September 8, 2015

Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016

Dear Acting Administrator Slavitt:

On behalf of Providence Health & Services, thank you for the opportunity to provide comments to the Centers for Medicare & Medicaid Services regarding the proposed modifications to the calendar year 2016 physician fee schedule.

Providence Health & Services is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves — especially for those who are poor and vulnerable. Providence and its secular affiliates, including Swedish Health Services, offer a combined scope of 34 hospitals, 475 physician clinics, home health and hospice, senior services, supportive housing and many other health and educational services. The combined health system employs more than 76,000 people across five states – Alaska, California, Montana, Oregon and Washington.

As a large, integrated health care system providing services to patients across the continuum of care — from primary to acute care to home health and hospice — we are committed to clinical excellence with compassion. We know that quality of life improves when individuals and families have broad access to high-quality, patient-focused, affordable care. Together, Providence ministries and secular affiliates are working at scale to improve overall health in every community we serve through innovation in care delivery, new economic models and expert-to-expert collaboration. Given this perspective, we hope you find our feedback helpful in developing the final rule.
Advance care planning

Last year the American Medical Association CPT Editorial Panel and RUC committee established and codes and recommend payment levels for advance care planning services: CPT 99497 and 99498. In this proposed rule, CMS proposes to recognize the codes and adopt the valuation recommended by the RUC.

Studies on advance care planning have shown that these conversations have a positive influence on the quality of care, patient satisfaction with care, and the family experience (see excerpt from the Institute of Medicine report, Dying in America):

- Advance care planning gives patients and families the opportunity to start preparing mentally and emotionally for death (Steinhauser et al., 2000a; Martin et al., 1999).
- Advance care planning supports several of the primary concerns of people with life-limiting illnesses: staying involved, clear communication, shared decision making (Steinhauser et al., 2000b), and maintaining control (Edwards et al., 2010; Martin et al., 1999).
- By stating the kind of care they want in advance, patients may alleviate the burden of decision making on family members (Detering et al., 2010; Billings, 2012).
- Among children and youth, participation in systematic advance care planning programs may enhance positive emotions and facilitate communication, lead to treatment modifications (for example, withdrawal of ventilator support and addition of opioid analgesia), and support having death occur at home (Lotz et al., 2013).

Advance care planning is important at any stage in life, but is particularly challenging for patients with complex conditions or facing life-limiting illness. Coverage of advance care planning conversations with clinicians is critically important and recognizes the time, skills, and acumen necessary to facilitate these discussions.

As a Catholic organization, Providence has provided steadfast support for advance care planning as an important tool for our vision of answering the call of every person we serve to “know me, care for me, ease my way.” We applaud CMS for proposing to recognize and value advance care planning and urge CMS to finalize the proposal. We also encourage CMS to permit separate payment at the time of annual wellness visit. Advance care planning is not part of the valuation of the annual wellness visit, and was in fact removed from the annual wellness visit list of services, so we do not think this would be a duplicative payment. It is also important to recognize that patients may or may not want to discuss advance care planning at the time of the annual wellness visit, so keeping this service separate and distinct honors patient preferences and their readiness to engage in these discussions.

As CMS and the administrative contractors develop guidance for billing these codes, we stress advance care planning services should include both completing standardized forms, like advance directives and POLST, and also documentation in the medical record of goals, values and patient preferences for care. If CMS adopts guidelines regarding how many times the code may be charged or billed, allowances should be made for patient requests to change the advance care plan and changes in the patient’s medical condition which warrant re-evaluation of the plan.
Improving payment for primary care and chronic care management services

Providence supported the chronic care management fees approved by CMS in the CY2015 physician fee schedule and appreciates the commitment to further refine the accuracy of these payments and incorporate information from emerging research and initiatives.

In this proposal, CMS considers three new developments:

1. Creating CCM add-on codes to reflect the additional time and resources beyond 20 minutes per month.
2. Providing separate payment for “collaborative care” to support the care and management of Medicare beneficiaries with multiple chronic conditions, complex disease or acute condition, or behavioral health condition that requires extensive discussion, information sharing, and planning between primary care and specialists.
3. Providing separate payment for collaborative care models for beneficiaries with common behavioral health conditions.

Providence encourages CMS continue developing these policies and move aggressively in this direction. We appreciate that CMS is mindful of the administrative burden for recording CCM and TCM activities and supports efforts to streamline. We suggest that CMS engage with stakeholders outside of the rulemaking process (e.g. convene technical expert panels) to develop and improve these policies in time to be proposed next year for rulemaking.

Comprehensive Primary Care initiative

Providence is deeply involved in the Comprehensive Primary Care initiative, participating as a payer through Providence Health Plan and implementing the model in thirteen Providence Medical Group practice sites. Providence is committed to new care delivery and economic models. Based on our experience to date with CPCi, we feel this model holds promise, noting the Medicare evaluation from the first performance year indicates the program was budget neutral. One year of results is not a reliable indicator and we share CMS’ eagerness to understand the longer term impact and sustainability of the model.

As an Innovation Center initiative, we encourage CMS to designate CPCi as an “alternative payment model” under MACRA. We support CMS providing a multiple, diverse APM options for providers.

Providence encourages CMS to make decisions about expansion within the current seven CPCi regions collaboratively with CPCi payer and practice partners. CPCi payers are making significant investments in this joint venture and would be impacted differently than the practices by an expansion.

The CPCi model is designed to transform care for all patients served by a practice, not just patients covered by a participating payer. It weakens the model when a practice does not have a majority of their payer mix contributing. Reduced funding means a practice is limited in what transformational elements can be put in place. CMS should use their evaluation of the model to expound on the business case for payers to participate. An “all payer” model might be out of reach, but strengthening
the multi-payer participation in CPCi should be an explicit goal for CMS. In addition, CMS might consider building greater alignment between CPCi and the Medicare Advantage Stars program as a way to strengthen the interest and engagement from other payers.

In an initiative of this scale, it is important that stakeholders have the opportunity for routine, sustained engagement so that all benefit from the experience of the model test. Stakeholder collaboration should include payer engagement opportunities, peer-to-peer learning sessions for practices, regional in-person learning sessions for practices and payers, and annual in-person meetings that include both payers and practice representatives. We recognize that this level of engagement is an added expense for implementing the model, but strongly believe routine collaboration and dedicated facilitation is critical to successful implementation of a collective impact, multipayer model. As CMS considers expansion, it should considering enhancing the CMMI resources devoted to support collaboration among payers. We also encourage CMS to sustain the technical assistance to practices, in particular the in-person peer learning sessions.

One of the features of CPCi that distinguishes it from other CMS program is that the unit of accountability is the practice site, meaning all of the physician and non-physician primary care providers that work together in a physical location. Other CMS programs use the eligible provider (NPI) or the medical group, as defined by a tax ID number (TIN) as the unit of measurement or accountability. CMS reinforces this design element in the following ways:

1. Each practice site applied to participate
2. Beneficiaries are attributed to sites
3. Implementation of the performance milestones and reporting is completed by site, including the budget for use of the care management fee
4. Quality is measured by site

The practice site has proven to be a natural and logical accountability structure because it is the unit of service delivery. Providence supports CMS maintaining this approach in any expansion of CPCi.

We note that it been challenging to only have select sites within Providence Medical Group participate in the model test. CMS limited participation to approximately 70 practices per region and intentionally selected a diversity of practices. As CMS considers expansion, we recommend factoring in the benefits of an entire medical group participating (if each site applies to participate) so that the workflow changes, IT modifications, and other investments necessary to accomplish CPCi can be shared and implemented by the whole group.

One of the benefits of a practice-level intervention is that the milestone performance reporting encompasses changes that benefit all patients served by the practice. Under the model, practices report their milestone performance to CMS, but do not have to duplicate reporting efforts by submitting performance reports to other payers. Providence encourages CMS continue with this approach and share the milestone report data with payers participating in CPCi to support shared learning about the practice transformation.
We have appreciated that CMS shares Medicare data with CPCi practices and these reports have provided helpful insights about health care utilization across the medical neighborhood. Providence has been investing in new analytic capabilities so that we can receive and use claims data from payers to inform our population health strategies. **We encourage CMS to enhance the data sharing offered under CPCi practices and provide the option for practices to receive raw claims data, comparable with MSSP, if they have the capacity to receive and analyze the data.**

And finally, CPCi is one of the main primary care models that CMMI is testing at a large scale. If this model is intended to inform how CMS supports a “medical home” model of care within traditional Medicare, we **encourage CMS to modifying design so that primary care practices are permitted to participate in CPCi and a Medicare ACO.** While the medical home is an aim unto itself, it is also an important building block for providers to take on risk and participate in larger accountability arrangements. Under the current design, a practice must leave CPCi in order to join a Medicare ACO because under statute, a provider may not be in more than one shared savings model. This means that a CPCi practice must forgo an important source of care management fee revenue that has been used to build primary care functions of care management, enhanced access, patient and family engagement, and care coordination across the medical neighborhood if they want to join an ACO. CMS can remedy this issue while still maintaining the requirement that a CPCi practice be in a shared savings arrangement.

**We encourage CMS to create two CPCi tracks –under option one, practices are clustered by region to determine shared savings (as currently designed); under option two, practice shared savings are determined under a Medicare ACO calculation, not separately for CPCi.** Essentially, option two allows a practice to “opt-out” of the CPCi shared savings program element, which allows the practice to be eligible to participate in an ACO. This modification will allow for a seamless transition into an ACO and sustain the infrastructure and practice changes implemented through CPCi. **Conversely, as CMS considers expansion into regions that may already have Medicare ACOs in place, we recommend that CMS allow primary care practices that are involved in ACO to also be eligible for CPCi.** We understand that CMS would include the CPCi care management fees in the shared savings calculation of the ACO, consistent with how they account for other CMMI program overlaps.

**Telehealth**

The proposed rule would add five new CPT codes to the list of services eligible for Medicare telehealth benefit for prolonger service in the inpatient or observation setting and ESRD services related to home dialysis. CMS also proposes to amend regulations to include CRNAs as practitioners for telehealth services as allowed per state license. **Providence supports all of the modifications and continues to encourage CMS to overhaul the telehealth benefit, particularly in relation to alternative payment models.**

**Changes for computed tomography**

Under the PAMA Act of 2014, the technical component of CT services will be reduced for services furnished by equipment that does not meet the National Electrical Manufacturer Association standards
for dose optimization and management. To implement this requirement, CMS proposes to establish a new modifier for specific CPT codes, effective January 1, 2016.

Providence fully supports the intent of this policy and protecting patients from unnecessary radiation during health care services. However, the implementation timeline proposed by CMS is concerning and we agree with the Healthcare Management Association that this modifier should be presented to the National Uniform Claim Committee and enforcement delayed until the third quarter of 2016 to allow adequate time for CMS to work with stakeholders.

**Statin quality measure to be used in MSSP and PQRS measure sets**

CMS proposes to add a Statin Therapy for the Prevention and Treatment of Cardiovascular Disease to the Preventive Health domain. We agree that statin use is an important quality measurement topic and should be addressed in the measure sets of both MSSP and PQRS. Providence has been monitoring the development of the HEDIS 2016 measures, which are still in development, and had questions about whether this new measure proposed by CMS would align with the finalized HEDIS measures for statin prescriptions. Our experts had a number of technical questions about each of the three proposed denominators and how the measure would account for patients with contraindications to statin therapy or other exclusions. **We are concerned about the complexity of the statin measure and recommend CMS test the measure further before finalizing.**

**MSSP changes**

The proposed rule would adopt a general policy to maintain MSSP measures as pay-for-reporting, or revert pay-for-performance measures to pay-for-reporting measures, if the measure owner determines the measure no longer meets best clinical practices due to clinical guideline updates. CMS also addresses stakeholder concerns that that ACOs are being assigned patients that have long SNF stays, but would otherwise not be served by the ACO. The proposal would amend the definition of primary care services for purposes of the MSSP assignment methodology to exclude services billed under CPT codes 99304 through 99318 when the claim includes the place of service (POS) 31 modifier for SNF. **Providence endorses both proposals as logical and sound policy.**

Thank you for the opportunity to provide comments on this important proposed rule. We hope that you find our input informative. For more information, please contact Christa Shively, director, federal regulatory affairs and engagement, at (503) 893-6456 or via email at christa.shively@providence.org.

Sincerely,

Rod Hochman, MD
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Providence Health & Services