



CAMPAIGN FOR Better Care

August 24, 2010

The Honorable Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

File Code: CMS-1503-P

RE: Comments on the CMS Proposed Rule Regarding Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2011

Dear Dr. Berwick:

The Campaign for Better Care is a broad-based coalition of consumer organizations with a direct stake in improving the health and quality of life for older adults with multiple health conditions and their family caregivers. We welcome the opportunity to share our perspective on the 2011 Physician Fee Schedule proposed rule.

Medicare has always been a leader in payment reform and it has the chance to do so again. The Affordable Care Act provides the opportunity to fundamentally change the way we pay for physician services – eliminating the perverse incentives that exist in the current fee for service system, getting better quality and value for every health care dollar spent, and ensuring that a strong foundation of primary care undergirds our entire system. The 2011 Physician Fee Schedule begins to move Medicare in that direction and we encourage CMS to make changes as expeditiously as possible.

The Campaign has focused its comments on six key issues addressed in the proposed rule:

- better valuing and prioritizing payment for primary care;
- ensuring access to essential therapy services for the most vulnerable beneficiaries;
- ensuring adequate beneficiary protections and effective, evidence-based use of new telehealth services;
- guaranteeing adequate access to prevention and wellness services;
- strengthening quality measurement and accountability, through appropriate reporting and payment incentives, to improve quality and coordination of care for beneficiaries; and
- improving incentives and accountability for e-prescribing.

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Our comments are organized in the order of the proposed rule.

II. Provisions of the Proposed Rule for the Physician Fee Schedule

C. Identifying, Reviewing, and Validating the RVUs of Potentially Misvalued Services under the PFS

In its June 2008 Report to the Congress, the Medicare Payment Advisory Commission (MedPAC) linked mispricing in the fee schedule to undervaluation of primary care. MedPAC noted that efficiency gains are harder to realize in the delivery of primary care services compared with procedures and services where technology and other advances can more readily drive efficiency. As MedPAC has said, “Ideally, when such efficiency gains are achieved, the fee schedule’s RVUs for the affected services should decline accordingly, while budget neutrality would raise the RVUs for the fee schedule’s primary care services.”¹ However, this rebalancing tends not to happen, raising concerns that primary care services are undervalued.

The Affordable Care Act (ACA) directs the Secretary to review potentially misvalued codes in several specific areas. The Campaign supports these provisions in the ACA and urges CMS to move quickly to expand its review of potentially misvalued codes. In the proposed rule, CMS outlines its on-going activities in this area and the relation to the specific categories of codes identified in the ACA. We note that CMS’ activities are, in most cases, dependent on the work of the American Medical Association’s (AMA) Relative Value Update Committee (RUC). We further note that MedPAC has recommended the creation of a standing panel of experts to help CMS identify overvalued services and to review recommendations from the RUC. In its March 2006 Report to Congress, MedPAC said, “CMS relies too heavily on physician specialty societies to identify services that merit review and provide evidence in support of increasing or decreasing the relative values of services under review. Although the RUC provides valuable expertise, the review process would benefit if CMS had an additional means of identifying misvalued services and if supporting evidence were collected and analyzed not only by specialty societies but also by experts who were less invested financially in the outcome.”² We strongly encourage CMS to develop strategies for receiving independent input into the code review process and for engaging consumer representatives with appropriate expertise in this process. It is important that CMS create a process that ensures that the ongoing valuation of services is reflective of what society values and the public’s best interest.

¹ Hackbarth, G. correspondence to Weems, K., regarding the CY2009 physician fee schedule. Medicare Payment Advisory Commission. August 29, 2008. Retrieved from: <http://www.medpac.gov/documents/Physician%20fee%20schedule%202009%20NPRM%20comment%20letter%20to%20CMS.pdf>

² *Report to the Congress: Medicare Payment Policy.* (2006) Medicare Payment Advisory Commission. March 2006: 143.

III. Code-Specific Issues for the PFS

A. Therapy Services

The proposed rule outlines three short-term policy options that CMS is considering as part of its effort to develop alternative payment approaches for outpatient therapy services. CMS identifies specific topics of interest on which it seeks feedback, including “what function information should be collected and how it could be utilized to ensure necessary care, while minimizing payment for inefficient services or those of limited patient benefit.”

The Campaign is committed to improving quality and measuring performance. We value the role of data collection in supporting these goals as well as in ensuring that payment appropriately reflects patient complexity and risk. We are concerned, however, that CMS is proposing to create new codes and require new clinical data collection that it believes would, at a minimum, “allow contractors to more easily identify and limit the claims for beneficiaries that show no improvement over reasonable periods of time.” We strongly believe that the appropriate standard for therapy services is that the service is medically necessary, not that the service meets an undefined “improvement” standard. A therapy service that is prescribed to help maintain current functioning is medically necessary, yet it would fail an “improvement standard” test. This is particularly troubling for those beneficiaries with progressive conditions such as Alzheimer’s disease, Multiple Sclerosis, or Parkinson’s disease where therapy can help to prevent a beneficiary’s decline in functioning, but may not produce measurable improvement.

We encourage CMS to revisit the approach to therapy services, functional status, and payment discussed in the option section. CMS should recognize the role that therapy services can play in maintaining current functional status and also reducing costs associated with decline in patients’ functional status. We urge CMS to omit any reference to an improvement standard in its proposed options, future coding changes, and other related proposals.

IV. Medicare Telehealth Services for the Physician Fee Schedule

C. Submitted Requests for Addition to the List of Telehealth Services for CY 2011.

CMS has been approached by various providers to add numerous services as Medicare telehealth services. The Campaign believes that as technology advances, the needs of the patient must come first. We urge CMS to focus on where research demonstrates that technology can facilitate medically equivalent services and improve beneficiary access to providers. Further, we urge the agency to carefully monitor implementation of any new telehealth services to ensure that patients’ experience of the care is positive and that patient outcomes are not compromised.

We encourage CMS’ continued attention to the evidence and the role of patient needs as it evaluates telehealth requests. For example, in declining to recognize hospital discharge day management services as a Medicare telehealth service, CMS concluded that most of

the studies requesters submitted in support of their call for CMS to add these services “concluded that more research was required in order to establish medical equivalence between telehealth and in-person services.” CMS also concluded that, “hospital discharge day management services should be provided in-person in light of the acuity of hospitalized patients, their typically complex post-hospitalization care needs, and the importance of patient education by the admitting practitioner who had ongoing responsibility for the patient’s treatment during the hospital stay.” We look forward to CMS applying appropriate rigor in this area to best reflect patient needs and preferences.

V. Provisions of the Patient Protection and Affordable Care Act of 2010

Q. Section 4103: Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan

The ACA establishes an annual Medicare wellness visit, which includes (or takes into account) a health risk assessment (HRA) and creates a personalized prevention plan for beneficiaries with certain eligibility and other limitations.

Definitions: CMS proposes to add §410.15 to codify the coverage of the annual wellness visit providing personalized prevention plan services. CMS proposes to define several terms related to these visits. Among the terms to be defined is “detection of any cognitive impairment.” The proposed definition reads as follows, “detection of any cognitive impairment, for purposes of this section, means assessment of an individual’s cognitive function by direct observation, with due consideration of information obtained by way of patient report, concerns raised by family members, friends, caretakers, or others.” We propose adding to this definition a caregiver assessment to understand the primary caregiver’s capacity. As the ACA’s investments in fully engaging caregivers in the care process attests, the role of caregivers is essential to the management of complex chronically ill beneficiaries, particularly those with cognitive impairments.

Further, CMS proposes to define “review of the individual’s functional ability and level of safety,” for purposes of these rules, as, at a minimum, assessment of the following topics:

- Hearing impairment;
- Ability to successfully perform activities of daily living;
- Fall risk;
- Home safety.

We urge CMS to add to this definition, “assessment of level of support at home” to recognize that the availability of a caregiver is an important indicator of a beneficiary’s ability to function and of their level of safety.

In the proposed definition of “medical and family history,” CMS includes “use or exposure to medications and supplements, including calcium and vitamins.” Although this language is included in the definition, given the importance of updated medication lists for beneficiaries with complex chronic conditions, we urge CMS to amend the medical history provision in the list of requirements for the first visit for Medicare personalized prevention

plan services to read as follows, “Establishment of the individual’s medical and family history, including a detailed current medications and supplements list.” For the subsequent Medicare annual wellness visits, we believe that CMS should amend the medical history update provision to read, “An update of the individual’s medical and family history, including an update of all current medications and supplements.”

Services. We are pleased that CMS includes depression screening and functional status assessment in the first annual wellness visit and encourage you to include these in subsequent visits as well. These are appropriate assessments for an aging population and frequent concerns for the caregivers of the vulnerable elderly. In fact, a functional status assessment may be even more important for beneficiaries as they age than when they first become Medicare eligible. Further, all wellness visits should assess gait and balance. The update of medical history should include an inquiry about any falls since the last visit and whether the beneficiary is a caregiver – both are indicators that the beneficiary is potentially vulnerable for health risks.

In addition, we believe that the HRA is a fundamental component of the prevention plan service. The HRA is intended to help make the service more personalized than the current one-size-fits-all Welcome to Medicare Visit. We understand that CMS is still in the process of developing the standards and guidance for the HRA. Until further guidance is available, we urge CMS to reiterate that the office visit must take into account the results of the HRA and that HRAs should identify individuals’ chronic diseases, injury risks, modifiable risk factors and urgent health needs.

Payment and Quality. Finally, CMS has proposed a lower reimbursement rate for the subsequent visits for prevention plan services than for the initial visit. We believe that the rate for subsequent visits should vary depending upon the complexity of the visit and the severity of the problems addressed, as it does now for outpatient visits involving low, moderate, or high complexity. In addition, we encourage CMS to use some of the resources made available through the ACA to support the development of measures to assess the quality of the wellness visits and personalized prevention plan services. Measures should capture both the care delivered in the home and support programs delivered in the community, including evidence-based, community-level support programs and services.

R. Section 4104: Removal of Barriers to Preventive Services in Medicare

The ACA requires 100 percent Medicare payment for those Medicare preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B.

Beneficiary education. In the proposed rule, CMS notes that not all current Medicare preventive services, such as glaucoma screening and diabetes self-management training, are recommended with an A or B by the USPSTF. These services will generally not be eligible for the waiver of coinsurance and deductibles. Given some variation with respect to preventive services and the waiver of cost-sharing, we urge CMS to use plain-language

and clear information to inform beneficiaries about their ability to access most preventive services without cost-sharing. Outreach efforts and educational materials should clearly note those instances where beneficiaries will encounter cost-sharing.

Current USPSTF Recommendations. Medicare beneficiaries should have the same access to preventive benefits recommended by USPSTF that the ACA establishes for enrollees in commercial health plans. To that end, CMS should establish a process to promptly review all current USPSTF grade A and B recommendations that are not yet covered Medicare preventive services and use its authority to quickly add the services as Medicare benefits.

USPSTF and Public Input. We urge CMS to work with the Secretary and the Agency for Healthcare Research and Quality to increase the transparency of the USPSTF. As the USPSTF's role evolves to become more policy-focused, we encourage the agency to support increased opportunities for consumer stakeholders to become recognized USPSTF partners and for more public input into the work of the USPSTF.

S. Section 5501: Expanding Access to Primary Care Services and General Surgery Services.

The ACA creates 10 percent incentive payments for primary care practitioners' delivery of primary care services from 2011 through 2015. It also provides for 10 percent payment incentives for major surgical procedures delivered by a general surgeon in a Health Professional Shortage Area (HPSA) from 2011 through 2015.

The Campaign supports these investments in primary care and general surgery in HPSAs. We urge CMS to view these investments as important first steps in an ongoing process of increasing support for primary care services and reducing the gap between payment for specialty and primary care services. We also urge CMS to use the opportunity these investments create to consider ways to collect data about utilization patterns during the incentive periods. These data could inform policymakers' thinking about future primary care investments. CMS' review could consider, for example, whether there is any relationship between incentive payments to primary care and overall health care utilization in a community.

VI. Other Provisions of the Proposed Regulation

F. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

1. Section 131: Physician Payment, Efficiency, and Quality Improvements — Physician Quality Reporting Initiative (PQRI)

We strongly encourage CMS to consider strategies to move the PQRI program toward a more robust role in quality improvement. Individual clinicians and smaller groups' self-selection of measures, the small number of measures required to be reported, and

variations in the required sample sizes make the measures less meaningful than they could be if the program was more structured and rigorous.

Measures. We urge CMS to move beyond process measures and require the development and use of measures that better reflect patient preferences, patient experience, functional status, and care coordination. We believe that CMS should expand the criteria it uses to select measures and should prioritize: measures that address patient-centered care; measures that assess patient experience of care; and measures that capture demographic data in ways that enable measures to be stratified and used to identify and address health disparities.

Patient Experience. We also strongly recommend that collection of measures of patient experience eventually become an across-the-board, minimum requirement for participation in PQRI. This is particularly important in light of the fact that scientifically validated measures of patient experience are the best means we have of assessing the quality of care being received by patients with multiple chronic conditions for whom clinical process measures pertaining to single conditions have limited utility. It is also critical that CMS recognize that patient experience measures are, for the foreseeable future, the best proxy we have for whether the most complex, high cost patients are getting better coordinated care that can improve their outcomes, encourage appropriate patient engagement, reduce errors, and lower costs.

Data Collection and Reporting. We support CMS efforts to encourage physician reporting through registries, Maintenance of Certification (MOC), and electronic health records (EHRs). We believe that registries approved to report PQRI data should be required to have mechanisms in place to allow for independent validation of the data. Further, we support the goal of alignment of PQRI and the ARRA meaningful use measures to encourage reporting on a common set of measures in both programs. We also strongly encourage CMS to require the collection and reporting of data on patient race, ethnicity, language, and gender. This is essential to our ability to stratify quality performance for different population groups and address health disparities.

We are pleased that CMS intends to move forward with public reporting of PQRI data starting in 2011. For the data to be meaningful for beneficiaries, it must allow for comparisons among clinicians. The current practice of allowing individual clinicians and small groups to self-select measures limits the usefulness of public reporting to consumers. Beneficiaries will need a more comprehensive set of standardized measures in order to make comparisons and use the information in a meaningful way. Beneficiaries also should know which providers choose not to participate in PQRI.

Standards. We do not agree with CMS' proposal to weaken the standard for claims-based reporting. CMS proposes to allow providers to report on 50 percent of their Medicare Part B patients rather than the current 80 percent standard. It is unclear why CMS would suggest that it wants to move toward more meaningful reporting mechanisms such as registries and EHRs, while at the same time lowering the bar for claims-based reporting. We urge the agency to withdraw this proposal.

Maintenance of Certification programs. The ACA provides an additional 0.5 percent bonus payment for clinicians who satisfactorily report PQRI measures through a Maintenance of Certification (MOC) program. We support the use of MOC programs and, in particular, the practice assessment component, as a means of obtaining a more comprehensive assessment of physician performance and focusing on continuous professional development and quality improvement. We also strongly support the inclusion of patient experience of care surveys as a required element of the MOC practice assessment component.

2. Section 132: Incentives for Electronic Prescribing (eRx) – The Electronic Prescribing Incentive Program

The Campaign strongly supports incentives for electronic prescribing to help physicians offset the cost of switching from paper to electronic prescriptions. In a 2006 report to Congress, the Institute of Medicine recommended that all prescriptions be written electronically by 2010, estimating that preventable medication errors cost the health care system \$77 billion annually and result in 7,000 deaths per year. E-prescribing can help to eliminate errors due to poor handwriting and enable clinical decision support on patients' allergies, drug-drug interactions, overly high dosage, and clinical conditions.

These outcomes can only be realized if the electronic prescribing incentive program has meaningful standards in place. We are concerned that the "25 visit" threshold in the proposed rule is too low a standard for incentive payments. It is unclear how this low threshold will drive improvements for all Medicare beneficiaries, which should be the program's goal. We urge CMS to include a more robust standard in the final rule.

Conclusion

The Campaign commends CMS for moving quickly to implement the ACA. As this work progresses, we look forward to working with you and the agency's staff to better value primary care, improve care coordination, strengthen quality measurement and accountability, and promote prevention and wellness. We strongly urge CMS to consider patient needs and preferences in the development and design of each of its rules and guidance documents.

Thank you for your consideration of our views. We look forward to a final rule that reflects the needs of Medicare beneficiaries with multiple chronic conditions.

Sincerely,

AARP
AFL-CIO
Advocacy for Patients with Chronic Illness, Inc.
Center for Medicare Advocacy
Center for Medical Consumers
Community Catalyst
Consumer Health Coalition

Consumers for Affordable Health Care
Consumers Union
Families USA
Family Caregiver Alliance
Health Care For All
Hotel Employees and Restaurant Employees International Union Welfare Fund
Medicare Rights Center
National Academy of Elder Law Attorneys
National Council of Jewish Women
National Council on Aging
National Family Caregiver Association
National Health Law Center (NHeLP)
National Multiple Sclerosis Society
National Partnership for Women & Families
Nevada Healthcare Policy Group
North Carolina Justice Center's Health Access Coalition
OWL - The Voice of Midlife and Older Women
The Empowered Patient Coalition
UHCAN Ohio
Well Spouse Association