September 10, 2018

VIA ELECTRONIC SUBMISSION

Administrator Seema Verma
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: CMS-1693-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the on CMS-1693-P. Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year.

In the comments that follow, which are informed by our experience assisting people as they navigate the Medicare program, we discuss the importance of ensuring access to care and including the beneficiary perspective in efforts to create a person-centered health care system that both promotes value and protects individuals and families.

Evaluation and Management (E/M) Visits

In the CY 2019 physician fee schedule proposed rule, the Centers for Medicare & Medicaid Services (CMS) is seeking a number of significant changes to the documentation and billing requirements for Medicare's Evaluation & Management (E/M) services. We appreciate CMS's recognition that there are longstanding problems with the current system and applaud the agency for revisiting this issue.

However, we cannot support the agency's proposed solution. The new payment policy CMS has put forth could have devastating—if unintended—consequences for people with Medicare.

Single Payment Level

Of particular concern is the proposal to consolidate several billing codes for physician E/M services. Such an approach would result in a flat payment rate for all office visits, regardless of the visit's length or the complexity of the beneficiary's condition. Doing so would effectively cut rates for time-intensive visits that are currently reimbursed at higher levels, penalizing Medicare providers who treat people with complicated health issues.

To offset this reimbursement cut, many providers would likely seek to maximize revenue by reducing the length and narrowing the scope of office visits, asking beneficiaries to make additional visits to address additional issues. This would increase the financial, emotional, and physical burdens on older adults, people with disabilities, and their caregivers: more trips to the doctor would mean more copayments, more travel, more time spent in waiting rooms, and more stress for all involved. These challenges would be amplified for low-income Medicare beneficiaries and/or those who live in rural areas, for whom lack of transportation can be a significant obstacle to accessing care.

Though the proposed rule fails to consider that the outlined payment policy would incentivize such provider behavior, this response is nevertheless well documented within CMS. The agency's own actuary has long found a "behavioral offset"[1] that occurs when providers respond to a reduction in visit fee levels by generating more office visits, upcoding, or both. Since codes would be irrelevant under the proposed payment methodology, so would upcoding. However, because payment for a five minute visit would be the same as payment for a 30 minute visit, physicians would be much more likely to schedule multiple short, singularly-focused visits than to address multiple issues in one longer visit.

That likely behavioral response would also compromise quality. Sometimes, a long visit is needed for providers to collect and analyze information, as well as to permit good medical decision making, and to create open sharing pathways with the patient. Under the proposed rule, the financial temptation to compromise on this need would be powerful. Shortening office visits would, therefore, increase the stress on both providers and patients, as every interaction would be even more rushed than it is currently. Patients, feeling ignored, may withhold clinically important information while providers, feeling hurried, may miss critical signs and diagnoses.

Similarly, we are concerned that this proposal could encourage providers to cherry-pick healthier patients to avoid financial losses. People who are dually eligible for Medicare and Medicaid would be at particular risk. Compared to non-duals, they are more likely to be in worse health, to face provider access issues, and to need longer, comprehensive office visits.

While we agree with CMS that "current E/M coding does not reflect important distinctions in services and differences in resources" we do not agree that ignoring any distinctions in services and differences in resources is the solution.[2] We are extremely concerned that collapsing the E/M codes, as proposed, would have the immediate and lasting effect of restricting beneficiary access to care.

Accordingly, we urge CMS not to move forward with this rule as written, and to instead engage stakeholders—including people with Medicare and their families—in order to develop a meaningful, alternative approach that increases access, affordability, and quality. Though every system has its tradeoffs, we suggest the agency in particular explore adopting level coding that relies on a simple metric: time. If designed appropriately and

[1] Richard S. Foster, "Estimated Volume-and-Intensity Response to a Price Change for Physicians' Services" HCFA (August 13, 1998), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PhysicianResponse.pdf.

[2] 83 FR 35839

thoughtfully, such a policy could pave the way for codes that better incentivize providers, protect beneficiaries, and reflect clinical considerations.

Valuation of Specific Codes

To compensate for the reimbursement shortfalls that some providers would experience as a result of the flattened E/M codes, CMS proposes to create add-on codes for primary care ($5) and for certain specialty care services ($13.70).

That CMS recognizes the need to boost payments for some specialties and primary care services underscores a critical flaw with the proposed changes to the E/M codes—that providers would be at significant risk of underpayment. The potential underpayment would put their continued participation in the Medicare program at risk, which would, in turn, jeopardize beneficiary access to appropriate, affordable care.

As the Office of the Assistant Secretary for Planning and Evaluation notes, "[t]he extent to which providers participate in Medicare can affect beneficiaries' access to timely, affordable care. For example, if provider participation in Medicare were low, beneficiaries might face long waits for appointments or larger out-of-pocket payments for care."[3] Currently, such access is not a concern. As of 2015, more than nine in ten primary care physicians accept Medicare, and more than 70% accept new Medicare patients. In rural communities, more than 80% accept new Medicare patients.[4] In recent years, overall provider participation in Medicare increased.[5] But this stability of access could be threatened if providers see a real or perceived decline in their reimbursement for aging or complex patients, or patients with multiple chronic conditions who require more extensive evaluation and management than the average patient might need.

We appreciate that the proposed payment policy is an attempt to address a very real problem where ambiguity in coding creates uncertainty and a level of gaming. However, the solution to this problem is to simplify and clarify the codes, rather than failing to compensate providers for their time, effort, and expertise. The addition of small add-on payments cannot offset the payment cuts and damaging incentives that flattening the fee schedule would create.

Multiple Procedure Payment Reduction

To remain budget neutral, these add-on codes would be funded by a Multiple Procedure Payment Reduction (MPPR) for certain E/M services furnished on the same day as a procedure.

Specifically, CMS is proposing to extend the MPPR from a surgical context to office outpatient E/M visits. The PFS MPPR would pay 100% for the single most expensive procedure or visit a physician (or a physician in the same group practice) furnishes on a day with a separately identifiable E/M code, but would cut by 50% all of the less expensive procedures with the same indicator. We are deeply concerned that this proposal would create nearly irresistible incentives to split procedures and visits across multiple days. This would compound the consequences of a flattened fee schedule—beneficiaries would be further burdened with repeat visits to a provider or provider group. Many beneficiaries—in particular low-income beneficiaries in rural areas or those

[3] Adele Shartzer, Rachael Zuckerman, Audrey McDowell, and Richard Kronick, "Access to Physicians' Services for Medicare Beneficiaries," ASPE (August 2013), https://aspe.hhs.gov/basic-report/access-physicians-services-medicare-beneficiaries.
[4] Cristina Boccuti, Christa Fields, Giselle Casillas, & Liz Hamel, "Primary Care Physicians Accepting Medicare: A Snapshot," Kaiser Family Foundation (October 2015), https://www.kff.org/medicare/issue-brief/primary-care-physicians-accepting-medicare-a-snapshot/.
[5] Adele Shartzer, Rachael Zuckerman, Audrey McDowell, and Richard Kronick, "Access to Physicians' Services for Medicare Beneficiaries," ASPE (August 2013), https://aspe.hhs.gov/basic-report/access-physicians-services-medicare-beneficiaries.

who rely primarily on family or other caregivers—would have their lives disrupted and their physical, financial, and time resources stretched by such requirements. In the worst scenarios, these patients may not return to the provider for the follow up procedure, to the detriment of their health and well-being.

As noted above, instead of this combination of a flattened fee schedule plus add-on payments and a harmful pay-for, we suggest CMS consider modifying the current E/M visit coding to use time as the criterion for determining each visit's coding level. Doing so could more effectively incentivize primary care providers and specialists who care for patients with complex health needs.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS is proposing to expand access to certain telehealth services, and to pay for services that are defined by and use communication technologies. Medicare Rights is generally supportive of using technology to reduce the financial and physical burden that unnecessary office visits can place on people with Medicare, and we recognize that provider reimbursements for these check-ins, consultations, and evaluations may encourage providers to use these time- and money-saving technologies. This may prove especially valuable for Medication Assisted Therapy for substance use disorders and interprofessional consultations that currently results in an office visit when it is not necessary for the health of the patient.

However, these new pathways must be carefully designed to ensure beneficiaries are fully informed and empowered. For example, any changes—such as to charges and office visits—must be clearly explained to the beneficiary and agreed to prior to the service being delivered. Beneficiaries should separately consent to receive these services and understand the accompanying financial liability. This discussion should be explicit, particularly if patients were previously not charged separately for the virtual check-in.

In addition, there must not be any incentives for providers to schedule or not schedule check-ins or resulting office visits in an effort to avoid bundling. This is especially important if the payment would be incorporated into the proposed flattened E/M code, since this change alone (as discussed above) would incentivize providers to truncate visits. Bundling additional work into those payments could disincentivize the check-ins, the visits, or both. A necessary in-office visit must never be delayed because it could result in an insufficient bundled payment.

Similarly, CMS asks whether and how time periods should be set to determine whether the new services are to be bundled into an office visit. It is extremely important that any bundling time limit not encourage providers to time shift needed check-ins or visits. CMS also asks whether there should be frequency limits on these check-ins. Again, it is vital that check-ins not become a money-making opportunity for practices that are financially squeezed by any changes to the E/M reimbursement.

Regarding the remote evaluation proposal, CMS asks if the service may be offered to new patients. We believe this should be a medical decision, not a billing one.

In addition, check-in services should not be designed in a way that conflicts with existing free nurse advice lines. If a new service simply shifts beneficiaries from getting free advice to having to pay for substantially similar advice, that is not to their benefit.

Bundled Payment Model for Management and Counseling Treatment for Substance Use Disorders

Medicare Rights supports the development of a bundled payment model designed to improve access, quality and efficiency of substance use disorders treatment. We appreciate the emphasis placed on increasing access to medication-assisted treatment (MAT), which is proven to be an effective treatment for opioid addiction.[6] The proposed model has the potential to increase MAT, and to reinforce that MAT includes medication as well as counseling.

As CMS looks to design and implement this model, we urge the agency to include all substance use disorders. Specifically, we recommend that the payment model be available to treat the array of substance use disorders, rather than limited to opioid-used disorders. Addiction to cocaine and methamphetamine are already outpacing opioids in some communities,[7] and alcohol continues to take more lives than any other substance. This pattern of shifts in the most prevalent misused substance has a long history. We encourage CMS to seek solutions that help all communities tackle all addictions, including communities of color who have faced life-threatening drug issues for decades. Similarly, to maximize this model's reach and efficacy, we recommend that it include a range of provider types and services, such as acute care, outpatient counseling, recovery supports, and other community supports.

We also urge CMS to preserve provider choice in the model's design. Under a bundled payment model, consumers should retain their choice of provider among a variety of Medicare participating service providers that are not part of a bundled payment system, as well as be able to continue receiving care from current providers regardless of the provider's participation in the bundled payment system.

We also recognize the importance of embedding proper provider incentives into such a model. Accordingly, we are concerned that a budget neutral model could be ineffective in improving access to care. We recommend that CMS provide adequate reimbursement rates for the services of an entire care team—ranging from psychiatrists and other mental health professionals to nurses and peer counselors. We also recommend that CMS consider creating additional reimbursement for treatment of patients with complex health care needs (e.g., co-occurring mental health or physical illness) who need more intensive services.

Though beyond the scope of any one model, we continue to encourage CMS to include recovery support services as part of outpatient rehabilitation under Medicare Part B. Making these cost-effective services available to people with Medicare would be an important step in addressing substance use disorders for seniors and people with disabilities.

Updates to the Quality Payment Program

A high-value health care system requires value-driven payment arrangements which should result in better health outcomes, improved care coordination, an improved experience of care by the individual, and decreased costs for the whole system. The intent of the Quality Payment Program (QPP) is to encourage providers toward alternative payment models (APMs) that reward high-value care and support care delivery innovations. We generally support CMS's efforts to recognize provider movement away from traditional fee-for-service payment arrangements that often may not meet the needs of consumers and purchasers. Accordingly, we support CMS's intention to:

[6] Pew Charitable Trusts, "Medication-Assisted Treatment Improves Outcomes for Patients with Opioid Use Disorder," (2016), http://pew.org/2fLEhLA.
[7] Substance Abuse and Mental Health Services Administration, "Results from the 2016 National Survey on Drug Use and Health" (2017), https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.htm.

- Adopt four new patient-reported outcome measures. The individual's perspective must be at the forefront of any definition of "value";
- Continue to require reporting of quality measures for a full year rather than just 90 days;
- Require the use of 2015 Certified Electronic Health Record Technology (CEHRT) starting in the 2019 performance year; and
- Strengthen the Advanced APM CEHRT threshold to require that at least 75% of eligible providers in each APM entity use Certified EHR Technology (CEHRT).

However, the proposals for Year 3 do not go far enough to prepare providers for a fully mature QPP or a transformed health care system. We are particularly concerned by the following proposals:

- Extending the delay in public reporting of quality measures from one year to the first two years a measure is in use in the quality performance category;
- Low-volume thresholds, which exempt large numbers of providers from required participation in the program;
- Continuation of the menu approach to measure selection in the quality performance category; and
- Elimination of patient engagement measures that encourage patients and family caregivers to use online health information and communicate electronically with providers in the promoting interoperability performance category.

The QPP should evolve in a way that drives continuous performance improvement among all providers. Indeed, the Bipartisan Budget Act of 2018 requires CMS to continue to increase the MIPS performance threshold year-over-year. We must not lower the bar but raise it to meet this legislative imperative, and build a system that meets the needs of consumers and purchasers.

Request for Information: Promoting Interoperability and Electronic Healthcare Information Exchange

CMS is requesting stakeholder feedback through a Request for Information on ways to promote electronic data sharing, especially by hospitals. We continue to support the goal of widespread electronic exchange of health information and incentives that encourage providers to participate. However, it must never put access to care at risk. CMS must be clear about how any penalties or requirements may affect small or rural providers, and work to ensure their continued availability for people with Medicare.

Request for Information: Improving Beneficiary Access to Provider and Supplier Charge Information

CMS is requesting stakeholder feedback on ways to improve consumer access to hospital price information. We continue to support transparency in pricing in general, and in particular when it helps beneficiaries understand the magnitude of costs between services and procedures. However, while price posting may be useful for advocates, reporters, and researchers, the ultimate utility of "chargemaster" prices for consumers is much more limited. We are also concerned that such price posting might be assumed to give beneficiaries a tool to help contain health costs, transferring responsibility for systems-wide cost containment onto overburdened patients and their families.

It is important that efforts toward price transparency are helpful to the individual beneficiary, in that they provide estimates that are specific to the beneficiary's personal circumstances. This includes tailored projections of all out-of-pocket costs in advance of the service being provided. Cost information should always be

supplemented with data on provider quality and health outcomes to prevent their conflation, as consumers may be led to believe that higher prices are indicative of better quality care.

Conclusion

Thank you again for the opportunity to provide comment. As noted throughout, Medicare Rights has significant concerns with this proposed rule. In particular, though well-intended to reduce documentation and reporting burdens on providers, collapsing the E/M codes would have detrimental and lasting effects on people with Medicare and their families. We urge CMS not to finalize this proposal, and to instead work with stakeholders to identify ways to reduce the administrative burden on providers without jeopardizing the health and economic security of people with Medicare. If, however, CMS is convinced that flattening the fee schedule is preferable and would lead to better outcomes, a small-scale demonstration could test that theory more appropriately than the proposed large-scale, rapid, and unproven systems change.

We look forward to continuing to work together to advance policies that consider and balance the needs of beneficiaries and providers, while promoting high-value and high-quality care. For additional information, please contact Lindsey Copeland, Federal Policy Director at LCopeland@medicarerights.org or 202-637-0961 and Julie Carter, Senior Federal Policy Associate at JCarter@medicarerights.org or 202-637-0962.

Sincerely,

Joe Baker
President
Medicare Rights Center