



September 6, 2016

Andrew Slavitt
Administrator
Center for Medicare and Medicaid Services (CMS)
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS-1654-P, Medicare Program, Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Loss Ratio Data Releases; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Dear Administrator Slavitt:

I write to share the comments of the National Coalition on Health Care (NCHC) on the proposed Medicare Physician Fee Schedule (PFS) Rule for CY 2017.

NCHC is a coalition of health care stakeholder organizations committed to promoting an affordable, high-quality health system in the United States. As the nation’s oldest and most diverse group working to achieve comprehensive health reform, we represent more than 85 member organizations, including health care providers, purchasers, payers, and consumers.

The fee-for-service (FFS) payment model, as it exists today, encourages volume and complexity in health care services and drives up health care costs. It provides little incentive for the robust care coordination and high quality care that patients, especially the most vulnerable, deserve. Improving health care affordability will require both expanding alternatives to fee-for-service and improving existing payment systems like Medicare’s physician fee schedule.

Therefore, NCHC is encouraged that CMS is taking steps to bolster payment for care coordination in the PFS and cover the Diabetes Prevention Program, even as it continues to improve the Medicare Shared Savings Program. Detailed comments follow.

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Detailed Comments

Medicare Telehealth Services

Telehealth and remote monitoring technology have great potential to improve quality and reduce costs. Policymakers should utilize a full range of legislative and regulatory avenues to empower plans and provider organizations which are accountable for patient outcomes and costs to deploy telehealth—regardless of the originating site and interactivity requirements now in force.

While these broader reforms are pursued, however, coverage of ESRD services and advance care planning services delivered via telehealth modalities would be a constructive, interim step forward. **NCHC supports CMS' proposal to include ESRD and advance care planning codes in the list of approved telemedicine services.**

Potentially Misvalued Services Under the Physician Fee Schedule

As a coalition, we take no position at this time on the individual codes which CMS has identified in the NPRM. However, NCHC does support continual assessment of the accuracy of Medicare's payment for services. This continual assessment is of particular value to those clinicians who rely on upstream cognitive services, primary care, and care coordination to keep their patients healthy, thereby reducing utilization of more expensive, more intensive acute care services. **We applaud CMS for its efforts to identify codes sufficient to meet the statutory threshold of 5% of fee schedule spending.**

We note that the failure to meet the statutory requirement in CY 2016 resulted in an across-the-board pay cut to all health professionals reimbursed through the Physician Fee Schedule. We urge CMS to take all necessary steps to ensure another such cut does not occur either this year or in the future.

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

In general, NCHC agrees with CMS that current policy fails to fully recognize the time and effort that may go into furnishing and coordinating care for complex cases. And we applaud the agency's efforts to more accurately reward those services. As it pursues these corrections to the fee schedule's deficiencies, however, we would urge CMS to persist in its broader effort to transition more providers to alternative payment models and advanced alternative payment models.

Establishing Separate Payment for Behavioral Health Integration

NCHC strongly supports behavioral health integration and proper reimbursement for the Collaborative Care Model (CCM). A rich body of evidence has demonstrated that the CCM model improves outcomes, increases consumer satisfaction, reduces costs, and reduces health disparities. Yet Medicare Part B's failure to properly reimburse for collaborative care effectively penalizes those providers who abide by this established standard of care. In so doing, Medicare may contribute to downstream costs attributable to exacerbation of physical and behavioral health conditions. We are pleased that CMS is correcting this problem.



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

NCHC strongly supports rewarding clinicians for the more intensive care coordination which high-cost, high-need beneficiaries require and that may not be accurately or adequately addressed through fee-for-service codes or previously adopted chronic care management codes. **Paying for CPT codes 95358 and 95359 is a reasonable step to improve reimbursement across Medicare for care coordination services. We appreciate CMS' proposal in this regard and urge its implementation.**

NCHC also supports the proposed revisions to the chronic care management requirements for Federally Qualified Health Centers (FQHCs) and Rural Health Centers (CCM). These changes will more closely align the chronic care management requirements to those of other providers and further encourage health centers to provide these critical services to their patients.

Diabetes Prevention Program

NCHC strongly and enthusiastically supports coverage of the Diabetes Prevention Program. The model has great potential to reduce Medicare spending while helping empower consumers to improve their health. This new proposed benefit is consistent with the requirements of the Affordable Care Act with respect to preventive services, and therefore should be provided to the appropriate beneficiaries with no cost-sharing.

As CMS expands this program, we would stress that flexibility is needed to ensure the broadest access to the DPP. To better accommodate those that are home bound, disabled, or unable to attend an in person group meeting at designated sites, **NCHC supports furnishing the DPP through virtual telehealth technology.** Additionally, to better serve beneficiaries residing in medically-underserved and rural areas, **we recommend that FQHCs and RHCs be provided a clear opportunity, outlined in regulation or guidance, to qualify as DPP suppliers.**

NCHC is concerned that the Notice of Proposed Rule Making makes little mention of how MA enrollees might access to DPP and whether that service would be offered through the plan or some kind of FFS reimbursement. A full 31% of Medicare beneficiaries are enrolled in MA. Yet CMS has not yet detailed how MA enrollees can access the services to which they would be entitled. CMS should work closely with plans and DPP suppliers alike to craft an approach that ensures that all Medicare enrollees have access to this important benefit. **As soon as possible, CMS should present for public comment a clear proposal detailing guidelines for furnishing the DPP under Medicare Part C and how plans and providers would be compensated for that benefit.**

Medicare Shared Savings Program (MSSP)

Quality Measurement

In general, NCHC is encouraged by CMS' effort to adjust MSSP measure sets in response to input from the Core Measures Collaborative. We support the move toward core measure sets across payers, as exemplified by the work of the Collaborative. Broader use of core measure sets can support comparability across clinicians, ultimately making the reported measures more useful for consumers, providers and plans.



Incorporating Beneficiary Preference into ACO Assignment

NCHC agrees with CMS that supplementing the MSSP attribution model with beneficiary attestation could help increase patient engagement, improve care management and health outcomes and lower expenditures for beneficiaries. **We support improvements to attestation processes and the expansion of attestation in the Medicare Shared Savings Program, whenever practicable.**

However, to maximize the value of attestation to meaningful patient engagement, beneficiaries' personal understanding of their relationship with their 'main doctor' as well as to the ACO is critical. In the future, CMS must do more to improve beneficiaries' awareness and understanding of their relationship to the ACO and their main doctor's role in that ACO.

We appreciate the opportunity to offer comments on these important issues. If you have any questions, please contact NCHC's Policy Director, Larry McNeely, at lmcneely@nchc.org or 202-638-7151.

Yours truly,



John Rother
President and CEO

