September 2, 2014

Marilyn Tavenner
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-1612-P – Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule
79 Fed. Reg. 40318 (July 11, 2014)

Dear Administrator Tavenner:

We are writing collectively as members of the Patient Quality of Life Coalition, which was created to advance the interests of patients and families facing serious illness. The Coalition includes more than 20 nongovernmental organizations representing the interests of health professionals, health care systems, and patients.

The Coalition appreciates the opportunity to provide comments on the proposed changes to the Medicare Physician Fee Schedule for calendar year (CY) 2015. We offer the following recommendations with respect to specific policy proposals.

II. Provisions of the Proposed Rule for PFS

E. Medicare Telehealth Services

CMS proposes to add seven CPT and HCPCS codes to the list of telehealth services, including an initial wellness visit (G0438) and an annual wellness visit (G0439). The Coalition supports CMS’ proposal to expand Medicare’s telehealth service program to include additional codes. Telemedicine has been one proven way to ensure patients who face geographic barriers can have access to necessary health care services.

As CMS looks to improve the Medicare telehealth service program in the future, we urge CMS to particularly look for ways the program could be expanded to specifically include palliative care services. The goal of palliative care is to support the best possible quality of life for patients and their families. Palliative care professionals work with patients and their family caregivers to ensure proper communication and coordination, provide expert management of pain, nausea, fatigue, and other symptoms of their disease or condition, as well as support for family and other caregivers. Palliative care is often provided in conjunction with curative treatments.
Palliative care teams work with patients to mitigate the burden of their disease and/or treatment regimens. Specifically, palliative care teams provide a wealth of services including: education of family members on stages of palliative care and the physical decline of the patient; facilitation and discussion of support system of the patient and the family; review treatment protocols that are taking place (including reviewing medications, oxygen regimen, skin care, titration process, and other services); provide education on pain management; provide on-call physician and advance practice nurses symptom management consultations for home-bound patients; and, face-to-face evaluations for continued hospice eligibility. Such services result in the avoidance of high cost care, improve patient quality of life, and result in fewer crises requiring acute care. Individuals whose care is managed by palliative care professionals have reduced hospitalizations or re-hospitalizations.¹

One example of a successful palliative care program model is Aetna’s Compassionate Care Program, which uses care managers who provide a comprehensive assessment of the patient’s needs by telephone and consult with the patient, physician, and the patient’s family. These care managers provide education and support, give assistance with pain medications and psychosocial needs, and help ensure that advance directives are in place and complied with.² Another study focused on nurse-led, palliative care-focused interventions focused on physical, psychosocial and care coordination provided in consultation with oncology services for patients with advanced cancer in a rural area. The study concluded that those receiving the palliative care services had higher quality of life and mood scores compared to those receiving oncology services alone.³

Providing patients with palliative care through expanded telehealth programs will allow beneficiaries to access palliative care services. Given the shortage of palliative care professionals, expanding the telehealth program to include palliative care services will allow beneficiaries in care centers and communities that lack palliative care professionals access to these vital services.

¹ For example, a 2008 study of eight diverse hospitals showed that palliative care consultations resulted in adjusted net savings of $1,696 in direct costs per admission and $279 in direct costs per day, including significant reductions in laboratory and ICU costs. Morrison RS, Penrod JD, Cassel JB, Caust-Ellenborgen M, Litke A, Spragens L, Meier DE. Cost savings associated with hospital palliative care consultation programs. Arch Intern Med 168(16)1783-1790 (2008). Similarly, a 2011 study found that Medicaid patients at four New York hospitals who received integrated palliative care consultations incurred $6,990 less in hospital costs during a given admission, spent less time in intensive care, and were less likely to die in the ICU. Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman T, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. Health Affairs 30(3)454-463 (2011).


G. Chronic Care Management (CCM)

In the CY 2014 Physician Fee Schedule Final Rule, CMS finalized a policy (beginning in CY 2015) to pay for chronic care services for Medicare beneficiaries. Specifically, CMS designed the new code to pay separately for non-face-to-face care coordination services and adopted the following code for reporting these services:

GXXX1 Chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days.

CMS proposes to assign a work relative value update (RVU) of 0.61 and 20 minutes of clinical labor time as direct practice expense (PE) for the CMM code.

Overall, the Coalition supports the addition of a new chronic care management code. Chronic care management has been shown to increase health care quality. However, we are gravely concerned that the proposed RVU and PE for staff time results in inadequate reimbursement for these services. Care coordination requires extensive interaction with the beneficiary to develop care plans, discuss options with the beneficiary, repeated follow up with multiple specialists and providers in other settings, and assurance of continuous coordination and communication among and between all professional and formal and informal caregivers. A single complex beneficiary with multimorbidity and an acute decompensation can require hours (not minutes) of time on these activities, with the number of hours varying depending upon the acuity of the situation.

The amount of reimbursement is particularly concerning given that CMS will only permit providers to seek reimbursement once every 30 days. In order for chronic care management to be an adequate service to beneficiaries, providers should maintain regular contact to ensure the beneficiary’s care is properly managed. Without adequate reimbursement, this code could go underutilized by many providers who would otherwise be inclined to engage in chronic care management for these vulnerable Medicare beneficiaries. Research has demonstrated that good care management can help avoid costly, trips to the emergency room, hospital admissions or readmissions.\(^4\) Thus, the widespread use of the CCM code has the potential to not only improve quality of care, but also reduce health care expenditures. The Coalition urges CMS to reevaluate the reimbursement assigned to this new code to ensure that the reimbursement amount is adequate to encourage providers to offer this valuable service.

III. Other Provisions of the Proposed Regulation

E. Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models

The preamble notes that CMS intends to conduct rigorous and quantitative analysis of the impact of the delivery system models being tested by the Center for Medicare and Medicaid Innovation (CMMI). CMS proposes to require entities participating in the CMMI delivery system models to provide individually identifiable health information and other information deemed necessary to evaluate such models.

The Coalition supports CMS’ proposal to grant CMMI the information it needs to properly evaluate the delivery system models, but urge the Agency to ensure that the disclosure of this protected health information is subject to proper security measures in order to protect individuals and prevent a privacy breach.

Such properly-protected data sharing will help CCMI evaluate its delivery system models including the new Medicare Care Choices Model, which will allow hospice-eligible beneficiaries not enrolled in hospice to continue concurrent curative services. The Coalition applauds CMMI for undertaking this new model of care and we look forward to working with CMMI as it implements and evaluates the program. The Coalition urges CMS to conduct rigorous and valid evaluation of the Model and to engage and consult with leaders in the field of palliative and hospice care research as you endeavor to evaluate this model.

K. Physician Payment, Efficiency, and Quality Improvements – Physician Quality Reporting System

CMS proposes to use 18 cross-cutting measures to the Physician Quality Reporting System (PQRS) beginning in 2015. Included in these measures are the following:

- **Closing the Referral Loop: receipt of Specialist Report:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

- **Pain Assessment and Follow-Up:** Percentage of visits for patient aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.

- **CAHPS for PQRS Clinician/Group Survey:** Getting timely care, appointments, and information; how well providers communicate; patient’s rating of the provider, access to specialists; health promotion & education; shared decision making; health status/functional status; courteous and helpful office staff; care coordination; between visit communication; helping you to take medication as directed; and, stewardship of patient resources.

The Coalition supports the addition of the new cross-cutting measures, specifically the measures discussed above, to the PQRS. These measures will help to foster better care coordination for beneficiaries, which can improve health outcomes.
Conclusion

On behalf of the Patient Quality of Life Coalition, we thank you for the opportunity to comment on the Medicare Physician Fee Schedule proposed rule. If you have any questions, please contact Keysha Brooks-Coley with the Patient Quality of Life Coalition at 202-661-5720 or Keysha.Brooks-Coley@cancer.org.

Sincerely,

American Association of Colleges of Nursing
American Cancer Society Cancer Action Network
American Heart Association | American Stroke Association
C-Change
Cancer Support Community
Center to Advance Palliative Care
CHE Trinity Health
Colon Cancer Alliance
George Washington Institute for Spirituality and Health
National Comprehensive Cancer Network
National Palliative Care Research Center
Oncology Nursing Society
Partnership for Palliative Care
Prevent Cancer Foundation