September 8, 2015

Andy Slavitt  
Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-1600-P  
P.O. Box 8013  
Baltimore, MD 21244-8013


Dear Acting Administrator Slavitt:

AMDA - The Society for Post-Acute and Long-Term Care Medicine (AMDA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Proposed Rule for Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016. AMDA is the professional society of nursing home medical directors, nursing home attending physicians, and other professionals practicing in the post-acute and long-term care (PA/LTC) continuum. We work to ensure excellence in patient care and to promote the delivery of quality PA/LTC medicine.

AMDA applauds CMS’ efforts to continue to address the unique needs of the post-acute and long-term care population. Specifically, we want to encourage CMS to finalize its proposal to provide reimbursement for advance care planning (ACP) services. ACP is an integral component of providing optimal care to the PA/LTC population—the majority of whom are living with multiple chronic conditions and/or are facing end of life issues. Published, peer-reviewed research shows that ACP is among the most significant factors leading to better person-centered care, higher patient and family satisfaction, fewer inappropriate hospitalizations, and lower rates of caregiver distress, depression, and lost productivity. Consultations on care preferences are voluntary on the part of the patient and help practitioners provide care that patients wish for—and avoid providing care that patients wish to avoid. Additionally, timely ACP consultations can also lift a heavy burden from family members and other caregivers who must otherwise make difficult and immediate decisions during a very trying time without adequate information, often with a crisis looming.

Similarly, AMDA encourages CMS to finalize its proposal to amend the definition of primary care services at section §425.50, for purposes of the Shared Saving Program, to exclude services billed under codes 99304 through 99318 when the claim includes the POS 31 (skilled services in skilled nursing facility [SNF]) modifier. We believe the agency’s recognition that although the same CPT codes are used to describe patient services in skilled nursing facilities (SNFs) (POS 31) and nursing facilities (NFs) (POS 32),
physician visits to skilled SNF patients (SNF—POS 31) and to custodial residents of nursing facilities (NF—POS 32), the patient population is unquestionably quite different. Most skilled SNF residents are more acutely ill, with multiple chronic conditions, and receiving rehabilitative services with an eye to returning home or moving to a lower level of care, making them more like hospital patients. On the other hand, custodial (NF) residents are generally going to live out the rest of their lives in the nursing home, and therefore much more like outpatients, since they are at “home”. Recognizing this within the CPT framework will strengthen all value-based programs within CMS.

While we applaud CMS for this proposal, we believe it does not go far enough. As policies continue to move away from fee-for-service into a value-based system where physicians and other clinicians are evaluated on quality and resource metrics, the agency must ensure that these measure target the appropriate population and clinicians are evaluated in appropriate comparison groups. We believe that the current valued-based programs, the Physician Quality Reporting System (PQRS), the value-based payment modifier (VM) and meaningful use (MU), all fail to achieve these goals for our population and providers. Therefore, we urge CMS to develop appropriate quality benchmarks and resource use comparison groups that more accurately reflect the populations PA/LTC clinicians serve. These programs must also align with the person-centered goals and requirements of facility based valued-based purchasing programs (i.e., the SNF Value-Based Purchasing Program). This requires alignments of quality measures and incentives. We believe the Medicare Access and CHIP Reauthorization Act (MACRA) provides CMS an ideal opportunity and authority to re-evaluate its current value-based programs and implement changes that will improve the quality of PA/LTC patient care.

In addition to our general comments, we have specific comments on the sections delineated below.

**Advance Care Planning (ACP)**

CMS proposes to recognize and provide separate payment for ACP with or without an E&M services.
- CPT code 99497, ACP including explanation of advance directives by physician or other qualified health professional; first 30 minutes, face-to-face with patient, family members and/or surrogate
- CPT code 99498, ACP each additional 30 minutes

CMS proposes to use RUC recommended values
- 99497 – approximately $80 (facility) and $86 (non-facility)
- 99498 – approximately $75 (facility and non facility).

For 2016, CMS proposes to assign each CPT code a status indicator “A” which means that the codes are paid separately under the PFS. The presence of an “A” indicator does not mean that Medicare has made a national coverage determination regarding the service, and the proposed rule also notes that contractors remain responsible for local coverage decisions in absence of a national Medicare policy.

CMS seeks comment on whether ACP services are appropriate in other circumstances, such as an optional element, at the beneficiary’s discretion, of the annual wellness visit.
Comment

AMDA strongly supports this proposal and urges that the agency finalize reimbursement for this important patient service as stated in the introductory paragraph. AMDA members work in PA/LTC facilities where they take care of patients who are often seriously, critically or terminally ill, have multiple chronic conditions including dementia, and are sometimes at a pivotal point in end-of-life decision making. Very often, clinicians who take care of this population deal with complicated family situations where an absence of an advance directive creates confusion and disagreement about goals and plans of care. These services will improve the access for patients and their families to have important discussions about goals of care with their physicians, which will improve their quality of life, help assure they receive treatment that is concordant with their goals of care, and ultimately reduce unnecessary transfers and procedures.

Given the importance of this service, we urge CMS not to establish any burdensome requirement that may reduce the ability of clinicians to utilize the code. The option to utilize this code should be available at several appropriate junctures, for example, during a hospitalization, before major surgery, or after decompensation of an existing condition, or requirement for organ support with assistive technologies. At the same time, we believe that some overall national parameters are necessary to ensure that clinicians have an understanding of the intent and appropriate use of the codes. Without these parameters, the codes may be plagued by inconsistent local interpretations, which will be particularly confusing for physician practices that serve in two or more local coverage areas.

Medicare Shared Saving Program (MSSP): Assignment of Beneficiaries Based on Certain Evaluation and Management Services in SNFs

CMS proposes to amend the agencies definition of primary care services at Section §425.50, for purposes of the Shared Savings Program, to exclude services billed under CPT codes 99304 through 99318 when the claim includes the POS 31 modifier. CMS anticipates applying this revised definition of primary care services for purposes of determining ACO eligibility during the application cycle for the 2017 performance year, which occurs during 2016, and the revision would be then applicable for all ACOs starting with the 2017 performance year. CMS states that excluding services furnished in SNFs from the definition of primary care services will complement the agencies’ goal to assign beneficiaries to an ACO based on their utilization of primary care services. CMS does not anticipate that this change would result in a significant reduction in the number of beneficiaries assigned to ACOs.

Comment

AMDA strongly urges CMS to finalize this proposal. We raised this issue in our comments on the MSSP proposed regulations as well as during discussions with CMS and we appreciate CMS’ research and willingness to consider our concerns. We fully agree with CMS’ assessment of the differences in medical care and the physician relationship with patients residing in SNF (POS 31) and NF (POS 32). As we have stated in our previous comments, services provided in SNF (POS 31) are post-acute services
of medically complex patients and much like a hospitalist, the majority of physicians who provide these services are functioning as a “stand-in” for the patient’s community primary care provider. Therefore, attributing SNF (POS 31) to post-acute care physicians leads to attribution of costs that are only minimally under their control, after the patients have already had a large hospital bill accrued, on which the post-acute physician has generally not had any input whatsoever. In fact the SNF is often the site for completion of extensive intravenous antibiotic courses, dialysis for acute kidney injury, or complex wound care modalities which were all initiated in the hospital.

Value-Based Payment Modifier (VM)

CMS continues to implement the value-base payment modifier for physicians and beginning in 2018 proposes to expand the program to non-physician EPs who are PAs, NPs, CNSs, and CRNAs, in groups and those who are solo practitioners and not to other types of professionals who are nonphysician EPs. CMS does not propose changes to patient attribution for VM application but is considering to stratify the cost measure benchmarks so that group and solo practitioners are compared to other groups and individual practitioners treating beneficiaries with similar risk profile.

Comment

AMDA previously submitted comments expressing concerns about the application of the VM for physicians who practice in PA/LTC settings. We continue to be concerned with the attribution methodology, inappropriate comparison groups, and ineffective risk stratification that plague this program. However, we applaud CMS for its recognition of this important issue and willingness to work with stakeholders to find an amicable resolution. We provide the following comments:

- **Attribution** – we believe that since the VM and MSSP attribution methodologies are very similar, and since CMS proposes to alter the definition of primary care for MSSP attribution, it would be appropriate to apply similar logic to the VM program. Physicians who treat patients in SNFs (POS 31) are attributed costs under the VM that they do not have complete control over and these patients, are likely under the care of their community primary care physicians as well as hospitalists.

- **Risk Adjustment** – we support CMS’ idea to stratify the cost measure benchmarks so that groups and solo practitioners are compared to other groups and individual practitioners treating beneficiaries with similar risk profile. We believe that appropriate comparison groups are key to ensuring valid and fair application of the value-based modifier. Several large physician groups that see patients in PA/LTC and that participate in current demonstrations such as Independence at Home have worked on their own risk stratification models. These models appear to provide a better risk stratification than that currently employed by CMS. In addition, we continue to advocate for the use of POS codes to identify more appropriate comparison groups for VM application. We strongly urge CMS to continue to work with stakeholders like AMDA to identify a better model that helps achieve the goal of a VM system that incentivizes quality and cost-effective care in the PA/LTC setting.
Chronic Care Management Services

**CCM Code**

CMS continues to implement proposals related chronic care management services and seeks general feedback on beneficiaries receiving these services and resources involved in providing these services.

**Comment**

AMDA requests that CMS clarify the use of the chronic care management code in the NF (POS 32) setting. Earlier this year, CMS issued MLN Matters number SE1516 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1516.pdf) that included the following FAQ:

“6. CPT code 99490 is payable to hospital outpatient departments (provider-based locations) under the hospital OPPS. Can physicians practicing in these departments or in locations that are hospital-owned (but not provider-based) also bill this code to the PFS? What if the patient is a hospital or SNF inpatient, or is otherwise in a Medicare-covered “facility” or “institution?”

If the patient resides in a community setting and the CCM service is provided by or ‘incident-to’ services of the billing physician (or other appropriate billing practitioner) working in or employed by a hospital, CPT 99490 can be billed to the PFS and payment is made at the facility rate (if all other billing requirements are met). We discuss this further under the section below addressing billing for CCM furnished in the hospital outpatient department setting. As we discussed in the CY 2014 PFS final rule, the resources required to provide care management services to patients in facility settings significantly overlap with care management activities by facility staff that are included in the associated facility payment. Therefore, CPT 99490 cannot be billed to the PFS for patients who reside in a facility (that receives payment from Medicare for care of that beneficiary, see 78 FR 74423) regardless of the location of the billing practitioner, because the payment made to the facility under other payment systems includes care management and coordination. For example, CPT code 99490 cannot be billed to the PFS for services provided to SNF inpatients or hospital inpatients, because the facility is being paid for extensive care planning and care coordination services. However if the patient is not an inpatient the entire month, time that is spent furnishing CCM services to the patient while they are not inpatient can be counted towards the minimum 20 minutes of service time that is required to bill for that month. Billing practitioners in hospital-owned outpatient practices that are not provider-based departments are working in a non-facility setting, and may therefore bill CPT 99490 and be paid under the PFS at the non-facility rate. However, CPT 99490 can only be billed for CCM services furnished to a patient...
who is not a hospital or SNF inpatient and does not reside in a facility that receives payment from Medicare for that beneficiary.”

While this FAQ clarifies that the code cannot be billed in a facility, it only prohibits billing if that facility receives payment from Medicare for that beneficiary. Providers may use the same CPT codes (99304-99318) for custodial nursing home patients (nursing facility or NF—POS 32) as for skilled patients (skilled nursing facility or SNF—POS 31), and these can be performed in the same facility since almost all nursing homes provide some skilled and some custodial care. While skilled SNF patients’ nursing home stay is generally covered by Medicare, custodial NF patients’ stay is never reimbursed by Medicare. Therefore, it is still possible for overlap to occur with care management activities by facility staff that are included in the associated facility payment. This FAQ raises a great deal of confusion and leaves it open for different interpretation by local coverage determinations in different regions. However, AMDA has also received inquiries from physicians who would like to bill the code in NF (POS 32) because they spend a significant time providing these services and believe they meet the requirements given the complexity and their involvement in the care planning process for long-stay NF patients. In the past, AMDA has sought this clarification of CMS’ intent for use of this code directly with CMS staff and is again seeking this clarification as part of this rulemaking cycle.

Add-on Codes

In response to comments that there is more cognitive work required for some patients than the work typically required to supervise clinical staff performing care management services, CMS seeks comments on ways to recognize these resources including:

- Information about the time and intensity associated with this work
- Possibility of “add-on” codes in addition to care management codes for professional time in excess of 30 minutes
- Whether additional resources need to be recognized or whether this is already incorporated into codes

AMDA signed-onto a more detailed letter that outlines specific concerns about the deficiencies in the definitions and valuations of these services. We agree with our colleagues that while 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. Thus, we also agree with our colleagues and stress that the current SNF/NF E/M services do not properly describe or value the care provided to this population. Yet, this population is the fastest growing segment that will require care under newly developing payment models. Therefore, we agree with our colleagues that CMS should undertake a study to further understand the work of clinicians in these settings. AMDA is ready to work with CMS to help with technical aspects of this research. Until such research is completed, under valuation of these services in the fee-for-service model will persist in new payment models. This could exacerbate the current workforce shortage trend of well-trained geriatric and PA/LTC clinicians.
Collaborative Care

CMS acknowledges that care management for beneficiaries with multiple chronic conditions or behavioral conditions can require extensive discussion and planning between a primary care physician and specialist.

- CPT codes 99446-99449 describe interprofessional telephone/internet consultations, are not recognized by Medicare

CMS seeks comments on ways to account for these resources including:

- Are there specific conditions that require separate payment;
- How are these collaborations different from services included in E/M services;
- Should these interprofessional consultations be linked with a beneficiary encounter; and
- Should this benefit be included in a CMMI model and CMS can waive the beneficiary financial liability.
- CMS requests similar information about collaborative care models specifically for beneficiaries with common behavior conditions.

Comment

AMDA supports proposals that provide reimbursement for services that promote patient-centered care and care coordination. Practitioners in PA/LTC setting often spend time talking with patients and their families and/or surrogates, as well as specialists about complex courses of treatment which could in many instances include palliative care and advance care planning discussions. The impact of these services are currently underappreciated and undervalued, yet research has shown that focus on these conversations reduces hospitalizations, medication errors and Medicare costs. We believe such consultations should be linked to both SNF (POS 31) and NF (POS 32) patient encounters. We agree that CMMI should develop models that promote these services and waive any beneficiary financial burden. Patients should not have to cover the cost of good patient-centered, coordinated interprofessional care.

Section III. J. Physician Compare Website

CMS proposes to publicly report all measures submitted and reviewed and found to be statistically valid and reliable in the Physician Compare downloadable file. However, CMS proposes that not all such measures would necessarily be included on the Physician Compare profile pages. This is because
consumer testing has shown that including too much information and/or measures that are not well understood by consumers on these pages can negatively impact a consumer’s ability to make informed decisions. CMS says that its analysis of the measure data once collected, consumer testing, and stakeholder feedback would determine which measures are published on the Physician Compare profile pages.

CMS requests comment on creating composites using 2015 data and publishing composite scores in 2016 by grouping measures based on the PQRS Group Practice Reporting Option (GPRO) measure groups, if technically feasible. CMS gives the following examples of possible composites: care coordination/patient safety measures; coronary artery disease module; diabetes mellitus module; and preventive care measures. CMS also requests comment on creating composites and publishing composite scores in the case of individual practitioners, and offers the following examples of potential composites: coronary artery disease; diabetes mellitus; general surgery; oncology; preventive care; rheumatoid arthritis; and total knee replacement.

Comment:

While we appreciate CMS’ focus to evolve Medicare into a more transparent system and provide public information about the quality of physicians, we are concerned doing so under the PQRS program creates significant challenges and may provide inaccurate and confusing information to the public. AMDA previously submitted comments on CMS’ proposal for the Physician Compare website in response to proposed physician fee schedule FY2014.

We remain concerned about public reporting of PQRS measures. While we appreciate and support CMS’ attempt to streamline the information for consumers’ benefit, we believe that the program is potentially too complex for consumer consumption, and reporting participation in this program at this stage is premature. We believe more public education is required regarding understanding the significance of the reported measures in the context of age, medical comorbidities and patient preferences. In particular, AMDA members may treat a vastly different population in their office-based practices and their PA/LTC practices. Thus, public reporting for physicians practicing in PA/LTC settings in comparison to physicians who practice in ambulatory settings under PQRS may not accurately reflect their PA/LTC work. We urge CMS to delay posting such information, or at the least provide clear explanation as to the significant limitations of these data.

In addition, physicians who practice in PA/LTC facilities who can also serve as medical directors of the facility, work in concert with the facility to improve care, which is reflected through CMS’ Nursing Home Compare website. We continue to urge CMS to explore ways to align publicly reported data between PA/LTC facilities and their individual physician performance where appropriate. Finally, we urge CMS to consider posting added qualifications, such as the Certified Medical Director designation and the Certificate of Added Qualification in Geriatric Medicine or in Hospice and Palliative Medicine, for physicians who practice in PA/LTC settings.
Section XX Physician Payment, Efficiency, and Quality Improvements – PQRS

CAHPS Surveys

CMS proposes to modify the group practices which would be required to report CAHPS for PQRS survey to include practice of 25 or more EPs that register to participate in the GPRO and select the GPRO interface as the reporting mechanism. The provider named in the survey provided the beneficiary with the plurality of the beneficiary’s primary care services delivered by the group practice. Plurality of care is based on the number of primary care service visits to a provider. The provider named in the survey can be a physician (primary care provider or specialist), nurse practitioner (NP), physician’s assistant (PA), or clinical nurse specialist (CNS). Exclusion Criteria for Local Providers: Several specialty types are excluded from selection as local provider such as anesthesiology, pathology, psychiatry, optometry, diagnostic radiology, chiropractic, podiatry, audiology, physical therapy, occupational therapy, clinical psychology, diet/nutrition, emergency medicine, addiction medicine, critical care, and clinical social work. Hospitalists are also excluded from selection as a local provider.

Comment:

AMDA requests that CMS add SNFs (POS 31) and NFs (POS 32) CPT encounters to the list of exclusion criteria for local providers. The PQRS CAHPS survey was designed for use in office-based settings and is not appropriate for use in SNFs and NFs. This requirement will eliminate the possibility of using the GPRO reporting mechanism for groups that practice in these settings. In addition, CMS policies should be consistent and the agency should finalize its proposal to eliminate SNFs (POS 31) from the primary care definition for MSSP attribution - which is based on plurality of care like this proposal.

PQRS Experience Reports

CMS currently provides PQRS experience reports that highlight performance on the program based on physician specialties. The proposed rule discusses in general the physician feedback program for the value-based modifier but does not address any changes to the PQRS feedback reports.

Comment

AMDA requests that for future PQRS experience reports, CMS include frequency of reported measures and quality thresholds based on the SNF CPT code family 99304 through 99318 in addition to specific specialties. Given that AMDA members fall under the general internal or family medicine specialty, and
that many tend to practice in multiple locations; and that quality measures contain multiple sites of care in the denominator, it is difficult to determine both which measures are currently being reported in PA/LTC settings and the quality thresholds of these measures. In addition, this more detailed information would help our society and CMS better track performance on these measures and educate physicians who have not begun participating in this program.

Proposed New Quality Measures

CMS proposes changes to and additions of several individual and group measures within the 2016 PQRS program.

Comment

- In our review of individual and group measures in the PQRS program we have identified measures that include SNF initial and subsequent care CPT codes 99304-99310 but puzzlingly exclude the SNF CPT discharge codes, 99315-99316, and the annual examination code, 99318. We believe that these measures are applicable to be reported with these codes, and request that CMS add the SNF CPT discharge codes and annual examination to all measures that contain 99304-99310 in their denominator.

- Multiple Chronic Conditions Measures Group – While we recognize that CMS does not issue specification of the measures until after the publication of the final rule, AMDA requests that CMS ensure this measures group is reportable in the SNF setting by adding SNF CPT codes 99304-99318 to the measure denominator. We believe the specifications of the measures included in the group are appropriate to be reported for SNF patient encounters.

- Proposed new measures: Cognitive Impairment Assessment; Depression Remission; Health Proxy for the Cognitively Impaired; Osteoporosis Management for Women with History of Fracture; Unnecessary Screening of Colonoscopies – patients age >85. We request that SNF CPT codes 99304 through 99318 be added to each of these measures given that the patient population targeted by these measures is likely to be treated in this setting.

Merit Based Payment System (MIPS)

CMS seeks input on what activities should be included in the clinical practice improvement activities part of the MIPS. CMS will issue future requests for information (RFI) that will discuss other components of MIPS as well as requirements for Alternative Payment Models (APM).
Comment

AMDA urges CMS to include quality improvement activities that physicians and other EPs already participate in as part of the SNF or NF requirements. On July 16, 2015 CMS issued a notice of proposed rulemaking (NPRM) that revises conditions of participation for long-term care facilities. These proposed changes bring sweeping changes and new requirements for physician participation in the facility Quality Assurance and Performance Improvement Process (QAPI). We believe CMS should count participation in these robust, data-driven quality-enhancing activities as having met the MIPS clinical practice improvement activity requirements.

AMDA looks forward to submitting more detailed comments on this and other components of MIPS and APMs in the upcoming RFI.

We appreciate the opportunity to provide comments. If you have questions please contact Alex Bardakh, AMDA Public Policy Director at abardakh@amda.com or 410-992-3132.

Sincerely,

Naushira Pandya MD, CMD, FACP
President