

September 10, 2018

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
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 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Ms. Verma,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule in regard to its effects on those living with advanced illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high- quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is made up of over 140 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving advanced illness care in the U.S.

C-TAC's definition of advanced illness is when one or more conditions becomes serious enough that general health and functioning begin to decline, treatment may no longer lead to preferred outcomes, and care oriented toward comfort may take precedence over attempts to cure – a process that extends to the end of life and that for some individuals and their families may lead to transition to hospice.

We have several comments on this proposed rule as various sections will significantly impact the care of those with advanced illness. Specifically:

Modernizing Medicare Physician Payment by Recognizing Communication Technology- Based Services

Brief Communication Technology-based Service, e.g. Virtual Check-in

We support the addition of this option as it will be helpful for those advanced illness management programs using remote contact with patients. Having 24/7 access is a key

factor in avoiding emergency department visits or hospitalizationsⁱ and so allowing practitioners to have a virtual check-in with an established patient could help reduce unnecessary utilization.

The virtual check-ins should allow communication with caregivers for patients who do not manage their own health care. An example is a patient with dementia in which the practitioner is communicating with the family caregiver. There should also be no restrictions based on place of service/originating site or living setting, such as assisted living or nursing facility.

We also feel that a frequency limit should not be set for such encounters as symptom management, for instance, might require several consecutive interactions to resolve. An example would be a heart failure patient having problems with fluid overload who might need to touch base with a provider daily for a couple of days to make sure that any diuretics are effective. If there is a concern about potential unlimited virtual check-ins, we suggest having an internal CMS trigger when a set number of encounters occur to review them to make sure all were appropriate.

Interprofessional Internet Consultation

We also support this since practitioners doing advanced illness management or palliative care often work as consultants and so could use these codes to better coordinate care with the patient's other practitioners.

Additional Telehealth Comments

While a move in the right direction, these proposed changes still do not address the issues related to an appropriate originating site. In this case, an assisted living facility is not listed as an approved originating site, even within the current rural guidelines. Domiciliary codes are also not approved to be billed in conjunction with the 02-Telehealth place of service code that was finalized in the 2017 PFS final ruling. Several states have updated their regulations to allow for telehealth services in the assisted living setting, such as Minnesota and Wisconsin, and we would encourage CMS to explore the connection between an assisted living originating site and the appropriate use of domiciliary CPT coding in that setting.

Finally, we would also encourage CMS to find ways to include family caregivers in virtual interactions since for some patients, such as those with dementia or end-stage illness, the family caregiver is the both person providing the needed information and requiring information and assistance in return from practitioners.

II. I. 1. Evaluation & Management (E/M) Visits

Simplifying by Reducing Billing Levels

We strongly echo the practical concerns Jean Acevedoⁱⁱ raised along with those voiced by the AMAⁱⁱⁱ, leading professional societies, and by the Democratic House Ways and Means committee regarding removing the highest intensity E/M billing codes. We are concerned by the AMA analysis^{iv} that shows that removing levels 4 and 5 would reduce E/M payment for office visits for hospice practitioners alone by 20%, not to mention the impact to

critically important geriatricians and palliative care practitioners. We also understand that the proposed add-on payments would not be sufficient to offset these payment reductions. *We therefore strongly recommend that these changes not be made* and urge CMS to ensure that any simplification in coding/billing not discourage practitioners from spending the needed time with complex/advanced illness patients or promote more frequent, shorter interactions, which would be burdensome for such patients. The currently proposed reduction from the five levels to only two and eliminating the ones for the most complex interactions unfortunately do both.

Surely there are better ways to simplify billing and coding while promoting appropriate care for those with advanced illness. One might be to reduce the currently confusing five levels to only three by eliminating levels 2 and 4. That would allow for a simple encounter, level 1, a moderate one, level 3, and a complex one, level 5. Another and likely superior way to is to tie billing to the patient's complexity- not the provider's activity or specialty. We also support a multi-year process to implement any new process as any such change will need preparation, training, and revised information systems to be effective. Changing this by January 1 of 2019 is not possible.

Eliminating Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty

We support this change as it will be helpful to interdisciplinary teams that have multiple billing practitioners who may see the same patient on the same day. An example could be when a patient comes to an outpatient clinic and sees their oncologist and then their palliative care nurse practitioner. More importantly, it would also allow practitioners boarded in specialties like internal medicine, but working as palliative specialists, to bill on the same day as a patient's other internal medicine provider(s).

II. F. Medicare Shared Savings Program Quality Measures

Proposals for changes to the CAHPS measure set

We support the goal of modifying CAHPS for ACOs and see the proposed changes as an effort to move from process measures to outcome ones. However, we acknowledge that the proposed changes, will likely not yet make much of a real difference in that regard and urge CMS and NQF to work on validating true outcome measures going forward.

In regard to changing CMS' data collection procedures to collect data from the same ACO assigned beneficiaries over time we support this and see it as a way to help know when to shift patients to palliative or hospice care. We also suggest adding a measure about transition to hospice and feel this would not be burdensome to ACO's as they are already tracking this information.

III. H. H. CY 2019 Updates to the Quality Payment Program

Additional eligible clinicians as MIPS eligible clinicians.

We support the addition of these clinicians such as clinical social workers, physical therapists, occupational therapists, or qualified speech-language pathologists as they can be important members of an interdisciplinary team delivering coordinated care to

those with advanced illness. Our only suggestion is that CMS provide more clarity around expectations for these new MIPS practitioners.

Proposed Measure: Query of Prescription Drug Monitoring Program (PDMP)

C-TAC supports the intent of this measure but has concerns about how challenging this may be for some practitioners. The logistics for PDMPs vary by state depending on how each was set up and so this measure could be burdensome if a provider cannot easily access the PDMP from their EMR. Having to log out of that EMR, log into the PDMP, and then back into the EMR would be likely burdensome. We have polled our members and request that time and assistance be provided for organizations to prepare to implement this change. In that regard meeting this goal by 2020 seems unlikely logistically.

Proposed Measure Description: Opioid Treatment Agreement

We have very serious concerns with this proposed measure and do not support it. Many with advanced illness are justifiably taking opioids for at least 30 cumulative days within a 6-month look-back period and requiring their MIPS-eligible clinician to identify the existence of a signed opioid treatment agreement is not evidence-based and will undermine good care. We know that numerous states are proceeding with requiring such treatment agreements, which is unfortunate.

You asked for comment on whether these types of agreements could create a burden on clinicians and patients, particularly clinicians who serve patients with cancer or those practicing in hospice, as well as the patients they serve. Our response is an emphatic “YES”. *Both of those populations and those on palliative care and residents of a long-term care facility should be excluded from this measure, as they are for the Part D opioid overutilization program finalized earlier this year^v.* In addition, we suggest also excluding populations in which the condition is not expected to improve, such as degenerative arthritis or neuropathy, and those seen with a domiciliary place of service. In lieu of an agreement with these excluded populations, practitioners should document an attestation of the management of the condition and the treatment via HCPCS. This would be a simple entry done with prescribing.

MIPS Scoring Bonus for Complex Patients

We support the continuation of the complex patient bonus of up to 5 points for eligible clinicians who care for complex patients, based on Hierarchical Condition Categories (HCC) risk scores and the percentage of dual-eligible beneficiaries treated. Many of these patients have advanced illness and this bonus will continue to assist practitioners in caring for them. However, we also recommend that CMS extend the bonus beyond the 2019 performance year and potentially increase the cap so that it is higher than 5 points. With the aging population there will only be more complex patients over time.

IV. A. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Practitioners and Suppliers

The lack of interoperability is a key factor in the continuing fragmentation of care for those with advanced illness. Therefore, we strongly support efforts to improve this. Our suggestion is that CMS expand the concept of interoperability beyond just clinical facility to facility, although care will be better once that truly occurs, to also include interoperability with community resources by linking them with other aspects of health care. CMS should focus on testing and helping community organizations and hospices with funding interoperability efforts as these agencies lack adequate resources to do so on their own.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or mgrant@thectac.org.

Sincerely,

Marian Grant

Marian Grant, DNP, CRNP, ACHPN, FPCN
Senior Regulatory Advisor
Coalition to Transform Advanced Care (C-TAC)
1299 Pennsylvania Ave, Suite 1175
Washington, DC, 20008

ⁱ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5296930/>

ⁱⁱ <https://www.chattmd.org/blog/2018/7/19/vbqd1zugifrgvpbwltz7ior23ooak>

ⁱⁱⁱ <https://www.ama-assn.org/170-groups-send-letter-proposed-changes-physician-payment-rule>

^{iv} https://osma.informz.net/osma/data/images/HealthMatters_Docs/AMA_EM_ImpactAnalysis.pdf

^v : <https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/CY2019-Medicare-Advantage-Part-D-Final-Rule.pdf>