September 8, 2015

Acting Administrator Andrew Slavitt
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Submitted electronically to www.regulations.gov

Dear Acting Administrator Slavitt:

On behalf of the American Medical Group Association (AMGA), thank you for the opportunity to provide comments on the above-referenced proposed rule regarding revisions to the payment policies under the Medicare Physician Fee Schedule (MPFS) for Calendar Year (CY) 2016.

AMGA represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. AMGA represents 435 medical groups that employ nearly 170,000 physicians who treat approximately one in three patients in the United States. Our member medical groups work diligently to provide innovative, patient-centered medical care while doing their part to reduce federal health care expenditures. Many of them are also participating in alternative payment models such as the Medicare Shared Savings Program, the Pioneer Accountable Care Organization (ACO) Program, the Comprehensive Primary Care Initiative, and bundled payments initiatives. We therefore have a strong interest in the physician payment and policy proposals that the Centers for Medicare and Medicaid Services (CMS) has put forward in its proposed regulation. AMGA's specific comments on various areas of the proposed regulations follow in the paragraphs below.

Collaborative Care Models

The proposed rule discusses "collaborative care" models for Medicare beneficiaries with common behavioral health conditions. Collaborative care models, which have now been tested and documented in the medical literature, provide a framework for primary care teams to furnish structured care management with regular assessments of clinical status using validated tools, and modification of treatment, when needed. In this care model, psychiatric consultants provide regular

consultation to the primary care team to review clinical status and care of patients, and make recommendations. Several AMGA member medical groups have established collaborative care models within their organizations to provide effective treatment to patients with common behavioral health conditions that may otherwise go untreated, improve health outcomes, and reduce the costs of treatment. Our member medical groups report that their patients who have chronic health conditions, such as diabetes, chronic obstructive pulmonary disease, and chronic pain, often experience depression or anxiety. Therefore, being treated for these conditions as part of their care plan can improve treatment outcomes, reduce future office visits, and reduce hospital admissions. Collaborative care is also an effective and efficient strategy for addressing workforce shortages of mental health professionals, and AMGA is very supportive of the proposals to support collaborative care through appropriate Medicare reimbursement. In the proposed rule, CMS asks a series of questions about the appropriate valuation and reporting of collaborative care services in the Medicare Physician Fee Schedule (MPFS).

Concerning patient consent to receive these non-face-to-face services, we suggest that verbal consent followed by documentation of the discussion in an electronic health record (EHR) would be optimal. Resource inputs for collaborative care services should include the primary care physician time with the patient, the care management time, the initial assessment, documentation in an EHR, the population health management system in use, information technology support, and the ongoing follow-up with a licensed mental health professional and the primary care physician.

Any payments made for collaborative care services should not be included in total expenditures for Accountable Care Organizations (ACOs), however. Otherwise, ACOs will be effectively penalized for providing the services by having the costs contribute to the year's total expenditure. For ACOs who are participating in capitated payments models such as the Next Generation ACO program, these services should be a separate per beneficiary/per month (PBPM) payment from the capitated PBPM payment, analogous to a care management fee. It is essential that the agency consider the ways in which various programs interact with one another to avoid inadvertently penalizing physicians and medical groups for doing the right things to provide high-quality integrated care to their patients while reducing healthcare expenditures.

CMS is also soliciting input on the necessary qualifications for psychiatric consultants. Given the benefits and cost savings associated with collaborative care models, they should be as expansive as possible to permit medical groups to implement the models in a way that works best for their patient population. Accordingly, qualified professionals could include several types of licensed mental health professionals including psychologists, licensed clinical social workers, psychiatrists, and licensed counselors. Any of these licensed mental health professionals could consult with primary care physicians to address the behavioral health needs of their patients.

And finally, CMS requests information about whether collaborative care models should be tested through the Center for Medicare and Medicaid Innovation (CMMI). First of all, AMGA would recommend implementation of codes to begin reimbursing for the types of services currently being

implemented in medical groups across the country, without delay. However, future CMMI demonstrations that would target certain high-risk patients with multiple medical comorbidities could be worthwhile. For example, a demonstration on how best to treat and influence the outcomes for specific disease states that are complicated by behavioral health conditions would be useful. A study of collaborative care for a patient population with poorly controlled diabetes and major depressive disorder, not an uncommon combination, would provide additional information on what variables would influence outcomes.

Reducing Administrative Burden for Chronic Care Management (CCM) Services

AMGA appreciates the agency's recognition of the administrative burden associated with implementation of the CCM code that was finalized in 2015, and the expressed a desire to consider steps to simplify requirements in order to improve beneficiary access and healthcare provider adoption of the code.

Even before the CCM code was implemented, AMGA members expressed concern about the additional beneficiary co-payment associated with the CCM code, since most AMGA member medical groups have long provided non-face-to-face care management services to their patients with chronic conditions with no additional financial liability to them, and they have had difficulty explaining the need for the additional co-payment for services their patients have been receiving all along. To address this issue, CMS could consider establishing a waiver process by which physicians could apply to waive the co-payment requirement for specific groups of patients who would benefit from CCM services.

In addition, the feedback we have received from our medical group members is that the payment may not be adequate for the scope of services provided, because providing non-face-to-face care management services requires the ongoing involvement of a care team, and can vary depending on the medical complexity of individual patients. In general, 20 minutes per month, per patient, may not adequately represent the care management services being provided between office visits for the eligible patient populations. CMS should collect detailed information on the actual time spent on chronic care management activities, and how they may differ according to complexity, to determine adequate reimbursement for these important services.

Concerning the documentation requirements, AMGA believes the service elements could be simplified by permitting patients to opt-in to the care management services verbally and noting the consent in the EHR, rather than being furnished through yet another form for patients to sign. This would help eliminate the administrative burden of obtaining patient consent to receive these important services. In addition, we feel that the service elements could be streamlined by deleting the requirement to provide an electronic copy of the care plan. This is a redundant service element because healthcare providers are already required to provide an after visit summary which also contains the plan of care.

Advance Care Planning Services (ACP)

CMS is proposing payment for CPT code 99497 (advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family members(s) and/or surrogate); and an add-on CPT code 99498 (advance care planning including the explanation and discussion of advance directives such as standard forms [with completion of such forms, when performed], by the physician or other qualified health professional; each additional 30 minutes (list separately in addition to code for primary procedure)). CMS is proposing to assign an "A" status indicator, which means "Active code." These codes are separately payable under the MPFS. There will be RVUs for codes with this status."

AMGA strongly supports payments for these two codes. Many AMGA member medical groups devote significant time and resources to training their clinical staff on how to discuss sensitive end-of-life issues with their patients, and appropriately document patient preferences. Some medical groups have implemented formal physician/patient engagement programs to provide specialized training in effective advance care planning. We are therefore encouraged by the proposals to reimburse for these services, which will support these critical activities at the right time for patients. CMS is proposing to adopt RUC-recommended values for these codes, but states that absent a Medicare national coverage determination, Medicare Administrative Contractors (MACs) are responsible for making local coverage decisions to implement the codes. We would request that clear direction be given to the MACs so that these important services will be reimbursed in a consistent manner throughout the country.

As with the collaborative care services discussed above, any payments made for advance care planning should not be included in total expenditures for ACOs, however, since they would effectively penalize ACOs for providing these essential services. For ACOs who are participating in capitated payment models such as the Next Generation ACO program, we recommend that advance care planning services be reimbursed as separate PBPM payments.

Expansion of Telehealth Services

CMS proposes that several new codes be added to the Category 1 telehealth list for 2016. Category 1 consists of services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. AMGA strongly supports expansion of Medicare coverage for telehealth services, and recognizes the need to not only expand covered services, but also consider the location of patients. For example, frail elderly patients in both rural and metropolitan areas may find it difficult to attend in-person visits with their practitioner on a frequent basis and could benefit greatly by being able to receive appropriate services via telehealth services. We also understand that the CPT Editorial Panel has recently announced the creation of a new CPT Telehealth Services Workgroup that will include members from medical societies, payers, and other

stakeholders. This is a positive development, and places necessary focus on the promise of telehealth in efficient healthcare delivery.

"Incident to" Proposals

The CMS proposals regarding "incident to" services, although we have since learned were an attempt to clarify current policy, initially caused a lot of confusion among stakeholders, and we request clarity in the final rule. CMS also proposes to remove the last sentence from the applicable regulation that specifies that the physician, or other practitioner, supervising the auxiliary personnel need not be the same physician, or other practitioner, upon whose professional service the "incident to" service is based. We have concerns about how the removal of this language could be interpreted by MACs, and we strongly recommend that CMS clarify the restatement of current policy in the final rule to eliminate any possibility of confusion among healthcare providers or MACs.

CCM Services for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

AMGA supports the proposal to provide additional payment for the costs of CCM services that are not already captured in the RHC all-inclusive rate or the FQHC prospective payment system. CMS proposes that a RHC or FQHC can bill for CCM services furnished by, or incident-to, a RHC or FQHC physician, nurse practitioner, physician assistant or certified nurse midwife for a RHC or FQHC once per month. The service elements are nearly identical to those under the MPFS, including 20 minutes of qualifying CCM services per calendar month to patients with two or more chronic conditions that are expected to last at least 12 months, or until death of the patient, and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. CPT code 99490 sets forth the eligibility guidelines, as in the MPFS, and would be used for potential medical review.

Although we welcome these proposals, since RHCs and FQHCs are often not eligible for participation in many other programs affecting Part B payments, due to their billing methodologies. We are concerned that not all RHCs or FQHCs will have the health information technology in place to support some of the requirements, given that these facilities were never eligible for Meaningful Use incentives to adopt and use these systems. For those facilities that have the appropriate infrastructure, these CCM reimbursements will be welcome, but those who do not have the health information technology requirement in place will once again be excluded. Nonetheless, for those RHCs and FQHCs that have the necessary information technology infrastructure, we feel implementation of the CCM code is a step in the right direction, given the critical role these facilities play in improving access to primary care services in areas of the country that otherwise may not be able to furnish these services to patients.

Medicare Shared Savings Program (MSSP)

CMS makes a limited number of proposals affecting the MSSP. AMGA supports efforts to continue aligning quality measures with those in the Physician Quality Reporting System (PQRS), in addition to

the proposal to amend the definition of primary care services to exclude claims submitted by Skilled Nursing Facilities in order to improve the patient attribution process.

Concerning the proposal to add Statin Therapy for the Prevention and Treatment of Cardiovascular Disease to the Preventive Health Domain, we recognize the need to align this measure with the PQRS program and feel that the evidence supports the use statin therapy as the best treatment option for patients with high cholesterol affecting several disease states. CMS requests stakeholder input on whether the agency should aggregate multiple risk groups into a single metric, or break them out by disease states. After consultation with member medical groups, AMGA recommends against aggregating patients with multiple disease states into a single metric, for several reasons, including medication adherence rates among differing patient populations.

The addition of new measures in the middle of a contract cycle has the potential to be extremely disruptive, however. AMGA therefore suggests that these new metrics remain in pay for reporting, for a three year period, in order to gather data and gain insight into accurate benchmarking for these measures.

Physician Self-Referral Proposals

CMS proposes changes to the physician self-referral provisions that would make it easier to conduct recruitment of nonphysician practitioners (NPPs) to FQHCs and RHCs. The new exception would permit hospitals, FQHCs, and RHCs to offer remuneration to NPPs in order to help ease primary workforce shortages. AMGA supports the proposals to simplify physician self-referral provisions, and urges CMS to move forward with this change. As with the proposal to ease recruitment of NPPs, we support the additional simplification of the physician self-referral proposals that will provide additional clarity around the disclosure requirements for public notification of physician-ownership on the public website of a hospital. We ask the agency to insure that the finalized policies are very clear as to what is permitted, and leave no room for ambiguity, given the nature of penalties for non-compliance with the complex physician self-referral regulations.

The Merit-Based Incentive Payment System (MIPS)

CMS is requesting input on two issues related to MIPS implementation. MIPS, passed in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), will sunset the PQRS, the Medicare EHR Incentive Program, and the Value-Based Modifier. The proposed rule enumerates subcategories of clinical practice improvement activities to include expanded practice access, population management, care coordination, beneficiary engagement, patient safety and practice assessment, and participation in alternative payment models, and asks for stakeholder input on what activities could be classified as clinical practice improvement activities according to this definition. We support the subcategories as currently defined, and AMGA member medical groups have been at the forefront of clinical practice

improvement for many years. AMGA's Acclaim Award honorees and recipients provide rich examples of how these clinical practice improvement activities work in their medical groups[1].

In further defining clinical practice improvement activities, AMGA suggests that participation in programs such as Measure Up/Pressure Down®[2], which leverages participating medical groups' coordinated care delivery to achieve high blood pressure control in 80% of their patients with the condition, be considered clinical practice improvement activities. To date, more than 140 medical groups and health systems delivering care to more than 42 million patients have joined the Measure Up/Pressure Down® campaign. Such activities have the potential to contribute significantly to clinical practice improvement and should therefore be considered a qualifying clinical practice improvement activity in the MIPS.

The development of MIPS provides an unprecedented opportunity to create a program that will streamline the disparate requirements of multiple quality reporting programs, which are currently straining the resources and capacity of physicians and medical groups. AMGA therefore strongly supports the creation of the Physician Focused Payment Model Advisory Committee. The input of practicing physician leaders is essential to the development of new payment models that are both successful in meeting the goals of the Triple Aim, while ensuring administratively workable and efficient measurement, and reporting, of quality data.

Alternative Payment Models (APMs)

In the proposed rule, CMS states the agency is broadly seeking comment, and will be issuing a Request for Information (RFI) on certain MACRA provisions related to implementation of APMs. Topics will include increasing transparency of physician-focused payment models, criteria and process for submission and review of physician-focused payment models, incentive payments for participation in eligible alternative payment models, and integrating Medicare alternative payment models in the Medicare Advantage program, among others, and AMGA will welcome the opportunity to respond to the RFI once it has been issued, as all of these issues will need to be addressed in order for APMs to be successful.

Several issues that have surfaced as challenges in the MSSP and Pioneer ACO programs provide insight into the challenges all APMs will need to overcome to ensure success. Such challenges include developing effective attribution methodologies so that healthcare providers will have a clear sense of the patients they are responsible for under the models, patient engagement opportunities, timely data sharing between healthcare providers and CMS, and greater transparency around financial benchmarking for the programs.

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[1] The Acclaim Award: Past Recipients and Honorees: http://www.amga.org/wcm/PI/AcclaimAward/wcm/PI/Acclaim/past_acclaim.aspx

[2] Measure Up/Pressure Down®: http://www.measureuppressuredown.com/About/index_about.asp

We appreciate the opportunity to comment on these proposals and we look forward to working with CMS to address the challenges related to successful implementation of MACRA. If you have questions, please do not hesitate to contact Karen Ferguson at kferguson@amga.org.

Sincerely,

Donald W. Fisher, Ph.D.
President and CEO