data also likely undercount the frequency of advance care planning conversations in fee-for-service Medicare for multiple reasons. First, not all such conversations will meet the requirements to be billable, such as lasting at least sixteen minutes. Second, some conversations presumably took place absent an advance care planning claim, and this practice likely continues, particularly among some providers who might not be aware of the new billing codes, among those who do not have the codes integrated into their electronic health record system, and among hospice and palliative care providers who have long provided advance care planning in their standard care.[9]

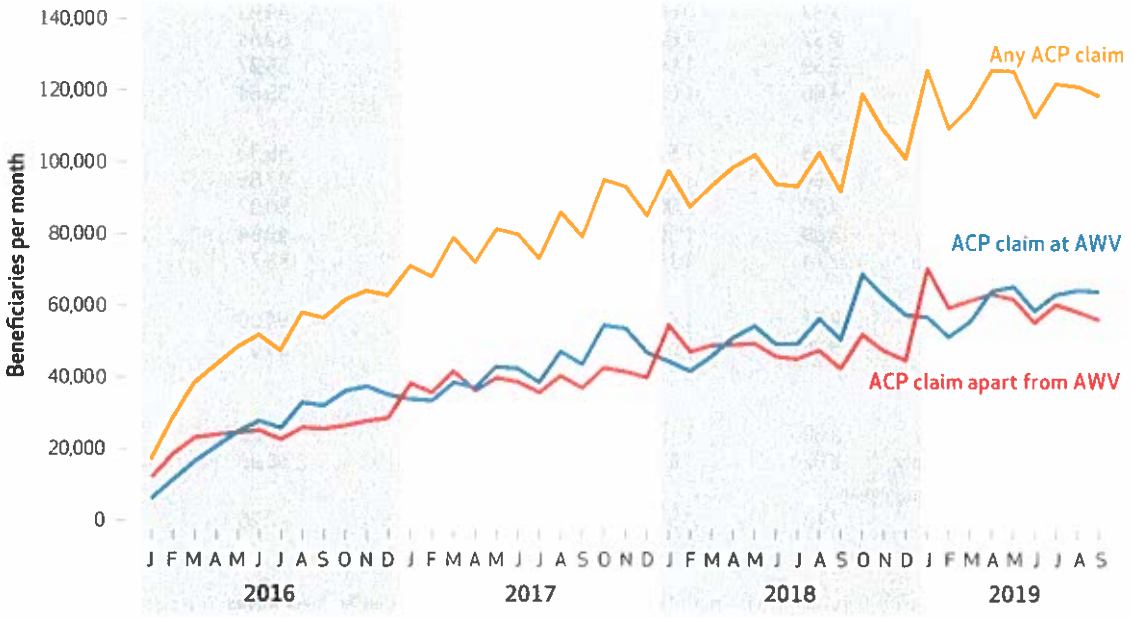
Finally, because our data were from fee-for-service Medicare, they could not speak to advance care planning conversations for the 33 percent of beneficiaries in Medicare Advantage plans in 2017.[14,15]

Study Results

NATIONAL TRENDS Exhibit 1 depicts steady growth in the number of fee-for-service Medicare

EXHIBIT 1

Fee-for-service Medicare beneficiaries with outpatient advance care planning (ACP) claims, per month, January 2016–September 2019



SOURCE Medicare Part B Outpatient and Carrier files. **NOTES** This figure depicts the number of fee-for-service Medicare beneficiaries with outpatient ACP claims by month from January 2016, when reimbursement for ACP conversations started, through September 2019. The number of beneficiaries with ACP claims at an annual wellness visit (AWV) and apart from an AWV are shown separately, along with the combined totals of beneficiaries with ACP claims at either type of visit.

beneficiaries with outpatient advance care planning claims between January 2016 and September 2019. Although just over 17,000 beneficiaries had such claims in January 2016, the number of beneficiaries with claims was just under 120,000 per month by 2019. Annually, by 2018, our last complete year of data, 3.67 percent of beneficiaries had an advance care planning claim (data not shown). Roughly half (51.85 percent) of beneficiaries with an advance care planning claim had the claim at an annual wellness visit, with growth occurring similarly across annual wellness visits and other visits (data not shown).

PREVALENCE BY DEMOGRAPHIC GROUP Exhibit 2 measures the prevalence of advance care planning claims in 2017 by demographic group (see online appendix exhibit A.2 for 2016 data).[16] We show prevalence separately for all advance care planning claims, as well as for claims at an annual wellness visit or apart from that visit. The exhibit also shows the percentage of all advance care planning claims that occurred during an annual wellness visit. Claim prevalence remained below 7.5 percent for all demographic and health categories analyzed, and it increased with beneficiary age. The youngest group had the lowest claim prevalence despite their eligibility for Medicare based on disability status. Among beneficiaries with newly diagnosed conditions (see appendix exhibit A.1),[16] all but those with hypertension had higher claim prevalence than beneficiaries overall. Beneficiaries with a lung cancer diagnosis or a hip fracture in the same calendar year were the most likely to have an advance care planning claim.

Advance care planning patterns varied in important ways across settings. Among those eligible for Medicare based on age (that is, ages sixty-five and older), the share of advance care planning claims that occurred at an annual wellness visit decreased with age. As a consequence, older beneficiaries who had a claim were more likely to do so outside of an annual wellness visit. Women had higher prevalence of advance care planning claims overall, but the share of claims that occurred at an annual wellness visit was similar for

EXHIBIT 2

Outpatient advance care planning (ACP) claims of fee-for-service Medicare beneficiaries, by patient characteristics, 2017

	Beneficiaries who had:			
Characteristics	(1) Any ACP claim	(2) ACP claim at annual wellness visit	(3) ACP claim apart from annual wellness visit	(4) Beneficiaries with an ACP claim who had ACP at annual wellness visit
Total	2.86%	1.54%	1.40%	54.03%
Age, years				
<65	1.37	0.68	0.73	49.92
65–74	2.57	1.62	1.04	62.84
75–84	3.59	1.99	1.71	55.37
85+	4.66	1.66	3.13	35.64
Race/ethnicity				
White	2.83	1.57	1.35	55.30
Black	2.84	1.36	1.57	47.85
Asian	4.00	2.00	2.16	50.02
Hispanic	3.09	1.50	1.71	48.64
Other and unknown	2.14	1.19	1.01	55.77
Sex				
Male	2.61	1.41	1.28	54.06
Female	3.06	1.65	1.51	54.01
Dual eligibility status				
In FFS Medicare, Medicaid eligible	2.80	1.15	1.73	41.25
In FFS Medicare only	2.87	1.64	1.33	56.93
Died within the calendar year				
Yes	7.16	0.52	6.72	7.26

SOURCE Medicare Beneficiary Enrollment files and Medicare Part B Outpatient and Carrier files. **NOTES** The sample consists of 33,704,729 beneficiaries who were continuously enrolled in fee-for-service (FFS) Medicare for 2017. Columns 1–3 show the percent of beneficiaries by demographic or eligibility group who had any ACP claim, an ACP claim with an annual wellness visit, and ACP apart from an annual wellness visit. Because a beneficiary can have ACP both at and apart from an annual wellness visit during the year, the sum of columns 2 and 3 exceeds column 1. Column 4 shows the share of beneficiaries with ACP claims who had an ACP at an annual wellness visit (the ratio of column 2 to column 1). An unabridged table with billed claims by newly diagnosed conditions is in appendix exhibit A.1 (see note 16 in text).

both men and women. Dual-eligible enrollees had a slightly lower prevalence of claims and a lower prevalence of annual wellness visit–advance care planning claims, but a higher prevalence of non–annual wellness visit–advance care planning claims. Those with newly diagnosed conditions who had claims were more likely to have them outside of an annual wellness visit.

Decedents had an overall advance care planning claim prevalence of 7.2 percent. Although 54 percent of beneficiaries with a claim had that claim at an annual wellness visit, only 7.3 percent of decedents had a claim at an annual wellness visit.

In contrast to prevalence, appendix exhibit A.3 shows the number of visits with advance care planning claims in 2017 by demographic group,[16] with multiple visits per beneficiary counted separately. Most beneficiaries with claims had them at only one visit; advance care planning claimants averaged 1.2 claims. Rates were similar in 2016 (see appendix exhibit A.4).[16]

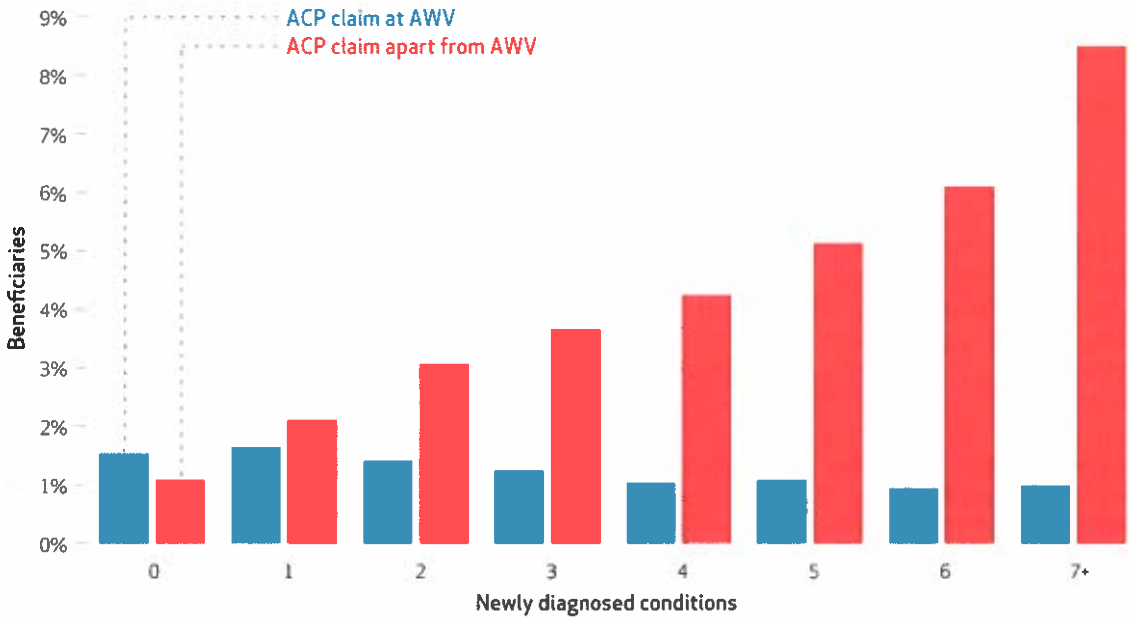
PREVALENCE BY NEW DIAGNOSIS Exhibit 3 shows advance care planning claim prevalence by number of newly diagnosed conditions. As the number of new diagnoses increased, the prevalence of annual wellness visit–advance care planning claims decreased and the prevalence of non–annual wellness visit–advance care planning claims increased. Fewer than 1 percent of beneficiaries had four or more newly diagnosed conditions; therefore, although advance care planning claim prevalence was high among these beneficiaries, they accounted for only 1.8 percent of visits with a claim (see appendix exhibits A.3, A.5, and A.6).[16]

MULTIVARIATE ANALYSIS Exhibit 4 examines the association between beneficiaries' characteristics and the odds of a visit with an advance care planning claim while adjusting for covariates. Relative to White beneficiaries, Asian beneficiaries were more likely to have a claim. Compared with White beneficiaries, the odds of having a claim were slightly lower for Black beneficiaries and were even lower for beneficiaries of Hispanic origin. The site of a visit with an advance care planning claim varied by race/ethnicity as well. Asian patients had higher odds of a claim during an annual wellness visit compared with White patients. Both Black patients and Hispanic patients had lower odds of a claim during an annual wellness visit compared with White patients. Black patients had higher odds of a non–annual wellness visit–advance care planning claim than White patients.

To determine whether these variations in advance care planning claim site were due to racial/

EXHIBIT 3

Percent of fee-for-service Medicare beneficiaries with outpatient advance care planning (ACP) claims, by number of newly diagnosed conditions, 2017



SOURCE Medicare Beneficiary Enrollment files and Medicare Part B Outpatient and Carrier files. **NOTES** This figure partitions 2017 beneficiaries with ACP claims by their number of newly diagnosed conditions, as listed in appendix exhibit 1 (see note 16 in text). ACP claims at and apart from an annual wellness visit (AWV) are shown separately. Cancers are counted separately by site of original presentation.

EXHIBIT 4

Relative odds of outpatient advance care planning (ACP) claims for fee-for-service Medicare beneficiaries, by patient characteristics, 2017

Characteristics	Had any ACP claim	Had ACP claim at annual wellness visit	Had ACP claim apart from annual wellness visit
Age, years (ref: 65–74)			
<65	0.54****	0.47****	0.67****
75–84	1.39****	1.22****	1.64****
85+	1.79****	1.03****	2.90****
Race/ethnicity (ref: White)			
Black	0.99**	0.88****	1.13****
Asian	1.03****	1.21****	0.88****
Hispanic	0.94****	0.96****	0.95****
Other or unknown	0.84****	0.85****	0.84****
Sex (ref: male)			
Female	1.10****	1.14****	1.05****
Dual eligible status (ref: in FFS Medicare only)			
In FFS Medicare, Medicaid eligible	1.17****	0.89****	1.49****
Condition (ref: no newly diagnosed conditions)			
Alzheimer disease	1.32****	0.82****	1.67****
Acute myocardial infarction (heart attack)	1.16****	0.87****	1.37****
Breast cancer	1.15****	1.01	1.32****
Colorectal cancer	1.34****	0.91***	1.72****
Endometrial cancer	1.25****	1.03	1.47****
Lung cancer	1.71****	0.71****	2.68****
Prostate cancer	1.17****	1.16****	1.17****
Chronic obstructive pulmonary disease	1.25****	1.10****	1.39****
Chronic kidney disease	1.27****	1.21****	1.31****
Diabetes	1.11****	1.05****	1.19****
Congestive heart failure	1.25****	0.99	1.48****
Hip fracture	1.19****	0.80****	1.47****
Hypertension	0.97****	1.04****	0.90****
Ischemic heart disease	1.09****	1.03****	1.16****
Arthritis	1.12****	1.14****	1.10****
Stroke or transient ischemic attack	1.27****	1.02	1.49****

SOURCE Medicare Beneficiary Enrollment files and Medicare Part B Outpatient and Carrier files. **NOTES** Table reports odds ratio for the likelihood of a beneficiary having an ACP claim, ACP at an annual wellness visit, or ACP apart from an annual wellness visit as a function of patient demographics and newly diagnosed conditions. For example, the odds of being billed for any ACP claim is about half as large (0.543) for those younger than age 65 as for those ages 65–74. The sample consists of 33,703,729 fee-for-service (FFS) Medicare beneficiaries who were continuously enrolled in 2017. In addition to coefficients reported, regressions also include fixed effects for states. Appendix A.7 contains a more detailed table (see note 16 in text). **$p < 0.05$ ***$p < 0.01$ ****$p < 0.001$

ethnic variations in annual wellness visits, appendix exhibit A.8 examines overall demographics of beneficiaries with annual wellness visits.[16] Black and Hispanic patients had lower annual wellness visit rates, at 19 percent and 18 percent, respectively, compared with 26 percent of both White and Asian patients with such visits. Among beneficiaries with an annual wellness visit, the percentage of advance care planning claims at the visit were actually higher for non-White patients than for White patients: 7.7 percent of Black, 8.8 percent of Hispanic, and 8.3 percent of Asian patients had an advance care planning claim compared with 6.4 percent of White patients. Appendix exhibit A.9 repeats the multivariate logistic regression analysis from exhibit 4 but controls for having an annual wellness visit.[16] Analysis indicated that after the annual wellness visit was controlled for, Black, Hispanic, and Asian patients had slightly higher odds of having an advance care planning claim than White patients (see appendix exhibit A.9).[16]

Dual-eligible beneficiaries had higher odds of advance care planning claims compared with other Medicare beneficiaries, but lower odds of an annual wellness visit–advance care planning claim and higher odds of a non–annual wellness visit–advance care planning claim. Here again, differences in annual wellness visit prevalence by dual eligibility status, rather than differences in advance care planning claim rates among those with an annual wellness visit, accounted for this difference.

Discussion

PREVALENCE AND GROWTH OF CLAIMS The first contribution of our study is the analysis of national trends in Medicare outpatient advance care planning claims. We found a linear increase in claims after the billing code's introduction in 2016. This pattern suggests that growth in advance care planning billing will continue both at and apart from annual wellness visits. Consistent with prior studies, advance care planning claim prevalence was higher among those who were older, who were female, and who had a newly diagnosed condition.[10,13,17–22] However, prevalence of claims remain low even for high-risk populations. Fewer than 7.5 percent of beneficiaries who experienced recent onset of any of the conditions studied here or who died within the year had an advance care planning claim.

Advance care planning claims represent a new and specific subset of all advance care planning conversations and are understandably lower than prevalence estimates of overall advance care planning conversations (both within and outside of health care services), which range up to 76 percent in survey data among older adults.[7,18,19,23–26] Further, studies of decedents using survey data of older adults have found that about 45 percent had an advance directive at the time of death,[27,28] and among these, more than 71 percent completed the advance directive one year or more before death.[28] Physician offices have not been a common venue for discussions of end-of-life care, a key focus of advance care planning conversations. Although about 60 percent of Medicare beneficiaries ages sixty-five and older reported engaging in an end-of-life conversation,[24] only 27 percent reported that such conversations were with a physician.[29] Because end-of-life conversations have primarily occurred in conjunction with estate planning, surveys have found socioeconomic disparities in end-of-life planning.[18,21] This is concerning, as patients likely have questions about end-of-life care that physicians are better equipped to answer than lawyers, especially when questions relate to their particular health conditions and risks.

CLAIMS AT AND APART FROM ANNUAL WELLNESS VISITS The second contribution of our study is its analysis of the interaction between advance care planning claims and annual wellness visits. Our results suggest that advance care planning claims at and apart from annual wellness visits may play different roles. The nature and content of these two types of advance care planning conversations, although outside the scope of the current study, may differ in ways reflected by patient demographics. Advance care planning conversations conducted apart from annual wellness visits were more common among those who had newly diagnosed conditions or who died within the calendar year, which suggests that these non–annual wellness visit–advance care planning conversations are likely addressing both emerging and urgent needs.[30]

In contrast, patients engaging in advance care planning at an annual wellness visit may represent advance care planning visits conducted earlier in the disease trajectory. In a systematic review of patients' preferences on end-of-life conversations, several studies found that the majority of patients preferred to discuss their end-of-life preferences and that many patients wanted conversations to happen sooner rather than later.[31–34] Thus, annual wellness visits may facilitate early advance care planning discussions.

IMPLICATIONS FOR DISPARITIES Our third contribution is that this is the first national-level analysis of the characteristics of patients using the new advance care planning claim. In contrast to the literature's findings of racial disparities in advance care planning conversations,[7,18,19,21,23–26] our findings indicate smaller (although still significant) differences for Black and Hispanic patients relative to White patients. In contrast to economic disparities in advance care planning conversations found in the literature,[7,18,21,23–26] we found that dual-eligible beneficiaries had significantly higher rates of overall advance care planning claims than more affluent beneficiaries. Although the advance care planning billing rates we report remain far below those seen outside the Medicare billing system, our findings suggest that growth in billed advance care planning has the potential to reduce disparities in which beneficiaries have advance care planning conversations.

Furthermore, although Black, Hispanic, and dual-eligible beneficiaries were less likely than White beneficiaries to have an advance care planning claim at an annual wellness visit, this difference is largely due to differences in annual wellness visit rates. In other words, consistent with prior work,[35–38] Black, Hispanic, and dual-eligible beneficiaries were less likely to have annual wellness visits. However, among beneficiaries with an annual wellness visit, advance care planning claim rates were slightly higher among members of racial/ethnic minority groups than among their White and non-dual-eligible counterparts. This disparity in receipt of an annual wellness visit among members of racial/ethnic minority groups reduces the opportunity for advance care planning at an annual wellness visit; therefore, advance care planning among these groups may be less preemptive and more likely to be brought about by pressing health needs. It also means that Black and Hispanic beneficiaries are more likely to face cost-sharing requirements

during advance care planning conversations than White beneficiaries. Overall, billable advance care planning may be useful in narrowing disparities in advance care planning conversations, but there may be greater opportunity to engage members of racial/ethnic minority groups and low-income populations in early advance care planning through efforts to increase annual wellness visits among these groups.

Policy Implications

Despite low advance care planning prevalence, the steady growth in outpatient visits with advance care planning claims indicates room for continued growth in these claims both at and apart from annual wellness visits. Given the literature showing that patients are often more willing to have and more comfortable having these conversations than physicians,[31,39] policies to encourage billable advance care planning should target supply-side (for example, physician and clinic) barriers.

A first barrier is lack of awareness of the new advance care planning billing code. A survey in the first quarter of 2016 at a large academic medical center found that 35 percent of primary care physicians and 24 percent of specialists were aware of the change,[40] which might have affected initial uptake of advance care planning billing. The percentage of providers who have billed for an advance care planning conversation increased between 2016 and 2017 but remains low.[13] This might reflect a lack of awareness, lack of interest, or the need to make institutional changes to accommodate advance care planning conversations.

The current rate of $80–86 for the first thirty minutes is considered too low to encourage the widespread adoption of advance care planning conversations.[13,40,41] One survey of physicians in early 2016 found that 75 percent felt the new advance care planning benefit made them more likely to talk about the subject,[42] but another early survey found that just 16 percent of primary care physicians and 4.4 percent of specialists said reimbursement was enough to incentivize advance care planning.[40] The opportunity cost of an advance care planning visit for primary care physicians relative to specialists reinforces the patient-side cost-sharing incentive for billable advance care planning to be done at annual wellness visits. To increase billable advance care planning among patients in critical situations, Medicare should consider setting a higher reimbursement rate for specialists. More broadly, to expand adoption, the reimbursement rate may need to increase even among primary care physicians.

Lack of training has been consistently identified as a barrier for physicians to engage in advance care planning conversations.[40–44] Before Medicare advance care planning reimbursement, practitioners had little incentive to be trained to provide those services.[42,44] A 2016 survey found that 68 percent of physicians reported having no training in end-of-life care conversations.[29] Although training resources readily exist, the change in the payment rule may be insufficient motivation for physicians to spend hours—or even days—engaging in unpaid advance care planning training courses.

Conclusion

As demonstrated by the recent COVID-19 pandemic, health conditions can arise and change suddenly, providing limited opportunity for care planning conversations and shared decision making. Engaging in an advance care planning conversation in a hospital, in direct response to a medical development and during an already challenging time, is more difficult than following through on earlier discussions among patients, providers, and, potentially, loved ones in an outpatient setting.[1] Expanded use of Medicare's advance care planning billing codes offers another tool to encourage earlier advance care planning conversations between patients and providers and, particularly when billed with annual wellness visits, may help reduce racial/ethnic disparities in these conversations. ■

Mireille Jacobson acknowledges support from the Navigage Foundation and the Gordon and Betty Moore Foundation. The authors thank Katrina Kaiser for excellent programming assistance as well as the editors and three anonymous reviewers for suggestions made to improve this article.

NOTES

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