September 8, 2015

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1631-P
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule (CMS-1631-P)

Dear Acting Administrator Slavitt:

On behalf of the Society of General Internal Medicine (SGIM), representing approximately 3,500 general internists, we are pleased to comment on 42 CFR Parts 405, 410, 411, 414, et al. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Proposed Rule (80 FR 41686). SGIM's members provide clinical services and conduct research and educational activities to improve the health of adults, often with multiple complex, chronic conditions.

SGIM particularly appreciates the opportunity to address specific aspects of the proposal of Medicare physician payment policy. SGIM supports the agency's commitment to ensuring that our payment systems are updated to reflect changes in medical practice and the relative value of services and looks forward to working closely with CMS as this proposed rule moves toward implementation. We offer the following comments which focus on areas of particular importance to our members:

1. Improved Payment for the Professional Work of Care Management Services
2. Establishing Separate Payment for Collaborative Care
3. Complex Chronic Care Management (CCM) and Transitional Care Management (TCM) Services
4. Advance Care Planning Services
5. The Comprehensive Primary Care Initiative

Improved Payment for the Professional Work of Care Management Services

We applaud the Centers for Medicare and Medicaid Services (CMS) for recognizing care management as a critical aspect of helping individuals achieve better health outcomes and reducing expenditure growth. We commend the agency for proposing to address the deficiencies in the existing evaluation and management (E/M) services, particularly as they relate to the delivery of comprehensive, coordinated care management.

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We support CMS' proposal to create add-on codes to reimburse currently uncompensated physicians work associated with E/M services as a practical and expedient, though limited, solution to the undervaluation of E/M services. We favor an initial focus on the outpatient new and established patient E/M code families, since these represent the most substantial of the many deficiencies in the existing codes.

We recommend two categories of new add on codes be developed for use by all specialties: one for new and one for established patients. Each category should have two levels – the first for a high level of intensity and the second for even higher levels of intensity. Our members will suggest the corresponding vignettes.

These codes should follow the resource-based paradigm of RBRVS using work intensity as the unit of resource use. For primary care, the levels of intensity would recognize both the complexity of multiple interactions of medications and health problems and the post-visit work intensity for patients with multiple chronic conditions. For the specialist, the levels of intensity would correspond to disease state complexity and medical decision making.

More Research Needed in Order to Understand E/M Services

While we appreciate CMS' current proposal to more fairly recognize physician work in providing E/M services, the proposal's limited scope will hinder its ability to be successful. New payment models being studied and implemented by CMS continue to rely on the resource-based relative value scale (RBRVS) when determining physician compensation. Yet, the existing E/M codes continue to be inadequately defined and valued – a gap that has grown substantially in the 30+ years since their initial Harvard valuation.

In particular, the variability and intensity of the E/M work done by many specialties both within the face-to-face encounter as well as during the post-service period continues to evolve in complexity. Unfortunately, the existing E/M codes remain limited and fail to capture the diverse and growing efforts required within the current health care continuum.

Previously, SGIM and 15 other specialty societies proposed that CMS improve the accuracy in the Physician Fee Schedule (PFS) by developing new outpatient E/M codes using a research-based model. The model would be developed by studying the work done by physicians across the country before, during and after E/M services. If successful, this research-based model could then be used to address the deficiencies in the other E/M code families.

We urge CMS to commit to underwriting this research by hiring an expert contractor who can work with stakeholders to develop a comprehensive understanding of outpatient E/M work currently performed by physicians and their clinical staff. This research would: 1) describe in detail the full range of intensity for outpatient E/M services, 2) define discrete levels of service intensity based on this observational and electronically stored data combined with expert opinion, 3) develop documentation expectations for each service level that place a premium on the assessment of data and resulting medical decision making, 4) provide efficient and meaningful guidance for documentation and auditing, and 5) ensure accurate relative

valuation as part of the PFS.

We urge CMS to commit to the research necessary to develop new outpatient E/M codes. This research will also be critical in identifying and valuing the uncompensated work associated with E/M services which the agency intends to support through the add-on code proposal. This research will provide the agency with an accurate and reliable description of E/M activities and will clarify what physician work should be attributed to the E/M services, allowing a clear definition of what Medicare should expect from chronic care management (CCM) and transitional care management (TCM) services.

We applaud and fully support the commitment on the part of CMS to address the longstanding problem of inadequately defined and undervalued E/M services. We will gladly provide support to any contractor hired to pursue this research and will be pleased to serve as a resource for the agency in its efforts to ensure accurate service code definitions and valuations.

Establishing Separate Payment for Collaborative Care

We support CMS' proposal to reimburse physicians for collaborative care since the existing E/M services do not reimburse for the services provided in this context. While we understand that this proposed payment is not a replacement for the consultation codes, this proposal would address a gap in reimbursement that has existed since the elimination of those service codes. We envision that these payments will reimburse physicians who may collaborate on a patient's case but never have face-to-face patient interactions.

As CMS considers how to operationalize this proposal, we are concerned about the imposition of potential health information technology (HIT) requirements. If these requirements are too burdensome, they could prove to be too challenging for small practices and solo practitioners. We recommend that primary and collaborating physicians be able to share clinical data and electronic health records (EHR), with no requirement that their EHRs be fully interoperable. We also recommend that patient out-of-pocket liability be waived for all physicians who provide collaborative care, extending beyond those participating in certain Innovation Center projects. Increasing access to specialty knowledge and to decision support will improve the accuracy of the primary physician's medical decision making and improve efficiency by eliminating the wait to incorporate specialized care recommendations as part of a patient's health plan.

We endorse CMS' proposal to reimburse for collaborative care for common behavioral health conditions and believe that a CCM type model should be employed in situations where there is ongoing co-management of the patient.

We make the same recommendations regarding the HIT requirements and waiver of patient liability for collaborative care with a behavioral health component.

Complex Chronic Care Management (CCM) and Transitional Care Management (TCM) Services

SGIM commends CMS for looking for ways to improve beneficiary access to both the CCM and TCM services. We believe that this non-face-to-face care is critical to improving beneficiary health outcomes and lowering costs. As implemented, the requirements for the TCM service are reasonable and we believe utilization will continue to increase as physicians become more familiar with its requirements. However, we believe that the CCM code utilization will not increase unless specific changes to the service are made.

SGIM believes that reimbursement for this service is too low, and that the proposed practice expense payment is particularly inadequate. Currently, the PE RVUs are 0.54 for non-facility and 0.26 for facility. These numbers do not cover the salary support necessary for the services expected and needed. The current payment for non-facility care management would grossly under support these activities as they are currently designed.

This concern is based on the following analysis:

Assuming that a care manager works 50 weeks per year, 40 hours per week and 60 minutes per hour and that care requires 20-minute sessions per beneficiary, the total number of 20 minute segments per year works out to 6000. Assuming that roughly half of the care manager's time is consumed by pre and post-encounter work (roughly equal to the pre and post face-to-face time of an E&M service code), that would yield roughly 3000 individual segments per calendar year.

At the CY 2016 Medicare payment rates of $36.1096 per RVU, this would yield $108,328 of total payment per year. Assuming that overhead is at least 50%, this would yield a total payment of $54,164 per year. Assuming a 30% fringe rate, this would yield an annual salary of $37,914. This is roughly one-third of the current nurse payment level in most metropolitan areas. The current proposed payment for non-facility care management would grossly under support these activities as they are currently designed.

Within a facility-based primary care practice, the payment covers a fraction of what is required. Most primary care practices based in facility settings are required to cover their overhead. The amount of cross subsidization from hospital to outpatient practices has dramatically declined, and therefore, the payments available to provide for care management at facility based programs are not sufficient to attract the administrative and infrastructure support to deliver this service.

SGIM asserts that the current use of time metrics for code documentation is inefficient and impractical. The experience with care management indicates that multiple short phone calls add up over a one-month period. Documenting these conversations disrupts the practice's work flow to the detriment of the care delivered to patients. Since multiple providers may be involved in the care of patients, it becomes even more difficult to keep track of the time allocations. This administrative burden associated with this service limits the value of care management.

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The care management needs of beneficiaries vary considerably from month to month. The average might be 20 minutes per beneficiary per month, but there are some months where a 5-minute phone call is all that is necessary to assure that a patient is stable. There are other months where an hour or more of telephone contact will be required to resolve conflicts and improve patient outcomes. The requirement of 20 minutes per beneficiary per month imposes an unrealistic expectation that will challenge practices and foster unnecessary phone calls and documentation. This will detract from the care of those patients who require extended intervention.

We recommend that CMS eliminate the 20 minute per month requirement and replace it with a requirement that 60 minutes per quarter be spent on care management. This change would account for the differences in care management each month. We propose this as a temporary requirement until a database could be developed that could serve as the foundation for revisions to this service and the development of future similar services. CMS should also consider adopting the CPT code for the care management of more complex patients with its higher reimbursement level

Advance Care Planning Services

SGIM supports the agency's proposal to reimburse providers for the advance care planning (ACP) services described by CPT codes 99497 and 99498. We recommend that providers be able to bill for these services as required by the patient. CMS should consider allowing for the service to be billed in conjunction with the Annual Wellness Visit and requiring that the discussion occurred in the patient notes.

While we support the agency's proposal to reimburse for these services, we are concerned that each Medicare Administrative Contractor (MAC) would have the authority to determine if the ACP services would be reimbursable in their jurisdictions. SGIM strongly believes that this service should be available to all Medicare beneficiaries regardless of what jurisdiction in which they live and recommends that CMS implement it as a nationally available benefit.

The Comprehensive Primary Care Initiative

SGIM supports the potential expansion of the Comprehensive Primary Care Initiative (CPCI). We are encouraged by the preliminary results of this program and believe that its design will continue to improve health outcomes for patients and lower costs, as practices become more familiar with the requirements of the model. We also believe this model will help strengthen the primary care system.

We believe that part of the reason for the initial success of this program is that it is does not have the administrative requirements that other care management initiatives, including the CCM code, do. While the program includes sophisticated reporting requirements, it does not require that patients be responsible for a co-pay or require that physicians document the time spent on care coordination and management. If expanded, we urge CMS not to add these or other similar requirements. We also commend CMS for working to harmonize the CPCI

reporting requirements with those of the other quality reporting programs and urge the agency to continue to do so.

Thank you again for your efforts to improve the valuation of E/M services and for the opportunity to comment on this proposal. If you have questions or require further information, please contact Erika Miller at 202-484-1100 or emiller@dc-crd.com.

Sincerely,

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