



AMERICAN ACADEMY OF
HOSPICE AND PALLIATIVE MEDICINE

Submitted electronically via [regulations.gov](http://www.regulations.gov)

September 6, 2016

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
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 2017 [CMS-1654-P]

Dear Acting Administrator Slavitt:

On behalf of the nearly 5,000 members of the American Academy of Hospice and Palliative Medicine (AAHPM), thank you for the opportunity to comment on CMS's recent proposed rule that would update payment rates for physicians in 2017 and modify other payment policies.

AAHPM is the professional organization for physicians specializing in Hospice and Palliative Medicine. Our membership also includes nurses and other health and spiritual care providers deeply committed to improving quality of life for patients facing serious or life-threatening conditions, as well as their families. As many of the proposed policies in this rule affect practicing hospice and palliative medicine physicians across settings, they hold the potential to have a sizable impact on the care these patients receive. AAHPM acknowledges CMS's commitment to ensuring that impact is positive, and we stand ready to contribute to this effort to the greatest extent possible.

In the sections below, we provide both general and detailed comments on specific proposals in the proposed rule.

Medicare Telehealth Services

In general, AAHPM is strongly supportive of CMS's proposals to add coordination services to the list of Medicare telehealth services beginning in CY 2017. Providing these services is often complex, especially for patients with multiple illnesses, complicated treatment options, significant emotional distress, and conflict among family members. We agree with CMS that these telehealth services should be reimbursable.

Specifically, AAHPM supports CMS's proposal to add the following codes to the list of Medicare telehealth services beginning in CY 2017 on a category 1 basis:

- *ESRD-related services 90967 through 90970. The required clinical examination of the catheter access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by a physician, CNS, NP, or PA.*
- *Advance care planning (CPT codes 99497 and 99498)*
AAHPM strongly supports the addition of these CPT codes and urges CMS to finalize this proposal. Our members care for the sickest and most vulnerable patients, including those near end of life, and they can attest to the fact that advance care planning services are essential to ensuring high-quality care for Medicare beneficiaries. Each day, our members see what a difference it makes when patients and families facing serious illness have had an opportunity to engage in these critical discussions about goals of care, treatment options, values and preferences. Allowing these services via telehealth will not only expand access to them but allow for broader engagement by patient surrogates who may live at a distance and are unable to be physically present for these important services. Further, for frail older adults with cognitive impairment, a trip away from their home or alternative living environment can be extremely disorienting and fatiguing, which makes quality advance care planning conversation all the more difficult. Allowing conversation to occur in patient’s living environment leads to better care.
- *Telehealth Consultations for a Patient Requiring Critical Care Services (GTTT1 and GTTT2)*
We agree that these codes more accurately describe the types of services provided to critically ill patients via telemedicine than do the critical care codes 99291 and 99292. We support the proposed payment amounts but recommend that CMS solicit comment on the payment for GTTT1 and GTTT2 in two years, after physicians have an opportunity to become familiar with the procedures.

However, while we are encouraged that allowing these important services to be performed via telehealth will expand access for patients in rural and underserved areas, we’d remind CMS that many of those very areas lack the required IT infrastructure to take advantage of the change. We urge CMS to work with Congress and the Administration to improve this infrastructure, as well as provider capacity and training, so the benefits of telehealth can be maximized.

Finally, we request that CMS specify in its final rule how these telehealth services would be differentiated from face-to-face services. Does CMS envision that they would take the place of face-to-face services, when convenient, or are these telehealth services meant to supplement face-to-face visits?

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

CMS is proposing a number of changes to coding and payment policies under the Medicare Physician Fee Schedule. According to CMS, these proposals are intended to accomplish the following:

- 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 and one to address behavioral health integration 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 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.
- Recognize for Medicare payment CPT codes for non-face-to-face Prolonged E/M services by the physician (or other billing practitioner) that are currently bundled, and increase payment rates for face-to-face prolonged E/M services by the physician (or other billing practitioner) based on existing RUC recommended values.

AAHPM appreciates and supports CMS's ongoing efforts to appropriately reimburse clinicians for care management and other high-value, patient-centered services.

For CY 2017, CMS proposes to establish the following codes for use in certain care management services. AAHPM offers its support as follows:

- ***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.

AAHPM commends CMS's effort to expand Medicare coverage and payment to additional services involving care for patients with behavioral health conditions based on the recognition that significant time and resources are expended on patients with behavioral health conditions that are not currently compensated. However, it is not clear from the proposed rule precisely which services, practitioners, patients, and circumstances would qualify for the billing of the GPPPX code, and we would request clarification be included in the final rule.

We support CMS's proposal to adopt a general consent standard for the behavioral health integration codes. However, while we acknowledge the statutory restrictions regarding coinsurance, we think that coinsurance is counterproductive and is an impediment to patient engagement in collaborative care. We thus recommend moving ahead with coverage while also simultaneously establishing a CMMI demonstration project to assess the impact of coinsurance on beneficiary participation.

- ***GPPP6***: Cognition and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, by the physician or other qualified health care professional in office or other outpatient setting or home or domiciliary or rest home.

AAHPM commends CMS for recognizing that developing a care plan for a cognitively impaired beneficiary can be a time-consuming process. We support the proposal to use a temporary G-code for assessment and care planning for patients with cognitive impairment in CY 2017 and appreciate CMS accepting the CPT language. However, we disagree with the CMS proposals for physician work and clinical staff time and strongly recommend that CMS accept the RUC recommended physician work RVU of 3.44 and the RUC recommended clinical staff times and types.

We are particularly pleased that CMS recognizes the value of ACP and palliative care services by including them as required service elements of GPPP6. However, high-quality palliative care encompasses a range of services, including in-depth pain and symptom management, expert communication (including advance care planning), and care coordination. We therefore recommend that CMS separate the advance care planning and addressing of palliative care needs into two separate service elements:

- Advance care planning, if applicable and consistent with beneficiary preference.
 - Addressing palliative care needs (including symptoms and stressors), consistent with beneficiary preference
- ***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).***

AAHPM commends CMS for recognizing the added work that may be performed in a face-to-face assessment of a beneficiary requiring chronic care management services in addition to what would typically be performed in the initiating visit. AAHPM supports implementation of GPPP7 and believes CMS should allow 99358 and 99359 to be reported with GPPP7. We also believe CMS should support the proposed work RVUs, and we urge CMS to work with the CPT Editorial Panel to transition the code to a CPT code. Otherwise, we encourage CMS to solicit feedback on possible revisions once physicians have gained experience using the code. We agree with requiring an initiating visit for new patients and then again only for patients who have not received any E/M services from the practice in the previous year, so as to “re-establish” the care plan.

- ***GDDD1: 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).***

AAHPM appreciates CMS’s concern about providing appropriate care to patients with disabilities and agrees with the goal of the code. However, the utilization of this code could vary dramatically depending on its intended use. So, while AAHPM does not believe that CMS should require the use of assisted devices discussed in the proposal, we urge CMS to clarify when the code may be reported for patients with respect to patient condition and equipment used and to monitor the use of the code to ensure it is being used in accordance with policies specified in the final rule. Regardless, we agree that the code should be reportable with any face-to-face E/M service provided in the physician office setting.

Non-Face-To-Face Prolonged Evaluation & Management (E/M) Services

CMS proposes to establish separate payment for the following non-face-to-face prolonged E/M service codes that are currently considered to be “bundled” under the PFS:

- CPT code 99358: Prolonged evaluation and management service before and/or after direct patient care, first hour; and
- CPT code 99359: Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes (List separately in addition to code for prolonged service).

AAHPM appreciates that, with these codes, CMS recognizes the increasing non-face-to-face work needed to treat complex patients, and we strongly support the proposal to make separate payment for these codes and to value these services using the RUC recommended physician work RVUs. We believe the proposed thresholds for time are sufficiently high to ensure program integrity, though our experience is that physicians often spend more time than recognized within the E/M post-service periods yet less than a full hour. AAHPM anticipates that CMS and CPT may refine the time thresholds in coming years, as we learn about the use and limitations of these codes.

AAHPM opposes CMS's proposal to require that 99358 and 99359 be performed on the same date as the underlying face-to-face E/M. Not only is it contrary to CPT instructions (which could be confusing and lead to miscoding) but, more importantly, a physician may interact with a complex patient on several occasions during a given month. For example, a palliative medicine physician may have regular interactions, including phone calls, with patients and/or their family caregivers to help manage pain, nausea, breathlessness or other troubling symptoms. Careful non-face-to-face attention may save office visits for patients with poor mobility or significant symptom burdens, and may prevent visits to the emergency department or hospital admissions. In many cases, the total non-face-to-face time may be under 60 minutes for each day, but may be much more than 60 minutes when the time is summed for an entire month.

Therefore, to encourage the efficient physician management of patients, we recommend that CMS revise its proposal so as to allow codes 99358 and 99359 to be used to bill for total physician time with a single patient over the course of a calendar month, rather than during a single day. We will also recommend to the RUC/CPT Emerging Issues Workgroup that CPT and RUC address these revisions through their processes. Finally, we urge CMS to allow reporting of 99358 and 99359 during the service period of other non-face-to-face services, such as all CCM services and TCM services, provided that the time required is related to services distinct from those included in TCM or CCM. In the clinical experience of AAHPM members, this happens regularly.

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

As hospice and palliative medicine physicians provide significant care management services to their patients, we are encouraged by CMS proposing several changes in the payment rules for CCM services. However, we continue to be concerned that the requirements for reporting 99490 are excessive and burdensome and are, in part, responsible for the low utilization of this service. AAHPM believes that 99490 will continue to be underreported as long as CMS requires all the elements listed in Table 11 of the proposed rule. We therefore strongly recommend that CMS reduce the required elements for performing 99490 such that only one of the following is required in order to report the code: comprehensive care management, management of care transitions, or home- and community-based care coordination.

We are very appreciative and strongly support CMS's proposal to make separate payment for complex CCM (CPT codes 99487 and 99489). The AMA and the RUC have long advocated for compensating these more comprehensive services for more complicated patients. These codes were developed with substantial input from AAHPM and numerous other specialty societies (of physicians and non-physicians) working in consultation with CMS staff. We strongly recommend that CMS finalize its proposals to make separate payment for CPT codes 99487 and 99489 and to base payment on the RUC recommendations for physician work and practice expense inputs.

We also commend CMS for proposing to simplify CCM codes by not requiring 24/7 access to electronic care plans, the use of any specific electronic technology in managing a beneficiary's transition, the documentation of redundant information, or a specific method for obtaining beneficiary consent.

- **Initiating Visit**

AAHPM would agree that an initiating visit be required at the start of CCM services but subsequent visits should not be required at any specific intervals. However, if a patient has not received any E/M services (including CCM services) in over a year, then an initiating visit to "re-establish" the care plan and assure that complex CCM is necessary and provided appropriately, should be required.

- **24/7 Access to Care, Continuity of Care, and Electronic Care Plan**

AAHPM supports CMS's efforts to simplify and align CCM services with CPT provisions when appropriate. For practitioners in rural and other areas with limited access to the internet, the requirement to have 24/7 access to electronic care plan information is especially burdensome. We also appreciate CMS's recognition that not all after-hours care warrants follow-up or a feedback loop with the physician managing the beneficiary's care overall, and that desired feedback can be achieved through oral, telephone, or fax methods. Therefore, we ask CMS to finalize its proposal to change the CCM service element to require timely electronic sharing of care plan information within and outside of the billing practice, but not necessarily on a 24/7 basis, and to allow transmission of the care plan by fax. We do encourage CMS to be specific in the final rule and clarify what is meant by "timely."

- **Clinical Summaries**

AAHPM agrees with CMS's assertion that it is unnecessary to specify how the billing practitioner creates, exchanges, or transmits continuity of care documents as long as it is done within a timely fashion.

- **Beneficiary Receipt of Care Plan**

AAHPM appreciate and supports CMS's proposal to simplify the current requirement to provide the beneficiary with a written or electronic copy of the care plan, by instead adopting the CPT language specifying more simply that a copy of the care plan must be given to the patient or caregiver.

- **Beneficiary Consent**

AAHPM appreciates CMS's proposal designed provide flexibility to providers and beneficiaries regarding how beneficiary consent is obtained. We encourage CMS to offer additional direction to help ensure participate in a meaningful conversation with the beneficiary to obtain that consent. This is particularly important given the beneficiary cost-sharing related to CCM services.

- **CCM Requirements for Rural Health Clinics and Federally Qualified Health Centers**

AAHPM supports CMS's proposed revisions that would keep CCM requirements for Rural Health Clinics and federally qualified health centers consistent with, and not more burdensome than, the CCM requirements for practitioners billing under the Medicare Physician Fee Schedule.

The Medicare Shared Savings Program

Incorporating Beneficiary Preference into ACO Assignment

AAHPM supports CMS's proposal to utilize an automated mechanism that will allow beneficiaries to voluntarily align with the provider or supplier that they believe is responsible for coordinating their

overall care starting early in 2017, making it possible for CMS to use beneficiary attestations for assigning beneficiaries to ACOs in all three tracks for the 2018 performance year. Assignment based on patient choice will lead to more accurate assignment of beneficiaries and help ACOs achieve more stability in their patient populations.

The Value-based Payment Modifier (VM) and Physician Feedback Program

Expansion of the Informal Inquiry Process to Allow Corrections for the VM

Due to data errors CMS has encountered, CMS proposes to make the following revisions to the VM informal review process for requests that fall under four of the below scenarios:

- Scenario 1: TINs Moving from Category 2 to Category 1 as a result of PQRS or VM Informal Review Process:
- Scenario 2: Non-GPRO Category 1 TINs with Additional EPs Avoiding PQRS Payment Adjustment as a result of PQRS Informal Review Process
- Scenario 3: Category 1 TINs with Widespread Quality Data Issues
- Scenario 4: Category 1 TINs with Widespread Claims Data Issues

AAHPM supports CMS's proposed revisions to the VM informal inquiry process as we believe they would achieve the goal of preventing negative adjustments for eligible professionals and groups due to data errors beyond their control and improve equity in the program.

Thank you again for the opportunity to provide feedback on these policy proposals under the CY 2017 Medicare Physician Fee Schedule. The challenges CMS presents in this proposed rule create new opportunities for AAHPM to advance its core mission of expanding access of patients and families to high-quality palliative care and advancing the discipline of Hospice and Palliative Medicine. We are eager to collaborate with CMS to address the many issues discussed here. Please address questions or requests for additional information to Jacqueline M. Kocinski, MPP, AAHPM Director of Health Policy and Government Relations, at jkocinski@aahpm.org or 847-375-4841.

Sincerely,



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