AMGA
Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318
O 703.838.0033
F 703.548.1890

September 11, 2017

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of AMGA, we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed "Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program" (CMS-1676-P). AMGA, founded in 1950, represents more than 450 multi-specialty medical groups and integrated delivery systems representing about 177,000 physicians who care for one-in-three Americans. Our members continue to work toward achieving the triple aim of better care for individuals, improved population health and reduced spending. We therefore have a strong interest in several regulatory changes CMS has put forward in this proposed rule.

We have comments on seven proposed regulatory changes. Our comments are not necessarily presented in priority order.

Telehealth Services

CMS is proposing to expand telehealth services by adding five new related billing codes. These include telehealth care related to health risk assessments and care planning under the agency's chronic care management program. CMS also is seeking comment on ways the agency can further expand telehealth services.

We well recognize the ongoing debate whether telehealth services are substitutive or duplicative. For example, the Congressional Budget Office (CBO) has frequently, however not uniformly, scored telehealth services as a net cost. This explains why CMS has been very hesitant to expand telehealth even with originating site and other 1834(m) benefit-limiting restrictions. As the agency is certainly aware, Medicare spending on telehealth services is trivial. In 2015, reimbursement equaled $17.6 million, or approximately 0.005% of total Medicare spending.

AMGA is on record for strongly supporting substantial expansion of telehealth services. For example, we have consistently urged CMS to expand telehealth services under all Medicare Shared Savings Program (MSSP) or Accountable Care Organization (ACO) tracks and via Center for Medicare and Medicaid Innovation (CMMI) demonstrations, including the Next Generation ACO and the Comprehensive Primary Care Plus (CPC+), and other models, in part, because research shows telehealth expands access to primary care. (An August 2017 Office of the Inspector General report found high performing ACOs used comparatively more primary care services.) AMGA also has supported legislative efforts to expand both telehealth services and remote patient monitoring (RPM). For example, AMGA has expressed support for the CONNECT for Health Act of 2017 and supported the Senate Finance Committee's passage this past May of its CHRONIC Care Act, which would expand ACO and Medicare Advantage (MA) telehealth coverage.

Since CMS under this proposed rule is seeking comment on ways to expand telehealth, we will again note telehealth services have been in wide use for approximately 40 years, predominantly in private payer insurance programs. These services can and do fundamentally change or disrupt the way healthcare is delivered since they offer numerous methods and modalities to expand care delivery capacity/efficiency and improve health care outcomes particularly in under-served and rural areas. Telehealth, whether it be synchronous or asynchronous, offers the ability to enhance consultations between patients and providers, enable remote monitoring, improve the transmission of medical information, support patient's self-management and generally improve communication and education between primary and specialty care providers and patients. In primary care, telehealth applications have a myriad of uses in preventing or managing numerous leading causes of illness, disability, and death. In sum, telehealth services facilitate prevention, coordination, and cure and deserve to be widely available to Medicare beneficiaries.

More specifically, studies of telehealth's use in primary care show, for example, it is cost effective in reducing hospital admissions and re-admissions as well as reductions in both emergency visits and transfers between emergency departments. Studies also show telehealth services are less expensive, are not additive (they are moreover a substitute for in-person care) and are unlikely to induce utilization. For example, actuary reports prepared for the Alliance for Connected Care found telehealth visits resolved a patient's health concern 83 percent of the time, i.e., no follow up care was needed and found, not surprisingly, the majority of these encounters replaced urgent care visits. Concerning quality of care, systematic reviews show telehealth has had a significant positive effect for several predominate diseases, including heart disease and psychiatric conditions. Patient satisfaction with telehealth use, specifically interactive video, telephone consultations, and remote monitoring, has on balance been high.

As is well documented, the Veterans Administration (VA) and its patients continue to benefit substantially from the VA's telehealth programming. As of 2013,approximately one million veterans used some type of VA telehealth offering. The VA expects this number to increase to more than four million, or two-thirds of all veterans receiving some form of VA health care, before the end of the decade. VA use of telehealth includes a host of counseling services, prosthetic and other check-ups, and the sharing of electronic medical record access for veteran family caregivers. Another essential use of telehealth is RPM, which provides a form of secondary prevention for patients with chronic illness. RPM use to monitor VA patients with

chronic obstructive pulmonary disease, congestive heart failure, diabetes, and other chronic conditions showed a reduction in VA hospital bed days of care in excess of 40% on pre-enrollment figures. RPM use by the VA has also led to an 81% decrease in nursing home admissions and a 66% reduction in emergency department visits. The VA reports its telehealth and related RPM programming generally has, among other things, reduced overall bed days for veterans by 58% and hospital admissions by 38%.

Similar results in the use of so-called consumer-facing technologies have been achieved in the private sector. Cardio-vascular disease patients in Boston's Partners Healthcare receiving RPM services experienced a 50% reduction in related hospital re-admissions. Similar results were achieved for Colorado patients enrolled in Centura's Health at Home program. In sum, in October 2014 the Office of the National Coordinator for Health Information Technology (ONCHIT) noted in a paper titled, "Health Information Technology Infrastructure to Support Accountable Care Arrangements," remote monitoring would produce as much as $200 billion in cost savings over the next quarter century.

As suggested above, the use of telehealth may be particularly beneficial in rural communities. For example, the Indian Health Service (IHS) has used both live video conferencing and asynchronous technologies to improve Native American health in remote locations. For example, IHS has been successful in improving diabetes control by significantly lowering low-density lipoprotein cholesterol and hemoglobin A1c levels. The IHS also has used the technology to consult with specialists throughout the country to improve its delivery of specialty care.

Likely the most rudimentary use of telehealth is electronic communication or e-visits. Studies show these encounters are both convenient and efficient while also producing high patient satisfaction. However, e-visits are only conducted by a fraction of physicians, less than 10%, in large part because these services too are not typically reimbursed.

We recognize all Medicare benefits are subject to overuse and abuse. To ensure the appropriate use of telehealth and RPM services, CMS could, for example, require providers, at least in their initial use of the benefit, to: outline how telehealth services will improve chronic care management; and, have a mechanism in place to electronically transmit a record of the telehealth encounter to the patient's primary care provider if one exists. In addition, if the benefit is offered on a provisional basis, providers could be required to publicly post their use/approval of the waiver; providers could be subject to waiver denial or revocation; and, could have their related billing practices audited to discourage or reduce abuse.

We believe substantially expanding Medicare telehealth and RPM coverage is past due. It is striking to note that comparatively more than two-thirds of state Medicaid programs require telehealth parity under private insurance. Numerous studies have, again, shown telehealth to be substitutable, cost effective, quality improving, and preferred by beneficiaries. We again urge CMS to substantially re-evaluate its telehealth and RPM payment policies particularly related to Alternative Payment Models (APMS).

Medicare Diabetes Prevention Program (MDPP)

Among other proposed MDPP changes, for program integrity purposes, CMS is proposing additional supplier enrollment requirements and supplier compliance standards. CMS is proposing that if a beneficiary develops diabetes during the MDPP service period, the beneficiary could still continue to receive MDPP services. CMS is proposing a two-year limit on ongoing maintenance sessions, making the MDPP service period a total of three years. CMS is proposing to make less restrictive the link between payment and beneficiaries meeting weight loss targets. CMS is also proposing a Center for Medicare and Medicaid Innovation (CMMI) demonstration to test a virtual MDPP.

AMGA remains strongly supportive of the MDPP program. We support the proposal to allow beneficiaries that develop diabetes while participating in the program be allowed to continue participation. To allow for wider participation, we recommend CMS expand the program's single exception rule to include major life events, such as a death in the beneficiary's immediate family or a serious hospitalization. We support the agency's proposal to make the weight loss targets less restrictive. Since, however, MDPP is ostensibly a pay for performance program, providers are incented to enroll beneficiaries who comparatively are more likely to succeed. This suggests the need for appropriate risk adjustment. Finally, AMGA supports a CMMI virtual MDPP demonstration. Should CMS forward a CMMI demonstration, we encourage the agency to test the model using all appropriate telehealth and remote monitoring technologies.

Medicare Shared Saving Program

CMS proposes to remove the requirement that ACOs include a narrative describing any financial relationships that exist between the ACO, Skilled Nursing Facility (SNF) affiliates, and acute-care hospitals in their SNF three-day waiver application. CMS also is proposing to remove the requirement that an ACO must submit documentation that demonstrates that each SNF on their list of SNF affiliates has an overall rating of three stars under the CMS Five-Star Quality Rating System. AMGA generally supports these proposed changes. However, we are concerned the SNF three star prerequisite may impede beneficiary access or cause or require beneficiaries to receive care at a SNF facility that is a greater distance from their family.

AMGA supports the agency's proposal to include Rural Health Center (RHC) and Federally Qualified Health Center (FQHC) claims as primary care services furnished by a primary care provider in ACO beneficiary assignment methodology. We also support the proposal to include the use of three chronic care management service codes and four behavior health integration service codes for ACO beneficiary assignment purposes beginning in performance year 2019. AMGA also supports CMS' proposed changes to the use of TIN claims data in the patient attribution process and the agency's proposal to reduce to the quality measure validation audit match rate from 90% to 80%.

Appropriate Use Criteria (AUC) for Diagnostic Imaging Services

CMS is proposing to delay until January 1, 2019 the requirement that physicians use AUC in ordering advanced imaging services as mandated under the Protecting Access and Medicare Act of 2014. The proposed rule states further that 2019 would be considered a testing and education year, and that the AUC would have no effect on reimbursement. CMS also proposes to allow physicians to voluntarily participate in using AUC in 2018.

AMGA supports this proposed change since it will allow providers more time to align AUC with their use of Clinical Decision Support Mechanisms (CDSM) and would allow the agency time to weigh incorporating AUC in the Quality Payment Program (QPP) or via QPP incentives. We note the connection to the QPP because over utilization largely becomes moot under value-based arrangements. Therefore, we do not see its relevance as related to the APM pathway.

Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM) Programs

CMS is proposing for the final PQRS payment year, or 2018, to reduce the number of quality measures reported from nine to six. CMS states it is proposing this change retrospectively to align with the requirement that eligible clinicians under the Medicare Access and CHIP Reauthorization Act's (MACRA) Merit-based Incentive Payment System (MIPS) report six quality measures. CMS also is proposing to make the Consumer Assessment of Health Plans (CAHPS) survey for PQRS optional under CMS web interface reporting for practices 100 or more in 2016.

As noted in previous comment letters, AMGA strongly supports regulatory policies that improve quality and consequently patient outcomes. For example, in our August 21 MACRA comment letter we supported CMS' proposal to retire topped out measures, and we supported publicly reporting of MIPS quality scores via the agency's Physician Compare website. However, we opposed the agency's proposal to increase the MIPS exclusion thresholds such that, again in 2019, two-thirds of eligible clinicians would be exempted from reporting on quality. Therefore, we do not support this proposed change.

CMS also is proposing retroactive changes to the Value-based Payment Modifier (VM) program. For those not meeting VM's minimum quality reporting requirements, CMS is proposing to reduce the negative payment adjustment from -4 to -2 for groups of ten or more and from -2 to -1 for solo and groups two to nine. CMS also is proposing to hold harmless all groups and solo practitioners who meet the minimum quality reporting requirements from a downward payment adjustment for performance under quality tiering. We also oppose these proposed VM regulatory changes for the reason noted immediately above. We also oppose proposing retroactive changes to these programs since these have the de facto effect of penalizing those providers that fully and faithfully participated in these program and rewarding those that did not.

Evaluation and Management (E/M) Guidelines

CMS states in the proposed rule the agency is in agreement with stakeholders that E/M documentation guidelines should be revised to reduce clinical burden and improve care coordination and provider work flow. The agency is seeking comments on specific changes to reduce documentation, specifically concerning changes to beneficiary history and physical exam guidelines. CMS is asking whether it would be appropriate to remove documentation requirements for beneficiary history and physical exams for all E/M visits at all provider levels. CMS questions whether this documentation is still useful in light of population based screening efforts.

The current documentation requirements were developed to allow providers to differentiate the complexity of E/M visits to determine the appropriate fee-for-service (FFS) reimbursement. This requires the provider to document the chief complaint (CC) and a brief history of present

illness (HPI) while a detailed history requires the documentation of a CC, an extended HPI, plus an extended review of systems (ROS) and pertinent past family and/or social history (PFSH).

Current E/M visits, particularly complex patient visits, involves a substantial amount of required documentation (as demonstrated, in part, by the fact Medicare Learning Network's "Evaluation and Management Services" guide is 90 pages). Frequently, however, the level of documentation is not commensurate with delivering care that is both high quality and time efficient. For example, if a Medicare beneficiary presents with new onset diabetes, which warrants a level 5 visit, the provider is still required to document their examination of unrelated organ systems that do not contribute to treating and stabilizing the diabetic beneficiary. In addition, this level of documentation increasingly is unjustified as the Medicare program moves increasingly to value-based payments – where the provider is no longer incented to drive utilization to maximize FFS reimbursement but instead improve quality and reduce spending.

Documentation requirements should align and support reimbursement. That is, documentation requirements under FFS should not and cannot be the same as under value based arrangements if we expect these arrangements to succeed. Documentation under value based arrangements should provide the necessary information to allow the primary provider and all other cross-covering providers to treat the patient longitudinally. These comments aside, there remains the need for providers to be appropriately reimbursed for more complex patients or populations. Risk adjustment is the best way to do this. As is currently the case, dividing visits into numeric levels actually punishes the provider by having to spend more time instead of less on documenting complex patient care.

<u>Physician Coding for Insertion and Removal of Subdermal Drug Implants for the Treatment of Opioid Addiction</u>

CMS is proposing three new HCPCS G-codes to recognize a 4-rod, long-acting subdermal buprenorphine hydrochloride drug implant utilized for the treatment of opioid addiction.

AMGA is on record strongly supporting an array of efforts to address the opioid addiction. On August 16, AMGA sent a letter to the White House and congressional leaders urging them to take immediate action to address an epidemic that kills 90 Americans every day, or more than 35,000 annually. <u>The New York Times</u> reported on September 5 that total drug overdose deaths numbered approximately 64,000, which is a 22% increase from 2015. Fentanyl and fentanyl analogue-related deaths numbered more than 20,000 in 2016 and are up a staggering 540% over the past three years. Because the addition of these three codes promises to provide more accurate payment and therefore greater use and adoption of this addiction treatment, AMGA supports the proposal.

Thank you for your consideration of AMGA's comments. If you have any questions please do not hesitate to contact David Introcaso, Ph.D., Senior Director of Regulatory and Public Policy, at dintrocaso@amga.org or at 703.842.0774.

Sincerely,

Ryan O'Connor
Interim President and Chief Executive Officer
AMGA