



Working Together for an Affordable Future

September 8, 2015

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

Re: Revisions to Payment Policy under the Physician Fee Schedule and Other Revisions to Part B for CY 2016 (CMS-1631-P)

Dear Administrator Slavitt:

I write to share the comments of the National Coalition on Health Care (NCHC) on the proposed CY 2016 Physician Fee Schedule Rule.

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 100 member organizations, including health care providers, purchasers, payers, and consumers. Collectively, our organizations represent, as employees, members, or congregants, more than 100 million Americans.

The current fee-for-service (FFS) payment model in health care encourages volume and complexity in health care services and drives up health care costs across the United States. It provides little incentive for the robust care coordination and quality care that patients, especially the most vulnerable, require. For this reason, expanding new models of care and payment is vital to building a high-quality health system we all can afford.

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Yet we recognize that existing payment arrangements like Medicare’s physician fee schedule remains an important form of reimbursement and a powerful lever for improvement. Therefore, we are encouraged that CMS is taking steps to enhance value and transparency in traditional Part B payment, while continuing to support alternative payment models.

We offer specific comments on several issues raised in the NPRM below.

Improving Accuracy for Primary Care and Care Management Services

To improve access to Transitional Care Management (TCM) and Chronic Care Management (CCM) services, NCHC urges CMS to pursue waivers of cost-sharing for care coordination codes- either by rulemaking or if necessary, by requesting new statutory authority. CMS’ efforts to implement and refine codes for transitional care management and chronic care management are essential to proper care for the beneficiaries with the greatest needs and the highest costs. For patients undergoing care transitions or facing chronic disease, care coordination activities can often be among the highest value services they receive. However, requiring cost-sharing for those services creates additional and unnecessary barriers to their utilization. CMS should do all it can to bring down those barriers.

Advanced Care Planning Services

NCHC strongly supports payment for Advance Care Planning services. When chronic disease evolves into advanced illness, it is particularly critical that patient’s own preferences and choices determine the course of treatment. Assigning CPT codes 99497 and 99498 active status represents a step toward that goal, and NCHC supports CMS’ proposal to do so. We also suggest that CMS pursue waivers of cost-sharing for these Advanced Care Planning codes.

Chronic Care Management Services for Rural Health Centers and Federally Qualified Health Centers:

NCHC supports the NPRM’s proposal to provide payment for Chronic Care Management services that are not already captured in the existing Rural Health Center and Federally Qualified Health Center payment systems. RHCs and FQHCs can often serve populations facing higher-than average rates of chronic disease. Ensuring the availability of chronic care management for these populations is critical to better health and lower costs over the long-term.

Payment for Biosimilar Biological Products Under Section 1847a

Substitution of generic for brand name drugs, both by prescribing clinicians and by pharmacists, has been central to the estimated \$1.46 trillion in cost savings attributable to generics between 2004 and 2013. It has helped keep prescription drugs broadly accessible and constrained the growth in overall health care costs. To facilitate substitution, all therapeutically equivalent generics and their reference products have historically been placed in the same reimbursement code. Medicare’s reliance on weighted average of these products’ sales price (i.e. blended price) for those products has promoted the use of lower cost, therapeutically equivalent alternatives.

However, the NPRM proposes to exclude the brand price from the blended price for its biosimilars - with real consequences for the feasibility of substitution and the overall affordability of prescription drugs. Excluding the brand price greatly reduces the incentive for providers to consider substitution of therapeutically equivalent biosimilars for a more costly brand product. In light of the long-term consequences this could have for prescription drug affordability, reconsideration of CMS' current approach is warranted. **In particular, we support blending the price for the reference product with its interchangeable biologics and therapeutically equivalent biosimilars.**

If CMS does proceed in a manner similar to that proposed in the NPRM, **at a minimum, final regulations should explicitly exclude interchangeable biologics or defer the inclusion of interchangeable biologics to future rulemaking.** One significant advantage of interchangeable biosimilar products is that they can be substituted at the pharmacy without the physician specifically prescribing the biosimilar product. We are concerned that application of the NPRM's proposed approach to interchangeable biologics would discourage substitution at the pharmacy level.

Additionally, CMS may wish to consider adding code modifiers or requiring the use of NDCs for biosimilars so that health plans can track utilization of each product within a code. This information is crucial when health plans use formularies and enter into rebate agreements with manufacturers and helps curb costs in Medicare and elsewhere in the health system.

Physician Compare Website

Accurate and meaningful provider-specific performance measures, combined with timely feedback to providers, appropriate public reporting and user-friendly consumer transparency tools, is fundamental to the transformation of America's health system. **NCHC supports the NPRM's proposal to make available on Physician Compare quality metrics for individual eligible providers and its proposal to make individual providers' value modifier performance data and service utilization data in a downloadable format.**

Efficient Physician Payment and Quality Improvement

NCHC appreciates CMS' decision to emphasize higher-quality measures, such as outcome measures, as recommended by the Measures Application Partnership 2015 report. As CMS continues to implement existing measurement and incentive programs and proceeds to implement *the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)*, NCHC recommend the following principles:

1. HHS quality measurement programs should rely on measures endorsed by a multi-stakeholder process whenever possible.
2. In general, patient-specific quality measures should move toward a parsimonious set of core outcome measures, with a focus on patient-reported experience and functional outcomes.

3. Incentives should be provided to providers who utilize the highest-value measures. One constructive approach would be to adopt modest additional “pay for reporting” incentives for use of the following measure types:
 - i. more advanced registry or EHR-based quality outcome measures, and;
 - ii. patient reported outcome measures, addressing patient experience, the level of functional restoration or improvement, and quality of life.

Request for Input regarding Provisions of the Medicare Access and CHIP Reauthorization Act of 2015

We appreciate CMS’ commitment to a robust stakeholder engagement in the implementation of MACRA and look forward to responding to future RFIs and rulemaking. At this time, however, one particular issue requires CMS’ prompt attention.

For those eligible professionals who receive a certain proportion payment through Alternative Payment Models, MACRA calls for a 5% bonus. However, if the magnitude of those bonuses is calculated as a percentage of an eligible professional’s FFS income, clinicians who had billed more in the previous year will receive a greater bonus. This runs contrary to the law’s overall intent of incentivizing value and quality, not just volume. **CMS should ensure MIPS and APM bonuses do not encourage volume in this way**, either through exercise of its administrative and regulatory authority or by proactively pursuing additional statutory authority.

Potential Expansion of the Comprehensive Primary Care Initiative (CPCi):

Advanced medical home models have enormous potential to engage a broad range of health care professionals in improving care and lower costs for chronically ill Medicare beneficiaries. **NCHC supports continued testing and expansion of advanced primary care models, including the Comprehensive Primary Care Initiative (CPCi).**

Specifically, when warranted by the results of the current initiative, NCHC supports extension of CPCi in current regions and prompt expansion of the model to other regions of the United States. In other regions, CMS should work to ensure that any expansion aligns with, rather than runs counter to, successful primary care payment reform initiatives undertaken by other private and public payers.

In addition to the CPCi, CMS should continue to test and, if warranted, expand payment models focused on the highest cost, highest need beneficiaries. These models have yielded remarkable cost-savings in the private market and have captured the interest of stakeholders including private sector purchaser and provider organizations alike. We note that the Intensive Outpatient Care Program, operated by the Pacific Business Group on Health, is now being tested under CMMI’s Health Innovation Model. In recent recommendations provided to the Senate Finance Committee, Premier has recommended its own such model, the Ambulatory ICU (A-ICU).

NCHC thanks you for your ongoing efforts to transform the care available to Medicare beneficiaries and all health care consumers. Should you have questions regarding these comments or other issues, please do not hesitate to contact myself at jrother@nchc.org or NCHC's Policy Director Larry McNeely at lmcneely@nchc.org.

Yours truly,



John Rother
President and CEO