HCMS
Harris County Medical Society

September 6, 2016

Centers for Medicare & Medicaid Services
Department of Health and Human Services
CMS–1654–P, P.O. Box 8013
Baltimore, MD 21244–8013

Filed Electronically

To: Centers for Medicare & Medicaid Services (CMS), HHS

Re: 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 Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Proposed Rules

INTRODUCTION

On behalf of over 11,500 physician and medical student members of the Harris County Medical Society (HCMS), thank you for the opportunity to participate in commenting on the proposed rule regarding the "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 Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model; Proposed Rules" published in the *Federal Register* on Friday, July 15, 2016.

PLATFORM BEHIND OUR COMMENTS

HCMS represents grassroot physicians in all medical and surgical specialties who transact with all of the Medicare payment policies on a daily basis. Our comments are reflective of the feedback we receive from our members and their staff. Our 5 million patient area of Houston Texas contains approximately 360,000 fee-for service Medicare patients. One of our primary concerns is drop off of physicians from the Medicare program.

Section II, A. Determination of Practice Expense (PE) RVUs

Comment

HCMS supports physician payment methodologies that measure true "cost" and "work." Pertaining to the joint 2007-2008 Physician Practice Information (PPI) Survey by the American Medical Association (AMA) and 72 medical specialty societies and other health care professional organizations, we question the validity of the data to 2017 "cost" and "work" since it is almost ten years old. As "work" is becoming more streamlined with technology, the cost of the technology on top of all the Medicare mandates over these years has increased remarkably.

HCMS recognizes CMS's desire to standardize Clinical Labor Tasks for every CPT code. It is important to recognize that the healthcare industry is a unique industry. HCMS understands the benefit of time labor

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studies in regard to certain industries such as the manufacturing industry. However, healthcare is not delivered via an assembly line, but instead focuses on preventing, curing, and healing the sick in order to ensure a healthy population. For example, Medicare recipients diagnosed with Diabetes Type I with cardiac involvement, 'time' will be treated as though socioeconomic, cultural and literacy are all the same for this diagnosis. Which, in fact, it is known that this is not the case as shown by the risk adjusting for Medicare Advantage Plans and risk adjusting for health plans participating on the Insurance Exchanges.

If CMS is going to pursue developing a clinical time labor study per CPT code it will be imperative for CMS to work with appropriate organizations including physicians/healthcare professionals, specialty societies and community based stakeholders impacted by the implementation of such a study.

Section II, D. Potentially Misvalued Services Under the Physician Fee Schedule
D4. Identification and Review of Potentially Misvalued Services
Comment
HCMS supports targeting those physicians that may be found to be over utilizing E/M with a Modifier 25 in a global period. HCMS does not support changing payment policies that affect **all** physicians due to a few potential noncompliant physicians.

D6-2. Data Collection and Revaluation of Global Packages Required by MACRA
Comment
HCMS opposes collection of data on **all** 10 and 90-day global services from **all** physicians who perform these services. The MACRA language is clear on CMS collecting data from a representative sample of physicians, **not from all** physicians. This proposed policy is extremely burdensome. Most physicians would not even be able to comply by Jan. 1, 2017, which once again challenges CMS in the ability to collect accurate and usable data. HCMS supports CMS slowing down the process and working with the affected specialty societies to develop a policy.

We also oppose the use of the eight G-codes that CMS has proposed. These G-codes present issues that CMS may have overlooked. They are as follows:

- Tracking time in 10-minute increments is onerous and may result in under-reporting or over-reporting of data which will flaw the outcome data;
- The time-based G-codes are not aligned with clinical workflow;
- The G-codes lack validation and comparability with existing E/M codes; and
- The G-codes are not comparable with existing E/M services assumed to be bundled into the current global package.

Section II, E. Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services
Comment
HCMS supports CMS efforts to improve chronic care services and care management. We applaud CMS efforts on improving payment for behavioral health services. Particularly, by including the G-code GDDD1 in the 2017 PFS for Resource-intensive services for BHI patients that are in need of specialized mobility-assistive technology. However, HCMS believes this code description should be broader. People with disabilities include others besides those needing specialized mobility assistance.

For example, patients who are hearing and visually impaired require additional resources. However, the CMS allowable cost does not cover the true cost of these services. In Houston the minimum cost to have a hearing impaired translator is $60.00 per hour with a minimum of two hours which mandates a $120.00 expense. The allowable for CPT code 99213 in Houston is $74.16. Therefore, it is costing the physician

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$45.84 to see the patient. If the patient does not show for the appointment the physician is still responsible for paying the $120.00 to the translator as mandated by an agreement.

Section II
Beneficiary Consent
Comment
HCMS congratulates CMS on recognizing the need to ensure patients have access to mental health services as this is an area that is often overlooked. Therefore, HCMS supports that a specific patient consent for Behavioral Health Integration (BHI) services should not be mandated. In addition, HCMS supports the unbundling of CPT codes 99358 and 99359 and agrees that a limit should not be placed on the use of these codes.

Furthermore, HCMS agrees that CMS should consider waiving the coinsurance for BHI. We understand that CMS believes it does not have the authority to waive the coinsurance for the services, however, if these services are considered preventative then CMS could waive the coinsurance to ensure patients are able to access BHI services.

Section II, E-4. Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM) Services
Comment
HCMS supports the changes CMS is proposing by adding CPT codes 99487 and 99489 to the CCM program. These code descriptions will assist physicians in being able to evaluate their time management in caring for this sicker population and a step in the right direction to improve utilization of the CCM program.

HCMS supports the addition of G-code GPPP7 to the CCM program in 2017.

HCMS supports CMS' decision to remove the requirement in the CCM program that requires after hours urgent care to have an electronic care plan, and TCM "continuity of care" documents. HCMS, at this time, would encourage CMS to strongly engage with the EHR industry to create standardized interoperability for all areas of health care for a reasonable cost. Presently, if there was just 10% interoperability between EHRs in all provider areas throughout the nation, CMS would be saving millions of taxpayer dollars.

HCMS supports CMS' proposal to require practitioners to document that the beneficiary was informed about the required CCM services in the beneficiary's medical record and note whether the beneficiary accepted or declined these services, instead of obtaining a written agreement.

HCMS supports CMS' proposal to remove the language requiring beneficiary authorization for the electronic communication of his or her medical information with other treating providers as a condition of payment for CCM services. The Health Insurance Portability and Accountability Act's (HIPAA) Privacy Rule covers providers for treatment thus patient authorization is not needed.

Section II E-6. Improving Payment Accuracy for Care of People with Disabilities
Comment
Same comment as in Section II, E. Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services.

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Section II, F. Improving Payment Accuracy for Services: Diabetes Self-Management Training (DSMT)

Comment

HCMS supports any CMS initiative that improves the health and wellbeing of Medicare beneficiaries as long as:

- Reimbursement covers the cost;
- Administration of the program is minimal; and
- Beneficiary noncompliance in the program does not affect the physician's Quality Payment Program scoring.

Barriers to Low Utilization

Comment

Diabetes self-management has been shown to improve preventative care practices and clinical outcomes. However, the self-management program as explained in the proposed rule is confusing and may be overwhelming to patients. Barriers consist of things like:

- Lack of knowledge of diet plan
- Lack of understanding of the plan of care
- Frustration from lack of blood sugar control and how to properly monitor it
- Cultural awareness
- Health literacy

Individuals on a self-managed diabetic program struggle with information overload. A collaborative relationship with a provider and having a support person who provides encouragement and accountability is needed. Diabetes is a chronic illness that requires many decisions daily. Guidance from a physician with clear, simple instructions may help take away some of the confusion patients experience and increase their utilization of self-care. For physicians, more clarification is needed on the program.

Section II, G. Target for Relative Value Adjustments for Misvalued Services

HCMS supports CMS' estimates that there will be no "Target Recapture Amount" by which to reduce payments made under the PFS in 2017.

Section II, I. Geographic Practice Cost Indices (GPCIs)

Comment

HCMS opposes any decrease in the GPCI. The cost of doing business has increased significantly through the Harris County Appraisal District (HCAD). According to HCAD's 2015 Reappraisal Values found at *http://www.hcad.org/Reappraisal/2015Values/*:

"The robust economy has residential and commercial properties increasing in value. Single-family homes, multi-family apartments, office buildings, warehouses and retail have all gone up in value. Companies moving to Houston have created a need for additional office space and spurred office construction. **Office buildings have increased in value by approximately 12 percent** while apartment values have gone up 22 percent and retail values have grown 21 percent."

Section III, F. Prohibition on Billing Qualified Medicare Beneficiary Individuals for Medicare Cost-Sharing

Comment

HCMS is aware that it is against federal regulations to collect Medicare Part A and B deductibles, coinsurance, or copays from Qualified Medicare Beneficiaries (QMBs). There are times when patients inadvertently receive a bill because physicians' staff are unaware that the patient is a QMB.

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HCMS is requesting that CMS ensure that Medicare Administrative Contractors (MAC) and Medicare Advantage Plans provide current up to date information that allows for the physician's office to accurately identify if a patient is a part of the QMB program. Another suggestion is to add "QMB" to the patient's ID card to alert physicians and providers of the QMB's financial exemption.

Section III, G. Recoupment or Offset of Payments to Providers Sharing the Same Taxpayer Identification Number

Comment

HCMS opposes CMS' proposal to recoup money from physicians that are all under a single TIN. HCMS recommends recoupment of payments be based upon the combination of the Tax ID **and** individual NPI. Frequently, physicians practice under the same Tax ID, but their compensation structure is based upon the revenue that is created from the services they individually provide. Therefore, recouping payment from Dr. X when Dr. Y provided the service could negatively impact Dr. X's overall compensation.

Section III, H. Accountable Care Organization (ACO) Participants Who Report Physician Quality Reporting System (PQRS) Quality Measures Separately

Comment

HCMS supports amending regulation§ 425.504 and§ 425.504(c)(2) as well as revising the Group Reporting Option and Submission by QCDRs to allow physicians to report separately as an individual or group for purposes of the 2018 PQRS payment adjustment only (2016 Rpt Year) when the ACO fails to report on behalf of physicians who bill under the TIN of an ACO participant. These revisions will allow physicians who were previously subject to a negative penalty adjustment as part of an ACO an opportunity to submit as an individual and potentially avoid that adjustment. Individual physicians are not in direct control of decisions or actions taken by the larger ACOs and should not, therefore, be penalized. In fact, many clinicians do not even know they are part of an ACO and opt instead to report more directly relevant measures, such as those available through a QCDR. In addition to giving these physicians another opportunity to report their data, we recommend that CMS also consider offering physicians who fall under this scenario a waiver should they not want to go through the effort of reporting again. We urge CMS to advance in strategies to prevent these situations from occurring by providing ACOs with more frequent feedback on their reporting compliance throughout the year.

Section III, I. Medicare Advantage Provider Enrollment

Comment

HCMS does not support the proposal to require physicians within MA organizations to enroll in Medicare. This requirement would be redundant as all payers have a multitude of rigorous screening and rescreening processes as well as programs to ensure quality and cost effectiveness. Physician quality data is transparent and made available through payer websites/portals to provide members with the opportunity to choose highly rated qualified physicians. In addition, managed care advantage plans should be responsible for ensuring that they are enrolling the most qualified physicians into their networks. HCMS supports CMS's efforts to prevent fraud, waste and abuse and therefore would encourage CMS to ensure that health plans are consulting the OIG exclusion list to guarantee that physicians who have been convicted of such crimes are not in the Medicare Advantage networks.

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

Comment

HCMS opposes any Medicare payments being associated with patients' compliance. A physician can educate, advise and recommend, but cannot force the patient to comply. The burden of compliance should be on the Medicare beneficiary and not on the physician.

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In addition, HCMS supports the "phase-in" approach. This approach will allow CMS to revise the program as issues arise.

If you have any questions about our comments, please call Ms. Pat Harris, Senior Vice President, at 713-524-4267. You may also email Ms. Harris at *pat_harris@hcms.org*.

These issues are very important to the physicians in Harris County, Houston Texas. Thank you for taking our comments into consideration.

Sincerely,

Walter. P. Moore, III, MD
Chair
Board on Socioeconomics

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