National Health Council

1730 M Street NW, Suite 500, Washington, DC 20036-4561 ■ 202-785-3910 ■ www.nationalhealthcouncil.org ■ info@nhcouncil.org

September 6, 2016

The Honorable Sylvia M. Burwell
Secretary, Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

RE: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model (the PFS Proposed Rule)

Dear Secretary Burwell:

The National Health Council (NHC) is pleased to provide comments on the above-referenced PFS Proposed Rule.

The NHC is the only organization that brings together all segments of the health community to provide a united voice for the more than 133 million people with chronic diseases and disabilities and their family caregivers. Made up of more than 100 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient advocacy organizations, which control its governance and policy-making process. Other members include professional and membership associations, nonprofit organizations with an interest in health, and representatives from the insurance, pharmaceutical, generic drug, medical device, and biotechnology industries.

The NHC applauds the Centers for Medicare & Medicaid Services' (CMS) recognition, in the PFS Proposed Rule, of the need to appropriately pay clinicians treating individuals with multiple chronic conditions and disabilities. The NHC views CMS' proposals directed toward improving care and care coordination for individuals with complex, chronic, and multiple chronic conditions as an important step in enabling greater incorporation of the patient[1] voice in health care goals and decision making.

This letter offers NHC's general recommendations and highlights specific recommendations and concerns with the proposed rule. As more fully set forth below, the NHC's generally:

- Supports CMS' efforts to appropriately pay for "primary care, care management, and patient-centered services' and urges CMS to ensure

[1] The term "patient" is intended to include both the patient and their family caregivers.

that clinicians furnishing these services focus on patient engagement and patient-centered outcomes in treatment planning and care coordination;
- Supports CMS' proposal to add a new set of G-codes for behavioral health integration services; and
- Applauds CMS for cautioning clinicians against billing individuals enrolled in the Qualified Medicare Beneficiaries (QMB) program.

While the NHC supports CMS' efforts to improve both access to care and the quality of care for patients with chronic conditions, we have concerns with the potential impact of some provisions of the Proposed Rules. Specifically, the NHC:

- Commends CMS' efforts to adequately reimburse clinicians treating persons with disabilities, but is concerned that the proposed G-code specific to persons with mobility-related disabilities may have unintended discriminatory impacts.
- Encourages CMS to develop ACO quality-reporting measures in a manner that incorporates the patient voice and patient-specific outcomes into patient-centered measures;
- Urges CMS to adopt telemedicine codes for complex chronic care management that, like those proposed for Critical Care Evaluation and Management, recognize the potential benefit of these services when furnished remotely; and
- Is concerned that removal of the requirement that a care plan be available remotely to individuals providing after-hours chronic care management service may compromise patient care.

General Recommendations

The NHC supports CMS' efforts to appropriately pay for "primary care, care management, and patient-centered services' and urges CMS to ensure that clinicians furnishing these services focus on patient engagement and patient-centered outcomes in treatment planning and care coordination.

NHC appreciates CMS' recognition that special consideration is needed to adequately reimburse clinicians treating patients with multiple chronic conditions (MCC). According to the U.S. Department of Health and Human (HHS), about one in four Americans has multiple chronic illnesses and approximately two-thirds of Medicare beneficiaries have at least two chronic conditions.

CMS noted in the PFS proposed rule that:

> We believe the focus of the health care system has shifted to delivery system reforms, such as patient-centered medical homes, clinical practice improvement, and increased investment in primary and comprehensive care management/coordination services for chronic and other conditions. This shift requires centralized management of patient needs and extensive care coordination among practitioners.

The NHC supports CMS' efforts to encourage chronic care management (CCM), and we urge CMS to require meaningful patient engagement (i.e., bidirectional, reciprocal, and continuous), and incorporation of patient-centered goals and outcomes into treatment planning activities eligible for

enhanced Medicare payment. We note that CMS' recent proposed rule implementing the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) included a treatment planning Clinical Practice Improvement Activity specifying that the clinician "engage patients, family, and caregivers in developing a plan of care and prioritizing their goals for action, documented in the certified EHR technology. At a minimum, CMS should maintain the quality standard set forth in the proposed MACRA rule when determining eligibility for add-on payments.

The NHC similarly applauds CMS for its proposal to recognize currently-bundled prolonged evaluation and management services for Medicare payment. Combined with the enhanced payment for complex CCM services, adequate payment for prolonged office visits should reduce any current disincentives to treat Medicare's most complex and vulnerable patient populations.

The NHC is, however, concerned that the Resource Use component of the Medicare Incentive Payment System (MIPS) may unintentionally punish providers who are treating patients with higher associated medical costs. Individuals with chronic conditions, particularly those with the multiple chronic conditions often encountered in the Medicare population, are uniquely vulnerable to changes in clinician behavior resulting from incentive shifts toward performance and value-based payment strategies. We suggest that the Agency utilize the newly-recognized complex chronic care management CPT codes as a means of differentiating patients likely requiring higher resource utilization to ensure that clinicians treating these patients are not penalized for providing the care that CMS explicitly recognizes in its PFS Proposed Rule as appropriate, valuable, and necessary.

The NHC supports CMS' proposal to add a new set of G-codes for behavioral health integration services.

The NHC supports CMS' proposed addition of a set of G-codes to encourage greater collaboration in care management and planning associated with behavioral health services. For many patients, chronic conditions can be accompanied by and/or complicate mental and behavioral health concerns. The reimbursement add-on codes are an important step toward increasing access to appropriate, quality care for patients with behavioral health needs, and should enable a more holistic, team-based approach than the fragmented care patients often encounter.

The NHC applauds CMS for cautioning clinicians against billing individuals enrolled in the Qualified Medicare Beneficiaries (QMB) program.

As the advocacy organization focused on representing the patient voice in health care policy, the NHC is acutely aware of the impact of out-of-pocket costs on patient ability to seek necessary healthcare. Low-income Medicare beneficiaries, including those participating in the QMB program, are particularly vulnerable to declining or avoiding medical care if cost is a consideration.

Given the voluminous nature of the PFS Proposed Rule, the NHC suggests that CMS reiterate its reminder "that federal law prohibits [clinicians] from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments, from beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB) program" and provide guidance to providers on identifying these patients in a separate bulletin of more general circulation and applicability to the provider community.

Specific Recommendations and Concerns

The NHC commends CMS' efforts to adequately reimburse clinicians treating persons with disabilities, but is concerned that the proposed G-code specific to persons with mobility-related disabilities may have unintended discriminatory impacts.

CMS noted in its PFS Proposed Rule that the current Medicare reimbursement framework does not consider the resources required to serve individuals with mobility-related disabilities. CMS proposes adopting add-on code GDDD1 to capture the increased resources needed to treat patients for whom use of specialized mobility-assistive technology such as wheel chair accessible scales, lifts, stretchers and transfer boards, and moveable exam tables is medically necessary and utilized during a routine office visit.

The NHC supports CMS' efforts to eliminate barriers to care for individuals with disabilities and mobility limitations. We are, however, concerned that (1) it disfavors, and potentially discriminates against persons with non-mobility-related disabilities that similarly increase clinician resource use; 2) any incremental increase in coinsurance accompanied by use of a G-code would have a discriminatory financial impact on persons with disabilities; and (3) mobility impairments can impact access to appropriate care for patients without a diagnosed "disability." The NHC is reluctant to support CMS' well-intentioned proposal without the modifications detailed below.

First, the NHC urges CMS to expand its proposal to include a set of G-codes to enable meaningful access to quality care for the various subpopulations of disabled persons requiring greater resource use, specialized knowledge, and assistive technology than the general population. This would clearly include persons with mobility impairments, as well those with communication impairments and disabilities (e.g., advanced amyotrophic lateral sclerosis, hearing impairments, brain injury), cognitive issues (e.g., Alzheimer's Disease, traumatic brain injury, Down syndrome), or severe emotional/behavioral health issues complicating appropriate and quality care (e.g., opioid use disorder, posttraumatic stress disorder, severe dissociative disorders, schizophrenia).

Second, the NHC opposes increased cost sharing for those impacted by the new G code. CMS' intent in proposing the new code to enable adequate payment for clinicians treating patients with mobility impairments is admirable, and the approach appears well considered and likely to advance greater access to quality care for these individuals. The NHC expects that CMS did not intend to burden its disabled beneficiaries with higher copayment obligations simply by virtue of their disabilities, and we cannot support such a provision. We suggest that the Agency categorize the G code in a manner that eliminates any additional copayment burden (e.g., similarly to preventive care services), and that it ensure clinicians do not collect or attempt to collect additional funds from their disabled patients.

Finally, the NHC requests that CMS recognize that for many Medicare beneficiaries, particularly those with multiple chronic conditions, mobility impairments may be related to underlying chronic medical conditions, episodic and/or variable, and potentially unrelated to a disability that would be listed among the diagnoses reported on a claim. These circumstances may include acute worsening of chronic disease symptoms such as a multiple sclerosis relapse or an unrelated mobility impairment due to skeletal fracture, recent surgery, or traumatic injury. We ask that CMS clarify that clinicians can properly include the mobility impairment add-on code when the patient has any

mobility impairment at the time of the office visit for which use of assistive technology is appropriate.

The NHC encourages development of ACO quality-reporting measures in a manner that incorporates the patient voice and patient-specific outcomes into patient-centered measures.

Under Section 1899(b)(3)(A) of the Social Security Act, CMS is charged with developing "appropriate measures to assess the quality of care furnished by ACOs, such as measures of clinical processes and outcomes; patient, and, wherever practicable, caregiver experience of care; and utilization such as rates of hospital admission for ambulatory sensitive conditions. Our principal goal in selecting quality measures for ACOs has been to identify measures of success in the delivery of high-quality health care at the individual and population levels with a focus on outcomes."

Patient centeredness is created by engaging, informing, and actively listening to people with chronic diseases. Clinical guidelines that generally drive value-based payer strategies tend to be population-based and do not account for an individual's goals and personal circumstances, and have predominantly been developed by clinicians without patient input. As such, a individual patient's treatment plan may diverge from the treatment recommendations upon which quality measures are based due to individual circumstances and preferences. Additionally, CMS should incorporate into its quality measures an understanding that many patients with progressive or degenerative conditions will likely see worsening health status despite receiving the highest quality care possible.

In developing and selecting quality measures, CMS must ensure that clinicians treating patients with chronic diseases and disabilities are rewarded for using their medical expertise to select the most appropriate care for their patients rather than penalized for them their patients' health status. The NHC strongly urges CMS to ensure that its quality measures are developed within the context of extensive stakeholder outreach, with a focus on patient engagement activities. In our comments to CMS' proposed rule implementing MACRA, NHC made recommendations that are applicable to ACO quality measure development.[2] Specifically, we urge CMS to:

- Form an administrator-level patient advisory council (PAC) to guide the organization on patient engagement and patient centeredness in all of its programs, including MIPS, the implementation of APMs, and quality measure development for ACOs;
- Include patients and caregivers in the measure development process;
- Develop measures that improve care for patients with multiple chronic conditions;
- Develop patient-reported outcomes-based performance measures (PRO-PMs) to support patients' immediate and long-term goals; and
- Ensure that measures are risk-adjusted for patient characteristics.

The NHC urges CMS to adopt telemedicine codes for complex chronic care management that, like those proposed for Critical Care Evaluation and Management, recognize the potential benefit of these services when furnished remotely.

CMS proposes to add codes to describe critical care consultations furnished via telehealth, noting that these codes will allow the Agency to "recognize the additional resource costs in terms of time

[2] http://www.nationalhealthcouncil.org/sites/default/files/MIPS_APMs.pdf

and intensity involved in furnishing such services under the conditions where remote, intensive consultation is required to provide access to appropriate care for the critically ill patient."

While we support this provision, we believe it can be expanded to consultation for people with complex and/or multiple chronic conditions. Patients in remote or rural areas, as well as those with relatively rare conditions or combinations of conditions, may not have ready access to face-to-face consultation with highly experienced or specialized clinicians.

The NHC supports the proposal to create new codes to describe critical care consultations furnished via telehealth. This type of collaborative approach to treating individuals with critical conditions is likely to result in improved care. The NHC suggests that a similar inter-professional collaboration model is appropriate in connection with treatment planning for individuals with complex chronic care management needs.

The NHC is concerned with the removal of the requirement that a care plan be available remotely to individuals providing after-hours chronic care management services.

In considering the appropriateness of removing the 24/7 Access to Care and Continuity of Care requirement that a care plan be available remotely to individuals providing after-hours CCM services, CMS noted that "[w]e continue to believe these elements are important aspects of CCM services." The agency, however, cited the need for alignment with CPT provisions and removed this important aspect of patient care.

The NHC understands that there may be times when a patient has urgent care needs and the circumstances make it difficult to obtain care from a clinician with the ability to remotely access the care plan. However, we urge CMS to encourage clinicians to develop this ability. A more patient-centered approach may be to maintain the requirement but create an exception that captures the circumstances under which it would be unfair to deny CCM payment due to inability to access the care plan.

Conclusion

The NHC appreciates the opportunity to submit comments on CMS' proposed rule. As the voice for individuals with chronic diseases and disabilities and their family caregivers, the NHC applauds CMS for its efforts to improve care for individuals with complex and/or multiple chronic conditions. We remain committed to working with CMS to ensure that Medicare beneficiaries receive quality care that improves and maintains the outcomes they care about.
Please do not hesitate to contact Eric Gascho, our Vice President of Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable by phone at 202- 973-0545 or via e-mail at egascho@nhcouncil.org.

Sincerely,

Marc Boutin, JD
Chief Executive Officer