



September 6, 2016

Andy Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8013

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 (CMS-1654-P)

Dear Mr. Slavitt:

On behalf of the Cognitive Care Alliance (Alliance), representing over 92,000 physicians from eight cognitive specialty societies, we appreciate the opportunity to provide comments on the CY2017 Physician Fee Schedule proposed rule. Our members, representing the specialties of primary care, endocrinology, infectious disease, gastroenterology, hepatology, neurology, and rheumatology, provide evaluation & management (E/M) services to their patients and remain concerned about the deficiencies in the definitions and valuations of these services. As such, we submit the comments on the following issues:

1. Collecting Data on Resources Used in Furnishing Global Services
2. Improving Payment Accuracy for Primary Care, Care Management, and Patient Centered Services

Collecting Data on Resources Used in Furnishing Global Services

The Alliance supports the premise under which CMS proposes to collect data on the resources used and care delivered to patients during the 10 and 90 day global periods. To maintain the accuracy and validity of the physician fee schedule, CMS's payment policies must be based on a well-constructed, valid and representative knowledge-base. Therefore, we have similarly proposed that CMS commit to developing an evidence base from which E/M services can be redefined and valued to more accurately describe and value the work performed by cognitive physicians.

We appreciate the agency's recognition of our core position. The agency states, "It is essential that the RVUs under the PFS be based as closely and accurately as possible on the actual resources involved in furnishing the typical occurrence of specific services." To ensure this is the case, an evidence base derived from health services research is necessary; this applies equally to the services delivered as part of the global periods as to E/M services delivered by cognitive physicians.

As the agency appropriately notes, the global periods include E/M services drawn from the existing physician fee schedule (PFS) based on the assumption that the resources required, including work

intensity, are identical to those provided outside of the global package. The Alliance firmly believes that the follow-up work performed within the global periods and the continuity work performed by cognitive physicians cannot be represented by the same codes. The care required by a patient recovering from a procedure is fundamentally different from the typical follow-up of an established outpatient or inpatient, especially when there are multiple simultaneous interacting conditions, a single metastable chronic illness, or one or more acute exacerbated chronic illnesses that requires inpatient care and expertise.

We anticipate that the data collected as part of the agency's proposal to assess the work performed in the global periods will support our contention that the services provided are fundamentally different. We believe that pursuing accurate valuations for the global E/M activities necessarily means that further study of all E/M service codes will be needed. We believe that such a comparative study will ultimately demonstrate that the existing set of E/M codes is being used to represent substantially different types of work.

With respect to this data collection and research effort, CMS asserts the authority to "...conduct surveys, other data collection activities, studies, or analysis, as the Secretary deems appropriate, to facilitate the review and appropriate adjustment of potentially misvalued services." CMS also recognizes that, "To the extent that such mechanisms prove valuable, they may be used to collect data for valuing other services." As stated, we believe that research focused on the global services will provide the agency with data that can help better describe E/M work that is typically performed in conjunction with procedural services, but this is will not provide a complete picture of the E/M work being delivered to Medicare beneficiaries. Therefore, we fully support the agency's assessment of the global E/M work and urge the agency to commit to the larger and broader assessment of E/M activities.

Our Alliance was formed because of the shared belief by all its members that the E/M work we typically perform is misvalued and must be revised based on a solid evidence base. We urge CMS to use the Alliance as a valuable resource as the data collection tools and analytics are developed for the proposed research. We are willing to work with the agency and its contractors in any capacity to further this effort.

Improving Payment Accuracy for Primary Care, Care Management, and Patient Centered Services

The Alliance commends CMS for proposing to reimburse for currently uncompensated care provided by cognitive physicians. The issues addressed by the Alliance and now by the agency extend well beyond improving reimbursement for primary care, as we seek to improve reimbursement for all cognitive services. The imbalance in payment that has shifted Medicare part B payments toward procedures has undermined the value of this work. Moving forward, the Alliance looks forward to working with CMS in its efforts to improve payment for care management and all cognitive services.

We appreciate that the agency has recognized that "...the current CPT code set is designed with the overall orientation to pay for discrete care services and procedural codes as opposed to ongoing primary care, care management and coordination, and cognitive services." The proposed rule states that "...we recognize that the current set of E/M codes limits Medicare's ability under the PFS to appropriately recognize the relative costs of primary care, care management/coordination and cognitive services relative to specialized procedures and diagnostic tests."

While we strongly support CMS's proposal to reimburse proposed services that are currently assumed to be bundled into the existing E/M codes, this should only be considered a temporary solution until the agency can complete the research necessary to properly define and value cognitive E/M services.

We continue to believe that CMS must exercise its authority to ensure the accuracy of the fee schedule and conduct evidence based research to be used to redefine and value cognitive E/M services. There continues to be considerable variability in the work completed by different specialties within the existing E/M service codes and a wide range of post-service work completed as a result of these encounters. Some are relatively overpaid and some are relatively underpaid. There are just too few basic choices. As outlined above, we believe the research being proposed to determine the resources and work required to deliver services in the global period can serve as a model for what we are proposing.

Unfortunately, the existing E/M codes have not been meaningfully evaluated since their inception nearly three decades ago. Continued exclusion of the E/M codes from study represents a disservice to Medicare beneficiaries, the physicians that provide these services, and the broader health care system. Furthermore, efforts to move toward value-driven models of care and delivery as outlined in the Medicare Access and CHIP Reauthorization Act (MACRA) will be potentially undermined unless the E/M service codes are adequately defined and provided with appropriate relative valuations. We recognize a study of the E/M codes will be resource intensive. However, its importance cannot be understated as this research will cost a fraction of the total amount paid by CMS annually for these services. This will be as a wise, but necessary, investment that will serve the greater need to improve health care value.

Specifically, we support CMS' proposal to reimburse for the non-face-to-face prolonged E/M services (CPT codes 99358 and 99359) at the RUC recommended values. The Alliance has previously proposed that the agency do this as an intermediate step until the E/M codes can be properly evaluated. While adding new add on codes is important, we reiterate that it is not a permanent solution because it does not recognize that the existing base set of E/M codes do not properly value the expertise and experience that cognitive specialists bring to their patient encounters. We believe that new E/M codes must factor in this expertise to truly capture the value of the work being performed.

Thank you for the opportunity to provide these comments. If you require any further information or require additional information, please contact Erika Miller, Executive Director of the Cognitive Care Alliance, at emiller@dc-crd.com or (202) 484-1100.

Sincerely,

A handwritten signature in black ink, appearing to read "John Goodson" with a stylized flourish at the end.

John Goodson, MD
Chair, Cognitive Care Alliance
Washington, DC

Cognitive Care Alliance Member Organizations:

American Academy of Neurology

American Association of the Study of Liver Diseases

American College of Rheumatology

American Gastroenterological Association

Coalition of State Rheumatology Organizations

Endocrine Society

Infectious Diseases Society of America

Society of General Internal Medicine