September 27, 2019

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

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.

Here are our specific comments:

**Physician Supervision for Physician Assistant (PA) Services**
We support the proposed change that the statutory physician supervision requirement for
PA services would be met when a PA furnishes their services in accordance with state law and state scope of practice. PAs are part of the teams delivering primary and palliative care to those with advanced illness and allowing their full participation will improve access to these kinds of care.

**Care Management Services**

We are in general agreement with the proposed changes with the following comments on specific billing codes:

- **Transitional Care Management**- We support allowing these services to be billed concurrently as people with advanced illness often have multiple providers, all of whom should be encouraged to help with transitioning care. It also allows multiple providers from a team-based practice, like palliative care, to bill for these services concurrently.

- **Chronic Care Management (CCM)**- We recommend the number of times this service can be billed not be limited since people with advanced illness often have complex medical needs that can take multiple visits/encounters to address.

- **Complex CCM Services**- We support the new G codes as, as noted above, those with advanced illness and complex medical care may need multiple encounters to address their issues even when the care plan is not revised.

- **Typical Care Plan**- We agree that the simpler language proposed, “interaction and coordination with outside resources and practitioners and providers,” is an improvement and acknowledges the involvement of resources, like palliative care teams, working together with a person’s other providers to improve their quality of life. We also suggest CMS seek feedback from community-based organizations about their involvement in this aspect of the care plan.

- **Comprehensive Care Plan elements**- the list on page 230 includes many important elements for caring for those with advanced illness. Our only suggestion is that advance care planning be included on the list, since ascertaining what the person’s goals and values are is essential to crafting a concordant care plan.

We would also stress that there not be the expectation that outcomes, prognosis, and function be improved or even maintained for those with advanced illness. Most will experience expected, natural declines in the last stages of an illness, and the care plan should acknowledge that and seek to optimize function and quality of life, to the extent possible.

- **Principal Care Management Services**- We agree that there is a gap at present for those patients with only one chronic condition. While many with advanced illness have multiple chronic conditions, advanced cancer or heart failure alone can require extensive care management effort and time, which should be acknowledged and reimbursed. Further, the situation noted in the proposed rule “that most of these
services would be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management” exactly describes the role of palliative care providers or post-acute and long-term care providers when caring for someone with an advanced illness.

- **Chronic Care Management (CCM) Services Summary** - Table 18 includes many helpful aspects of CCM. However, as noted earlier, we suggest adding advance care planning to this list since it is important that the care being coordinated is in line with the person’s goals and values.

**Comment Solicitation on Opportunities for Bundled Payments under the PFS**
We support the expansion of the concept of bundling to “recognize efficiencies among physicians’ services paid under the PFS and better align Medicare payment policies with CMS’s broader goal of achieving better care for patients, better health for our communities, and lower costs through improvement in our health care system.” Moving to value-based care would improve care for all people but especially those with advanced illness, who often struggle with multiple providers and interventions that are not always focused on meeting their personal goals or improving their quality of life.

**Payment for Evaluation and Management (E/M) Visits**
We support the alignment of E/M coding with changes laid out by the CPT Editorial Panel for office/outpatient E/M visits. The additional add-on CPT code for prolonged service time and the increased payment for office/outpatient E/M visits will assist those providers caring for people with advanced illness to be more adequately reimbursed for the time and effort such care can require. However, given that these changes could be abused, we suggest CMS be proactive in monitoring the use of these changed codes so as to detect and guard against their inappropriate use.

**Medicare Shared Savings Program- Quality measures**
We strongly support the inclusion of Advance Care Plan -NQF #0326; CMS Quality ID #047. Advance care planning is a key activity for those with advanced illness, as identifying their individual goals and values should result in more personalized care plans. (For that reason, this measure should be included in all Medicare models and programs.) Of course, patients have every right to decline to participate in advance care planning, but those patients’ refusal could be noted, and their provider should not be penalized for it.

**Medicare Enrollment of Opioid Treatment Programs and Enhancements to General Enrollment Policies Concerning Improper Prescribing and Patient Harm**
We support efforts to ensure that opioid treatment programs are held to high standards and required to practice evidence-based medicine. Treatment for opioid use disorder is a pressing need and must be of high quality to ensure success. However, we are concerned with the proposed new authority to revoke or deny a practitioner’s enrollment in Medicare or other government program if they have been subject to a prior action from a state oversight board or other body. First, there is a great deal of fear at the state and local level about opioid prescribing, and we foresee situations where a state board could cite a practitioner for prescribing high-dose or ongoing opioids to someone with advanced illness.
who is not enrolled in hospice, even if such treatment would be medically appropriate. Further, it is no longer evidence-based practice, nor should it be policy, that practitioners be penalized for their own participation in rehabilitation or mental/behavioral health programs. Practitioners should be encouraged to seek evidence-based care for substance misuse or mental health issues when needed. Penalizing them by revoking their Medicare or other privileges is not 21st-Century medicine nor should it be 21st-Century policy.

Scope of Practice Requirements-Hospice
We support the proposal to allow hospices to accept orders from a physician, NP, or PA, as long as they are acting within their state scope of practice. However, we have concerns with the proposed requirement that a hospice may only receive medication orders from a physician assistant not employed by or contracted with a hospice as that could negatively impact both patient choice and workforce shortage issues.

We also appreciate having the opportunities to answer the following posted questions:

- **What is the role of a non-physician practitioner (NPP) in delivering safe and effective hospice care to patients?**
  The evidence is strong that nurse practitioners and physician assistants deliver safe and effective care to patients, and NP’s more holistic approach can be of particular value to patients with advanced illness. We therefore feel that both should be used to the fullest extent of their training and state scope of practice, especially given the workforce shortage of hospice and palliative care clinicians.

- **What duties should they perform? What is their role within the hospice interdisciplinary group and how is it distinct from the role of the physician, nurse, social work, and counseling members of the group?**
  The NPP should generally perform tasks similar to those of a physician, within the parameters of their permissible scope of practice, their license, and their individual education, training and experience. This may include performing face-to-face visits, physical assessment, ordering of durable medical equipment, prescribing medications, and otherwise participating on the IDG in any appropriate fashion based on the attributes of the individual hospice and team. The NPP should provide the full range of complex symptom management, assessment, goals of care discussions, plan of care development and prescribing.

- **Nursing services are a required core service within the Hospice benefit, as provided, which resulted in the defined role for NPs in the Hospice COPs. Should other NPPs also be considered core services on par with NP services? If not, how should other NPP services be classified?**
  We supports the concept that all APPs be considered as equals to the NP role currently defined in the hospice COPs. We believe that appropriately trained advanced practice nurses should not be prohibited from providing functions within hospice that nurse practitioners are permitted to provide. In other words, as long as a non-NP advanced practice nurse is practicing within the scope of practice in their state, and appropriate to their education, training and experience, they
should be given equivalent standing in providing hospice services.

- **In light of diverse existing state supervision requirements, how should NPP services be supervised? Should this responsibility be part of the role of the hospice medical director or other physicians employed by or under contract with the hospice?** What constitutes adequate supervision, particularly when the NPP and supervising physician are located in different offices, such as hospice multiple locations? We believe that just as all of the care provided by the hospice is ultimately under the purview of the hospice medical director (HMD), the care and treatment provided by an NPP should naturally be supervised, assessed, and monitored by the HMD. It is probably not necessary to specify a minimum percentage of charts monitored/audited by the HMD if they are working in a different physical location or not personally involved in the IDG process with the NPP.

- **What requirements and time frames currently exist at the state level for physician co-signatures of NPP orders? Are these existing requirements appropriate for the hospice clinical record? If not, what requirements are appropriate for the hospice clinical record?** We would suggest not getting involved in time frames or requirements for physician co-signatures and instead suggest that all supervision or collaboration be in accordance with prevailing state law.

- **What are the essential personnel requirements for PAs and other NPPs?** That they have training from an accredited school, successful completion and passage of a national certification exam, state licensure in good standing and participation in required continuing education. If hospice and palliative care certification is available, we recommend it as an option, but not as a requirement.

**Proposed Changes to Measures for the e-Prescribing Opioids**

We support the proposed changes as they will reduce administrative burden on prescribers. As we noted in our comments on the CY 2019 PFS, while we supported the intent of the Query of PDMP measure, we had concerns about how challenging it would be for some prescribers. We also voiced serious concerns about the Verify Opioid Treatment Agreement measure and did not support it. We appreciate the decision to remove it, as many with advanced illness are justifiably taking opioids for at least 30 cumulative days within a 6-month look-back period. Therefore, requiring their MIPS-eligible clinician to identify the existence of a signed opioid treatment agreement would undermine good care.

**Request for Information (RFI) on Potential Opioid Measures for Future Inclusion in the Promoting Interoperability performance category**

We do not have specific suggestions here other than to again reiterate that any measures should not discourage the appropriate use of opioids for those with advanced illness who legitimately need them. Perhaps exclusions for the patient populations of those with cancer, on hospice, or receiving palliative care (the CDC Pain Management Guideline excluded groups) should be part of any interoperability measures.
Request for Information (RFI) on NQF and CDC Opioid Quality Measures

- **Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)** - We appreciate the consideration to possibly include this measure as it recognizes that there are other patient populations who legitimately require higher opioid doses, such as those with sickle cell anemia or musculoskeletal disorders.

- **Use of Opioids from Multiple Providers in Persons Without Cancer (NQF #2950)** - We appreciate the value in considering this measure and recommend that you consider identifying multiple providers from the same practice as a singular prescriber since they may be covering for one another or co-managing the patient receiving opioids. Therefore, opioid prescriptions from such providers shouldn’t be seen as problematic.

- **Use of Opioids from Multiple Providers and at High Dosage in Persons Without Cancer (NQF #2951)** - See comment above.

- **CDC measures** - In addition to noting that these measures should all exclude people with cancer, on hospice or receiving palliative care, we have comments on the following:
  - **Measure 5: Three days’ supply for acute pain** - This is appropriate for most acute pain situations but may need to be a longer period for those with advanced illness and/or frailty or transportation issues, for whom a longer supply could be more appropriate.
  - **Measure 6: Dosage of > 50 morphine milligram equivalents (MMEs)** - The evidence does not support any dose limit on opioids and dosing should be individualized to meet the functional needs of the person, regardless of what the MME is. Determining dosage is best left to providers and there are patients who fall outside of the excluded categories who might also require higher doses, such as those with sickle cell anemia.
  - **Measure 7: Dosage of > 90 MMEs** - See comment above.
  - **Measure 8: Concurrent prescribing of opioids and benzodiazepines** - While this is a potentially dangerous combination, some patients require concurrent prescribing of these two drug classes, e.g., those with shortness of breath, for whom this combination can ease breathing and the anxiety associated with breathlessness.

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
The Coalition to Transform Advanced Care (C-TAC)
1299 Pennsylvania Ave, Suite 1175
Washington, DC, 20004

\[2\] https://www.aanp.org/advocacy/advocacy-resource/position-statements/quality-of-nurse-practitioner-practice