Advancing High Performance Health

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

Dear Mr. Slavitt:

AMGA appreciates the opportunity to comment on the Centers for Medicare and Medicaid Service's (CMS) proposed rule, "Medicare Program: Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017." (CMS-1654-P). AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for one-in-three Americans. Many AMGA members participate in Alternative Payment Models (APMs), such as the Medicare Shared Savings Program, the Pioneer and Next Generation Accountable Care Organization (ACO) demonstrations, the Comprehensive Primary Care demonstration, and the Center for Medicare and Medicaid Innovation's two bundled payments demonstrations. Consequently, our members have a substantive interest in Medicare and Medicaid physician payment and related Medicare Part B policies. AMGA's comments on several provisions in the proposed rule follow below.

Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management

AMGA appreciates the proposed changes to improve the implementation of the 2014-initiated Chronic Care Management (CCM) code. As we have noted previously, providing non-face-to-face care management services requires continuous care team involvement. However, the time dedicated to each patient will vary depending on the medical complexity of the patient. AMGA noted in earlier comments that 20 minutes per month per patient may not adequately account for all care management services for all patients. AMGA recommended CMS work to more accurately assess the amount of time spent in providing chronic care management activities, particularly to what extent time intensity varies according to the patient's medical complexity. CMS also should rely on the agency's analysis of the Medicare Medical Home Demonstration which suggests higher reimbursement may be needed to support care coordination efforts for "even moderately complex Medicare beneficiaries."[1]

By proposing to recognize and pay for other codes in the Current Procedural Terminology (CPT) family of CCM services, CMS has acknowledged AMGA's concern that the 20 minutes per month, per patient may not sufficiently recognize and reimburse all CCM services delivered. In addition, as patient enrollment increases, the costs associated with providing CCM services would "rapidly increase," according to a modeling study published in the September 2015 issue of the Annals of Internal Medicine.[2]

CMS is proposing to simplify advance beneficiary consent and documentation requirements for CCM services. In earlier comments, AMGA maintained that patients should be permitted to opt-in to the care management services verbally and that consent be noted in the electronic health record (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. AMGA also believes 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, to the patient.

Regarding patient consent, AMGA agrees with the proposal to defer to the provider and the beneficiary on how best to establish consent. Beneficiary consent is, of course, vitally important to the provider-patient relationship. AMGA recommends CMS finalize its proposal to allow practitioners to specify in the medical record that the beneficiary was made aware of the availability of CCM services as well as their right to discontinue CCM services. AMGA also supports the proposal to simply require that a care plan be provided to the beneficiary without specifying the format of the plan. These proposals should be finalized.

We do remain concerned that use of the CCM codes requires beneficiaries pay a 20% copayment for the service. AMGA medical groups have repeatedly stated that they have found it difficult to make known or enforce the copay requirement because these services had been previously provided for free. AMGA members feel that the chronic care management code should be considered a preventive service. AMGA member medical groups have previously provided non-face-to-face care management services to their patients with no additional financial liability to them, and our groups have concerns about their patients being willing to accept additional co-pays.

The Collaborative Care Model and Behavioral Health Integration

"Behavioral health integration" (BHI) recognizes the need to improve coordination between primary care providers and behavioral health specialists in treating simultaneously both the patient's physical and behavioral health needs. Beginning January 1, 2017, CMS proposes to make separate payments for services using the psychiatric Collaborative Care Model (CoCM) using three new G-codes, GPPP1, GPPP2, and GPPP3. CMS also is proposing a new code for care management services for behavioral health conditions that describes services furnished using a broader application of behavioral health integration in the primary care setting (GPPPX). AMGA member medical groups have established collaborative care models within their organizations to provide effective treatment for patients with behavioral health conditions that may otherwise go untreated. We are pleased that CMS is proposing to pay for such services with new G-codes.

CMS requested comments on what type of services are appropriate for an initiating visit for the BHI codes. AMGA believes the goal of integrating BHI services and the proposed new G codes is to further care coordination. Primary care providers, however, have indicated that behavioral healthcare services are difficult for patients to access.[3] Given the complexity of this patient population, AMGA recommends CMS adopt a lenient view of an "initiating visit" so that the patients begin receiving mental health care as soon as possible.

Patients with behavioral health needs frequently present simultaneously with an acute medical problem. The need to address the most immediate problem can crowd out meeting other needs, such as engaging in social service supports, communicating with family caregivers, and coordinating with community-based services. These patients also have considerable difficultly accessing physician office care due to physical and cognitive impairments and transportation limitations.[4] Expecting such patients to schedule a timely initial visit is oftentimes unrealistic. Additionally, when referrals for behavioral health care are made, the percent of patients who keep these appointments are low. Initiating behavior health treatment involves several steps: problem identification, access to appropriate treatment resources, referral, referral acceptance, and treatment initiation.[5] Each step represents a potential failure point in progressing the patient from a primary care provider to a behavioral health one. Given the difficulties in coordinating comprehensive care for these patients, physicians should be encouraged to initiate behavioral health care services as soon as possible.

Regarding the time duration for code GPPX, as noted in a June 2016 Mathematica Policy Research issue brief, collaborative care for these patients includes numerous clinical features including standardized screening tools, evidence-based care protocols, care managers, patient and family education, ongoing tracking of patient status and continuous performance measurement and improvement."[6] These features and others that define successful behavioral health integration indicate that a longer duration is needed to fully reflect the time and resources associated with providing this care.

CMS also is requesting comments on the agency's proposal to require documentation in the medical record of beneficiaries who consent to receive behavioral healthcare through a collaborative care model. As stated in our comments on the CY 2016 proposed Physician Fee Schedule, we maintain our position that verbal consent followed by documentation of the discussion in an EHR would be optimal.

Expansion of Telehealth Services

On balance, AMGA supports CMS expanding Medicare and Medicaid coverage for telehealth services. AMGA member groups have recognized the care outcome benefits telehealth offers via more timely access to care and improves patient self-activation and consequently satisfaction.

AMGA is pleased that CMS is proposing to add CPT codes for End Stage Renal Disease (ERSD) to the list of telehealth services. While only a small percent of ESRD patients choose home hemodialysis, telehealth would support ESRD beneficiary independence and self-management, improve patient activation and quality of life, reduce iatrogenic harm, and potentially reduce spending or lower spending growth.

It is important to ensure the coding additions and place of service coding requirements do not indicate that telehealth is a distinct service, but rather a tool to improve access to care, patient engagement, and patient satisfaction.

AMGA also recommends CMS extend waiving geographic prerequisites for telehealth. Current Medicare payment regulations limit the use of telehealth services to rural Health Professional Shortage Areas (HPSAs). The Next Generation ACO telehealth wavier eliminates both the originating site requirement as well as the geographic prerequisites allowing assigned Next Generation ACO beneficiaries to benefit from telehealth services. CMS also has proposed waiving some geographic telehealth restrictions in its Cardiac Rehabilitation (CR) Incentive Payment Model demonstration. Beyond these, AMGA also supports, or is on record recommending, that CMS waive the geographic limitations for telehealth use for the entire Medicare ACO program, or for Track 1, 2 and 3 ACOs.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act of 2014 (PAMA) directed CMS to develop an appropriate use criteria (AUC) and clinical decision-support mechanisms (CDSMs) for advanced diagnostic imaging services. Because the AUC program is an effort to measure and influence resource use, AMGA believes that CMS could meet this requirement by aligning the AUC program with the Medicare Access and CHIP Reauthorization Act's (MACRA) Merit-Based Incentive Payment System (MIPS). Establishing the AUC program in isolation needlessly creates added provider burden. With the implementation of MACRA, inappropriate advanced imaging use will be reflected in provider MIPS scores. Rather than create a separate program, AMGA recommends CMS work to align and integrate the statutory goals of the AUC program with the MACRA MIPS resource use component score.

Beyond this, AMGA also is concerned that the development of AUC and its use within a CDSM will be administratively burdensome for providers. CMS is not proposing to be "prescriptive about specific IT standards" for CDSMs. This may result in administrative complexity for using an AUC. However, CMS does acknowledge this concern and may consider implementing standards in the future as stakeholders and standards development organizations reach a consensus on appropriate CDSM standards.

Chronic Care Management and Transitional Care Management Supervision Requirements in Rural Health Clinics and Federally Qualified Health Centers

Current CMS regulations require the clinical staff that provide non-face-to-face care management that is billed under the PFS at Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHCs) be under direct supervision. CMS is proposing to reduce the supervisory requirement by changing the direct supervision requirement to a general supervision requirement. AMGA supports this proposed change.

Medicare Diabetes Prevention Program

CMS is proposing to formalize the Diabetes Prevention Program, a primary care preventive model. CMS is proposing to rename the model the Medicare Diabetes Prevention Program (MDPP). CMS proposes to designate MDPP services as "additional preventive services" available under Medicare Part B reimbursement beginning January 1, 2018.

CMS proposes the MDPP be a 12-month program using the Centers for Disease Control and Prevention (CDC)-approved DPP curriculum. This would consist of 16 core sessions over 16-26 weeks with the option of monthly core maintenance sessions over 6 months thereafter if the beneficiary achieves and maintains a minimum weight loss in accordance with the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures.

AMGA well recognizes the importance of both preventing, and improving treatment for, diabetes. Among other things, AMGA recently launched a national campaign to improve care for patients with Type 2 diabetes. Named the Together 2 Goal® campaign, the effort challenges participating medical groups and health systems and patients to improve care for approximately one million people with Type 2 diabetes by 2019. AMGA supports this proposal.

Medicare Shared Savings Program

AMGA supports the proposal to add a beneficiary attestation option to the ACO or the Medicare Shared Savings Program (MSSP). CMS is proposing an automated mechanism for beneficiaries to voluntarily align with the ACO that is responsible for providing their care. This would make it possible for CMS to use beneficiary attestations for assigning beneficiaries to ACOs in all three tracks for the 2018 performance year. This voluntary designation would, in certain circumstances, override the claims based ACO assignment process. Additionally, under an automated process, beneficiaries would be able to modify their attestation designation at any time.

AMGA supports this proposal for all ACO tracks. This would not only enhance the attribution process, by reducing unstable assignment or year-over-year patient churn, it would also recognize patient choice and likely make patients more engaged in the care they receive. In an April 2015 Health Affairs blog post, Dr. Mark McClellan and others detailed how a beneficiary attestation process would address two issues with MSSP. First, voluntary attestation would provide the ACO with a better picture of their patient population. Second, such a process would encourage beneficiaries to be an active participant in their own care.[7]

Separately Reporting PQRS Quality Data

CMS has proposed to remove the prohibition on Eligible Professionals (EPs) who are part of a group or a solo practice that participates in an Accountable Care Organization (ACO) from separately reporting quality measures for the 2018 Physician Quality Reporting System (PQRS) payment adjustment. Under current Medicare Shared Savings Program (MSSP) regulations, EPs who participate in an ACO may not independently report their PQRS data apart from the ACO. This prohibition is designed to promote provider coordination within the ACO.

The vast majority of ACOs report their quality data completely or successfully. However, AMGA supports this option since not all ACOs report their data successfully. That is EPs should be able to be scored under PQRS if, through no fault of their own, their ACO did not adequately report.

Skilled Nursing Facility 3-Day Rule Waiver Beneficiary Protections

In earlier rule making, CMS implemented a waiver process that allows for prospectively assigned Track 3 ACO beneficiaries to be exempt from the 3-day hospital inpatient stay requirement to qualify for Medicare coverage for Skilled Nursing Facility (SNF) care. In previous AMGA comments to CMS, we encouraged CMS to extend this waiver to MSSP Track 1 ACOs since AMGA believes that SNF waiver would benefit all Medicare beneficiaries equally.

Here, CMS is proposing a number of beneficiary protections related to the 3-day rule. The intent of these is to protect beneficiaries from any financial liability. CMS is proposing to address possible financial risk to beneficiaries due to a potential lag in communication between the ACO and the beneficiary. CMS is proposing a 90-day grace period that would allow a beneficiary to continue to receive SNF services under the waiver for 90 days after the beneficiary has been dropped from the ACO beneficiary list. AMGA support this proposal. In addition, CMS should protect these beneficiaries by requiring they receive care from only those SNFs with a three or more star quality rating.

Value-Based Modifier and Physician Feedback Program

In earlier rule making, CMS established an informal inquiry process for physicians to review and identify any possible errors before CMS decides Value-Based Modifier (VM) payments. CMS is proposing to update this process. CMS intends to "lend confidence" to the informal review process, but AMGA disagrees with how the agency proposes to do this.

The agency's stated goal in the proposed rule is to "close out" as many informal reviews as possible before the VM payment factor is calculated, "lend confidence" to the adjustment factor, "provide finality" for clinicians, and "minimize claims reprocessing." However, as proposed, the changes to the informal review process will hold practices accountable for performance without a mechanism in place to ensure the accuracy of the data being used. CMS is proposing to for performance without a mechanism in place to ensure the accuracy of the data being used. CMS is proposing to reclassify a provider group or eligible provider's performance based on an incomplete understanding of their performance. CMS is proposing to "deem," rather than attempt to calculate, a quality composite. Doing so could possibly deny a group or eligible professional a positive VM adjustment. AMGA is concerned CMS is unable to properly collect and interpret data for the VM program and rather than work to improve the process or correct its own errors, the agency would rather close out cases.

Global Packages and Data Collection

Medicare pays for a variety of services, such as surgeries, using a global package. Such a package covers pre- and post-operative visits, as well as other bundled services that fall within a set time frame. In the agency's 2015 Physician Fee Schedule final rule, CMS finalized a policy that transformed all 10-day and 90-day global periods to 0-day global periods. This policy would have taken effect in 2017 but it was superseded by MACRA. MACRA prohibited CMS from implementing this policy and directed the agency to collect data on the value of surgical services. This requirement mirrors a recommendation that AMGA made in its 2015 Physician Fee proposed rule comments. AMGA restates our recommendation that CMS reevaluate the codes in question and revalue them. AMGA suggests that it would more beneficial to rebase the pricing of the questionable global surgical codes in question rather than eliminating them altogether, since payment bundles may expand in the future as alternative payment models and keeping the global surgical codes in place can contribute to better post-surgical outcomes.

MACRA also requires CMS to collect data to improve the accuracy of the valuation of surgical services. To do so, CMS is proposing to collect data via a three-pronged approach: a comprehensive claims-based reporting about the number and level of pre- and post-operative visits furnished for 10- and 90-day global services; a survey of a representative sample of practitioners; and, a study that includes direct observation of the pre- and post-operative care delivered in a small number of sites, including some ACOs. AMGA supports this proposal.

Release of Part C Medicare Advantage Bid Pricing Data

CMS is proposing to publicly release data associated with Medicare Advantage (MA) bid pricing that is time delayed on an annual basis subject to certain exclusions. AMGA supports the intent of this proposal, which is to introduce more transparency in the MA program.

Thank you for your consideration of AMGA's comments. If you have any questions concerning our comments please contact David Introcaso, Ph.D., Senior Director, Regulatory and Public Policy at 703.842.0774 or via dintrocaso@amga.org.

Sincerely,

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

Endnotes

1. Rich E, Lipson, et al. “Coordinating Care for Adults With Complex Care Needs in the Patient-Centered Medical Home: Challenges and Solutions.” White Paper prepared by Mathematica Policy Research (January 2012).

2. S. Basu S, et al., “Medicare Chronic Care Management Payments and Financial Returns to Primary Care Practices,” Annals of Internal Medicine (2015): 580-588.

3. P. J. Cunningham, “Beyond Parity: a Primary Care Physicians’ Perspectives on Access to Mental Health Care,” Health Affairs (2009): w490-w501.

4. See note 1.

5. R. Kessler, “Mental Health Care Treatment Initiation When Mental Health Services Are Incorporated Into Primary Care Practice,” Journal of the American Board of Family Medicine (February 2012):

6. K. Zivin, “Behavioral Health Integration in Primary Care: A Review and Implications for Payment

7. M. McClellan et. al, “Changes Needed To Fulfill The Potential Of Medicare’s ACO Program,” Health Affairs Blog, April 8, 2015.