

September 8, 2015

Mr. Andrew Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attn: CMS-1631-P  
Hubert H. Humphrey Building, Room 445-G  
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 2016; Proposed Rule (CMS-1631-P)

Dear Acting Administrator Slavitt:

On behalf of the undersigned organizations, we provide the following comments on the CY 2016 Physician Fee Schedule Proposed Rule, as published in the Federal Register. These 13 organizations represent 160,300 physicians, and their members provide evaluation & management services to their patients and remain concerned about the deficiencies in the definitions and valuations of these services. As such, we submit the comments on the following issues:

1. Improved Payment for the Professional Work of Care Management Services
2. Establishing Separate Payment for Collaborative Care
3. Complex Chronic Care Management (CCM) and Transitional Care Management (TCM) Services
4. Advance Care Planning Services

#### **Improved Payment for the Professional Work of Care Management Services**

We applaud CMS for recognizing care management as a critical aspect of helping individuals achieve better health outcomes and reducing expenditure growth. We commend the agency for proposing to address the deficiencies in the existing evaluation and management (E/M) services, particularly as they relate to the delivery of comprehensive, coordinated care management.

Though as individual societies, we may have separate priorities for E/M revision, as a group we fully support CMS' proposal to create add-on codes to reimburse currently uncompensated physicians work associated with E/M services as a practical and expedient solution to the undervaluation of E/M services.

We recommend that new add-on codes be developed for use by all specialties, and they should not be restricted to certain specialties. As an example, there should be two categories of add-on codes for both new and established outpatients that reflect the different levels of intensity of the work performed, the first for a high level of intensity and the second for even higher levels of intensity.

These codes should follow the resource-based paradigm of RBRVS using work intensity as the unit of resource use. For primary care, the levels of intensity would recognize both the complexity of multiple interactions of medications and health problems and the post-visit work intensity for patients with

multiple chronic conditions. For the specialist, the levels of intensity would recognize the complexity within a disease state and medical decision making of whether or not to pursue certain interventions.

As CMS considers how add-on codes should be structured and valued, we urge the agency to assess the relative valuation of this work as it relates to the health of a beneficiary. Besides being a more patient-centric assessment of value, it will allow resources to be evaluated as they relate to maintaining an individual's health, integrated care and appropriate use of resources.

### ***More Research Needed in Order to Understand E/M Services***

While we appreciate CMS' proposal to compensate physicians for this currently uncompensated work and view this proposal as an important first step, it does not go far enough. New payment models being studied and implemented by CMS continue to rely on the resource-based relative value scale (RBRVS) when determining physician compensation. Yet, the existing E/M codes continue to be improperly defined and valued. The inequities faced by physicians whose work consists of providing these services in the fee-for-service model will persist in new payment models until CMS addresses these service codes.

Specifically, there continues to be considerable variability in the work completed by different specialties within the existing E/M service codes and there continues to be a wide range of post-service work completed as a result of the encounter by different specialties. Some are relatively overpaid and some are relatively underpaid. There are just too few basic choices.

We previously proposed that CMS improve the accuracy in the Physician Fee Schedule (PFS) by creating new E/M codes that would be developed from a knowledge-base that reflects the current levels of physician work based on nationally representative samples and electronically accessible data. If successful, this research-based model could then be used to address the deficiencies in the other E/M code families.

We urge CMS to commit to doing this research and to hire a contractor to work with stakeholders to develop a comprehensive understanding of what physicians and their clinical staff do on a daily basis. We believe that the section 3021 of the Affordable Care Act provides the Innovation Center with the authority to conduct this research. Congress authorized the Center for the purpose of testing "innovative payment and service delivery models to reduce program expenditures ...while preserving or enhancing the quality of care." As long as new payment models use the RBRVS as the foundation for physician reimbursement, E/M services must be revised to accurately reflect the work provided to patients. More accurate reimbursement for cognitive work has the potential to enhance the quality care provided to patients while lowering costs, both goals of Innovation Center projects.

This research we requested would 1) describe in detail the full range of intensity for E/M services, 2) define discrete levels of service intensity based on this observational and electronically stored data combined with expert opinion, 3) develop documentation expectations for each service level that place a premium on the assessment of data and resulting medical decision making, 4) provide efficient and meaningful guidance for documentation and auditing, and 5) ensure accurate relative valuation as part of the PFS.

While we urge CMS to commit to the research necessary to develop new E/M codes, we believe that this research will also be critical to identifying and valuing the uncompensated work associated with

E/M services that the agency intends to support with the add-on code proposal. Since the current E/M codes were adopted, the uncompensated work associated with this service has grown as medical care has evolved to meet the changing needs of patients. This research will provide the agency with an accurate and reliable description of E/M activities. It will also help clarify what physician work should be attributed to the E/M services and allow a clear definition of what Medicare should expect from chronic care management (CCM) and transitional care management (TCM) services.

As consignees to this letter we applaud and fully support the commitment on the part of the agency to address the longstanding issues of the poorly defined and undervalued E/M services. We will provide added support to any contractor hired to pursue the needed research and we stand together as a resource for the agency in its efforts to ensure accurate service code definitions and valuations.

### **Establishing Separate Payment for Collaborative Care**

We support CMS' proposal to reimburse physicians for collaborative care since the existing E/M services do not reimburse for the services provided in this context. While we understand that this proposed payment is not a replacement for the consultation codes, this proposal would address a gap in reimbursement that has existed since the elimination of those service codes.

As CMS considers how to operationalize this proposal, we are concerned about the imposition of potential health information technology (HIT) requirements. If these requirements are too burdensome, they could prove to be too challenging for small practices and solo practitioners. We recommend that primary and collaborating physicians be able to share clinical data and electronic health records (EHR), with no requirement for full interoperability.

We also recommend that patient out-of-pocket liability be waived for all physicians who provide collaborative care, extending beyond those participating in certain Innovation Center projects. Increasing access to specialty knowledge and to decision support will improve the accuracy of the primary physician's medical decision making and improve efficiency by eliminating the wait to incorporate specialized care recommendations as part of a patient's health plan.

### **Complex Chronic Care Management (CCM) and Transitional Care Management (TCM) Services**

We appreciate CMS' ongoing recognition of the undervaluation of cognitive services, including the unreimbursed non-face-to-face time expended by physicians and their staff to improve patient care and outcomes. To that end, we welcome CMS' proposal to refine the complex chronic care management (CCM) and transitional care management (TCM) services that are currently underutilized. We view this as continued progress towards promoting accountable care for patients but believe there is much work to be done with respect to adequately capturing the work performed and promoting care coordination between physicians.

Many patient cases require the additional resources included in the CCM services, (i.e., regular physician development and/or revision of care plans; subsequent reports of patient status; review of laboratory and other studies; communication with other health professionals not employed in the same practice who are involved in the patient's care; integration of new information into the care plan; and/or adjustment of medical therapy). However, as structured, the administrative requirements of these codes is not commensurate with the reimbursement of approximately \$42.

The current use of time metrics for code documentation is inefficient and impractical. The experience with care management indicates that multiple short phone calls add up over a one-month period. Documenting these conversations disrupts the practice's work flow to the detriment of the care delivered to patients. Since multiple providers may be involved in the care of patients, it becomes even more difficult to keep track of the time allocations.

The care management needs of beneficiaries vary considerably from month to month. The average might be 20 minutes per beneficiary per month, but there are some months where a 5-minute phone call is all that is necessary to assure that a patient is stable. There are other months where an hour or more of telephone contact will be required to resolve conflicts and improve patient outcomes. The requirement of 20 minutes per beneficiary per month imposes an unrealistic expectation that will challenge practices and foster unnecessary phone calls and documentation. This will detract from the care of those patients who require extended intervention.

We recommend that CMS eliminate the 20 minute per month requirement and replace it with a standard that better reflects a patient's care management needs each month. This could be a temporary requirement until a database could be developed that could serve as the foundation for revisions to this service and the development of future similar services. CMS should also consider adopting the CPT code for more complex patients with its higher reimbursement level.

As structured not only do these codes have unrealistic administrative burdens, but they are also unworkable for many specialists represented by the groups signed onto this letter. We ask CMS to remember that many specialists engage in the chronic care management described by these codes and ask that CMS undertake revisions to these service codes in order to promote their use by these specialists primarily engaged in this variety of continuous cognitive work.

### **Advance Care Planning Services**

We support the agency's proposal to reimburse providers for the advance care planning (ACP) services described by CPT codes 99497 and 99498. We recommend that providers be able to bill for these services as required by the patient. After the ACP service is billed by the physician for the first time, any subsequent reimbursement of the service should be based on either a recent change in patient health status that has long term health implications or a patient condition or combination of conditions that has a clear trend toward imminent health decline. We believe that the reimbursement for these codes is the agency's method of expanding the coordination of care required by the TCM and CCM codes as well as some of the other proposals in the proposed rule. We request that the agency articulate this point clearly.

While we support the agency's proposal to reimburse for these services, we are concerned that each Medicare Administrative Contractor (MAC) would have the authority to determine if the ACP services would be reimbursable in their jurisdictions. We strongly believe that this service should be available to all Medicare beneficiaries regardless of what jurisdiction in which they live and recommends that CMS implement it as a nationally available benefit.

Thank you again for your efforts to improve the valuation of cognitive services and for the opportunity to comment on this proposal. If you have questions or require further information, please contact Erika Miller at 202-484-1100 or [emiller@dc-crd.com](mailto:emiller@dc-crd.com).

Sincerely,

AMDA – The Society for Post-Acute and Long-Term Care  
American Academy of Allergy, Asthma and Immunology  
American Academy of Neurology  
American College of Allergy, Asthma and Immunology and the Advocacy Council of the American College  
of Allergy, Asthma and Immunology  
American College of Rheumatology  
American Gastroenterological Association  
American Society for Blood and Marrow Transplantation  
American Society of Hematology  
American Psychiatric Association  
Coalition of State Rheumatology Organizations  
Endocrine Society  
Infectious Diseases Society of America  
Society of General Internal Medicine