



September 6, 2016

Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted electronically at: regulations.gov

Re: CMS–1654–P, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Dear Acting Administrator Slavitt:

Community Catalyst respectfully submits the following comments regarding the proposed Medicare Physician Fee Schedule for CY 2017.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1998, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. The Center for Consumer Engagement in Health Innovation focuses on health system transformation and bringing the consumer experience to the forefront of health. The Center works directly with consumer advocates to increase the skills and power they have to establish an effective voice at all levels of the health care system. We collaborate with innovative health plans, hospitals and providers to incorporate the consumer experience into the design of their systems of care. We work with state and federal policymakers to spur change that makes the health system more responsive to consumers.

We are pleased to see that the proposed rule places a strong emphasis on the value of primary care, care coordination, and patient-centered care and applaud CMS for efforts to improve payment accuracy for these services. In addition, we appreciate the opportunity to comment on proposed changes to the Medicare Shared Savings Program, including quality measurement and beneficiary assignment, which impact consumer experiences in these programs.

Improving Payment Accuracy for Primary Care, Care Management Services, and Patient-Centered Services

We strongly support CMS' efforts to improve payment accuracy for primary care, care management, and patient-centered services. We agree with CMS that current policy does not

fully recognize the time and effort that may go into caring for patients with complex needs, including managing care for beneficiaries with multiple chronic conditions, behavioral health conditions, cognitive impairments and disabilities. We support improving payment accuracy in order to better recognize the level of effort required to coordinate care for patients with complex conditions.

Specifically we support:

- **Payment for Non-Face-To-Face Prolonged Evaluation & Management (E/M) Services:** We recognize that there are many circumstances under which time spent by providers beyond the face-to-face visit is important to ensure that the plan of care is appropriate for the patient, is consistent with the patient's goals and values, and is coordinated with the patient's care team, including caregivers. We are hopeful that the inclusion of CPT codes 99358 and 99359, in addition to GPPP7, would expand efforts to improve coordination of care, such as to include patients whose visit diagnoses are complex but not necessarily chronic, and by encouraging better subspecialist and specialist communication.

While we are supportive of the inclusion of this code, we have concerns about the requirement that the services to be furnished on the same day as the companion E/M code. We recognize that non-face-to-face communication may not necessarily occur on the same day as the companion E/M code – particularly if the E/M visit occurred at the end of a providers' normal workday or required additional research, the non-face-to-face E/M activity may occur on the following business day. Thus, we encourage CMS to allow circumstances under which the billed services do not have to be furnished on the same day.

- **Establishing Separate Payment for Behavioral Health Integration (BHI):** We support separate payment for services furnished using the psychiatric Collaborative Care Model, which has been shown to improve outcomes, increase consumer satisfaction, reduce costs and reduce health disparities. Additionally, we support the separate proposal to pay for behavioral healthcare management delivered via other models to beneficiaries with diagnosed behavioral health conditions in an integrated primary care setting. These proposals allow for flexibility in addressing patients' needs and ensure providers are accurately paid for providing beneficiary-centered treatment. In many cases, behavioral health conditions exacerbate other chronic conditions and vice versa. Integration of care for mental illness and substance use disorders with treatment for other chronic conditions can improve outcomes for consumers and decrease costs.
- **Improving Payment Accuracy for Chronic Care Management (CCM) Services:** We commend CMS for recognizing that current policies do not accurately reflect the time and resources that may go into managing the complex needs of patients with multiple chronic conditions. We support proposals to pay for existing codes (CPT codes 99487 and 99489) to better recognize the level of effort required to coordinate care for patients with complex conditions.

We reiterate our previous support for eliminating the 20 percent Part B cost-sharing associated with care management services for beneficiaries with physical and/or behavioral health conditions.¹ We believe that this will help overcome resistance from both patients and providers to accessing these services, particularly among lower-income beneficiaries. Such individuals may be both less likely to have supplemental coverage and more likely to have multiple chronic health conditions.

- **Assessment and Care Planning for Patients with Cognitive Impairment:** Effective care planning is an incredibly important part of patient-centered care and we are pleased CMS is recognizing the importance of assessment and care planning services for patients with cognitive impairments. This type of care planning involves working closely with caregivers and family members as well as extensive evaluation of the patient's functional abilities, safety risks, and medications, so payment should accurately reflect the time and effort required. We support CMS' inclusion of several important required elements for the code that ensure the care planning process is patient and family focused, such as identifying and working with caregivers and developing a care plan that includes referrals to community resources.

As the final rule is developed, we urge CMS to recognize the debilitating nature of dementia to ensure that informal care partners are included fully in such care planning sessions; in more advanced stages of dementia, it may not be possible to have the beneficiary directly involved in such discussions. In such cases, CMS should ensure that the care planning services still are discharged, as appropriate, to the beneficiary's informal care partners. To that end, we also urge CMS to cover evidence-based programs which offer caregiver support, and improve the caregiver's ability to successfully care for beneficiaries with cognitive impairment.

Improving Payment Accuracy for Care of People with Disabilities

As noted in the proposed rule, people with disabilities report difficulties finding Medicare providers and accessing services. A recent study of medical offices in California found that 91.6 percent of offices did not have a height adjustable exam table and that 96.4 percent did not have an accessible scale.² Barriers such as these discourage people with disabilities from accessing care in the first place, and can lead to poorer quality of care when they do see a provider. For example, an inability to weigh a patient with a disability could make it harder to develop effective weight management strategies or even determine the proper dosage of a medication. Ensuring Medicare payments accurately reflect the additional resources needed to care for people with disabilities is an important step in improving health care access for this population. While

¹ Community Catalyst, Letter to Senate Finance Committee's Chronic Care Working Group, Submitted electronically January 28, 2016. Available at: <http://www.communitycatalyst.org/resources/comment-letters/document/CCEHI-SFC-CCWG-Comments-FINAL-1.28.16.pdf>

² Nancy R. Mudrick, et. al, *Physical accessibility in primary health care settings: Results from California on-site reviews*, (2012), Disability and Health Journal, available at: <https://dredf.org/wp-content/uploads/2015/02/Mudrick-Breslin-Liang-Yee-DHJO-article-V5-No3-2012.pdf>

we are supportive of the intentions behind this change, we have concerns with the provision as currently proposed.

The proposal in its current form is intended to meaningfully address the serious problem of health care disparities in access and quality experienced by Medicare beneficiaries with disabilities, but the proposal focuses narrowly on beneficiaries who use specialized mobility-assistive technology. Access barriers are not limited only to those with mobility-related disabilities, and we propose expanding this code to also take into consideration the needs of patients with severe cognitive issues, communication disorders and severe emotional/behavioral health issues.

Additionally, we are concerned about any cost-sharing for beneficiaries associated with this new code. Additional cost sharing could create a disincentive for beneficiaries with mobility impairment to seek care and create an additional barrier for a population that already faces numerous barriers to accessing care. We urge CMS to cover the new code without beneficiary cost-sharing.

We appreciate CMS's efforts to reduce barriers to care for people with disabilities and ask that CMS continue working with the disability community to find innovative solutions for improving care access for people with disabilities, for example providing payments for providers who utilize the Disability-Competent Care Assessment tool and take steps to fill in the gaps identified.³

Improving Payment Accuracy for Preventive Services: Diabetes Self-Management Training (DSMT)

We support CMS' efforts to increase utilization of diabetes self-management training (DSMT) and improve payment accuracy to better compensate for the level of resources that are required to fully implement the program. DSMT has great potential to reduce net Medicare spending while empowering people with diabetes to improve their health. We suggest making it easier for consumers to access this important service by:

- Allowing self-referral and expanding the list of providers who can refer patients for the program to include specialists who are treating a beneficiary's comorbidity (e.g., gangrene, vision loss), as well as physicians and qualified non-physicians treating the patient in an inpatient setting.
- Designating DSMT as an "additional preventive service" in order to eliminate co-insurance and deductible requirements.
- Considering expanding the refresher training benefit to all beneficiaries so they can receive additional refresher training in subsequent years without limitation.

Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing

³ Resources for Integrated Care, "Disability-Competent Care Self-Assessment Tool", available at: https://www.resourcesforintegratedcare.com/DCC_Self-Assessment_Tool

We thank CMS for reminding Medicare providers that federal law prohibits them from collecting Medicare Part A and Medicare Part B deductibles, coinsurance, or copayments from beneficiaries enrolled in the Qualified Medicare Beneficiaries (QMB) program. Despite prohibitions on collecting cost sharing from QMBs, advocates have reported repeated instances of providers billing QMBs for Medicare copayments, requiring copayment at the time of service, and even sending bills to collections when QMBs are unable to pay.⁴ This prohibition on cost-sharing for QMBs ensures that low-income Medicare beneficiaries are able to access the health services they need and aren't forgoing needed care because of costs. QMBs represent a very low-income segment of the Medicare population and rely on this cost-sharing prohibition to access care. Robust provider outreach, along with strong enforcement of the billing prohibition are vital to ensuring the QMB program works as intended and we are pleased to see CMS reinforce this in the proposed rule.

Proposed Expansion of the Diabetes Prevention Program (DPP) Model

We strongly support CMS' recommendation to expand the Diabetes Prevention Program (DPP). The model has great potential to reduce Medicare spending while helping empower consumers to improve their health. The program expansion is especially positive given the emphasis the program places on engaging consumers in their own health care and the potential to utilize community settings and diverse providers, such as community health workers, in the program's implementation. We look forward to further rulemaking on the program and hope that CMS preserves the program's emphasis on patient engagement and community linkages that have made it so successful.

- *MDPP Designation as "Additional Preventive Services"*
We are pleased CMS is proposing to designate MDPP as an "additional preventive service" available under Medicare Part B. However, CMS does not specifically indicate in the proposed rule that it will also waive the cost-sharing requirement. We urge CMS to clarify that by defining MDPP as an additional preventive service, they intend for beneficiaries to participate in this benefit with no cost-sharing. Ensuring this intervention is accessible to Medicare beneficiaries at risk of developing type 2 diabetes must be a top priority and providing coverage with no cost-sharing will enhance program and participant success.
- *MDPP Benefit Description*
In the MDPP guidance, CMS proposes that MDPP be a one-time benefit for Medicare beneficiaries at risk for type 2 diabetes. We encourage CMS to allow flexibility for beneficiaries to engage in MDPP more than once, such as if they experience a major life event that impacts their ability to attend MDPP sessions.
- *Site of Service*

⁴ Georgia Burke and Kevin Prindiville, *Improving the Qualified Medicare Benefit Program for Dual Eligibles*, (Nov 2011), Justice in Aging, available at: http://www.justiceinaging.org/wp-content/uploads/2015/05/RE_issue_briefQMB_4_3.pdf

We commend CMS for proposing to allow both in-person and remote/virtual delivery of MDPP services. One reason the DPP has been so successful is because it does not mandate a ‘one-size-fits-all’ approach to diabetes prevention. A recent evidence review by the Institute for Clinical and Economic Review found that virtual programs with human coaches offer comparable quality MDPP services when compared to in-person services.⁵ The CDC has already established successful processes for enrolling and monitoring digital programs, which CMS can utilize in developing the benefit for digital programs.

Medicare Shared Savings Program:

ACO Quality Reporting

While we understand CMS’s desire to reduce the burden on providers by aligning quality measures across programs, we note the limitations of the currently proposed measures for the Quality Payment Program. Community Catalyst has previously commented on the importance of ensuring that quality measures reflect the goals, preferences and needs of consumers, in particular low-income older adults and other vulnerable Medicare enrollees.⁶ As such, we would suggest strengthening the collection of patient experience and patient-reported outcome measures, including around experience of behavioral health care. CMS could use the “improving or maintaining mental health” question from the Medicare Health Outcomes Survey, as well as specific questions from the [Experience of Care and Health Outcomes](#) (ECHO) consumer survey on mental illness and substance use disorders, such as rating of ability to deal with daily problems, social situations and to accomplish goals; and asking consumers to assess their recovery.

We also note the importance of identifying disparities in quality and would ask that ACOs publicly report data stratified by: race, ethnicity, disability status, gender, primary language, gender identity and sexual orientation

Incorporating Beneficiary Preference into ACO Assignment

We are pleased to see CMS recognize the important role beneficiary preference in ACO assignment plays in increasing patient engagement and improving care management, but have concerns with the proposed method of voluntary attribution. The rule proposes that patients would select a “favorite” provider who they believe is responsible for coordinating their overall care and their alignment would be based on this provider. Active patient choice of a main primary care provider is different than active patient choice of attribution to an integrated delivery system and it is not clear that beneficiaries would have a clear understanding of what this choice of provider means for their care. We appreciate that CMS plans to undertake efforts

⁵ Institute for Clinical and Economic Review. Diabetes prevention programs: effectiveness and value. July 2016. Available online: https://icer-review.org/wp-content/uploads/2016/07/CTAF_DPP_Final_Evidence_Report_072516.pdf

⁶ Community Catalyst, Comments re: Notice of Proposed Rulemaking on Medicare Program; Merit-Based Incentive Payment System and Alternative Payment Model Incentive under the Medicare Physician Fee Schedule, and Criteria for Physician-Focused Payment Models (CMS-5517-P), Submitted electronically on June 27, 2016, available at: <http://www.communitycatalyst.org/resources/comment-letters/document/CCEHI-Comments-on-the-Quality-Payment-Program-June-27-2016.pdf>

to determine the best terminology for the chosen provider, but simply choosing an appropriate term without further patient education does not go far enough. While this proposal is a good first step towards promoting active consumer choice, future sub-regulatory guidance providing operational and implementation details must include robust education and outreach efforts. Specifically, we recommend:

- Beneficiaries should receive clear, detailed information about the ACO assignment process, participating providers, information about how care will be better coordinated within integrated systems, as well as risks of participation and their rights and protections.
- The mechanism through which consumers will select their provider should include not only information on the benefits of selecting a provider and performance data, but also additional pertinent information such as languages spoken and whether accessibility to provider sites meets the requirements of the Americans with Disabilities Act.
- Beneficiaries should receive information about the process for opting-out of alignment with an ACO.
- Information should be presented in culturally and linguistically appropriate ways, taking into account the health literacy levels of consumers and assistive or alternative communication needs.
- CMS should utilize the strong infrastructure already in place to address beneficiary questions and concerns, including well-trained State Health Insurance Assistance Programs (SHIPs) and include community-based organizations (CBOs), such as Centers for Independent Living, Aging and Disability Resource Centers and Area Agencies on Aging, as partners for information sharing

In addition to ensuring that beneficiaries are well-informed about what their choice of primary health care provider means for their care, we also recommend that:

- Voluntary alignment not preclude beneficiaries from receiving services from other providers of their choice and that this be clearly communicated to beneficiaries when they are designating their main health care provider.
- ACOs should not be able to opt in or out of voluntary alignment. In order to ensure all beneficiaries have the freedom to align in an ACO in which their preferred provider participates, CMS should require the new assignment methodology apply to all ACOs.
- CMS not use retrospective alignment to assign beneficiaries to ACOs, even if a patient does not utilize a plurality of services from their designated provider. As noted in the proposal, it is possible that beneficiaries may establish a closer relationship with another provider without changing their designation. We agree with CMS that proactive beneficiary designation should continue to be the primary means of ACO assignment and that this concern should be addressed through education and outreach efforts.

SNF 3-Day Rule Waiver Beneficiary Protections

While we believe that, ultimately, coverage of skilled nursing facility care should be based on appropriate clinical criteria, rather than on an arbitrary number of preceding inpatient days, we are supportive of protections that help beneficiaries avoid unnecessary costs while the 3-day

prior hospital stay requirement is still in place. We support the proposal to include a 90-day grace period that would permit payment for skilled nursing facility services provided to beneficiaries who were initially on the ACO's prospective assignment list for a performance year but were subsequently excluded during that performance year. This proposal helps ensure that beneficiaries are not unfairly charged simply because of a lag in updated data and communication. In addition, this problem underscores the importance of robust beneficiary education and outreach efforts, as well as a move toward voluntary alignment. Consumers should know when they are aligned with an ACO, when they are no longer aligned with that particular ACO, and what this means for their care and coverage.

We are excited about the work CMS is doing to promote better coordinated, patient-centered care and appreciate the opportunity to comment on changes to the Medicare Physician Fee Schedule for CY 2017. Please do not hesitate to contact me at ahwang@communitycatalyst.org should you have any questions or if you would like additional information.

Sincerely,

A handwritten signature in black ink, appearing to be 'Ann Hwang', written in a cursive style.

Ann Hwang, MD
Director, Center for Consumer Engagement in Health Innovation