



**American
Academy of
Home Care
Medicine**



September 8, 2015

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
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 (CMS-1631-P)

Dear Acting Administrator Slavitt:

The Academy represents the many physicians, nurse practitioners, physician assistants and others who are bringing home care medicine to home limited beneficiaries those who need it across the country. A nonprofit professional society, the Academy has been in existence since 1988. We are pleased to offer our comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule for calendar year (CY) 2016 to revise the Medicare Physician Fee Schedule and Part B (Proposed Rule), published in the Federal Register on July 15, 2015 (80 Fed. Reg. 41,686).

I. Executive Summary

- Responding to CMS request for input the Academy offers comments and is pleased to join with other medical associations in comments to improve payment for primary care and care coordination. The multispecialty coalition letter is added as an addendum to this letter.
- The Academy joins other medical associations to encourage CMS to reduce administrative burden for CCM and TCM. The Academy, however, is perplexed why at the same time the CMS seeks input to encourage the use of CCM and TCM and the 24/7 coverage of Part B providers, the CMS would propose to eliminate the general supervision incident to ability of non billing Part B providers who contribute to the rendering and supervision of CCM and TCM.
- Additionally, the Academy supports establishing separate Medicare payments for collaborative care. We also strongly support Medicare coverage of collaborative care models for patients with common behavioral health conditions. Additionally, and as noted below the Academy encourages the Congress and CMS to cover additional services in the home such as IV infusion in order to improve care and lower cost particularly in the context of alternative payment models.

- The Academy strongly supports the CMS proposal to accept the RUC recommendations for advance care planning services, and to begin paying for these services in 2016. The Academy encourages CMS to establish national coverage and payment and to not create the potential for variation in beneficiary access to this important service through the regional Medicare Administrative Contractors.
- The Academy supports the expansion of Telehealth coverage under Medicare including the proposed addition of prolonged service and end stage renal disease codes. We also encourage the Congress and CMS to add the home sites of service to those covered as originating sites.
- The Academy commends CMS for its proposal to provide a separate payment to rural health clinics and federally qualified health centers for chronic care management (CCM) services.
- CMS proposes to have the single transportation payment under the PFS allocated across all patients receiving portable x-ray regardless of insurance status not just Medicare patients. We encourage the CMS to consider the negative impact of such provision in the context of the improved care and lowered cost of service in the community as compared to facility based care.
- The Academy is pleased that CMS has not proposed substantial changes in the Physician Quality Reporting System (PQRS) but we remain concerned about the reporting requirements and offer suggestions to make the program more manageable and encourage greater participation by physicians and other eligible professionals.
- The Academy supports the CMS decision to “stabilize” the value-based payment modifier (VBPM) program rather than increasing penalties. Additionally, the Academy supports CMS’s proposal to stratify the cost measure benchmarks, so physicians, groups and others falling under VBPM and MIPS in the future are compared to like groups treating patients with similar profiles and we look forward to contributing and offering analysis in this area.
- The Academy appreciates the opportunity to offer comments regarding the impact of the self-referral regulations on health care delivery and payment reform. The Academy encourages CMS to expand its exceptions and issue waivers of certain of the physician self-referral prohibitions in order to support the development of innovative payment and delivery models.
- The Academy joined other medical associations in support of MACRA, its development of alternative payment models (APMs) and incentive payments for physicians who participate in APMs. The Academy offers specific suggestions in key areas relative to the forthcoming Request for Information regarding MACRA APMs.

II. Provisions of the Proposed Rule for the 2016 Physician Fee Schedule

1. Improving Payment for Primary Care Services and Care Coordination
 - a. Chronic Care Management (CCM) and Transitional Care Management (TCM) Services

The Academy appreciates CMS’ decisions to pay for non-face-to-face management and care coordination services via the Chronic Care Management (CCM) and Transitions of Care

Management (TCM) CPT codes (99490 and 99495/99496, respectively). CMS, in the proposed rule for 2016, asks for recommendations to reduce the administrative burden of these services. In addition to agreement with the comments in the attached Multispecialty Coalition Letter - the Academy provides the following recommendations re. Reduction in Administrative Burden to achieve the desired and anticipated benefits of CCM and TCM:

- Eliminate the beneficiary co-payment – Providers treating beneficiaries who would benefit from CCM report that beneficiaries are objecting to consent to receive CCM/TCM based on the co-payment. Many of the Academy members' patients are on stringently fixed and limited budgets and so any additional cost is resisted. The beneficiaries trust that the service will be rendered and thus, this is not a matter of needing these beneficiaries financially involved from a service audit perspective. In fact, some of these beneficiaries have already received CCM like services by their provider that was not historically paid by Medicare. The beneficiaries simply will not consent in light of the co-payment. We recognize that co-payment obligations may be a matter for Congressional involvement. Nonetheless, we encourage CMS to review elimination of the co-payment. Alternatively,
 - CMS should develop a means to reward beneficiaries in the traditional Medicare program for aligning with Medicare practices that offer CCM/TCM and like services. This would be akin to aspects of reduced co-payment and additional benefits that CMS is implementing or now soliciting participation for Next Generation ACOs and in the recently announced Value Based Insurance Design (VBID) test for Medicare Advantage health plans in certain states,
 - Permit Part B providers to submit claim for TCM when the face to face encounter has occurred,
 - Permit Part B providers to submit claims for CCM when the 20 minutes of service has been satisfied provided the elements of service for the code have been met and service continues through the month,
 - Require EHR vendors, including through certification requirement to demonstrate the ability to support CCM/TCM services documentation capture and cumulating of requisite code time.
 - Eliminate the requirement that staff time only count toward CCM/TCM when it is rendered by clinical staff. While we recognize this is part of code language, we strongly encourage CMS to adopt regulatory interpretation that the time of trained administrative staff could count when services that satisfy CCM/TCM service requirements are documented in the medical record. The clinical staff requirement is serving as an arbitrary bar to services delivery and the benefits of CCM/TCM. Many practices around the country have appropriately trained and experienced staff that is rendering the exact care coordination services required under CCM/TCM. It is only that this staff does not have "clinical staff"/paraprofessional and state regulated designation that their time is not counted. This is a hindrance to the rendering and benefits of CCM/TCM for beneficiaries, practices and the Medicare program itself.

Accordingly, we encourage CMS to consider adoption of an alternative standard that if the administrative practice staff is authorized to document in the medical record by their practice or organization then this standard should suffice to document the competency and quality assurance of the staff providing CCM/TCM services on an incident to basis. Authority to document in the medical record is recognized across other areas of Medicare medical record documentation and including hospital setting as reviewed by the Joint Commission.

This alternative, in addition to supporting the benefits of CCM/TCM will also importantly support the announced CMS goals of practice transformation to value including APMs.

- Maintain the ability of non billing Part B provider's to provide general supervision for incident to CCM/TCM services. As noted elsewhere in these comments (and unless we are misunderstanding the purpose and end result of the CMS proposal to eliminate the ability of non billing Part B providers to provide general supervision for CCM/TCM), we encourage CMS to maintain the current provisions for general supervision of CCM/TCM incident to services.

b. The Academy joins with other medical associations in recommending coverage and payment for;

1. Additional CCM Services. We believe that the payment for 99490 (*chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with required elements*) is inadequate to appropriately compensate practices for all the clinical activities and documentation requirements that Medicare established for physicians to bill for CPT code 99490. We hear from our members that CCM is not being utilized as much as it should, given the needs of the chronically ill Medicare population potentially eligible for this service.

We recommend that CMS recognize CPT code 99487 (*complex chronic care management services, at least 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with specified required elements*) in addition to 99490. The CPT manual includes guidelines for reporting complex care management services based on the total duration of staff time.

2. Collaborative Care

- i. Ongoing Collaborative Care Involving Face-To-Face Visits
- ii. Interprofessional Consultations Without a Face-to-Face Visit
- iii. Care Provided in a Multidisciplinary Clinic

3. Patients with Acute illness or on a Course of Chemo- or Immunotherapy

- i. Management of Patients on Chemo- or Immunotherapy
- ii. Non-Face-to-Face Care Provided During an Acute Illness

4. Interactive Complexity

5. Medication therapy Management and Genetic Counseling Services

- i. Medication Therapy Management by Pharmacists
- ii. Genetic Counseling by Non-Physicians]

6. Collaborative care models for beneficiaries with common behavioral health conditions that it discusses in the proposed rule and for,

7. The following existing CPT codes:

- i. CPT Codes 99358 and 99359 - Prolonged Service Without Direct Patient Contact and
- ii. CPT Codes 98960, 98961 and 98962, Education and Training for Patient Self-Management

Our recommendations for CMS to develop coverage and payment for the above services is based to great extent on the information gained from our Academy members who participate in the Medicare Independence at Home Demonstration, in other MSSPs and in private care coordination and shared savings programs with focus on the high cost multimorbid population.

This information provides that practices have to develop and render these services that are not currently described, covered and paid or that while codes are adopted the services are not covered and paid. Thus, the practices and affiliated organization are absorbing the cost of care.

At the same time we know through the results of these services and the various programs that care is being improved, satisfaction increased and savings accruing to CMS and private payors.

Therefore to encourage the development of these services and to increase the benefits obtained, CMS should develop coverage and payment for these services as soon as feasible.

2. Advance Care Planning

The Academy strongly supports the CMS proposal to accept the RUC recommendations for advance care planning services, and to begin paying for these services in 2016.

However, as with other Medicare Part B services, particularly with application to the home limited who have difficulty accessing services, we encourage CMS to adopt a national policy and not to leave the access to the needed ACP services to decisions of local Medicare Administrative Contractors. This is consistent with our view that covered and medically necessary Part B services should be available absent variation in access and coverage to a home limited Medicare Part B beneficiary based on the area of the country in which their residence is located. CMS national policy in this manner should work to decrease or at least serve to not exacerbate regional variation in access, utilization and cost of services.

Finally, we believe that these services should not be included in the net reduction target for CY 2016 given that like CCM and TCM they are new, intended to improve care and reduce cost through care coordination and management, and CMS is seeking input to improve payment in these areas.

3. Medicare Telehealth Services

The Academy supports the expansion of Telehealth coverage and payment under Medicare consistent with the establishment of an evidence base. Thus, we support the addition of the proposed codes for this year. Moreover, we encourage the Congress and CMS to add the home place of service and assisted living facility (ALF) place of service as originating sites subject to coverage and payment under Medicare Telehealth policies.

We encourage the addition of the home and ALF as originating sites as supporting evidence begins to emerge out of research being done in the Veteran's Administration, through the Independence at Home practices, and that which is underway in large, urban/rural health systems.

Our recommendations at this time:

- The home and ALF settings should be added as a covered site of service for the home-limited regardless of their geographic location as they are an underserved population. Such coverage will improve care, reduce frustration, isolation, trauma, and reduce cost of transport and care at a facility (often many miles and hours away).

Expressly adding these locations as approved originating sites also produces the benefit of regulatory consistency in that "housecalls" are covered "in lieu of an office visit" when specified medical necessity requirements are met. The office is an approved originating site for Telehealth, and, yet, there is no corresponding express "in lieu of an office visit" language to provide coverage through the Telehealth regulations. This equivalency should be established.

- In the interim, a (waiver) process should be considered such that the home on an expedited basis is covered where a medical team (of varying composition), is taking care of the chronic conditions of a home-limited beneficiary. Such waiver process should also be incorporated into the development of alternative payment models unless the home is a covered location by the time that APMs are established.
- A TEP or research task force should be established by CMS to review and develop coverage and payment policies to support the use of a) telemonitoring on a pre-acute basis to assure safety and to prompt intervention to avoid sudden status change leading to preventable admissions; and b) telemonitoring on a post-acute basis to assure a safe transition of care to the home. Thus, these will support the avoidance of initial admission and subsequent readmissions. This will also support the practice transformation to pro-active practice orientation necessary for population health management.

4. "Incident to" Proposal: Billing Physician as the Supervising Physician

CMS is proposing to require that a physician or other practitioner who bills for "incident to" services must be the same physician or practitioner who directly supervises the service. CMS is proposing to eliminate the current regulatory language that "the physician (or other practitioner) directly supervising the auxiliary personnel need not be the same physician (or other practitioner) upon whose professional service the incident to service is based," and substitute language requiring such services to be "furnished under the direct supervision of the billing physician."

The Academy encourages CMS to abandon this proposal as the Academy is perplexed why at the same time the CMS seeks input to encourage the use of CCM and TCM and the 24/7

coverage of beneficiaries that the CMS would propose to require that the billing physician and the supervising physician be one and the same.

This proposal could prove to significantly discourage the development of community provider relations of (health systems and) practices and the ability of practices to assure 24/7 access to beneficiaries requiring care coordination and chronic care management. This is especially true in the increasingly competitive market for primary care Part B providers and the need to develop the necessary workforce for the rapidly increasing number of beneficiaries especially those with multiple chronic diseases and disabilities.

Beyond undermining the development of the workforce and relationships reaching into the community and lowest cost home setting of care, this proposal does not take into consideration the premises of the cost effective arrangements of group practice in the office setting where the supervising physician and the billing physician may not be under the same roof at the same time, and yet, the quality and timing of care for the beneficiary is not questioned. The development of the workforce must take into consideration not only 24/7 access is required under the new codes but also the time off of physicians in practical terms such as not being on call 24/7 and appropriate time off for vacations and emergencies. Coverage arrangements are familiar and widespread across medical practices and, again, unless we misunderstand the purpose and intended results, this proposal does not recognize this practical reality of medical practice.

Finally, we observe that CMS announcements and MedLearn materials themselves note that;

“Practitioners may use individuals outside the practice to provide CCM services, subject to the Medicare PFS “incident to” rules and regulations and all other applicable Medicare rules. Supervision CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (*or other appropriate practitioner*) under the general supervision (rather than direct supervision) of a physician (*or other appropriate practitioner*).”

The Academy also observes as do others that CMS Form 1500 provides for this scenario by providing for both a “rendering provider” number listed in block 24J, and the “billing provider” number listed in block 33A.

If CMS were to adopt the proposed amendment, it should specify that physicians and other Part B practitioners in the same group practice or clinic are considered as one entity for purposes of linking billing and supervision. Otherwise, this proposal could further eliminate flexibility across group practice and again not provide for the workforce relationships necessary for the increase in beneficiaries requiring chronic care management and 24/7 access to care.

5. Chronic Care Management (CCM) Services for Rural Health Clinics and Federally Qualified Health Centers

The Academy commends CMS for its proposal to provide a separate payment to rural health clinics (RHCs) and federally qualified health centers (FQHCs) for CCM services, as part of the RHC and FQHC benefit. As proposed, an RHC or FQHC may bill once per calendar month for

at least 20 minutes of qualifying CCM services by a physician, nurse practitioner, physician assistant, or certified nurse midwife, to patients with multiple chronic conditions that pose a risk of death, acute exacerbation or complication, or functional decline. Payment will be based upon the Physician Fee Schedule (PFS) national average non-facility payment rate and subject to beneficiary notification, consent, coinsurance, and deductibles. We are also pleased by CMS' statement that "The CPT code descriptor sets forth the eligibility guidelines for CCM services and will serve as the basis for potential medical review" (page 41794) and we support the proposal to waive the RHC and FQHC face-to-face requirements when CCM services are furnished.

We agree this will support the Affordable Care Act's goal of furnishing integrated and coordinated health services. Moreover, it will help assure that rural and low-income individuals with limited options and resources who are served by RHCs and FQHCs, and who are among the most isolated of the nation's beneficiaries, can receive the care coordination and chronic care management to which they are entitled and that they need.

6. Single Transportation Payment for Portable X- Ray Allocated Across Patients

CMS proposes to have the single transportation payment under the PFS allocated across all patients receiving portable x-ray regardless of insurance status not just Medicare patients. We encourage the CMS to consider the negative impact of such provision in the context of the improved care and lowered cost of services in the community as compared to facility based care. Moreover, that CMS policy whenever possible should encourage and not discourage community based services. We are also concerned about provisions that encompass other than Medicare coverage and payment when it is often the case that other third party payment offsets reduced Medicare payment levels and this enables providers to be available to Medicare beneficiaries.

7. Physician Compare - Acceptance of Medicare Advantage

We appreciate that CMS' proposal to include Medicare Advantage plan acceptance on the Physician Compare profile page is well intentioned to provide Medicare consumers needed information. However, we want to point out a couple of concerns. While CMS has recently committed to improving the accuracy of MA provider directories in a timely fashion, this is an area where there has been a high degree of error.

More importantly, there remains misunderstanding of the benefits of home based primary care (HBPC) providers to Medicare Advantage plans. MA plans need the services of home care medicine providers for the same reasons as does the traditional program – that is to improve care and reduce cost. This is particularly the case with high utilizers who are frequently admitted to the ER, admitted as inpatients as and then more frequently than others readmitted. HBPC providers can assist MA health plans in managing the care of these enrollees to the benefit of the MA member, the MA plan and the Medicare program. The Academy would be pleased to present data and strategies in this area.

Unfortunately, many MA plans including those with national presence remain reluctant to contract with HBPC providers despite the fact that their office based primary care network

providers are not effectively or are simply no longer managing the care of these MA members. This is the case as the MA members are not accessing office based services nor are the office practices reaching into the community to avoid delayed care in the more expensive hospital setting. Thus, there is an appropriate and non-duplicative need for MA plans to directly contract with HBPC providers, both MDs and NPs alike along with team based practices. The Academy is interested in working with CMS on education, communication and regulatory approaches to encourage the appropriate contracting for such home based primary care. In the interim, we have concerns regarding the “message” that MA plan acceptance would present to beneficiaries absent the encouragement of MA plans to contract with HBPC providers.

8. Physician Quality Reporting System (PQRS)

The Academy is pleased to see that CMS has not proposed substantial changes to the 2016 PQRS program. This is the case as managing and implementing changes in reporting measures amidst competing and compounding demands such as Meaningful Use (MU), the Value Modifier (VM) and ICD-10, and transition to APMs and the MIPS program, is administratively burdensome, costly and can distract from Part B providers focus on beneficiary care.

For some physicians, this is simply not feasible and leads to the low PQRS participation rates. Beyond the impact on participation rates there is also clinical concern that PQRS requirements may hinder quality improvement efforts, particularly where requirements are not based upon the multimorbid status of the Part B provider’s beneficiary patient panel. We encourage CMS to conduct an overarching review in this area especially with the transition from the PQRS program to the MIPS.

We also concerned with CMS’ elimination of claims based measures when claims based reporting continues to be the most popular reporting option and one relied upon by small practices such as those who render HBPC. This is also the case given the potential discussed above for such providers to be penalized under the VM if EHR data is not accepted and CMS deems the Part B Provider (EP) average. This also serves to undermine the confidence of Part B providers to continue to invest in CEHRT for the first or multiple times.

Significant is the potential that if physicians are not considered to successfully report under PQRS, MU, and the VM for the 2016 performance period, then in 2018 they are potentially subject to total penalties of ten percent or more, plus the additional two percent adjustment due to sequestration. This is a material financial impediment to rendering already limitedly compensated primary care services. This is concerning when the need for such services is increasing and when CMS under other initiatives is seeking input on how to improve payment for primary care services. Thus, one way to improve payment is to not subject the extended hardworking primary care providers to the potential for such financial penalty.

9. Requirements for the PQRS Reporting Mechanisms

One of CMS’ goals is to report data on race, ethnicity, sex, primary language, and disability status. As we have learned from the facilitation of the Independence at Home Demonstration

Learning Collaborative such data is critical to accurate risk adjustment, to beneficiary and population risk stratification, and to performance improvement. Thus, we support the incorporation of code sets to capture such data. We also support the related need for standardization in the definition and collection of these elements to ensure meaningful interpretation and valuation by CMS in terms of risk adjustment and in relation to comparisons across providers and sites. The Academy is interested in assisting CMS in this area and notes that Academy leaders are already participating in related Technical Expert Panels. We look forward to expanding this assistance with CMS.

We do not anticipate that the capture of these data elements will be overly burdensome in and of themselves and the benefits as we know will far outweigh the cost. However, we do encourage based on our learning from other reporting requirements and the implementation of new covered services (CCM/TCM) that multiple parties such as EPs, health IT vendors and CMS require an opportunity to effectively build the elements into their workflow and to validate the reporting.

10. Proposed Changes to the Requirements for QCDRs

CMS is required by MACRA to create an option for EPs participating in the Group Practice Reporting Option (GPRO) to report quality measures via a QCDR. CMS proposes that QCDRs have the ability to submit quality measure data for group practices, in addition to individuals, starting in 2016. We support the further development of QCDRs as this reporting option often offers physicians more relevance in terms of their patient population to participate in PQRS. However, we request CMS provide QCDRs the flexibility to determine whether group practice-level reporting is even relevant and appropriate for the registry's target population and for the registry to determine if they are prepared to collect and report group practice level data to CMS. Accordingly, Group practice-level reporting should be an option for QCDRs and not a mandate.

11. Proposed Criteria for Satisfactory Reporting by Individual EPs for the 2018 PQRS Payment Adjustment

The Academy supports CMS' proposal to refrain from making substantial changes to the 2016 PQRS program. We are also pleased that CMS continues to maintain the widely-used claims-based reporting option.

12. Proposed Criteria for Satisfactory Reporting by Group Practices Participating in the GPRO

CMS proposes to require practices of 25 or more who report through the GPRO web-interface to have to report on the CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) survey through a certified survey vendor. The Academy encourages CMS to enhance outreach and disclosure regarding the cost to administer the "CAHPS for PQRS" survey through a CMS certified vendor, as well as the length of the survey. The "CAHPS for PQRS" survey currently has 80 questions and is 12 pages long without a cover letter, compared with the CG-CAHPS (Clinician & Group Consumer Assessment of Healthcare Providers & Systems) survey instrument which has 31 core questions and the HCAHPS survey

(for hospitals) which has only 32 core questions. Additionally, CMS should enhance education to groups and providers of how this survey fits into the overall fabric of federal quality reporting.

13. Informal Review and the Need for Additional Time to Request a Review

The Academy encourages CMS to extend the timeline from 30 to 90 days upon the release of the PQRS Feedback Reports. The process for accessing a PQRS Feedback Report is cumbersome and due to problems outside the physician practice control it often takes an EP or group practice 30 days just to obtain a PQRS Feedback Report, not to mention the time needed to analyze the report and assess whether to request an Informal Review. We also encourage CMS to extend the deadline as there are instances where CMS defaults to the Informal Review process when CMS has issues with data received from a physician or group practice data. We understand that in 2014, there were issues related to practices' GPRO registrations where group practices and individual physicians were unable to submit their PQRS data successfully.

Moreover, PQRS, the VM, QRURs, and public reporting on Physician Compare are becoming increasingly interwoven, and thus, filing an informal review may have downstream implications. This is the case as under current policy, if a practice files an Informal Review, their PQRS information within the VM is considered "average." Classifying a practice or physician as "average" is not reasonable if a practice is high cost or low quality and deemed "average" on PQRS, as they may be subject to a VM penalty. This also raises the question as to whether practices will also have to file a separate Informal Review for the VM. There are additional questions and issues to consider if that is the case:

- CMS can take up to 6 months to respond to a PQRS appeal. In such situation, by the time CMS gets back to a physician or practice as deemed successful in PQRS the VM Informal Review period would have closed. Therefore, there is a need for an extended VM Informal Review period too, especially if a practice must file a separate VM Informal Review.
- CMS has stated that if there is inadequate PQRS information or no PQRS data, the physician will have an incomplete QRUR. Does CMS have plans to re-issue a QRUR for the physician or practice with the updated information? If not, then this defeats the purpose of physicians having access to detailed information to improve and coordinate the care they provide.

Finally, we join with others to encourage CMS to allow EPs and group practices to contest their PQRS payment adjustment if they believe there were calculation errors due to ICD-10 transition.

14. Volume Based Payment Modifier/MIPS Risk Strata - Improvement to Current Risk Adjustment Methodologies

The Academy supports CMS's proposal to stratify the cost measure benchmarks, so physicians, groups and others falling under VBPM and MIPS in the future are compared to like groups treating patients with similar profiles. The Academy has presented analysis (developed external to the Academy), to CMS that demonstrates the inadequacy/inaccuracy of current HCC risk adjustment models that are currently in place and will be applied to VBPM/MIPS. The underestimate of current models was approximately 20 percent for certain Medicare beneficiary

populations. The presented analysis was then evaluated and accepted by CMS (and OMB) for more accurate shared savings calculation in the CMMI Independence at Home Demonstration. We would be pleased to present this analysis along with practicable recommendations for incorporation of more accurate risk adjustment/risk strata development for VBPM/MIPS.

Moreover, we encourage CMS review of this analysis for application to the high cost multimorbid Medicare beneficiaries regardless of Medicare payment model or quality program. We also continue to encourage CMS to review practicable site of service comparisons and the establishment of sub-specialty designations for Part B providers to make such comparisons practicable under the current claims based system. In addition, the Academy encourages CMS to move forward with expanding its risk-adjustment for socioeconomic status methodology into the calculation of the per-capita cost measures and the claims-based outcome measures. Risk-adjusting for socioeconomic status ensures the measures are more reasonable and sets the standard for comparison by adjusting for factors outside of a Part B provider's (EPs) control

15. Physician Self-Referral Updates

The Academy appreciates the opportunity to offer comments regarding the impact of the self-referral regulations on health care delivery and payment reform. As CMS noted in its proposed rulemaking, significant changes in health care delivery and payment have occurred since the enactment of the self-referral law, including numerous initiatives to align payment under Medicare, Medicaid, and non-federal programs with the quality of care delivered. We have learned through the very detailed care redesign that is occurring and producing success in Independence at Home that the existing regulations based on a siloed and volume driven delivery system are indeed dysfunctional and produce impediments to care. Accordingly, CMS, within the context of APMs and other shared savings models, should consider the development of regulatory relief in the following areas:

The 3 day requirement for SNF admission if the patient is being admitted from the home or from a qualified urgent care facility to a SNF sub-acute unit in lieu of hospitalization. This modification we understand has been finalized for Track 3 ACOs and we encourage that this be expanded to APMs and other shared savings models. the other tracks and programs noted above.

Homebound definition for home health agency services. CMS should cover and pay home health services when ordered by an APM/shared savings practice without the requirement for the beneficiary to meet the Medicare Part A "homebound" definition.

Waiver of Certain Hospice Provisions to a) reduce the hospice conditions of payment provisions with relationship to limits to the amount of beneficiary expense and b) exclude beneficiaries "enrolled" in the APM practice from the hospice cap penalty calculation.

Also, while not waivers of existing regulations the Committee should consider:

Referrals to urgent care centers related to Chronic Care Medical Practice Teams – a waiver of the Stark restrictions are granted for the provision of diagnostic and therapeutic services to the homebound and frail elderly by related entities.

Medicare Hospital Notification – A requirement of actionable notification of admission to both the ED and the hospital (possibly as a condition of payment) for all Medicare beneficiaries by the admitting institutions and that this database be available to shared savings/APM participants.
Coverage and Payment for Home Infusion Services

Financially Sustainable Payment for Diagnostic Services in the Community – We understand from our IAH work that an amount of admissions are driven by the need to obtain timely diagnostic information for medical decision making. In such cases, it is not always the case that the beneficiary needed to be admitted, rather, it was the lack of available and timely diagnostic services in the community. To the extent that CMS payment policies have a role in restricting the availability of such services as they are not financially feasible, we encourage CMS to review such payment policy in the light of the increased cost incurred by having such services rendered in a facility. This is one reason why we are concerned about CMS proposal to allocate the lab transportation payment across all patients, not just Medicare beneficiaries, as we believe this could exacerbate the lack of timely diagnostic resources in the lower cost community setting.

Coverage and Payment for Home Infusion – Congress and CMS should establish coverage and payment under Part B for all home infusion services in the context of APMs and shared savings models. Again, this avoids the need for the more expensive facility setting for services that can be appropriately rendered in the community. This also corresponds to the corollary input relative to Improvements for Primary Care and Care Coordination that includes recommendation for payment for Patients with Acute illness or on a Course of Chemo- or Immunotherapy.

Medicare covers infusion therapy in offices and institutional settings. Studies estimate that 23% of beneficiaries receiving antibiotic infusions would begin receiving services in the home setting if Medicare adequately covered infusion in the home. Estimated savings to the Medicare program for the 10-year period from 2015 to 2024 are \$80 million (12.6%), of the overall cost of infusion services that would migrate from HOPDs, physician offices, and SNFs to the home. This does not include travel cost and inconvenience to beneficiaries. This also does not include potential additional savings that could result from the avoidance of hospital stays, hospital-acquired infections and SNF admissions.

Under this recommendation Medicare Part B should cover the professional services, including nursing services (other than nursing services covered as home health services), administrative, compounding, dispensing, distribution, clinical monitoring, and care coordination services that are necessary for the provision of infusion therapy in the home. Part B payment would also cover all necessary supplies and equipment (i.e., medical supplies such as sterile tubing and infusion pumps) as well as other items and services that the Secretary of DHHS deems necessary to administer infusion drug therapies safely and effectively in a patient's home. Home infusion therapy providers would need to be accredited.

We recognize that legislation regarding Home Infusion coverage and payment has been introduced in the past and we support the passage of such legislation. That said, we believe that such coverage and payment would produce improved care and overall cost savings especially when combined with the recommendation for payment for service for Patients with Acute Illness or on a Course of Chemo-or Immunotherapy.

16. Defining Physician-Led Alternative Payment Models (APMs) under the MACRA

The Academy supports the development of Physician Led Alternative Payment Models. CMS, as you note in the Proposed Rule intends to publish specific questions related to the MACRA APM provisions in a forthcoming Request for Information (RFI). The Academy looks forward to providing input to CMS through the RFI process. In the interim, we provide the following observations;

Definition of Financial Risk

The issue of how “more than nominal financial risk” and “two sided risk” will be defined is a critical question in the development of APMs. Under current circumstances physicians and team based practices participating in APMs should only be accountable for those aspects of costs that they can control or influence, such as the costs associated with the services they deliver or order and the care implications associated with the specific health conditions that they manage. In other words, the more authority APMs have regarding care pathways and decisions, the greater accountability they can be expected to accept.

A key aspect to be recognized in the definition of nominal financial risk and two sided risk is that the cost incurred (and “*opportunity cost*” of time and deployment of capital resources), in establishing an APM should be considered as more than sufficient to satisfy nominal financial risk/two sided risk particularly in the absence of guaranteed payment or shared savings.

Accordingly, the following are examples of cost that should satisfy the financial risk criteria that CMS develops.

- Equity contribution(s) in order to form an Alternative Payment Entity or to support the costs of delivering services under an APM that would be lost if the Alternative Payment Entity were not successful.
- Securing loans or issuing bonds in order to form an Alternative Payment Entity or deliver services under an APM that would require repayment regardless of the success of the APM.
- The start-up cost to form an Alternative Payment Entity, recruit additional clinical and non clinical staff, to purchase equipment, contract for services, engage in training, etc. especially to participate in a payment model that does not directly pay for these expenses;
- Incurring ongoing operating costs in order to deliver services to patients that are not directly reimbursable under the APM (such as hiring care managers);
- Incurring interim losses in revenues and reductions in retained earnings/profit by avoiding the use of billable services, preventing the need for billable services, using alternative services or methodologies that generate lower payment, or accepting a discounted payment, and,
- Opportunity cost of management time to implementing the APM that reduces compensable time on other activities;

The RFI, therefore should ask about (a) the types of costs physician led APMs are likely to incur in order to participate as an APM, (b) the types of costs that physicians and the APM can and cannot control for the types of patients and health conditions that would be covered by an APM and (c) request for thoughts on how to increase APM ability/authority to impact care and reduce cost combined with questions regarding meaningful quality measures and patient satisfaction.

Eligible Alternative Payment Entities

MACRA requires that an “Eligible Alternative Payment Entity” must be at financial risk, not the individual physician. This is a positive feature of the law because the Eligible Alternative Payment Entity could:

- Pool the patient panels of multiple physician practices, thereby making it easier for small physician practices to participate in payment models (formation of virtual groups) and also for physicians to participate with respect to subsets of their patients with specific medical conditions;
- Accept the risk of participating in the APM without directly jeopardizing the assets of the participating physicians or their practices; and
- Employ or contract with individuals with expertise in administration of APMs without requiring individual physicians or their practice administrators to develop that expertise.

At the same time, it will be important for CMS to establish standards for organizations to function as Eligible Alternative Payment Entities. The RFI could include the following questions:

- What are lessons learned from successful and from less than successful examples of how entities have played an intermediary role in both existing CMS programs and demonstrations and also those in the private sector?
- What restrictions in existing CMS programs and demonstrations regarding organizations playing intermediary roles should be maintained or modified in regulations regarding Eligible Alternative Payment Entities?
- What information about participation standards should be available to patients, family members, private payors and the general public so they can evaluate the APM program and participants?

Participation Thresholds

Several questions should be asked in the RFI regarding attribution and the numerical thresholds for physician and group participation in APMs. For example, the RFI should seek advice about how to measure the proportion of payments for physician services and the services of non-physician practitioners that are attributable to APMs in the following circumstances:

- When multiple physicians share the care of patients or non-physician practitioners or staff of other organizations;
- When patients receive services from non-physician staff in a physician practice;
- When patients receive services from a physician or NPP that are not documented using procedure codes because they are not currently covered and paid.

The RFI should also ask for advice on how to measure the proportion of a physician's/NPPs' patients participating in APMs, and whether this alternative to the criterion based on proportion of revenues should be used in all or only some circumstances. This will become important as APMs /shared savings models mature in the market and become increasingly effective over time.

Andrew M. Slavitt
September 8, 2015

Finally, the RFI should seek input regarding benefit design and beneficiary features that would encourage alignment of beneficiaries with quality APMs.

Evaluating APMs and Communicating Information About APMs to Patients

The RFI should ask how APMs can be evaluated and whether there are criteria that would measure benefits for physicians and physician led teams in terms of the ability to impact continuous performance improvement (CPI). Questions should solicit;

- Specific changes that should be made in current CMS regulations or procedures in order to facilitate access to claims and clinical data that would help organizations to develop successful APMs and again to contribute to CPI,
- Questions that would support the meaningful evaluation of APMs and their individual providers and,
- Questions that would solicit input regarding the communication of quality and cost information to patients, caregivers, and interested third parties.

We appreciate the opportunity to comment and we would be pleased to answer any questions.

Sincerely,

Gary Swartz

Gary Swartz
Associate Executive Director
443-961-8610

Addendum to Academy of Home Care Medicine Comment Letter

Andrew M. Slavitt
September 8, 2015

September 8, 2015

SUBMITTED ELECTRONICALLY VIA

<http://www.regulations.gov>

Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1631-P
Mail Stop C4-26-05
7500 Security Boulevard,
Baltimore, Maryland 21244-1850.

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS-1631-P)

Dear Mr. Slavitt:

The undersigned medical specialty societies [hereinafter, "Coalition"] appreciate the opportunity to provide comments on the Medicare Physician Fee Schedule ("MPFS") Proposed Rule for Calendar Year ("CY") 2016 (CMS-1631-P) [hereinafter, "Proposed Rule"]. Below we discuss our comments on a number of proposals regarding payment for advance care planning, chronic care management, transitions of care management, cognitive care services and collaborative care services made in the above-captioned proposed rule. The members of the undersigned societies provide all of the services discussed in this comment letter and we urge CMS to adopt our recommendations.

1. Advance Care Planning (ACP) Services

We support CMS' proposal to establish separate payment for Advance Care Planning (ACP) services using the RUC-recommended physician work and practice expense inputs. The Coalition includes many of the specialty societies that surveyed this code for the RUC and recommended separate payment for CY 2015.

As we have previously commented, there is extensive published clinical evidence supporting the improvement of care when these services are furnished to Medicare beneficiaries who wish to discuss their values and preferences for care.

Recommendation: this Coalition applauds CMS for this proposal and strongly recommends that CMS finalize this proposal without modification.

The Coalition strongly opposes any restrictions or conditions of payment for the ACP codes. This is a service that has been demonstrated to improve the quality of care; we share the CMS goal of allowing all Medicare beneficiaries to have unfettered access to these important conversations thereby allowing them to happen when they are needed. Establishing practice eligibility or clinical

staff requirements, disease severity or life expectancy criteria or otherwise limiting the service to certain patient populations or certain types of practices would limit access to this valuable service and undermine our shared goal of improving care through a better understanding of patient values and goals for treatment.

2. Chronic Care Management (CCM) and Transitional Care Management (TCM) Services

The Coalition appreciates CMS' decisions to pay for non-face-to-face management and care coordination services via the Chronic Care Management (CCM) and Transitions of Care Management (TCM) CPT codes (99490 and 99495/99496, respectively). In the proposed rule for 2016, CMS asks for recommendations to reduce the administrative burden of these services. As many of the Societies that originally proposed these codes to CMS and submitted the code change proposals for these codes to the CPT Editorial Panel are signatories to this Coalition letter, we are pleased to make the following recommendations:

CCM Services. Our Coalition continues to believe that the payment for 99490 (*chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with required elements*) is inadequate to appropriately compensate practices for all the clinical activities and documentation requirements that Medicare established for physicians to bill for CPT code 99490. We hear from our members that CCM is not being utilized as much as it should, given the needs of the chronically ill Medicare population potentially eligible for this service.

Recommendation: The Coalition recommends that CMS recognize CPT code 99487 (complex chronic care management services, at least 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with specified required elements) in addition to 99490. The CPT manual includes guidelines for reporting complex care management services based on the total duration of staff time.

CMS should also adopt the requirements for billing codes 99490 and 99487 as described in the CPT manual:

“Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline...”

Complex chronic care management services are provided during a calendar month that includes criteria for chronic care management services as well as establishment or substantial revision of a comprehensive care plan; medical, functional, and/or psychosocial problems requiring medical decision making of moderate or high complexity...

Physicians or other qualified health care professionals may not report complex chronic care management services if the care plan is unchanged or requires minimal change (e.g. only a medication is changed or an adjustment in a treatment modality is ordered.) Medical decision making as defined

in the Evaluation and Management (E/M) guidelines is determined by the problems addressed by the reporting individual during the month.

Patients who require complex chronic care management services may be identified by practice-specific or other published algorithms that recognize multiple illnesses, multiple medication use, inability to perform activities of daily living, requirement for a caregiver, and/or repeat admissions or emergency department visits.

Typical adult patients who receive complex chronic care management services are treated with three or more prescription medications and may be receiving other types of therapeutic interventions (e.g. physical therapy, occupational therapy)...

All patients have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation / decompensation, or functional decline. Typical patients have complex diseases and morbidities and, as a result, demonstrate one or more of the following:

- *Need for the coordination of a number of specialties and services;*
- *Inability to perform activities of daily living and / or cognitive impairment resulting in poor adherence to the treatment plan without substantial assistance from a caregiver;*
- *Psychiatric and other medical comorbidities... and/or*
- *Social support requirements or difficulty with access to care.”¹*

Further, CMS should revise its requirements for use of the EHR to make it clear that facsimiles can be sent from a certified EHR technology in connection with providing CCM. Finally, CMS should establish relative value units (RVUs) for CPT Code 99487 based on the RUC’s recommendations to CMS for physician work and practice expense inputs. If CMS adopts these recommendations, payment will be appropriate for the requirements of each code.

TCM Services. The major administrative burden for billing TCM is the requirement that the claim not be submitted until the entire 30-day period for TCM is over. CMS’ current policy requires that physicians report the date of service as the 30th day from the date of discharge from the facility. However, these codes require practices to contact the patient within two days of discharge and have a face-to-face visit with the beneficiary within 7 days (99496) or 14 days (99495) of discharge. It is a tremendous obstacle to require providers to wait until the 30th day to bill for the service. This requires practices to calculate the 30-day period, which is different for every patient, and to hold on to claims until well after two of the most important requirements of the code have been met.

Recommendation: The Coalition strongly recommends that CMS allow practices to bill for TCM after the required face-to-face visit is furnished. Further, CMS should define the date of service of the claim to be the day the face-to-face service occurs. Such a policy would be consistent with the policy for submitting claims for 10- and 90-day surgical global services. For those global procedures, the claim is submitted after the surgical procedure is performed. We encourage CMS to adopt a similarly intuitive process for submitting claims

¹ American Medical Association, CPT Code Manual, 2015.

for TCM services, which would significantly reduce the administrative burden of reporting these services.

Removing the 30 day requirement will facilitate reporting of this immensely important service and be a big step forward in improving access to TCM services for Medicare beneficiaries.

Treatment for the Misvalued Services Target. With respect to ACP, CCM and TCM, the Coalition endorses the comments made by the American Medical Association regarding treatment of these services for the misvalued services target.

We are very disappointed to learn that CMS included the services in the net reduction target for CY 2016. The RUC, specialty societies and CMS have worked extremely hard over the past few years to develop several coding solutions that recognize the important components of care management, which lead to better health outcomes for individuals and help to reduce downstream costs within the health care system. Services like the TCM and CCM services represent targeted payment initiatives that were specifically created to provide appropriate support for furnishing the best patient care possible.

Given the implicit nature of services like advanced care planning, the AMA and the RUC are disappointed to learn that CMS included these services in the net reduction target for CY 2016. The advance care planning codes represent new services, which are not currently reportable. The RUC estimates that roughly \$4 million will be spent on these services in CY 2016. Creating a scenario in which payment for these services is immediately offset by a reduction in the conversion factor, resulting from not hitting the target, is counterintuitive to the recent work to recognize important care management services.

Recommendation: we recommend that CMS should estimate the cost of implementation of the advanced care planning services as “redistribution” from other services for CY 2016 and not include it in the net reduction target.

3. Improved Payment for the Professional Work of Care Management Services Including Recommendations for Establishing Separate Payment for Collaborative Care

General Comments on the CMS Proposal

In the Proposed Rule, CMS requests comment on new codes for the professional work of care management and for specified types of collaborative care. We support making separate payment for these services as we continue to be concerned that the current E/M codes do not describe a significant number of services that physicians and other qualified health care professionals who provide cognitive care are currently and regularly furnishing to patients with chronic and acute illnesses.

We agree with CMS' proposed approach to establish new codes for services not currently described or paid for under the MPFS and believe is feasible to design new codes that will enable payment for cognitive services that are being performed, but not reimbursed, under current payment policy. Notably, while CMS in the proposed rule suggests that all the new codes for the professional work

of care management could be structured as add-ons to existing E/M codes, the Coalition disagrees. While it is possible that some of these services could be add-ons to existing E/M services, we have not identified many services that would be appropriately described as add-on services. Add-on codes must be reported by the same physician who reports the underlying base code and the add on service must be performed on the same day as the base service; however, many of the care coordination and collaborative care services that we perform occur over an episode of care that typically last for many days. That said, as we discuss below, one possible candidate for an add on code could be interactive complexity, akin to CPT code 90785. Our specific ideas for code proposals are described further below.

Irrespective of the type of code adopted, it is critical that CMS focus on services that provide additional value and improve the quality of care.

The Coalition has four principal recommendations:

A. CMS should establish guidelines for creation of new codes for professional work and collaborative care to assist stakeholders in making recommendations.

B. CMS should establish new HCPCS codes and separate payment for the following services that are not described by existing codes:

1. Collaborative Care

Ongoing Collaborative Care Involving Face-To-Face Visits

Interprofessional Consultations Without a Face-to-Face Visit

Care Provided in a Multidisciplinary Clinic

2. Patients with Acute illness or on a Course of Chemo- or Immunotherapy

Management of Patients on Chemo- or Immunotherapy

Non-Face-to-Face Care Provided During an Acute Illness

3. Interactive Complexity

4. Medication therapy Management and Genetic Counseling Services

Medication Therapy Management by Pharmacists

Genetic Counseling by Non-Physicians

C. CMS should recognize and establish separate payment for the collaborative care models for beneficiaries with common behavioral health conditions that it discusses in the proposed rule.

D. CMS should recognize and make separate payment for the following existing CPT codes:

CPT Codes 99358 and 99359 - Prolonged Service Without Direct Patient Contact

CPT Codes 98960, 98961 and 98962, Education and Training for Patient Self-Management

Our detailed comments on each of these recommendations follow.

A. Recommended Guidelines for Recognizing Existing CPT Codes or Creating New Codes for Unpaid Services

We recommend that CMS establish guidelines for recognizing and making separate payment for new cognitive services going forward. It is very important for stakeholders to have a general idea of CMS' thinking in order to facilitate the provision of helpful recommendations.

Specifically, we believe that CMS should establish the following general guidelines:

- The physician or clinical staff time inherent to new services should be well beyond any pre- and post-service time included in face-to-face visit codes.
- Codes could include minimum physician and/or clinical staff time, as appropriate.
- Codes could include, where appropriate, patient condition criteria related to the severity and acuity of the patient's illness.
- Codes should not include any practice-specific criteria (e.g., certain EMR capabilities) unless those criteria are otherwise required for all physician practices by previous rulemaking.
- Codes may describe special situations that, while uncommon, need to be addressed to assure access to care.

Establishing guidelines such as these will help assure that the new services recognized by CMS are high-value services that improve the quality of care.

Consistent with the above criteria, our Coalition has developed the conceptual and coding proposals below. We would be pleased to work with CMS to develop these ideas further.

Specific Service Concepts and Proposals

We ask that CMS implement the specific service concepts, and in some cases, specific codes, enumerated below in rulemaking for CY 2017. These concepts are critically important for establishing payment for many of the non-reimbursed services commonly being performed by our members and for the transition to alternative payment models. Indeed, we believe these concepts are as important as TCM and CCM.

Establishing separate payment for these services in 2017 will allow physicians to gain experience with them and be better able to use them as they transition to new payment models. As importantly, the ability to report these services would facilitate the transition to alternative

payment models by (1) supporting the development and expansion of the infrastructure needed to provide care coordination and collaborative care, (2) facilitating collection of data on non-face-to-face care being provided, (3) better account for physicians' cognitive work for use in developing more accurate payment methodologies, (4) allow existing Accountable Care Organizations (ACOs) to evaluate productivity more accurately, and (5) more easily attribute patients to physicians and ACOs.

Given the limitations of electronic health records, especially in regards to interoperability and the ongoing controversy over meaningful use, the members of this Coalition are not in favor of CMS establishing technology requirements for practices to be eligible to report these services.

The Coalition thanks CMS for recognizing that stakeholders, such as this Coalition, are best positioned to provide suggestions for new codes.

B. Recommendations for New Services for Which Separate Payment Should be Made

Our recommendations for new coding concepts include collaborative care and inter-professional consultations, as well as care provided during a course of chemotherapy or immunotherapy or during an acute illness. We also discuss developing a code for interactive complexity that could be used by non-psychiatrists.

The Coalition understands that the CMS timeline requires that CMS create G codes for CY 2017 as the CPT/RUC calendar does not permit the creation of new codes until CY 2018. However, the Coalition is committed to submitting coding change proposals to the CPT Editorial Panel for the new codes recommended in this comment letter in time for CPT approval, RUC review and CMS adoption in CY 2018. This means that CMS can be confident that any codes it creates for 2017 will be vetted by the medical community and those RUC recommendations will be received in time for CY 2018.

It is important to emphasize that the recommendations below each represent distinct types of services that involve cognitive physician work not currently described by existing codes. In addition to describing the physician cognitive work we also discuss clinical staff activities inherent in these services. Other than interactive complexity, our recommended services would not adequately be described as add-ons to an existing E/M code.

1. Collaborative Care

CMS specifically solicited comments on establishing payments for collaborative care services. We have identified two types of collaborative care that are being commonly provided by many physicians and that are currently not paid separately under the MPFS. These are:

(1) Ongoing collaborative care furnished by a specialist in conjunction with a primary care physician where the specialist sees the patient face-to-face and is caring for the patient's primary condition and the primary care physician is providing support related to the patient's comorbidities. This type of collaborative care has also been called "principal care", and

(2) Specialist consultations where a specialist provides consultative support to a primary care physician on an intermittent or one-time basis but does not see the patient.

The Coalition also identified the multidisciplinary clinic as a type of care where face-to-face care is provided by multiple providers during a clinic visit and which may not always be described or paid appropriately by existing codes.

These types of collaborative care involve very different types and amounts of physician work and clinical staff activities and therefore will require unique coding and valuation.

Ongoing Collaborative Care Involving Face-To-Face Visits

These are non-face-to-face services provided by specialty physicians who are responsible for the care of a patient's primary condition but who are not the patient's primary care physician and are not responsible for coordinating care for all the patient's problems. This is a very common scenario often referred to as "*principal care.*"

Examples include:

- Neurologists caring for patients with epilepsy, multiple sclerosis or Parkinson's disease;
- Rheumatologists caring for patients with active rheumatoid arthritis or systemic lupus erythematosus;
- Gastroenterologists caring for patients with inflammatory bowel disease or cirrhosis;
- Endocrinologists caring for patients with out-of-control diabetes;
- Infectious disease specialists caring for patient with viral hepatitis or Human Immunodeficiency Virus (HIV); and
- Pulmonologists or allergists caring for patients with reactive airway disease.

In each of the above cases, the specialist cares for the patient in conjunction with a primary care physician. The care activities for this service include development and implementation of a disease-specific care plan; patient and caregiver education; and non-face-to-face follow up by clinical staff. The service is differentiated from CCM because the care plan and clinical activities are disease-specific and do not involve coordinating care over a wide range of providers. Furthermore, while these patients may have comorbid chronic conditions, many do not have multiple chronic conditions and would not be eligible for CCM services. These services take place over an extended period of time and are not always associated with a single face-to-face service. Therefore, they are not be appropriately described by add-ons to existing E/M codes.

This type of care involves long term, ongoing collaboration between the specialist and primary care physician where both physicians see the patient for face-to-face visits. The face-to-face visits should be separately billable. While the length of a given episode can vary, it is typical for the collaboration to continue for a minimum of one month. Therefore, payment should be made on a per calendar month basis for as long as the collaborative care is medically necessary.

The Coalition agrees that not all patients followed by specialists should be eligible for this service and that CMS needs to develop illness acuity and/or severity criteria. For example, CMS could

require that the disease be of sufficient severity to (1) make patients at high risk of hospitalization or to have been recently hospitalized, (2) require development or revision of the disease-specific care plan, (3) to require frequent adjustments in the medication regimen, and/or (4) management that is unusually complex due to comorbidities or socioeconomic/cultural factors.

CMS should establish a minimum number of activities to be performed by the physician and/or clinical staff under the direction of the physicians. It may also be appropriate to require a minimum amount of clinical staff time spent on activities related to implementing the care plan.

Collaborative care is often provided in a team environment by a group of specialist physicians, thus it may be difficult to tie this code to a single procedure or visit code and it may comprise work provided by several physicians in a group over time. Therefore, it would be inappropriate to make this an add on code.

The primary care physician would be expected to bill for CCM, if all the CCM requirements are met, and not for collaborative care; however, there should be no requirement for the primary care physicians to bill CCM in the same month for the specialist to be able to report collaborative care. For example, it may not be medically necessary for the PCP to perform CCM or the PCP may not meet the practice requirements.

Lastly, while levels of service eventually may be necessary, the Coalition believes that CMS should begin implementation of this concept by targeting payment to the sickest Medicare patients who will derive the most benefit from collaborative care. Examples of such patients include those at high risk for hospitalization due to decompensating heart failure or cirrhosis or poorly controlled reactive or obstructive pulmonary disease. CMS should also consider targeting payment to caring for Medicare patients who have a poor prognosis due to socioeconomic or cultural factors that may affect the course of their disease.

Interprofessional Consultations Without a Face-to-Face Visit

These consultations are less frequent than the ongoing collaborative care described above but are also an important service for which separate payment is not made by Medicare. Several time-based CPT codes exist to describe these services: 99446-99449 with the descriptor, *Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional.*

We recognize that several payment policy issues exist which make these codes, as currently described, problematic. These include beneficiary cost-sharing liability and the potential for abuse in the absence of patient eligibility criteria related to disease severity and acuity.

In this context, we note that Medicare does make payment for pathology consultation services under CPT codes 88321, 88323 and 88325. These codes are used with codes for surgical pathology procedures and are strictly for outside, non-face-to-face consult cases.

The CPT manual descriptors are as follows:

88321-- *Consultation and report on referred slides prepared elsewhere.*

88323 -- *Consultation and report on referred material requiring preparation of slides.*

88325 -- *Consultation, comprehensive, with review of records and specimens, with report on referred material.*

These codes all involve non-face-to-face services that require review of medical records, pathology specimens, and production of a written report. As opposed to the surgical pathology codes 88300-88309 where the unit of service is the specimen, for codes 88321-88325 the unit of service is the case (slides, medical records, referring pathology report, etc.). Importantly, the beneficiary liability issues appear not to be problematic and importantly, these codes are based on complexity, not time. That said, the relationship between a pathologist and a surgeon is different than the interactions between a surgeon and an internal medicine subspecialist which are more likely to be ongoing and involve a number of non-face-to-face consultations over time.

An example of non-face-to-face consultative services is the tumor board. Tumor boards are well-established formal conferences among specialists who provide one-time or intermittent input on a case where one or more of the participants do not see the patient face-to-face. In the case of tumor board, the specialists may include oncologists, radiologists, pathologists, surgeons, and others involved in managing the malignancy and comorbid (but non-cancerous) chronic conditions. Tumor boards may occur in person, by conference call, real-time interactive video and audio or a combination of the above.

These consultations are different from team conferences in that all participants in team conferences, as defined by CPT, see the patient face-to-face and the purpose is to review on-going care and to evaluate the patient's condition against the previously established care plan or to create a care plan. The consultations described in our recommendation are non-face-to-face and are performed by specialists in order to provide advice for the purpose of establishing a treatment plan or revising a treatment plan when the patient has failed therapy.

The Coalition believes that the value of these consultations lies in the complexity of the medical decision making - not the time required (e.g., to review medical records) or the location of the service (e.g., the consultation could be provided from the consultants home after reviewing records electronically).

Therefore, the Coalition believes that the existing CPT codes 99446-99449 do not adequately describe these consultations and may need to be replaced or revised. We intend to continue reviewing these issues and would be pleased to work with CMS to develop codes for these important services in time for the CY 2017 proposed rule.

Multidisciplinary Clinic

Over the last several years a new model of providing care to patients with complex chronic conditions has emerged. This model is called the "Multidisciplinary Clinic," which requires the ongoing, simultaneous, involvement of two or more physicians from different specialties. In this

care model physicians from different specialties see patients simultaneously and share the history-taking, physical examination and medical decision-making. An example is a musculoskeletal clinic where rheumatologists, orthopedists and physiatrists see patients together and where clinical staff with specialized training in the care of complex patients are involved.

The Coalition understands that many physicians are using E/M codes to describe services provided during these visits. We intend to continue reviewing the reporting of services in these clinics to determine whether there are situations where current E/M coding would not adequately or accurately describe the services provided and will make recommendations to CMS if the services that are not E/M can be more accurately described.

2. Patients with Acute illness or on a Course of Chemo- or Immunotherapy

Management of Patients on Chemo- or Immunotherapy

The Coalition recommends that CMS begin making payment for services provided by any physician or practice that is managing patients during a course of chemo or immunotherapy that is medically necessary for treatment of an underlying disease such as cancer, inflammatory bowel disease or rheumatoid arthritis. While this form of therapy has historically been provided by oncologists, the development of disease-modifying biologics for non-oncologic illness has required other specialists to administer such treatments.

Management of patients on chemo- or immunotherapy is complex and requires significant clinical staff time to be spent on patient/caregiver education, non-face-to-face follow up between cycles of medication administration, and development and revision of a disease-specific care plan. The physician work and clinical staff activities involved in this service are different from the work involved in ongoing collaborative care (as described above) and should be recognized by a distinct code with appropriate payment. These differences are due to the nature of the therapy, the lack of involvement of a primary care physician, and differences in disease acuity and severity. Therefore, we agree that collaborative care services cannot be reported at the same time as chemo- or immunotherapy management services.

The Coalition would be pleased to work with CMS on development of a code for this important service in time for the CY 2017 rulemaking cycle. Because these services are provided over time in connection with more than one administration service, it would not be appropriate to describe them with an add on code. Issues that need to be addressed include the need to differentiate 1) initial and subsequent management services, 2) chemo- from immunotherapy, 3) the duration of the service (e.g. per calendar month, per course of treatment), 4) the appropriate clinical staff mix (e.g., specially trained RNs, pharmacists), and 5) the required clinical staff time and activities.

Non-Face-to-Face Care Provided During an Acute Illness

The Coalition has identified this service as becoming more and more important as patients increasingly are being cared for at home or other places for acute illnesses that have historically been taken care of in the physician office or hospital. This shift in care is due to a number of factors;

the Coalition wishes to focus on two of them: (1) the increasing number of patients who wish to be taken care of at home and who have medically knowledgeable caregivers, and (2) the inability of many patients to come to the physician office (e.g., living in rural areas, inability to obtain transportation, etc.).

Typically, these services are provided by a physician, with clinical staff under the supervision of the physician when necessary, interacting with a patient or caregiver and other professionals to monitor and revise care for an acute illness that places the patient at high risk for hospitalization. Services may be provided over the phone, by email or by real-time interactive video and audio and may include review of biometric monitoring. Examples include caring for patients with pyelonephritis, pneumonia, heart failure, and inflammatory bowel disease or autoimmune disease.

While these services may be provided after a face-to-face visit that is separately reportable, in many cases no face-to-face visit occurs (e.g., a visiting nurse discovers an infection during a routine visit and contacts the patient's primary care doctor to initiate treatment). Therefore, the performance of a face-to-face visit should not be required in order to report this service.

The Coalition agrees that only a single practice would report this service for an episode of care and due to the likelihood that no face-to-face service is provided and the potential involvement of two or more physicians in the group being involved in the care, it would be inappropriate to make this service an add on to existing E/M services.

The physician work of these services is different from collaborative or chronic care services because only one physician or practice is involved in the care and the focus is on treating an acute illness over a shorter period of time; furthermore, this service would rarely, if ever, involve creation or revision of a care plan and there may not be the need to coordinate care among different providers.

Importantly, and consistent with the guidelines we recommended, this work goes well beyond the pre- and post-service work of any face-to-face visit that may occur during the acute illness. That said, we recognize the need to develop disease acuity and severity criteria, and to define minimum time and activity requirements for physician or clinical staff. These services are usually provided over 7-14 days and should include all non-face-to-face care furnished over that period. CCM and collaborative care should not be reported if performed during the time acute care services are provided.

In addition, these services are distinct from the non-face-to-face prolonged service codes, which are intended to be reported for prolonged pre- or post- service review of medical records or other data directly related to a face-to-face visit. The prolonged service codes are not intended to describe provision of care by a medical practice over 7-14 days to acutely ill patients.

The Coalition believes that two different codes are needed, 1) for patients living in a non-facility setting such as their home or an assisted living facility and 2) for patients in skilled nursing and other facilities that employ clinical staff to support the provision of these services. The practice expense inputs for the two settings of care differ, hence the need for two codes.

3. Interactive Complexity

The Coalition recommends that CMS establish a code for non-psychiatric interactive complexity. The Coalition reviewed CPT code 90785 (*interactive complexity, list separately in addition to the code for primary procedures*) that is reported by psychiatrists. The Coalition believes that CMS should establish a similar code for non-psychiatrists because many of the same complex communication and interaction issues arise in patients with non-psychiatric diseases.

The CPT code descriptor for 90785 includes the following:

“With interactive complexity” may be reported when one or more of the following is present:

- 1. The need to manage maladaptive communication... among participants that complicates delivery of care.*
- 2. Caregiver emotions or behavior that interferes with the caregiver’s understanding and ability to assist in the implementation of the treatment plan.*
- 3. Evidence or disclosure of a sentinel event and mandated report to third party (e.g. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and / or report with patient and other visit participants.*
- 4. Use of play equipment, other physical devices, interpreter, or translator to communication with the patient to overcome barriers between the physician or other qualified healthcare professional and a patient who:*
 - Is not fluent in the same language... or*
 - Has not developed, or has lost, either the expressive language communication skills to explain his or her symptoms and response to treatment, or the receptive communication skills to understand the physician or other qualified health care professional if he or she were to use typical language for communication.*

A similar code for non-psychiatric cognitive specialties could reflect the added intensity of services provided to patients with communication difficulties that result in highly complex interactions and discussions between physicians and caregivers about the patient’s medical condition.

The Coalition believes that the issues faced by non-psychiatrists are different from 90785 and require other types of physician work. For example, patients with dementia are unreliable historians and significant time must be spent obtaining the patient history and functional status information from caregivers who may be naïve about the patient’s medical problems and medically unsophisticated. These interactions require significant time and are more intense than the typical patient visit.

That said, the time required to provide these services is not typically long enough to allow reporting of the prolonged face-to-face services code(s). Creating a code for interactive complexity would allow physicians to report unusually intense and prolonged E/M services where the

physician work is well beyond that of the typical E/M but the time is insufficient to report the prolonged services codes.

The need for this code notwithstanding, the Coalition recognizes there are a number of patient/caregiver, medical severity/acuity and other eligibility requirements that need to be addressed before such a code could be established. The Coalition will continue to review these issues and intends to submit a coding proposal to the CPT Editorial Panel for this add-on service.

4. Medication Management and Genetic Counseling Services

The Coalition believes that CMS should explore opportunities to apply its regulatory discretion to pay for medication therapy management and genetic counseling services when they are provided incident to the service of a physician. We recommend that CMS pay separately for the following existing CPT codes and services:

99605 - 99607: Medication therapy management services provided by a pharmacist, individual, face-to-face with patient, with assessment and intervention if provided...and

96040: medical genetics and genetic counseling services, each 30 minutes face-to-face with patient / family

The CPT Manual states that medication therapy monitoring is provided to optimize the response to medications or to manage treatment-related medication interactions or complications and include the following documented elements:

- Review of the pertinent patient history
- Medication profile (prescription and non-prescription)
- Recommendations for improving health outcomes and treatment compliance.

The manual also states that these codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities.

The CPT manual says that genetic counseling services are provided by trained genetic counselors - not physicians - and may include:

- Obtaining a structured family genetic history
- Pedigree construction
- Analysis for genetic risk assessment
- Counseling of the patient and family.

The manual also states that these activities may include review of medical data and family information, face-to-face interviews, and counseling services.

We note that while medication therapy management services are part of Medicare Part D already, there are no practice expense inputs for these services under Part B. The services of genetic

counselors are not separately paid but are becoming increasingly important to the delivery of personalized diagnostics and therapeutics. We recognize the inherent difficulty of recognizing these non-physician health care professionals absent legislative action, but recommend that CMS explore the possibility of paying for these services when they are provided incident to a physician's service and by using the Center for Medicare and Medicaid Innovation's demonstration authority to do so.

C. Collaborative Care Models for Beneficiaries with Common Behavioral Health Conditions

CMS solicits recommendations for establishing payment for a specific, evidence-based model of collaborative care for certain behavioral health conditions. The Coalition supports the comments made by the American Psychiatric Association to this proposed rule.

The Collaborative Care Model (CoCM) is a team approach that gives patients seen in primary care settings access to behavioral health care that is effective both clinically and economically. In this approach, primary care providers treating patients with common behavioral health problems are supported by a behavioral health care manager and a psychiatric consultant who help implement effective, evidence-based treatment for common behavioral health problems in the primary care setting.

The Collaborative Care Model includes these three basic elements:

1. Care coordination and care management;
2. Regular, proactive outcome monitoring and treatment to target using validated clinical rating scales; and
3. Regular, systematic psychiatric reviews of the entire caseload and consultation for patients who do not show clinical improvement.

In discussing the coding proposition for this model, it is essential to recognize that the CoCM is a population-based model of care for a category of health conditions and that it has defined protocols. It is this specific model that has been thoroughly evaluated and has a published evidence base.

The Coalition believes that the work of all three practitioners needs to be accurately described and reimbursed. There are two key issues to be addressed: (1) should the primary care physician and care manager be paid using a single code or different codes? and (2) because the services provided by the psychiatrist include population management as well as individual patient care, how can payment reflect the work associated with population management be billed if it is not tied to individual patient care?

Additional issues to consider include: ensuring no overlap of services between CoCM and existing E/M services; qualifications of the care providers; minimum time requirements and care activities that need to be documented for billing; differentiation of these services from CCM services; and the need for beneficiary awareness and consent.

While the Coalition is not prepared at this time to make specific recommendations with regard to this proposal, we believe that these issues can be resolved with additional time and consideration,

and look forward to working with CMS to establish appropriate coding and payment policy for this important and valuable service.

D. Recommendations for Recognizing Existing CPT Codes for Which Separate Payment is Not Being Made Under the MPFS

The Coalition recommends that CMS recognize certain existing codes as part of its initiative to improve payment for care coordination. The Coalition believes that the following codes can be implemented with minimal additional payment policy because the CPT language and descriptors are clear and provide adequate guidance for accurate reporting of these services.

CPT Codes 99358 and 99359 - Prolonged Service Without Direct Patient Contact.

These codes describe significant additional non-face-to-face work performed by the physician in the review of medical records and other clinical information. These services are needed to care for patients with chronic illnesses that are complex and/or patients who are severely ill and have multiple comorbid conditions.

The most common use of these codes is to review extensive medical records, such as before or after a patient's office visit, or upon a patient's admission to or discharge from a facility. They are also used when it is necessary to review extensive diagnostic information and consult with other physicians such as radiologists and pathologists.

Importantly, while related to a face-to-face E/M visit, the time spent on this service may be on a different date than the E/M. The physician work and time clearly goes beyond the pre- and post-service physician work and time of any face-to-face E/M visit. The CPT instructions for use of these codes and the time requirements are clear and well understood by the physician community. These codes have been valued by the RUC and we recommend that CMS recognize these codes for separate payment, recognize the CPT instructions for use, and adopt the RUC recommendations when assigning RVUs. Notably, these codes represent stand-alone services and are not appropriate for add-ons to existing E/M codes.

CPT Codes 98960, 98961 and 98962, Education and Training for Patient Self-Management.

Due to the ever larger number of patients with multiple chronic conditions and/or who require the assistance of caregivers, it is becoming increasingly important for clinical staff under the supervision of the physician to train patients and caregivers to manage chronic illnesses at home. This is especially true for patients on multiple medications who must be educated about medication interactions, adverse events and the effect of diet and lifestyle on their conditions and medications.

For example, patients with dementia, and their caregivers, must be educated as to safety and functional status issues as the patient's cognitive function declines over time. While some of this education is performed over the phone by clinical staff and can be reported using CPT Code 99490,

Andrew M. Slavitt
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the CCM code, in many cases the education occurs during or immediately following a face-to-face visit when the treatment plan has been initiated and/or revised and the changes are fresh in the patient's mind. Face-to-face patient and caregiver education on the same date as an E/M service cannot be reported using 99490, the CCM code.

CPT Codes 98960-98962 are used to report education and training performed by clinical staff - not physicians. The education for self-management codes are well understood by the medical community. The CPT instructions for these codes are clear and well understood and they have been valued by the RUC. The type of education we believe should be reimbursed separately goes well beyond any staff education provided as part of an E/M service (e.g., education reportable under CPT code 99211). In addition, this service may be performed on a day where no other E/M is provided so it is not appropriately described using an add-on to an E/M code.
