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September 6, 2016

Andy Slavitt
Acting Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS – 1631-P
P.O. Box 8013, Baltimore, MD 21244–8013
Submitted electronically via www.regulations.gov.

Dear Acting Administrator Slavitt:

The Patient-Centered Primary Care Collaborative (PCPCC or Collaborative) appreciates the opportunity to provide comments on the proposed rule titled “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule (PFS) 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.” as published by the Centers for Medicare & Medicaid Services (CMS) in the July 15, 2016 *Federal Register*. We provide comments on sections of the proposed rule that impact the Collaborative’s mission to unify and engage diverse stakeholders in promoting policies and sharing best practices that support growth of high-performing primary care (including the patient-centered medical home or PCMH) to achieve the “Quadruple Aim”: better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

Founded in 2006, the Patient-Centered Primary Care Collaborative is a 501(c)(3) not-for-profit membership organization that supports high-performing team based primary care, consistent with the medical home of care, as foundational to US health system transformation. Person-centered team based primary care embraces the relationship between primary care providers and their patients, families, and caregivers; promotes authentic communication and patient engagement; and coordinates whole-person, compassionate, comprehensive, and continuous team-based care; all of which are crucial to achieving meaningful health system transformation that improves outcomes and lowers costs. Today, the Collaborative’s membership has grown to over 1,300 diverse stakeholder organizations that represent health care providers across the care continuum, payers and purchasers, and patients and their families.

The Collaborative appreciates CMS' continued focus on rewarding primary care within the proposed Physician Fee Schedule (PFS)¹, specifically by promoting policies that: (1) address payment accuracy and equity for primary care clinicians and their care teams within the Medicare Fee-For-Service (FFS) program (for example: expanded payment to support telehealth; new payment codes to support the integration of behavioral health services into primary care; expanded payment offering support for practices that care for patients with limited mobility), and (2) expand access to additional services requisite to the delivery of high-performing primary care (for example, expansion of the Medicare Diabetes Prevention Program (MDPP) to prevent diabetes among high risk beneficiaries).

As highlighted by the Medicare Payment Advisory Commission (MEDPAC) and other researchers, the current disparity between “cognitive” versus “procedural” medical services under the Resource Based Relative Value Scale (RBRVS) has resulted in primary care services being undervalued within the Medicare program. Corrections to the PFS are important to address now, since the fee schedule will serve as the basis for future payment reform efforts through the Medicare Access and CHIP Reauthorization Act (MACRA). CMS' expectations that the proposed PFS regulations will result in increased provider revenue by 1 percent to 3 percent in 2017, depending on the primary care specialty, is welcome news to primary care practices already preparing for changes under MACRA. More importantly, a more accurate assessment of primary care within the PFS will allow primary care practices to better accommodate the changing needs of the Medicare patient population. The 2017 PFS proposed rule serves as one of several proposed rules from CMS that reflect a broad commitment to primary care, and we are we are pleased to offer our perspective.

II. Provisions of the Proposed Rule for PFS

C. Medicare Telehealth Services

CMS is proposing to add several codes to the list of services eligible to be furnished via telehealth. These include:

- **End stage renal disease (ESRD) related services for dialysis;**
- **Advance care planning services;**
- **Critical care consultations furnished via telehealth using new Medicare G-codes.**

CMS is also proposing payment policies related to the use of new place of service code specifically designed to report services furnished via telehealth.

The Collaborative recognizes that under the current fee schedule, unnecessary barriers to efficient use of telehealth services exist. We applaud CMS' proposal to leverage technological advancements that improve Medicare beneficiaries access to care through expansion of telehealth, currently offered through numerous Medicaid programs through the country, and consistent with the medical home model of care. The Collaborative actively promotes the medical home attributes set forth by the Agency for Healthcare Research and Quality (AHRQ), which evolved from the Joint Principles of the Patient-Centered Medical Home

¹ The Physician Fee Schedule (PFS) pays for services furnished by physicians as well as other practitioners in all sites of service, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

published in 2007. Although the Collaborative supports the inclusive AHRQ medical home model (consistent with the Comprehensive Primary Care (CPC) and CPC+ initiatives), the payment reforms outlined in the 2007 Joint Principles provide a solid framework for appropriately recognizing and adequately paying for advanced primary care. Consistent with the proposed regulations on expanding telehealth, the Joint Principles of PCMH endorse a pay structure that:

- Reflects the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit;
- Supports adoption and use of health information technology for quality improvement;
- Supports provisions of enhanced communication access such as secure e-mail and telephone consultation; and
- Recognizes the value of physician (*and non-physician*) work associated with remote monitoring of clinical data using technology.

Advanced primary care models call for appropriate care delivered outside of traditional face-to-face office visits, consistent with evidence based practice (for example, e-mail, phone, telemedicine, group visits, etc.) Accordingly, the Collaborative supports CMS's continued efforts to expand telehealth services for ESRD, advanced care planning, and critical care consultations through new G codes, outlined in more detail below. As the Administration moves forward with shifting more Medicare provider payments to alternative payment models (APMs) as MACRA is implemented, telehealth and remote patient monitoring will play important roles, and is supported by the American Osteopathic Association (AOA), the American Academy of Family Physicians (AAFP), Community Catalyst, the Primary Care Development Association (PCDC), and other PCPCC member organizations.

We urge CMS to continue to explore ways to support telehealth through coding and valuation and consider inclusion of additional services not included in the 2017 proposed PFS. Expanding access to telehealth is especially important in underserved and rural communities that contend with geographic, workforce, and economic access-to-care challenges, and often suffer a disproportionate number of chronic conditions and co-morbidities. As such, we encourage CMS to continue to further evaluate and expand telehealth services within Medicare.

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

For CY 2017, CMS is proposing a number of coding and payment changes to better identify and value primary care, care management, and cognitive services.

- **Make separate payments for certain existing Current Procedural Terminology (CPT) codes describing non-face-to-face prolonged evaluation and management services**
- **Revalue existing CPT codes describing face-to-face prolonged services**
- **Make separate payments using new codes to describe the comprehensive assessment and care planning for patients with cognitive impairment**

The Collaborative is pleased to support CMS's effort to improve payment accuracy for a number of critical care-management and patient-centered services. Because current CPT

codes do not sufficiently acknowledge and reward the complexity of care management for Medicare beneficiaries with multiple chronic conditions, the Collaborative supports separate payments for prolonged evaluation and management services (non-face-to-face), revaluing the existing CPT codes (face-to-face), and separate payments with new codes for comprehensive assessment and care planning for patients with cognitive impairment. CMS' proposed changes are anticipated to provide adequate support to ensure that each patients' plan of care is appropriate, consistent with their respective goals and values, and coordinated with their care team (including family/caregivers), as well as improve the coordination of care across the medication neighborhood.

The Collaborative supports the positions of Community Catalyst, the American Association of Nurse Practitioners (AANP), and other PCPCC member organizations that endorse CMS' efforts in recognizing the importance of person-centered care planning that overtly includes families and caregivers, especially for patients with cognitive impairments. Because this type of care planning requires time intensive evaluation of the patient's functional abilities, safety risks, and medications – the Collaborative believes that payment should accurately reflect the time and effort required to fully engage with patients and their families/caregivers, and ensure that the care planning includes referrals to community resources.

- **Make separate payments using new codes to pay primary care practices that use interprofessional care management resources to treat patients with behavioral health conditions. Several of these codes describe services within behavioral health integration models of care, including the Collaborative Care model that involves care coordination between a psychiatrist or behavioral health specialist and the primary care clinician which has been shown to improve quality**

The Collaborative and our member organizations have a long and dedicated history of strongly supporting behavioral health integration (BHI) into primary care. Given that behavioral health conditions exacerbate other chronic conditions and vice versa, integration of care for mental illness and substance use disorders with treatment for other chronic conditions can improve outcomes for consumers and decrease overall health costs. Co-morbidity for those having both behavioral health and physical health disorders is very common, with more than 68 percent of adults with a mental disorder having at least one medical condition. However, integration of behavioral health into primary care is not adequately reimbursed today, nor is a sufficient trained workforce in ready supply.

As noted in the proposed rule, the Collaborative Care Model (CoCM) is a well documented evidence-based model for integrating behavioral health services into primary care. In the CoCM, primary care clinicians receive extensive support from a team that includes a trained behavioral health care manager and a psychiatric consultant. As described by the American Psychiatric Association (APA) and the American Academy of Child and Adolescent Psychiatry (AACAP), patients receive the heightened benefits of a collaborative, team-based approach that applies well-established principles of population-based behavioral health care and employs specific behavioral health expertise. This comprehensive, coordinated approach to behavioral health integration has led to improved patient outcomes, as well as increase consumer satisfaction and reduce health disparities in numerous randomized clinical trials.

The Collaborative supports the proposed updates to the PFS that more accurately describes and values the work of primary care and other cognitive specialties for complex patients, as well as

better valuing and paying for inter-professional consultation, between primary care and behavioral health that supports behavioral health integration (BHI) in primary care settings, both for children and adults. Along with many of our member organizations, the Collaborative urges CMS to assure that valuation of these codes is appropriate to incentivize primary care providers to utilize them. We also encourage CMS to allow multiple providers use these codes during the same month, since these codes may be appropriately used by more than one provider for complex patients.

Although the Collaborative supports separate payment for CoCM, the workforce challenges mentioned earlier (requirements for psychiatric consultation and behavioral health specialist services) may pose barriers for some primary care practices seeking to integrate behavioral health. This is especially true for small practices with limited resources who serve rural or underserved communities. Accordingly, the Collaborative urges CMS to allow behavioral health care managers for CoCM to be shared remotely across practices (using the telephone and telehealth/video technology) as appropriate. Additionally, we encourage CMS to evaluate other evidence-based care delivery models that support behavioral health integration into primary care that may be less resource and/or workforce intensive.

- **Make separate payments using new codes to recognize the increased resource costs of furnishing visits to patients with mobility-related impairments. Like several of these proposed codes, this is especially relevant for the Medicare-Medicaid dually-eligible population**
- **Make separate payments for codes describing chronic care management for patients with greater complexity**
- **Make several changes to reduce administrative burden associated with the chronic care management codes to remove potential barriers to furnishing and billing for these important services**

Although we reiterate our consistent concern that adding more payment codes to the PFS offers limited short term solutions to our fragmented FFS payment system, we recognize that health care providers need additional resources to care for complex patients, especially those with disabilities or with complicated social needs. The Collaborative thus supports the use of new payment codes that support care to patients with mobility-related impairments, especially those who are dually eligible; provide chronic care management for patients with greater complexity; and we support CMS' efforts to reduce the administrative burden associated with using the chronic care management codes. We do so with the hope that a swift move to alternative payment models with both provide additional resources and reduce administrative barriers inherent in the current CCM program.

The Collaborative has on multiple occasions expressed our concern about the administrative burdens for primary care practices to fully use CCM codes, and welcome CMS proposals to improve their use. In addition, we have historically supported waiving beneficiary co-payment associated with using CCM. Medicare beneficiaries, especially those who are dually eligible or of limited means, should not be dissuaded from using care coordination services based on cost. Recognizing CMS' statutory limitations to limit beneficiary cost-sharing, we support CMS efforts to minimize the burden for both practices as well as patients and their families to use these important services.

III. Other Provisions of the Proposed Rule for PFS

J. Proposed Expansion of the Diabetes Prevention Program (DPP) Model

CMS is proposing to expand the Diabetes Prevention Program into Medicare beginning January 1, 2018. The Medicare Diabetes Prevention Program section included in the PFS proposal specifically seeks comment on a number of provisions impacting implementation of the program.

The Collaborative applauds CMS's recommendation to expand the Diabetes Prevention program within Medicare (MDPP), critically important given the rising number of Americans at risk for diabetes. Although the Physician Fee Schedule (PFS) has long paid for services furnished by physicians as well as other practitioners in all sites of service, including nurse practitioners, physician assistants, physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities, this year's proposed PFS includes proposals to include community based organizations (CBOs) to participate in the Medicare Diabetes Prevention Program. The initial pilot of the DPP included more than 250 YMCAs from 47 states, serving over 46,000 individuals with pre-diabetes, 30% of whom were aged 65 and older. Not only did participants lose more than 5% of their body weight, but the program was shown to reduce new cases of diabetes in this older age group by 71%. Furthermore, the CMS Office of the Actuary recently confirmed the MDPP as the first preventive service to reduce Medicare costs and improve the quality of health care, especially encouraging given the MDPP's emphasis on both consumer and community engagement.

As CMS implements this precedent setting program, we urge you to use this opportunity to carefully consider how best to include community based organizations as partners in improving the health of Medicare beneficiaries. In order to fully unlock the potential of the MDPP to scale and spread, CMS must consider new ways in which to partner with non-clinicians at the community level, who are often part-time lay workers (or community health workers) unaccustomed to bureaucratic rules deemed confusing and unnecessary. The proposed PFS currently includes requirements that may be unrealistic for small community-based organizations. For example, CMS is seeking comment on whether participants in the MDPP obtain a National Provider ID (NPI). As non-health care providers, Lifestyle Coaches (and other community health workers) may find obtaining an NPI to be a significant obstacle to participation. In order to offer this new and groundbreaking program to Medicare beneficiaries at risk for diabetes, we strongly encourage CMS to consider a new paradigm for partnership with the YUSA and other CBOs.

K. Medicare Shared Savings Program

The CY 2017 PFS proposed rule includes the following proposed policies specific to certain sections on the Shared Savings Program regulations including:

- **Updates to ACO quality reporting, including changes to the quality measure set and the quality validation audit, revisions to terminology used in quality assessment, revisions that would permit eligible professionals in ACOs to report quality apart from the ACO, and updates to align with the Physician Quality Reporting System and the proposed Quality Payment Program;**

- **Modifications to the assignment algorithm to align beneficiaries to an ACO when a beneficiary has designated an ACO professional as responsible for their overall care**

As mentioned in our comment letter on the proposed MACRA rules, given the increasing “measurement fatigue” that primary care practices face in light of different and constantly changing requirements from various health plans and payers, both public and private, the Collaborative recommends that CMS identify and adopt measures that encourage all providers to report on a parsimonious unified set of quality measures – which includes Accountable Care Organizations (ACO). We reiterate our recommendation that CMS consider adoption of the recommendations from the Core Quality Measures Collaborative, developed through a multi-stakeholder process intent on reducing administrative burden and clinician burn-out. Creating core sets of measures for primary care and subspecialists is essential for comparing clinicians across payment models, and using the same measures across CMS programs creates the parsimony that clinicians are desperately seeking.

In terms of beneficiary assignment to an ACO, the Collaborative strongly supports CMS proposal that beneficiary choice for ACO assignment should prevail. In order to maximize patient engagement, it is critical that beneficiaries voluntarily select their “favorite” provider whom they wish to coordinate their overall care. Because choosing a clinician or health care provider is different than choosing an integrated delivery system or ACO, (and highly likely to be confusing for many beneficiaries), we encourage CMS to work directly with consumers and their caregivers/families to develop the simplest straightforward language meaningful to beneficiaries, and urge CMS to develop robust education and outreach efforts to them. The Collaborative echoes the more detailed recommendations provided from Community Catalyst on beneficiary engagement.

In conclusion, the Collaborative supports many of the 2017 PFS recommendations, especially the numerous provisions that continue to prioritize and promote primary care and concomitantly improve patient and population health in Medicare. Furthermore, we encourage CMS to develop, track, and report on primary care spending as a share of total health care spending within both Medicare FFS and valued based payment models. Monitoring overall spending on primary care – including types of primary care service and payment models used to pay primary care clinicians and their care teams – can provide invaluable insight to key drivers of quality and total cost of care. Tracking the percent of total health care costs spent on primary care by payment model will allow CMS to monitor whether enhanced payments are explicitly shared with primary care clinicians and their teams, or merely reserved for larger organizations and health systems with better access to financial and political capital. As always, we appreciate the opportunity to comment on the 2017 proposed Medicare Physician Fee Schedule and CMS ongoing efforts to create a health care system that results in better care, smarter spending, and healthier people.

Sincerely,



Marci Nielsen, PhD, MPH
CEO, Patient-Centered Primary Care Collaborative

