



September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS–1654–P
Room 445–G, 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 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 (CMS–1654–P)

Dear Acting Administrator Slavitt:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the proposed rule for the Calendar Year (CY) 2017 Medicare Physician Fee Schedule (PFS). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

I. Summary of ACP Recommendations

Throughout this letter, ACP provides a number of comments in support of proposals made by the Centers for Medicare and Medicaid Services (CMS) as well as recommendations to CMS in order to improve the final CY 2017 Medicare PFS. Our top priority comments and recommendations are summarized below and discussed in greater detail within this letter.

Medicare Telehealth Services

- **The College supports the proposed code additions to the list of Medicare approved telehealth services.** The services described by these codes will better serve the needs of patients in areas where telehealth services are an important access point of care.

Potentially Misvalued Services Under the Physician Fee Schedule

- **ACP supports CMS' proposal to review the 83 indicated codes and will be involved to the extent possible through the Relative Value Scale Update Committee (RUC) process.**

End-Stage Renal Disease (ESRD) Home Dialysis Services (CPT codes 90963 through 90970)

- **The College recommends CMS seek specific direction on how to revise and improve on the policies related to ESRD home dialysis. While seeking such direction, CMS could administratively set the payment rate for the adult home dialysis Medicare Claims Processing (MCP) at either the average payment for MCP services or at the upper payment level.**

Physician Payment Update & Misvalued Codes Target

- The College is pleased to see there will not be a "Target Recapture Amount" by which payments are reduced under the PFS in 2017. **ACP supports this proposal by CMS, which is consistent with comments previously made by the College.**

Collecting Data on Resources Used in Furnishing Global Services

- While the College is supportive of this effort, the complexity of the plan, as proposed, will create undue burden on physicians with little if any benefit to actual payment accuracy.
- **ACP recommends the use of CPT code 99024 (postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management (E/M) service was performed during a postoperative period for a reason(s) related to the original procedure) to identify the number of postoperative visits associated with a surgical procedure.** This service is currently status "B" (bundled) in Medicare physician fee schedule and is therefore not paid.
- **The College strongly urges CMS to hold clinicians providing global surgical services to the same documentation standards and guidelines as clinicians performing E/M services when providing a visit.**

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

Behavioral Health Integration

- *Psychiatric Collaborative Care Model (CoCM) codes*
 - The College supports the initiation of separate payment for services furnished using this code set as G-codes to start January 1, 2017. ACP appreciates the Agency's intent to support temporary codes GPPP1, GPPP2, and GPPP3 for one

year while recommendations for valuation in CY 2018 are worked on through the RUC process.

- **The College believes it would be more accurate for the work of the psychiatric consultant to be valued the same as that of the primary care physician. Therefore, we feel that the proposed values for these codes (GPPP1, GPPP2, GPPP3) would be insufficient to sustain the model and will negatively impact adoption of the CoCM.**
- *General Behavioral Health Code*
 - ACP supports the creation of an additional code, GPPPX, to be reimbursed for while more information is collected on how other behavioral health care models are being used and implemented.
 - **However, the College would like to reiterate our concerns that the CoCM model, particularly at the currently proposed valuation, is not financially feasible in many independent, small-, and medium-sized practices. The College also supports the creation of an add-on to the code that would allow for additional 20-minute increments.**

Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM) Services

- The College appreciates CMS recognizing our previous comments and recommendations to ease the administrative burden associated with reporting CCM services. **The College believes that all of the health IT-related changes are appropriate and greatly appreciates the Agency’s efforts to make this program viable for more practices and patients.**
- **Concerning the removal of the requirement for standardized content for clinical summaries, we urge CMS to provide specific guidance regarding what content is expected to be included.**
- **The College recommends keeping the term as “clinical summaries” as many clinicians are familiar with this terminology.**
- Additionally, as another avenue to address the underutilization of the CCM code (CPT code 99490), **ACP reiterates its recommendation from previous comment letters that CMS develop add-on codes for time increments greater than 20 minutes – such as 21-40 min and 41-60 min.**
- *Complex CCM Payment Updates*
 - **ACP applauds CMS for proposing payment of the additional complex CCM codes. We appreciate CMS’ support of patients with chronic illnesses and making provisions regarding appropriate payment of these codes – specifically, payment for CCM services that extend to 60 minutes in length.**
 - The College also appreciates and supports CMS’ proposal to add a G-code, GPPP7, to improve payment for visits that may qualify as initiating visits for CCM services.

Establishing a HCPCS G-code to Improve Payment Accuracy for Care of People with Mobility-Related Disabilities

- **The College urges CMS not to implement this proposal. We request CMS address this issue through practice expense, as with other services that require specialized equipment, using the RUC process.** This would allow CMS the opportunity to work more closely with the RUC and medical specialty groups in the development and guidance for treating patients with mobility-related disabilities.

Non-Face-to-Face Prolonged Services

- **The College appreciates and supports CMS' efforts to cover the non-face-to-face prolonged E/M codes (99358 and 99359).**
- **ACP recommends that CMS amend the proposal to adopt the CPT guidance for appropriate use of the non-face-to-face prolonged service codes.**
- **The College believes, under certain limited circumstances, when the non-face-to-face prolonged service (99359 and 99359) is unrelated to a patient's chronic conditions (99490, 99487, and 99489) being managed by the clinician, the clinician should be allowed to bill the non-face-to-face prolonged service code during the same service period as CCM with the use of modifier 25.**
- **ACP provides an alternate proposal for providing payment for non-face-to-face prolonged services through the creation and implementation of a new modifier and G-code.**

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

- **ACP recommends that CMS inform patients of the details of this new process, as well as provide an explanation of the needs and supposed benefits of requiring these additional steps.**
- **In order to ease other areas of undue burden or administrative delay, the College recommends that CMS engage with other payers and encourage them to follow the same criteria outlined by the Agency in order to lessen the administrative burden for participating physicians.**
- **ACP also recommends that CMS not require prior authorization along with these advanced imaging services as it will cause undue burden on the ordering physicians.**
- **Moving forward, ACP urges CMS to be transparent with expected costs to clinicians for implementation and use of the proposed AUC system and also recommends that CMS modify billing codes to reflect the additional costs of clinical decision support mechanism (CDSM) services.**
- **Overall, ACP recommends that a simpler approach for AUC involving the provision of relevant guidance at the point of ordering be implemented and evaluated before moving to this complex and expensive system – including a review of whether the program led to more appropriate use of advanced imaging and/or better or different code selection.**

Release of Part C Medicare Advantage (MA) Bid Pricing Data

- **The College appreciates and supports the Agency’s proposal to release MA plan bid data to the public as it aligns with ACP’s current healthcare transparency policy.¹**

Release of Part C and Part D Medical Loss Ratio (MLR) Data

- **ACP urges CMS to expend the necessary resources to ensure the MLR information is presented in a user-friendly manner that is understandable to the general beneficiary or health care consumer.**

Proposed Expansion of the Diabetes Prevention Program (DPP)

- **ACP is pleased that CMS is proposing to expand the Medicare Diabetes Prevention Program (MDPP). The College understands CMS must ensure program integrity, however, the College urges CMS to allow beneficiaries that previously failed the program to attempt the program again.**
- **We believe that any patient that meets the criteria, even if he/she failed the program previously, should be allowed to enroll in the MDPP.**
- **In support of continuity of care, the College also believes it would be beneficial for CMS to require non-health care MDPP providers to ask beneficiaries about their usual source of care and mandate that programs share results with the beneficiary’s self-identified primary care physician.**
- **ACP supports NQF measure #421. However, we would like to point out that the United States Preventive Services Task Force (USPSTF) recommends offering behavioral interventions for patients labeled as obese, not overweight individuals.**
- **ACP believes CMS should use the same waiver authority to cover all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines for Medicare beneficiaries.**

Medicare Shared Savings Program (MSSP)

Changes to the Quality Measure Set

- **ACP strongly supports efforts by CMS to better align MSSP quality reporting with the America’s Health Insurance Plans (AHIP) Core Quality Measures Collaborative and Quality Payment Program (QPP) Web interface measures.**

Changes to Align with Other Quality Reporting Programs

- **While the College appreciates CMS’ proposal to align the measures with those in the QPP, we recommend that CMS remove the Accountable Care Organization (ACO) #11 measure entirely as there should be no compulsion on ACOs to implement particular health IT and to use it in specific ways – especially if it does not add value to the delivery of care.**

¹https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/transparency.pdf

ncorporating Beneficiary Preference into Assignment

- **Because of the diversity in Medicare beneficiaries' preferred methods of communication and the potential challenges tied to using some of the systems suggested by CMS for automated voluntary alignment, the College recommends that CMS initially begin the beneficiary voluntary alignment process as a pilot.**
- **The College recommends that CMS utilize the pilot to test ways of doing outreach to patients to confirm the main doctor that they selected continues to be their preferred primary care physician.**

II. Detailed ACP Comments on Proposed Rule

Medicare Telehealth Services

Background:

CMS received several requests in calendar year (CY) 2015 to add various Medicare telehealth services effective for CY 2017. The Agency proposes to add four Current Procedural Terminology (CPT) codes related to end-stage renal disease (ESRD) services for dialysis (90967-90970) to the list of telehealth Medicare services on a Category 1 basis beginning in CY 2017. Category 1 involves services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. Although not specifically requested, CMS also proposes to add two CPT codes for advance care planning services (99497 and 99498) to the telehealth Medicare services list on a Category 1 basis beginning in CY 2017. Additionally, the Agency proposes to add to the list a new set of codes related to telehealth consultations for a patient requiring critical care services (GTTT1 and GTTT2) which are also on a Category 1 basis beginning in CY 2017. The Agency recognizes that the current set of CPT codes does not adequately distinguish between telehealth and in-person services provided for critical care.

CMS declined to add codes for observation care, emergency department visits, and psychological testing because the evidence provided for these services did not clearly demonstrate clinical benefit when the services are provided via telehealth. The Agency also declined to add codes related to physical and occupational therapy and speech-language pathology because they feel they do not have the statutory authority as these types of clinicians are not included in the list of telehealth clinicians within the law. Requests for services to be considered during the PFS rulemaking for CY 2018 must be submitted and received by December 31, 2016.

ACP Comments:

The College supports the proposed code additions to the list of Medicare-approved telehealth services. The services described by these codes will better serve the needs of patients in areas where telehealth services are an important access point of care. Patients in rural settings should not be denied access to needed care due to the absence of codes within the list of Medicare telehealth services. With the increasing lack of ideal access to care that can occur in rural areas, it is important that these services be allowed to be provided both as in-person or reimbursable telemedicine services.

Potentially Misvalued Services Under the Physician Fee Schedule

Background:

Medicare claims data for CY 2015 may indicate a possible problem with the valuation of 0-day global services. Routine evaluation and management (E/M) is included in the valuation of 0-day global services and the claims data shows that 50 percent of the time the E/M is billed with global services with Modifier 25. Reviewing the procedure codes typically billed with an E/M with modifier 25 as potentially misvalued may be one avenue to improve valuation of these services.

To prioritize the review of these potentially misvalued services, CMS will identify the codes that have not been reviewed in the last five years, and with greater than 20,000 allowed services. There are 83 codes indicated by CMS that meet these review criteria and are proposed as potentially misvalued codes for 2017. The Agency is requesting public input on additional ways to address appropriate valuations for all services that are typically billed with an E/M with Modifier 25.

ACP Comments:

In primary care/internal medicine, it is common for a clinician to manage patients with multiple health concerns at the same encounter. Caring for patients with multiple conditions may often require a procedure listed among the 83 codes under review – thereby extending the evaluation and management of the patient beyond the procedure. In this type of scenario, modifier 25 would be appropriate. **However, ACP supports CMS' proposal to review the 83 indicated codes and will be involved to the extent possible through the Relative Value Scale Update Committee (RUC) process.**

End-Stage Renal Disease (ESRD) Home Dialysis Services (CPT codes 90963 through 90970)

Background:

CMS created a monthly payment rate for managing the dialysis care of home patients, which requires a single in-person visit, that is approximately equal to the rate for managing and providing two to three visits to ESRD center-based patients. The Agency's intent was to incentivize physicians to prescribe home dialysis. However, the Government Accountability Office (GAO) found that, in 2013, the rate for managing home patients was lower than the average payment for managing ESRD center-based patients.

The GAO recommended that CMS examine Medicare policies for monthly payments to physicians to manage the care of dialysis patients and revise them if necessary to ensure that these policies are consistent with CMS' goal of encouraging the use of home dialysis among patients for whom it is appropriate. CMS is proposing to identify CPT codes 90963 through 90970 as potentially misvalued codes based on the volume of claims submitted for these services relative to those submitted for facility ESRD services.

ACP Comments:

According to the United States Renal Data System (USRDS) annual report 2015, home dialysis is not underutilized in the pediatric dialysis patient population 0-19 years old. Concerns regarding underutilization of home modalities should not apply to CPT codes 90963-90965 or 90967-90969 (the pediatric home and daily dialysis codes, respectively), where approximately 45% of all patients use home peritoneal dialysis (PD). However, the adult home dialysis services codes based on the volume of claims submitted are underutilized.

However, ACP believes that the causes of the underutilization are much more complex than the 10-15 percent payment difference in physician payment rates noted in the GAO report. Other factors that would impede progress toward wider use of home dialysis therapies in adults include: (1) gaps in nephrology training programs pertaining to home dialysis; (2) insufficient pre-dialysis patient education on all available dialysis modalities; (3) the inconsistency of dialysis facility cost report data associated with home dialysis, given its self-reported nature and inherent challenges in segregating cost report and staff time data specific to home dialysis from overall dialysis facility cost data; (4) the lack of infrastructure for appropriate staff support and supplies available to enable effective delivery of home therapies; (5) problems with the kidney disease education (KDE) benefit that have led to its underutilization and thus have likely had a negative effect on home dialysis downstream; (6) the current shortage of PD solution in the U.S., which has compelled some nephrologists to defer from prescribing PD out of concern that limited availability of PD solution will force PD patients away from the modality of their choosing; and (7) that the originating site limitations of current Medicare telehealth policy require ESRD patients to travel for services regardless of whether dialysis services are designated as Category 1 telehealth services, and thus serves as a deterrent for home dialysis.

The College recommends CMS seek specific direction on how to revise and improve the above mentioned policies. While seeking such direction, CMS could administratively set the payment rate for the adult home dialysis Medicare Claims Processing (MCP) at either the average payment for MCP services or at the upper payment level (figures noted in the GAO report and cited in the proposed rule).

Physician Payment Update & Misvalued Codes Target**Background:**

The estimated net reduction in expenditures done by CMS for 2017 from proposed adjustments to the relative values of misvalued codes is 0.51 percent. This exceeds the 0.5 percent target set by the Achieving a Better Life Experience (ABLE) Act, therefore, no additional reduction will be applied.

ACP Comments:

The College is pleased to see there will not be a “Target Recapture Amount” by which payments are reduced under the PFS in 2017. **ACP supports this proposal by CMS, which is consistent with comments previously made by the College.**

Collecting Data on Resources Used in Furnishing Global Services

Background:

Under the PFS, certain services, such as surgery, are valued and paid for as part of global packages that include the procedure and the services typically furnished in the periods immediately before and after the procedure.

In the 2015 PFS, CMS finalized a policy to transform all 10-day and 90-day global codes to 0-day global codes in 2018, to improve the accuracy of valuation and payment for the various components of global packages. Section 523(a) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibits the Secretary from implementing the policy and requires CMS to collect data to value surgical services. The Agency is required to develop, through rulemaking, a process to gather information needed to value surgical services from a representative sample of physicians, and requires that the data collection begin no later than January 1, 2017. The collected information must include the number and level of medical visits furnished during the global period and other items and services related to the surgery and furnished during the global period. This information must be reported on claims at the end of the global period or in another manner specified by the Secretary.

In this rule, the Agency is proposing a three-pronged approach to collect timely and accurate data on the frequency and inputs involved in furnishing global services.

First, CMS proposes:

- Comprehensive claims-based reporting about the number and level of pre- and post-operative visits furnished for 10- and 90-day global services. Physicians would be required to report a set of time-based G-codes that distinguish between the setting of care (e.g., hospital, office, email/telephone, etc.) and whether the services are furnished by a physician or by their clinical staff. Physicians would be required to report the G-codes for every 10 minutes dedicated to a patient before and after a procedure or surgery. CMS is proposing the following codes be used for reporting on claims the services actually furnished but not paid separately because they are part of global packages:

Inpatient	GXXX1	Inpatient visit, typical, per 10 minutes, included in surgical package
	GXXX2	Inpatient visit, complex, per 10 minutes, included in surgical package
	GXXX3	Inpatient visit, critical illness, per 10 minutes, included in surgical package
Office or Other Outpatient	GXXX4	Office or other outpatient visit, clinical staff, per 10 minutes, included in surgical package
	GXXX5	Office or other outpatient visit, typical, per 10 minutes, included in surgical package
	GXXX6	Office or other outpatient visit, complex, per 10 minutes, included in surgical package

Via Phone or Internet	GXXX7	Patient interactions via electronic means by physician/non-physician providers (NPP), per 10 minutes, included in surgical package
	GXXX8	Patient interactions via electronic means by clinical staff, per 10 minutes, included in surgical package

Second:

- Survey a representative sample of clinicians about the activities involved and the resources used in providing a number of pre- and post-operative visits during a specified, recent period of time, such as two weeks. The Agency expects to obtain data from approximately 5,000 clinicians.

Third:

- Conduct a more in-depth study, including direct observation of the pre- and post-operative care delivered in a small number of sites, including some Accountable Care Organizations (ACOs).

CMS states they are not proposing to withhold payment for non-compliance at this time, but may do so in the future.

ACP Comments:

The College applauds and supports the efforts of the Agency to ensure physician services are valued accurately and appropriately. While the College is supportive of this effort, the complexity of the plan, as proposed, will create undue burden on physicians, with little if any benefit to actual payment accuracy.

ACP recommends the use of CPT code 99024 (postoperative follow-up visit, normally included in the surgical package, to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) related to the original procedure) to identify the number of post-operative visits associated with a surgical procedure. This service is currently status “B” (bundled) in Medicare physician fee schedule and is therefore not paid.

This 99024 code is currently reported by several large hospital-based physician group practices that internally use the code to report each bundled post-operative visit, and therefore data are already being captured for many Medicare clinicians. Since several medical systems are already using this code, it is possible for CMS to already have denied claims data available for CPT code 99024 via the Medicare claims processing system.

CPT code 99024 should simply be used to collect the post-operative visits information and a separate process should be used to track the level of visits. It would not be appropriate to use CPT code 99024 in 10 minute increments; the existing E/M codes should be used in a claims-based approach to fairly address the level of services.

The College strongly urges CMS to hold clinicians providing global surgical services to the same documentation standards and guidelines as clinicians performing E/M services when

providing a visit. The administrative burden on surgeons should be no different and certainly no less than that of non-surgeons. To require anything less than the same level of documentation for all clinicians providing E/M services would be irresponsible and unfair and would defeat the very purpose of documenting the actual types and extent of these services in the post-operative period.

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

Background:

For 2017, CMS is proposing changes to a number of coding and payment policies for primary care under the PFS. The proposals in this rule include policy updates in the following areas:

- Improve payment for care management services provided in the care of beneficiaries with behavioral health conditions (including services for substance-use disorder treatment) through new coding, including three codes used to describe services furnished as part of the psychiatric collaborative care model (CoCM) and one to address behavioral health integration (BHI) more broadly.
- Improve payment for cognition and functional assessment, and care planning for beneficiaries with cognitive impairment.
- Adjust payment for routine visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities.
- Recognize for Medicare payment the additional CPT codes within the Chronic Care Management (CCM) family (for Complex CCM services) and adjust payment for the visit during which CCM services are initiated (the initiating CCM visit) to reflect resources associated with the assessment for, and development of, a new care plan.
- Make changes in the requirements for the initiating visit, 24/7 access to care and continuity of care, format and sharing of the care plan and clinical summaries, beneficiary receipt of the care plan, beneficiary consent, and documentation (these updates are described further in the “Reducing the Administrative Burden for CCM” section of this summary).
- Recognize for Medicare payment CPT codes for non-face-to-face prolonged E/M services by the physician (or other billing clinician) that are currently bundled, and increase payment rates for face-to-face prolonged E/M services by the physician (or other billing clinician) based on existing Relative Value Scale Update Committee (RUC) recommended values.

Table 1: Descriptions of Proposed Codes to Improve the Payment Accuracy for Primary Care

CPT/HCPCS^a	DESCRIPTION
GPP1	Initial psychiatric collaborative care management
GPPP2	Subsequent psychiatric collaborative care management
GPPP3	Initial or subsequent psychiatric collaborative care management
GPPP6	Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment
GPPP7	Assessment for Chronic Care Management care plan
GDDD1	Intensive service during Evaluation and Management

CPT/HCPCS ^a	DESCRIPTION
99358	Prolonged service without contact
99359	Prolonged service without contact additional time
GTTT1	Initial telehealth consult
GTTT2	Subsequent telehealth consult
99487	Complex Chronic Care Management without patient visit
99489	Complex Chronic Care Management additional 30 minutes
99490	Chronic Care Management services – 20 minutes
GPPPX	Care management services for behavioral health conditions
90792	Psychiatric diagnostic evaluation with medical services
99212	Office/outpatient visit established patient
99213	Office/outpatient visit established patient
99214	Office/outpatient visit established patient
99215	Office/outpatient visit established patient

^aCPT codes and descriptors only are copyright 2016 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.

The following four sections expand on the specific payment policies noted in the above summary as well as ACP’s specific comments on these proposed payment updates.

a) Behavioral Health Integration (BHI)

Background:

CMS recognized in the 2016 PFS Final Rule that the current PFS did not adequately recognize activities that were essential to the care and management of Medicare beneficiaries with behavioral health conditions. As a follow-up to that discussion, CMS is proposing the following service codes in the 2017 proposed rule (these codes are described in greater detail later in this section):

- GPPP1 (Initial psychiatric collaborative care management)
- GPPP2 (Subsequent psychiatric collaborative care management)
- GPPP3 (Initial or subsequent psychiatric collaborative care management)
- GPPPX (Care management services for behavioral health conditions)

All proposed codes require that the billing clinician must document in the beneficiary's medical record that the beneficiary's consent was obtained to consult with relevant specialists including a psychiatric consultant, and that, as part of the consent, the beneficiary is informed that there is beneficiary cost-sharing, including potential deductible and coinsurance amounts, for both in-person and non-face-to-face services that are provided. The initiating visit that is required to bill for these codes parallels the requirements under the CCM code 99490.

i) Psychiatric Collaborative Care Model (CoCM) codes:

Background:

CoCM is a specific, evidence-based, Behavioral Health Integration (BHI) model that is typically provided by a primary care team, consisting of a primary care clinician and a care manager (e.g. social worker, psychologist) who works in collaboration with a psychiatric consultant. Care is

directed by the primary care team and includes structured care management with regular assessments of clinical status using validated tools and modification of treatment as appropriate. The psychiatric consultant provides regular consultations to the primary care team to review the clinical status and care of patients and to make recommendations.

CMS is proposing to begin making separate payment for services furnished using the psychiatric CoCM codes beginning January 1, 2017. Specifically, CMS is proposing to establish and make separate Medicare payment using the following three new Healthcare Common Procedure Coding System (HCPCS) G-codes related to services provided under the CoCM position:

- GPPP1: Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
- GPPP2: Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
- GPPP3: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

To value HCPCS codes GPPP1, GPPP2, and GPPP3, CMS is proposing to base the portion of the work relative value unit (RVU) that accounts for the work of the treating physician or other qualified health care professional on a direct crosswalk to the proposed work values for the complex CCM codes, CPT codes 99487 and 99489. To value the portion of the work RVU that accounts for the psychiatric consultant, CMS is estimating ten minutes of psychiatric consultant time per patient per month and a value of 0.42 work RVUs, based on the per minute work RVUs for the highest volume codes typically billed by psychiatrists. Since the behavioral health care manager in the services described by HCPCS codes GPPP1, GPPP2, and GPPP3 should have academic and specialized training in behavioral health, CMS is proposing a new clinical labor type for the behavioral health care manager, L057B, at \$0.57 per minute, based on the rates for genetic counselors in the direct practice expense (PE) input database. CMS is seeking comment on all aspects of these proposed valuations. (Proposed valuations: GPPP1 - \$135.93/GPPP2 - \$119.83/GPPP3 - \$59.74)

The above are considered temporary codes and will likely be replaced in fiscal year (FY) 2018 by new codes currently being developed through the CPT process.

ACP Comments:

ACP commends CMS on the proposal to adopt an evidence-based approach to caring for patients with behavioral health conditions through the Psychiatric Collaborative Care Model (CoCM). Further, we appreciate that CMS is proposing to accept the code set and descriptors as recommended by the CPT Editorial Panel for this code proposal.

The College supports the initiation of separate payment for services furnished using this code set as G-codes to start January 1, 2017. ACP appreciates the Agency's intent to support temporary codes GPPP1, GPPP2, and GPPP3 for one year while recommendations for valuation in CY 2018 are worked on further through the RUC process.

ACP is generally supportive of the proposed values as they relate to the primary care physician and behavioral health care manager. However, the proposed work RVUs for the psychiatric consultant, which have been crosswalked to a psychotherapy service, may not adequately reflect the work of the psychiatric consultant and as a result are not sufficient to sustain the model.

The psychiatrist will evaluate the patient's condition based on the data provided by the primary care physician (PCP) and the behavioral health care manager and formulate treatment recommendations. This type of service typically requires a moderate level of medical decision-making (CPT codes 99204, 99214, etc.) based on the severity of the presenting problems and/or the lack of improvement. **Hence, the College believes it would be more accurate for the work of the psychiatric consultant be valued the same as that of the primary care physician and, therefore, feels that the proposed values for these codes (GPPP1, GPPP2, GPPP3) would be insufficient to sustain the model and will negatively impact adoption of the CoCM.**

ii) General Behavioral Health Code

Background:

CMS recognizes that there are primary care practices that are incurring, or may incur, resource costs inherent to treatment of patients with behavioral health conditions based on models other than the CoCM and are not currently reflected in the PFS. Thus, CMS is proposing the use of the following G-code that describes care management for beneficiaries with diagnosed behavioral health conditions under a broader application of integration in the primary care setting:

- GPPPX: Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional time, per calendar month, for collaborative care and care management for beneficiaries with behavioral health conditions

To value HCPCS code GPPPX (proposed value \$44.00), CMS is proposing a work value based on a direct crosswalk from CPT code 99490 (CCM services), which is a work value of 0.61 RVUs. To account for the care manager minutes in the direct PE inputs for HCPCS code GPPPX, CMS is proposing to use clinical labor type L045C, which is the labor type for social workers/psychologists and has a rate of \$0.45 per minute.

CMS is seeking stakeholder input on whether to consider requiring a longer duration of time for this code or an add-on to the code that would allow, for example, additional 20-minute increments. Feedback is also sought on the proposed valuation reference above.

ACP Comments:

ACP agrees that most primary care practices are integrating behavioral health services through models other than the CoCM and appreciates CMS's support of resource costs associated with furnishing behavioral health care management services to Medicare beneficiaries under related but different models of care. Therefore, we support the creation of an additional code, GPPPX, to be reimbursed for while more information is collected on how other behavioral health care models are being used and implemented. **However, the College would like to reiterate our concerns that the CoCM model, particularly at the currently proposed valuation, is not financially feasible in many independent, small-, and medium-sized practices. The College also supports the creation of an add-on to the code that would allow for additional 20-minute increments.**

b) Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM) Services

Background:

In CY 2015, CMS implemented separate payment for CCM services which incorporated many service elements and billing requirements that the physician or non-physician clinicians must satisfy in order to fully furnish these services and report these codes. These elements and requirements were relatively extensive and generally exceeded those for other E/M and similar services. CMS has recognized through comments from numerous professional societies and underutilization of the codes that some of the service elements and billing requirements are too burdensome and have proposed a number of changes to the current elements required to provide and bill CCM.

Previously, CMS required multiple CCM service elements be completed via certified or non-certified health IT. Since the Agency has not required adoption of certified or non-certified health information technology (health IT) as a condition of payment for any other PFS service – and other CMS programs already incentivize adoption of health IT (e.g., EHR Incentive Program or “Meaningful Use”) – they propose to remove this requirement for CCM service elements. Specifically, they propose the following revisions:

- Remove the requirement that the physicians or health care professionals providing CCM after hours must have access to the electronic care plan.
- Remove the requirement for 24/7 electronic sharing of the care plan information but instead require *timely* electronic sharing of the electronic care plan information within and outside the billing practice and to also allow transmission of care plan by fax.
- Remove the requirement for standardized content for clinical summaries and the requirement that the clinical summaries be transmitted electronically but instead require the physician billing CCM to create and exchange/transmit a continuity of care document(s) in a *timely* manner with other physicians or health care professionals. (Note: CMS also proposes to change the previous “clinical summaries” term to “continuity of care document(s)” due to their concern about physicians being able to distinguish between the requirements for “clinical summaries” under the EHR Incentive Program.)

- Remove the requirement that the care plan be provided to the beneficiary in electronic form and instead require that the care plan be shared with the beneficiary based on preference (e.g., electronic, hard copy, sharing with caregiver, etc.).
- Remove the requirement that the beneficiary authorize electronic communication of their medical information with other treating clinicians – as this authorization is covered under appropriate HIPAA rules and regulations.
- Remove the requirement that the billing physician use a qualifying certified EHR to document communication to and from home- and community-based physicians and other clinicians regarding the patient’s psychosocial needs and functional deficits as this type information is already required to be captured in the medical record.

ACP Comments:

ACP supports CMS’ proposal to simplify many of the service elements and billing requirements that physicians and non-physician clinicians must satisfy in order to fully furnish CCM services and report the codes. The College appreciates CMS recognizing our previous comments and recommendations to ease the administrative burden associated with reporting CCM services.

The College believes that all of the health IT-related changes are appropriate and greatly appreciates CMS’ efforts to make this program viable for more practices and patients.

Concerning the removal of the requirement for standardized content for clinical summaries, we urge CMS to provide specific guidance regarding what content is expected to be included.

Additionally, ACP is concerned that the Agency’s proposal to change the term “clinical summaries” to “continuity of care documents” to better align with the terms used under the EHR Incentive Program may cause confusion with specific Health Level-7 (HL7) and American Society for Testing Materials (ASTM) standards terminology. **The College recommends keeping the term as “clinical summaries” as many clinicians are familiar with this terminology.**

Additionally, as another avenue to address the underutilization of the CCM code (CPT code 99490), **ACP reiterates our recommendation from previous comment letters for CMS to develop add-on codes for time increments greater than 20 minutes – such as 21-40 min and 41-60 min.** These add-on codes provide the ability to capture the unquestionable amount of time spent with patients that reaches between 21 and 60 minutes. In order to meet the needs of physician practices, particularly small practices, as well as encourage and capture further involvement in chronic care management services, it is important to have these codes available.

i) Complex CCM Payment Updates

Background:

Additionally, CMS proposes to recognize for Medicare payment the additional CPT codes within the CCM family (for Complex CCM services) and adjust payment for the visit during which CCM services are initiated (the initiating CCM visit) to reflect resources associated with the assessment for, and development of, a new care plan. These codes are described in further detail below:

- **99487:** Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.
- **99489:** Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).
- **GPPP7:** Comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service (billed separately from monthly care management services) (Add-on code, list separately in addition to primary service)

ACP Comments:

ACP applauds CMS for proposing payment of the additional complex CCM codes. We appreciate CMS' support of patients with chronic illnesses and making provisions regarding appropriate payment of these codes – specifically, payment for CCM services that extend to at least 60 minutes in length. We also appreciate and support CMS' proposal to add a G-code, GPPP7 (comprehensive assessment of and care planning by the physician or other qualified health care professional for patients requiring chronic care management services, including assessment during the provision of a face-to-face service; billed separately from monthly care management services – add-on code, list separately in addition to primary service), to improve payment for visits that may qualify as initiating visits for CCM services.

- c) Establishing a HCPCS G-code to Improve Payment Accuracy for Care of People with Mobility-Related Disabilities

Background:

CMS is proposing payment adjustments for routine visits furnished to beneficiaries whose care requires additional resources due to their mobility-related disabilities. CMS proposes the following code descriptor: Resource-intensive services for patients for whom the use of specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports) is medically necessary and used during the provision of an office/outpatient evaluation and management visit (Add-on code, list separately in addition to primary procedure).

CMS recognizes that some physician practices may frequently furnish services to particular populations for which the relative resource costs are similarly systemically undervalued and they seek comment regarding other circumstances where these dynamics can be discretely observed.

ACP Comment:

It is estimated that the 2017 conversion factor will be reduced to 35.7751 (2016 conversion factor was 35.8043) based on the budget neutrality adjustment and the 0.5 percent update factor. This budget neutrality adjustment is primarily computed to capture the increased Medicare costs due to this new add-on payment to office visits for patients with mobility impairments. This proposal will also create additional cost-sharing for beneficiaries with disabilities.

Therefore, the College urges CMS not to implement this proposal. We request CMS address this issue through practice expense, as with other services that require specialized equipment, using the RUC process. This would allow CMS the opportunity to work more closely with the RUC and medical specialty groups in the development and guidance for treating patients with mobility-related disabilities.

d) Non-Face-to-Face Prolonged Services

Background:

CMS proposes to begin paying for CPT codes 99358 (prolonged evaluation and management service before and/or after direct patient care; first hour) and 99359 (prolonged evaluation and management service, each additional 30 minutes) which they have not previously recognized. The Agency also seeks public input on the intersection of the prolonged service codes with Chronic Care Management (CCM) and Transitional Care Management (TCM) services. CMS is also seeking public comment on the potential intersection of the prolonged service CPT codes 99358 and 99359 with proposed code GPPP7 (Comprehensive assessment of and care planning for patients requiring CCM services). Specifically, CMS is seeking comment regarding how distinctions among these services can be clearly delineated, including how the prolonged time can be clearly distinguished from typical pre- and post-service time, which is continued to be bundled with other codes. For all of these services, they have concerns that there may be program integrity risks as the same non-face-to-face activities could be undertaken to meet the billing requirements for any of the above. CMS is seeking public comment to help the Agency identify the full extent of program integrity considerations, as well as options for mitigating program integrity risks associated with these and other potentially overlapping codes.

ACP Comment:

The College appreciates and supports CMS' efforts to cover the non-face-to-face prolonged E/M codes (99358 and 99359). However, CMS proposes to only pay for the service if provided on the same day of service as an E/M visit. The proposal as written does not reflect the guidance of CPT, which allows non-face to-face prolonged services to be billed on a separate day from the initiating E/M visit. This would cause great confusion in the clinical community in reconciling this difference between the CMS and CPT guidance related to appropriate use of these codes. **The College recommends that CMS amend the proposal to adopt the CPT guidance for appropriate use of the non-face-to-face prolonged service codes**, including removing the requirement that the service to be provided on the same day as the E/M service. (Note: the full CPT guidance is listed as "This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and

management services at any level. This prolonged service may be reported on a different date than the primary service to which it is related.”)

Concerning the intersection of the non-face-to-face prolonged service codes with CCM and TCM services, the College understands CMS' need to safeguard program integrity. However, CMS' interpretation of the CPT prolonged service codes with and without patient contact are that they are services furnished during a single day that are directly related to a discrete face-to-face service. In contrast, the fact that CCM and TCM codes are billed monthly and focused on a broader episode of patient care are valid points to consider. There may be times when the prolonged service may be related to a single problem or unrelated to the patient's chronic conditions altogether. **The College believes, under certain limited circumstances, when the non-face-to-face prolonged service (99359 and 99359) is unrelated to a patient's chronic conditions (99490, 99487, and 99489) being managed by the clinician, the clinician should be allowed to bill the non-face-to-face prolonged service code during the same service period as CCM with the use of modifier 25.**

Alternatively, in lieu of the Agency's proposal for payment of the current CPT non-face-to-face prolonged service codes (99358 and 99359), the College recommends that CMS implement an approach to providing payment for non-face-to-face prolonged services, which includes the use of both a modifier and implementation of new G-codes. The modifier and new G-codes are described in the further detail below:

Use a Modifier

Modifier – X4: The modifier would work similar to surgical modifier 22 for circumstances outside of the typical level-4 patient. Unlike modifier 22, ACP advocates for a specific reimbursement of wRVUs to be associated with the use of this modifier. The proposed modifier would be for:

- patients with four or more chronic conditions being actively managed by the physician and documented during the visit;
- and/or receiving and reviewing unexpected abnormal studies (e.g. abnormal lab or imaging) that:
 - require additional work-up or
 - identify a new, separately identifiable problem from the visit that requires intervention or additional work-up;
- and/or a patient with 3 or more chronic problems that introduces an acute problem during their visit;
- and/or additional non-face-to-face time after the visit via electronic communication with the patient, lab, other clinicians.

Example Modifier Language:

Modifier –X4: Increased Cognitive Services: When the work required to provide a service is greater than typically required for a level-4 patient, it may be identified by adding modifier X4 to the evaluation and management code. Documentation must support the additional work and the reason for the additional work (i.e., increased intensity, time, severity of

patient's condition, mental effort required) (e.g., patients with four or more chronic conditions being actively managed by the physician and documented during the visit; and/or receiving and reviewing abnormal lab or x-rays leading to additional work-up or new intervention; and /or a patient with 3 or more chronic problems that introduces an acute problem during their visit).

Implement G-codes (in addition to the above Modifier proposal)

Codes GZZZ1 and GZZZ2 (add-on): This code, GZZZ1, is for non-face-to-face care for the identification and management of a new problem or exacerbation of an existing problem before and/or after direct patient care. ACP advocates for a specific reimbursement of wRVUs to be associated with the primary code as well as wRVUs for the add-on code, GZZZ2. The proposed code would be:

- Reported in relation to evaluation and management services at any level.
- Reported on a different date than the primary service to which it is related. For example, the Clinician has to react to an abnormal lab or personal review of abnormal imaging or medication reaction.
- Related to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management. A typical time for the primary service need not be established.

This specific G code is crafted to benefit internal medicine specialties. The electronic health record has expanded the walls of patient care and access. Internal medicine specialties spend more time dealing with the management and coordination of acute problems outside of face-to-face care (the office) including reviewing labs, viewing imaging, communication from patients and other clinicians etc.

Example G-Code Language:

GZZZ1: Prolonged evaluation and management service before and/or after direct patient care; first 15 minutes.

GZZZ2: each additional 15 minutes.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

Background:

The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to establish a program to promote the use of appropriate use criteria (AUC) for clinicians who order advanced diagnostic imaging services through clinical decision support mechanisms (CDSMs). The 2016 PFS rule first addressed the initial components of the AUC program through identifying relevant and applicable AUC. The current 2017 PFS proposed rule outlines specifications for qualified CDSMs; identifies the initial list of priority clinical areas; and establishes requirements and consulting/reporting exceptions related to CDSMs. Specifically, CMS proposes the following for this second phase of the AUC program:

- Timing and processes necessary to implement the AUC program including:
 - Pushing back the overall start date for the AUC program to January 1, 2018, since necessary aspects of the AUC program have not yet been finalized and published.

- Publishing in the 2017 PFS Final Rule with Comment Period on or around November 1, 2016 the final qualified CDSM requirements and processes.
 - Posting, no later than June 30, 2017, the first list of qualified CDSMs.
- The priority list of clinical areas will include: Chest Pain, Abdominal Pain, Headache (traumatic and non-traumatic), Low Back Pain, Suspected Stroke, Altered Mental Status, Lung Cancer, and Cervical or Neck Pain.
- A long list of specific, and very stringent, requirements that must be met in order for CDSMs to be considered “qualified.”(e.g., CDSMs must include applicable AUC that encompass the scope of the proposed clinical priority areas listed above and CDSMs must apply through the established CMS application process to be specified as a qualified CDSM.)
 - CMS states that it is in the best interest of the program to establish CDSM requirements that are not prescriptive about specific information technology (IT) standards. CMS proposes an approach that focuses on the functionality and capabilities of qualified CDSMs.
- Exceptions to the AUC consultation and reporting requirements including exceptions for imaging services ordered for someone with an emergency medical condition or exceptions similar to those under the EHR Incentive Program (e.g., inadequate internet access). CMS also proposes, to the extent technically feasible, that the year for which the eligible professional is excepted from the EHR Incentive Program payment adjustment is the same year that the ordering professional is excepted from the requirement to consult AUC through a qualified CDSM.

ACP Comments:

The College would first like to express our appreciation and support for CMS’ approach to establish CDSM requirements that are not prescriptive of specific IT standards. Instead, CMS proposes to focus on the functionality and capabilities of qualified CDSMs – and allow for the IT standards community to catch up to those requirements. For example, in the 2014 Edition of certification criteria, the Office of the National Coordinator for Health Information Technology (ONC) proposed to adopt two new Implementation Guides (IGs) from the Health eDecisions (HeD) S&I Framework initiative to support shareable clinical decision support (CDS). It quickly became clear that the proposed IGs would not have been capable of supporting new, emerging functional requirements that were fundamental to primary use cases. In this instance, ONC had to withdraw these proposals. Given the state of currently available standards and the likely functional requirements of AUC, there are no standards that are ready or nearly ready to fulfill the CDSM requirements. ACP also appreciates and supports CMS’ exception proposals – specifically, the exception from the AUC program during the same year in which an eligible professional is excepted from the EHR Incentive Program payment adjustment.

However, ACP has general concerns regarding the AUC program as proposed. By implementing the proposed AUC scheme, CMS is inserting a third-party between the doctor and the patient during the diagnostic process. This will result in some level of delay, confusion, and concern among patients who may be justifiably anxious to determine the cause of their symptoms. CMS has an obligation to inform patients of the details of this new AUC process – it should not fall to

the ordering clinician to have to explain and justify the process to each patient affected. **Therefore, ACP recommends that CMS inform patients of the details of this new process, as well as provide an explanation of the needs and supposed benefits of requiring these additional steps. In order to ease other areas of undue burden or administrative delay, the College recommends CMS engage with other payers and encourage them to follow the same criteria outlined by the Agency in order to lessen the administrative burden for participating physicians. ACP also recommends that CMS not require prior authorization along with these advanced imaging services as it will cause undue burden on the ordering physicians.**

The College is also concerned that the Agency did not identify a free CDSM option within its description of CDSM services. The implementation of this program could potentially result in very high costs for practices using CDSM services as well as any costs associated with required system upgrades. **Moving forward, ACP urges CMS to be transparent with expected costs to clinicians for implementation and use of the proposed AUC system and also recommends that CMS modify billing codes to reflect the additional costs of CDSM services.** And finally, we are concerned that if there are codes within the identified priority clinical areas that allow for the advanced imaging services in question and those that do not, the ordering clinician will quickly learn which codes result in approvals and which do not – decreasing the effectiveness of the program.

Overall, ACP recommends that a simpler approach for AUC involving the provision of relevant guidance at the point of ordering, which should be implemented and evaluated before moving to this complex and expensive system – including a review of whether the program led to more appropriate use of advanced imaging and/or better or different code selection.

Release of Part C Medicare Advantage (MA) Bid Pricing Data

Background:

In an effort to align with Presidential initiatives for transparency of federal information as well as to allow for public evaluation and research of the Part C Medicare Advantage (MA) program, CMS is proposing to release specific information within the MA bid pricing data that have not previously been released to the public. CMS hopes that these proposals will allow for research and a better understanding of the patterns of health care utilization and how managed care in the Medicare population differs across regions and from other beneficiary populations.

The definition of the MA bid pricing data that CMS proposes to release will include only CMS-accepted bids and contains the following elements:

- estimated revenue required by an MA plan for providing original Part A and B Medicare benefits and mandatory supplemental benefits, if any (including direct medical costs by service type, administrative costs, and return on investment);
- the plan pricing of enrollee cost-sharing for original Part A and B Medicare benefits and mandatory supplemental benefits; and
- beneficiary rebate amounts.

CMS proposes to exclude specific proprietary information that could put MA plans at a competitive disadvantage including: supporting documentation for actuarial basis of bid; strategic pricing and contracting information; information identifying Medicare beneficiaries; and any bid review correspondence between CMS and the MA plan or MA Organization (MAO). The Agency also proposes to standardize the timing of the annual release of MA bid data and to release the data no sooner than five years after the MA contract year as another effort to safeguard competition within the MA marketplace.

ACP Comments:

The College appreciates and supports the Agency’s proposal to release MA plan bid data to the public as it aligns with ACP’s current healthcare transparency policy.² This data will likely support a better understanding of health care utilization and how managed care in the Medicare population differs across regions and from other beneficiary populations. **The College recommends that CMS ensure the MA plan bid data is presented in a user-friendly and interpretable manner.** After review of the first annual release of MA bid data, ACP will assess whether the five-year delay in data still provides useful information and then make any necessary comments regarding the length of delay or need for certain data elements that were excluded from release.

Release of Part C and Part D Medical Loss Ratio (MLR) Data

Background:

Since 2014, all MA and Part D sponsors have been required to submit their medical loss ratio (MLR) data to CMS. The MLR is a ratio representing the percentage of revenue used for patient care rather than other administrative costs or profit. The MLR numerator is the sum of all amounts reported as claims or as health care quality improvement expenses, and the MLR denominator is the total revenue after subtracting the sum of any licensing or regulatory fees, federal and state taxes, and allowable community benefit expenditures. MA plans and Part D sponsors are subject to financial or other penalties if they do not reach at least an 85 percent MLR.

In this proposed rule, CMS proposes to release this MLR data to the public – which the Agency has not previously done. They believe this data will help the public and beneficiaries review the relative value of MA plans. The MLR data would be released 18 months after the contract year as CMS feels it will no longer be competitively sensitive. As with the MA bid data discussed previously, CMS proposes to exclude any narrative information used to describe methods for allocating expenses as well as exclude plan-level data, information identifying beneficiaries, and any correspondence between CMS and the MAO or Part D sponsor.

ACP Comments:

As stated previously, ACP policy on healthcare transparency³ is supportive of the release of MLR data. This data is a potential source of information to help the public and Medicare beneficiaries review the relative value of specific MA plans, and the College is very appreciative

²https://www.acponline.org/system/files/documents/advocacy/current_policy_papers/assets/transparency.pdf

³Id

of CMS' proposal. **However, ACP urges CMS to expend the necessary resources to ensure the information is presented in a user-friendly manner that is understandable to the general beneficiary or health care consumer.**

Proposed Expansion of the Diabetes Prevention Program (DPP)

Background:

A diabetes prevention program is an evidence-based intervention targeted to individuals at risk for diabetes. The risk of progression to Type 2 diabetes in an individual who is at risk is about 5-20 times higher than in individuals with normal blood glucose. The National Diabetes Prevention Program (DPP) administered by the Centers for Disease Control and Prevention (CDC), is a structured health behavior change program delivered in community and health care settings by trained community health workers or health professionals. The National DPP consists of 16 intensive "core" sessions of a CDC-approved curriculum in a group-based setting that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. After the 16 core sessions, monthly maintenance sessions help to ensure that the participants maintain healthy behaviors. The primary goal of the intervention is to reduce incidence of Type 2 diabetes by achieving at least 5 percent average weight loss among participants.

The DPP model was tested through the CMS Innovation Center (CMMI) and was determined to meet the legislatively-defined requirements for expansion by the Secretary throughout the Medicare program. The rule proposes expansion of this program beginning January 1, 2018 under the name of the Medicare Diabetes Prevention Program (MDPP), following an expected series of additional rule-making. The rule provides a framework for this proposed new preventive service to be offered under Medicare Part B and is requesting feedback of all aspects of the proposed framework. The proposed framework includes the following:

- Program description: The MDPP is proposed as a 12-month program using the CDC-approved DPP curriculum over 16-26 weeks and the option for monthly core maintenance sessions over 6 months thereafter if the beneficiary achieves and maintains a minimum weight loss (5 percent of baseline) in accordance with the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. CMS proposes that those beneficiaries who complete the 12-month program and achieve and maintain a required minimum level of weight loss would be eligible for additional monthly maintenance sessions for as long as the weight loss is maintained.
- Enrollment of New Medicare Suppliers: CMS proposes that any organization recognized by the CDC to provide DPP services would be eligible to apply for enrollment in Medicare as a supplier of these services beginning on or after January 1, 2017. CMS further proposes that all new MDPP suppliers enrolling in Medicare, must have either preliminary or full CDC recognition status and if an organization loses its CDC recognition status at any point, or withdraws from the CDC recognition program at any point, or fails to move from preliminary to full recognition within 36 months of applying for CDC recognition, the organization would be subject to revocation of its Medicare billing privileges for MDPP services. Existing Medicare clinicians and suppliers that wish to bill

for MDPP services would have to inform CMS of that intention and satisfy all other requirements.

- Requirements for MDPP Coaches: CMS proposes to require personnel who would deliver MDPP services, referred to as “coaches,” to obtain a National Provider Identifier (NPI) to help ensure the coaches meet CMS program integrity standards. CMS is also considering requiring that coaches enroll in the Medicare program in addition to obtaining an NPI. CMS further proposes to require MDPP suppliers to submit the active and valid NPIs of all coaches who would furnish MDPP services on behalf of the MDPP supplier as an employee or contractor. If MDPP suppliers fail to provide active and valid NPIs of their coaches, or if the coaches fail to obtain or lose their active and valid NPIs, the MDPP supplier may be subject to compliance action or revocation of MDPP supplier status.
- Expected MDPP Reimbursement: CMS proposes a reimbursement plan that is tied to number of sessions attended and achievement of a minimum weight loss of 5 percent of baseline weight (body weight recorded during the beneficiary's first core session.) The proposed reimbursement schedule provides a maximum payment per eligible beneficiary of \$360 for meeting all goals for the first 6 months of the program, an additional \$90 per beneficiary for full achievement of all goals over the second 6-month period, and a maximum of an additional \$180 per beneficiary for meeting all the goals after the first year.
- MDPP Eligible Beneficiaries: CMS propose that coverage of MDPP services would be available for beneficiaries who meet the following criteria:
 - (1) Are enrolled in Medicare Part B;
 - (2) Have as of the date of attendance at the first Core Session a body mass index (BMI) of at least 25 if not self-identified as Asian and a BMI of at least 23 if self-identified as Asian;
 - (3) Have within the 12 months prior to attending the first Core Session a hemoglobin A1c test with a value between 5.7 and 6.4 percent, or a fasting plasma glucose of 110-125 mg/dL, or a 2-hour post-glucose challenge of 140-199 mg/dL (oral glucose tolerance test);
 - (4) Have no previous diagnosis of Type 1 or Type 2 diabetes. A beneficiary with previous diagnosis of gestational diabetes is eligible for MDPP; and
 - (5) Does not have ESRD.

ACP Comments:

ACP is pleased that CMS is proposing to expand the MDPP and supports the Agency proposing to designate the MDPP as an additional preventive service available under Medicare Part B, thus allowing Medicare beneficiaries to utilize this service without being subjected to beneficiary co-pays.

The College understands CMS must ensure program integrity, however, **the College urges CMS to allow beneficiaries that previously failed the program to attempt the program again.** The proposal gives the impression that beneficiaries who meet the coverage criteria would only be able to enroll in the MDPP once. Evidence shows that even a modest amount of weight loss

improves health outcomes. **We believe that any patient that meets the criteria, even if he/she failed the program previously, should be allowed to enroll in the MDPP.**

The College also supports the proposals to allow community-referrals, self-referral by patients, and referrals by physicians and other health care clinicians to qualify as patients. **In support of continuity of care, the College also believes it would be beneficial for CMS to require non-clinician health care MDPP providers to ask beneficiaries about their usual source of care and mandate that programs share results with the beneficiary's self-identified primary care physician.**

CMS seeks input on the quality metrics that should be reported by MDPP suppliers. **ACP supports NQF measure #421. However, we would like to point out that the United States Preventive Services Task Force (USPSTF) recommends offering behavioral interventions for patients labeled as obese, not overweight individuals.** Additionally, there is no evidence about appropriate intervals for screening. As written, the measure would pressure physicians to spend a disproportionate amount of time on a patient's weight, when other conditions should take precedence.

The College would also like to comment on the Agency's proposal to use its waiver authority in this instance because the USPTSF has not granted MDPP a recommendation grade of A or B, which is typically required for Medicare coverage. CMS further explains that under its waiver authority, it will use the recommendations of the Community Preventive Services Task Force (CPSTF), which endorsed the use of diabetes prevention programs. **ACP believes CMS should use this same waiver authority to cover all Advisory Committee on Immunization Practices (ACIP) recommended vaccines for Medicare beneficiaries.** CMS has noted in years past that it cannot cover all recommended vaccines for adults since the Agency is limited by statute to cover only preventive services that have received a grade A or B from the USPTF. However, the Affordable Care Act required coverage for all ACIP-recommended vaccines for beneficiaries who are covered under private or exchange-sponsored health insurance policies. This has led to a two-tiered coverage system whereby some Medicare beneficiaries have received some of the ACIP-recommended vaccines (influenza and pneumococcal), while other Medicare beneficiaries have mandated coverage and therefore receive all ACIP-recommended vaccines.

The ACIP is a CDC-convened expert panel whose purpose is to "provide advice and guidance to the Director of the CDC regarding use of vaccines and related agents for effective control of vaccine-preventable diseases in the civilian populations of the United States."⁴ It is our understanding that ACIP uses evidenced-based research to make recommendations on the vaccines the U.S. population should be given. ACIP also uses other standards and concepts to formulate vaccine policy recommendations including:⁵

- Review of data on the morbidity and mortality associated with a particular disease;

⁴ ACIP Charter, updated April 20, 2016. <https://www.cdc.gov/vaccines/acip/committee/charter.html> Accessed on August 4th, 2016.

⁵ Smith, J. C. *The Structure, Role, and Procedures of the U.S. Advisory Committee on Immunization Practices (ACIP)*. Vaccine 285 (2010) A68-A75.

- Review of scientific literature (both published and unpublished) on the safety, efficacy, effectiveness, cost-effectiveness, and acceptability of the immunizing agent;
- Consideration of the quality and quality of all relevant data;
- “[Follow] specific rules of evidence, such as those followed by the USPTF to judge the quality of the data and to make decisions regarding the nature and the strength of recommendations;” and
- Other considerations including clinical trial results, information provided on packaging labels, equity in access to the vaccine, recommendations of professional liaison organizations, and feasibility of incorporating the vaccine into existing vaccine regimes and programs.

The College believes that ACIP is comparable to CPSTF in structure and recommendations and therefore meets the requirements for a waiver based on the rationale proposed for the expansion of the MDPP and – as stated previously – **we recommend the Agency use the same waiver authority to cover all ACIP-recommended vaccines for Medicare beneficiaries.**

Medicare Shared Savings Program (MSSP)

a) Changes to the Quality Measure Set

Background:

Groups that (are eligible to) report quality measures using the CMS web interface are required to report on all measures in the web interface. CMS proposes modifications to the quality measures set that an ACO is required to report to better align MSSP with the America’s Health Insurance Plans (AHIP) Core Quality Measures Collaborative and proposed reporting for the web interface in the Quality Payment Program (QPP). Under these proposals, the current 34 ACO quality measures will be reduced to 31 measures. All newly introduced measures would be pay for reporting for performance years 2017 and 2018 before being phased into pay for performance. The Agency proposes to add or replace ACO measures as follows:

- ACO-12 Medication Reconciliation Post-Discharge (NQF #0097): This measure intends to address adverse drug events through medication reconciliation. CMS proposes to replace the current ACO-39 (Documentation of Current Medications in the Medical Record) with ACO-12. This proposed change is being done to align ACO measures with the Core Quality Measures Collaborative and the QPP web interface measures.
- ACO-44 Use of Imaging Studies for Low Back Pain (NQF #0052): This measure reports the percentage of patients with a primary diagnosis of low back pain that did not have an imaging scan within 28 days (patients ages 18-50). CMS proposes to add this in the Care Coordination/Patient Safety domain to address a gap in measures pertaining to resource utilization as well as to align with the Core Quality Measures Collaborative and QPP. This measure would be calculated using Medicare claims data with no additional reporting required. CMS proposes to phase this measure in as pay for performance in year 2 of an ACO’s first agreement period. However, due to the possibility of small case sizes for this measure, the Agency seeks comment on whether it should remain pay for reporting for all three performance years.

- ACO-43 Ambulatory Sensitive Condition Acute Composite (AHRQ PQI #91): CMS proposes to add this measure to the Care Coordination/Patient Safety domain. It will be risk adjusted for demographic variables and comorbidities.
- CMS proposes to retire the two AHRQ Ambulatory Sensitive Conditions Admission measures because they report on a similar population with similar conditions as ACO-37 and ACO-38 (all-cause unplanned admission measures for heart failure and multiple chronic conditions).
- CMS proposes to retire or replace the following measures because they do not align with the Core Quality Measures Collaborative and QPP web interface:
 - ACO-39 Documentation of Current Medications in the Medical Record;
 - ACO-21 Preventive Care and Screening: Screening for High Blood Pressure and Follow-up Documented;
 - ACO-31 Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction;
 - ACO-33 Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy – for patients with CAD and diabetes or Left Ventricular Systolic Dysfunction.

ACP Comments:

ACP strongly supports efforts by CMS to better align MSSP quality reporting with the AHIP Core Quality Measures Collaborative and QPP Web interface measures. Alignment of measures between the MIPS and APM pathways will make the transition from fee-for-service to newer value-based models smoother for those practices that are ready to transition to APMs. We also encourage CMS to work to ensure that measure development and implementation is aligned across all payers. This is a much-needed step toward easing the administrative burden that reporting on a different set of measures for each payer places on practices. As discussed in ACP’s comments on the MACRA proposed rule,⁶ the College recommends that ideally any measures CMS proposes to use outside of the core set identified by the Core Quality Measures Collaborative be endorsed by the Measure Application Partnership (MAP). Many measures proposed by CMS in quality reporting programs are given a MAP designation of “encourage continued development,” which is reserved for measures that often lack strong feasibility and/or validity data. Therefore, prior to use in CMS quality reporting programs, measures given the “encourage continued development” recommendation should be resubmitted to the MAP once the suggested development occurs. Additionally, ACP continues to believe that it would be preferable for all measures, whenever possible and regardless of source, to go through a multi-stakeholder evaluation process—a role that is performed by the National Quality Forum (NQF). This process is important as it involves measures being evaluated against four important criteria—importance to measure, scientifically acceptable, usable and relevant, and feasible to collect. The College encourages CMS to consider these recommendations on selection of quality measures in MSSP in addition to other programs and models within QPP.

⁶ https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf

ACP supports the proposal to incorporate ACO-12 (Medication Reconciliation Post-Discharge -- NQF #0097) as a replacement for ACO-39 (Documentation of Current Medications in the Medical Record). In addition to the moving the MSSP quality measures to better align with those in QPP, ACO-12 is good clinical practice, will not cause harm or be a burden to physicians, and can help to eliminate medication errors that may occur during transitions of care.

The College also supports CMS' proposal to add ACO-44 (Use of Imaging Studies for Low Back Pain -- NQF #0052) to the MSSP quality measure set because of its' potential to prevent unnecessary screening. ACP recommends that CMS leave this measure as pay for reporting for all three performance years due to its potential for a small volume of cases. CMS should only consider a change to pay for performance if data suggests that there will be a sufficient volume of cases to produce reliable and valid quality data.

b) Changes to Align with Other Quality Reporting Programs

Background:

Current MSSP rules prevent eligible clinicians (ECs) who bill under the TIN of an ACO participant from participating in the Physician Quality Reporting System (PQRS) outside of MSSP participation. If an ACO fails to satisfactorily report on all ACO Group Practice Reporting Option (GPRO) measures through the Web Interface for each EC who bills under the TIN of an ACO participant, each EC who bills under the TIN will receive a downward payment adjustment under PQRS. CMS proposes to modify this by lifting the prohibition on separate reporting for the 2017 and 2018 payment adjustment. If an EC chooses to report apart from the ACO, the EC's data may be used for PQRS and VM purposes only when complete ACO-reported data is not available.

Following the 2018 payment adjustment period, PQRS, the Value-based Modifier Program (VM), and the EHR Incentive Program are sunsetted and QPP begins. Similar to MSSP reporting under PQRS, CMS proposes to require ACOs to report quality measures through the CMS Web Interface on behalf of the ECs who bill under the TIN of an ACO participant in order to satisfy the quality performance category under MIPS. ACOs must report all of the measures required by MSSP through the Web Interface to meet quality performance category requirements. The Agency also proposes to maintain the flexibility to allow ECs to report quality performance data separately from the ACO, though separately reported data cannot count in the assessment of the ACO's quality performance.

CMS also proposes changes to the EHR quality measure used in MSSP, ACO #11, in order to align with the policies in the QPP proposed rule. ACO #11, currently titled Percent of PCPs Who Successfully Meet Meaningful Use Requirements, assesses the degree of certified electronic health record technology (CEHRT) use by primary care physicians(PCPs) participating in the ACO. This measure is given twice the weight of other quality measures in MSSP for scoring purposes. In the QPP proposed rule, CMS proposes to use EC-reported data under the Advancing Care Information performance category to assess the ACO's overall use of CEHRT. In the PFS proposed rule, CMS proposes to modify the specifications of the EHR measure to assess the ACO on the degree of CEHRT use by all ECs who are participating in the ACO rather than

limiting it to PCPs. To align with this modification, CMS would revise the title of the measure to remove the reference to PCPs.

Additionally, because the modification to the specifications is a significant change in the measure, CMS proposes to consider ACO #11 a newly introduced measure. As such, it would be considered pay for reporting for performance years 2017 and 2018, meaning it is measured at the complete and accurate reporting level. In order to meet the complete and accurate requirement, CMS proposes that at least one EC who is participating in the ACO must meet the reporting requirements under the Advancing Care Information performance category. Beginning in 2019, it would be phased in as pay for performance in the second performance year of an ACO's first agreement period. During pay for performance years, the assessment of EHR adoption will be measured based on a sliding scale. This measure will continue to remain double weighted, and data will be derived using EC-reported EHR data through the MIPS requirements.

ACP Comments:

The fundamental point of the ACO model is that the practice manages its resources carefully, based upon evidence of value and effectiveness. If there were clear evidence that certified EHR technology (CEHRT) has a positive impact on value, then there would be no need for this measure or any other compulsion to impellent and use CEHRT. ACOs would simply implement CEHRT because of its positive impact. The fact that CMS feels the need to compel use of CEHRT over the better judgment of the ACO practices indicates that sufficient intrinsic value is not evident. Therefore, while **the College appreciates CMS' proposal to align the measures with those in the QPP, we recommend that CMS remove the ACO #11 measure entirely as there should be no compulsion on ACOs to implement particular health IT and to use it in specific ways – especially if it does not add value to the delivery of care.**

c) Incorporating Beneficiary Preference into Assignment

Background:

Under current MSSP assignment rules, beneficiary assignment occurs through a two-step process. In step one a beneficiary is assigned to an ACO if the allowed charges for primary care services furnished to the beneficiary by primary care physicians in the ACO are greater than the allowed charges for primary care services furnished by clinicians who are not participants in the ACO. Step two applies to beneficiaries who received at least one primary care service from a specialist in the ACO but none from primary care clinicians either inside or outside of the ACO. These beneficiaries are assigned to the ACO if the allowed charges for primary care services furnished by physicians with a specialty designation who are ACO participants are greater than the allowed charges for primary care services furnished by physicians with a specialty designation outside of the ACO.

For ACOs in MSSP Tracks 1 and 2, beneficiaries are preliminarily assigned at the beginning of a performance year, but final assignment is determined at the end of the performance year based on where the beneficiary chose to receive a plurality of primary care services. Track 3 ACOs use the same two-step process, but the prospective assignment is binding. The ACO is

held accountable for beneficiaries that are prospectively assigned, regardless of whether the beneficiary received most or all primary care services in the performance year outside of the ACO. Beneficiaries cannot be added to the prospective assignment list during the performance year even if they receive a plurality of primary care services from ACO participants.

CMS proposes to add an additional option for assignment to allow beneficiaries to voluntarily align with the clinician who they believe is responsible for coordinating their overall care (their “main doctor”). The Agency proposes to implement this beneficiary attestation process across all three MSSP ACO tracks. CMS proposes to use an automated mechanism to allow beneficiaries to select their primary care physician rather than requiring the ACO or the physician to collect the information and communicate it back to CMS. The Agency is considering options for how this automated process for selecting a physician could occur. For example, a beneficiary could select their “favorite” physician through www.mymedicare.gov, Physician Compare, or 1-800-Medicare. This voluntary alignment option would be available to beneficiaries starting in early 2017, and the beneficiary attestations would be used for assigning beneficiaries to ACOs beginning in performance year 2018. If an automated voluntarily alignment process for beneficiary attestation is not available by spring 2017, CMS proposes to allow a manual voluntary alignment process for Track 3 ACOs only until an automated process is available. Beneficiaries would continue to be assigned to ACOs based on the current two-step process if they have not designated a physician through the voluntary alignment process. The beneficiary voluntary alignment process overrides the claims-based two-step assignment process. If a beneficiary voluntarily aligns with a physician who is outside of an ACO, he/she cannot be added to the ACO’s list of assigned beneficiaries even if a plurality of primary care services are provided by a physician in the ACO. Physicians are prohibited from adopting any policy that coerces or otherwise influences a beneficiary’s decision to designate or not designate an ACO physician through the voluntary alignment process.

ACP Comments:

As ACP has stated in our recent letters to CMS in response to the MACRA proposed rule and the draft Measure Development Plan,⁷ the College strongly recommends that CMS work to ensure that patients, families/caregivers, and the relationship of patients and families/caregivers with their physicians are at the forefront of the Agency’s thinking in the development of both the Merit-based Incentive Payment System (MIPS) and Alternative Payment Model (APM) pathways. Therefore, the College strongly supports the proposal to allow beneficiaries to voluntarily align with the clinician who they consider to be their primary doctor (main doctor). ACP has joined with other organizations in requesting that CMS allow for a beneficiary voluntary alignment process in all three ACP tracks in previous comments on MSSP proposed rules,⁸ and we appreciate that CMS proposes to make this option a part of the all tracks of MSSP beginning with the 2018 performance year.

⁷ https://www.acponline.org/acp_policy/letters/comment_letter_macra_proposed_rule_2016.pdf;

https://www.acponline.org/acp_policy/letters/comments_cms_draft_quality_measures_development_plan_2016.pdf

⁸ https://www.acponline.org/acp_policy/letters/mssp-aco_collaborative_2015.pdf

Further, the College supports CMS' proposal to provide an automated mechanism for beneficiaries to select their primary care physician (main doctor). Allowing for automation in the beneficiary voluntary alignment process has the potential to limit the additional administrative burden placed on the practice when compared with the Pioneer ACO process, under which ACOs sent a CMS-approved form to beneficiaries to confirm their care relationship with the primary care physician. However, ACP has concerns with the suggested methods for allowing beneficiary self-assignment. Allowing beneficiaries to select their "favorite" physician through www.mymedicare.gov or Physician Compare may present challenges for beneficiaries who have little knowledge of or minimally use the Internet, as those websites can be difficult to navigate even for savvy web users. The search functionality in Physician Compare makes it difficult to find doctors or group practices without precise spelling of names and inclusion of location. If there are many practices under the same organization/system with similar names, selecting the correct practice to find a specific physician is difficult as well. Additionally, in Physician Compare, individual physicians and group practices that are part of ACOs are not clearly linked to or identified as a member of a specific ACO. The only indication that a practice/physician is in an ACO is a note that indicates that quality measures were submitted through an ACO. This may create confusion for beneficiaries who are trying to find their primary care doctor through the ACO. Using 1-800-MEDICARE as a method of beneficiary voluntary alignment may also present a challenge to patients that are hard of hearing.

Because of the diversity in Medicare beneficiaries' preferred methods of communication and the potential challenges tied to using some of the systems suggested by CMS for automated voluntary alignment, the College recommends that CMS initially begin the beneficiary voluntary alignment process as a pilot. This pilot should occur across all three MSSP tracks and allow for multiple methods of beneficiary voluntary alignment including via online platforms, 1-800-MEDICARE, and manually through a form or other similar process. Through the pilot, CMS will have the ability to test the functionality of systems used in the automated process and make adjustments/refinements as necessary prior to rolling out the program everywhere.

Additionally, ACP has concerns that the beneficiary voluntary alignment process overrides the current two-step assignment process indefinitely in absence of the beneficiary making a change in the system. This leaves no recourse for ACOs reassigning patients who no longer see the primary care physician with whom they initially chose to voluntarily align. For example, patients who no longer live in an area or who have chosen to switch practices may be assigned to ACOs that no longer have anything to do with their care and the costs associated with it, and patients who initially selected a non-ACO physician may be prohibited from assignment to an ACO despite receiving the predominance of primary care services from the ACO. While we agree that beneficiary choice in their primary care physician is essential, there will likely be many patients who select their primary care physician (main doctor) through an automated mechanism one time and never think to go back and adjust it, especially if it is through a system that they access infrequently. **The College recommends that CMS utilize the pilot to test ways of doing outreach to patients to confirm the main doctor that they selected continues to be their preferred primary care physician.** CMS could then utilize this patient preference confirmation methodology when the pilot is expanded to do outreach to patients in situations

where claims data indicates a likelihood that the patient has switched their primary care physician to verify the patient's decision on their preferred physician.

Thank you for considering ACP's comments. Please contact Shari M. Erickson, MPH, Vice President, Governmental Affairs and Medical Practice, by phone at 202-261-4551 or e-mail at serickson@acponline.org if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Robert McLean MD, FACP, FACR". The signature is fluid and cursive, with the letters "M", "A", and "I" being particularly prominent and stylized.

Robert McLean, MD, FACP, FACR
Chair, Medical Practice and Quality Committee
American College of Physicians