



September 4, 2012

The Honorable Marilyn Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1590-P
P.O. Box 8013
Baltimore, MD 21244-8013.

**Re: Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2013
[77 Fed. Reg. 44721, July 30, 2012]**

Dear Ms. Tavenner:

On behalf of AARP, we welcome the opportunity to submit comments regarding the proposed changes to the Medicare physician fee schedule and other revisions to Part B for calendar year 2013. In this letter, we focus on Medicare coverage of post-discharge transitional care management services, but offer some additional observations about several other provisions of the proposed rule.

Post-Discharge Transitional Care Management Services

AARP applauds CMS' initiative in taking this important step to provide better transitional care following discharge from a facility. While we strongly support the need for transitional care management (TCM) services, we have some concerns about the new code for TCM services that CMS has proposed.

CMS proposes a HCPCS code that specifically describes post-discharge TCM services, including all non-face-to-face services related to TCM furnished by the community physician or other qualified clinician within 30 days following discharge from an acute hospital, either inpatient or outpatient observation status, or skilled nursing facility (SNF), as well as several other types of facilities.

TCM services would include a wide range of important non-face-to-face services, such as reviewing the discharge summary, assessing the patient's post-discharge needs, adjusting the plan of care, conducting medication reconciliation, communicating with and educating the patient and/or caregiver, communicating with other health care professionals, assisting with scheduling follow-up visits, and assisting with arranging needed community resources.

While these are all important, indeed essential, TCM services, we note that proposed TCM services do not include a face-to-face visit prior to or within 24 hours after discharge by a qualified health professional, such as an advanced practice nurse, who has been trained to deliver TCM services. Nor do the proposed TCM services include follow-up home visits to facilitate assessment, medication reconciliation, care plan adjustment, and implementation. The importance of including such face-to-face contact, especially for high risk patients, has been confirmed by numerous studies.¹ Without such essential face-to-face contact, we are concerned that the proposed TCM

services will be less effective, and may suffer from problems similar to disease management programs that rely on telephone contacts.

We recognize that a physician or another clinician would be expected to conduct a face-to-face office visit with the patient within 30 days before or 14 days after discharge. However, we do not expect that such infrequent office-based visits would be sufficient to take the place of in-home face-to-face contact following-up promptly after discharge and repeatedly thereafter, as needed.

We are also concerned that, under the proposed rule, only physicians and other office-based clinicians, such as nurse practitioners, would be allowed to bill for TCM services. We believe it would be more effective to allow additional qualified Medicare providers, such as hospitals, home health agencies, SNFs, and others to furnish such services, as well as physicians and other clinicians.

Additionally, we are concerned that the 30-day window covered by the proposed rule will not be long enough to allow the intervention to break the cycle of readmissions and bend the trajectory of patients who have rough transitions. Studies suggest that a 90 day window is more likely to show lasting impact on these adverse outcomes and reduce avoidable readmissions.ⁱⁱ

We are also concerned that TCM services will be available to any and all beneficiaries who are discharged from designated facilities. Studies have shown that, to be most effective, TCM services should be targeted at high risk patients who are likely to experience rough transitions and readmission.ⁱⁱⁱ For purposes of targeting TCM services, studies have employed different criteria but, for the most part, these criteria have related to the presence of multiple chronic conditions, which correlates with expected service use and cost. For instance, the Medicare Community-based Care Transitions Program requires that TCM services be targeted at individuals at high risk for readmission. Under the proposed rule, many beneficiaries who are not in need of TCM services will receive them. This approach will dilute the potential impact of TCM services. Based on the evidence, we believe TCM services should be targeted at beneficiaries who are at high risk for readmission, as that phrase is defined in the Medicare Community-based Care Transitions Program.

We recognize that the payment method for proposed TCM services would be based on a single, fixed fee for a bundle of services delivered during a standard period of time. This payment method resembles the methodology used in several studies, including the Medicare Community-based Care Transitions Program. Such bundled payments for TCM services have been tested in studies and we agree reflect a sensible approach. However, we are concerned that the fee schedule payment amount for the proposed TCM services -- which would be based on a 30 minute hospital discharge day management visit (HCPCS code 99238) -- will not be sufficient to allow physicians and other clinicians to deliver necessary and appropriate TCM services to high risk beneficiaries. While there is, as yet, insufficient evidence to determine the optimal time necessary to deliver appropriate TCM services, we recognize that the optimal time may vary depending on the risk level of the target population. We are concerned that a payment rate that is inadequate would further dilute the impact of these potentially beneficial services.

Finally, we want to reiterate that, in concept, we are very supportive of the initiative CMS has taken to create a new payment code for post-discharge transitional care management services. However, we urge CMS to take steps to address our concerns in the final rule.

Medicare Telehealth Services for the Physician Fee Schedule

CMS proposes to add a number of preventive services to the list of telehealth services, such as screening for depression, behavioral health issues, and sexually transmitted diseases, among others. During CY 2012, CMS added coverage for these preventive services through the national coverage determination process.

AARP supports the proposed additions to the list of covered telehealth services. A recent report from the Institute of Medicine, *Geographic Adjustment in Medicare Payment - Phase II: Implications for Access, Quality, and Efficiency*, made recommendations to improve access to primary care services, including those that can be provided via telehealth. Coverage of these basic services is particularly critical to consumers in medically underserved and/or rural areas.

Advanced Primary Care Practices

CMS addresses the idea of an enhanced payment for primary care services furnished to Medicare beneficiaries in an advanced primary care practice environment. If this were to occur, CMS would have to establish criteria to determine whether a clinical practice qualified as an “advanced” primary care practice (medical home). One option would be to recognize the determinations of one or more of the nationally available accreditation programs, such as those of the Accreditation Association for Ambulatory Health, The Joint Commission, the National Committee for Quality Assurance, or URAC. AARP has supported deeming the criteria of private accrediting bodies under certain circumstances, but always in the context of CMS’ ability to conduct a crosswalk between the standards of the accreditor and its own requirements. We believe that clinical practices should not be encouraged to “venue shop” among competing accreditors. The standards and the assessment processes of competing accreditors are not the same — some are more rigorous than others. Deeming would help CMS avoid the need to establish elaborate review mechanisms to make the necessary qualification determinations.

Chronic Pain Management Services

AARP commends CMS’ proposal to broaden Certified Registered Nurse Anesthetist (CRNA) services to include pain management. CRNAs are often the primary providers of these services in rural and medically underserved areas, and coverage of these services will prevent consumers from having to travel long distances to unfamiliar providers where alternative care is available, costly and can involve extensive surgery, institutionalization in a nursing home, and significant detriment to quality of life. Without the availability of CRNAs’ pain management services, many Medicare patients -- particularly in rural areas -- would either be forced into nursing homes for this chronic care or go without the treatment and greatly suffer.

Durable Medical Equipment, Face-to-Face Encounters, and Written Orders Prior to Delivery

AARP is concerned by the provisions regarding durable medical equipment (DME), particularly the proposed physician sign-off on DME ordered by an NP, a CNS, or a PA. We agree with CMS’ efforts to curb fraud and abuse and understand the rationale for requiring a second check of orders for expensive or unusual items, such as battery operated wheelchairs, electric hospital beds, or

ventilators. However, the proposed requirement that physicians sign off on an extensive list of items – including commonly prescribed items, such as blood glucose monitors and standard wheelchairs that are currently ordered by APRNs and PAs – may create a barrier for consumers, many of whom routinely receive this needed equipment from nonphysician providers, and runs contrary to current Medicare reimbursement practice. CMS concludes that the above services are similar to services already on the list of telehealth services (i.e., they would be added on a category 1 basis). All coverage guidelines applicable to the services would continue to apply when they are furnished via telehealth (for example, if a service must be furnished by a primary care practitioner, the qualifying distant site practitioner must also qualify as a primary care practitioner).

Ordering Portable X-ray Services

AARP supports the proposed expansion of practitioners, including advanced practice registered nurses and other nonphysician practitioners, who may order portable x-ray and related diagnostic services. As CMS notes, these practitioners have become increasingly important in care delivery and the health care system must make full use of its health care team members. Two recent Institute of Medicine reports, *The Future of Nursing: Leading Change, Advancing Health* (2011) and *Geographic Adjustment in Medicare Payment - Phase II: Implications for Access, Quality, and Efficiency*, recommended that Medicare policies allow all practitioners to practice to the full extent of their education. These nonphysician practitioners are qualified to order portable x-ray services, and as a result, they may reduce consumers' wait time for needed care and expand access to those services.

Physician Quality Reporting System (PQRS)

The PQRS provides incentive payments to eligible professionals who satisfactorily report data on quality measures. The program remains voluntary until 2015, when it transitions to a penalty-based program for failure to report. We concur with CMS' view that PQRS is a "building block" initiative that should be aligned with its other programs. Therefore, PQRS must provide a strong foundation with rigorous measures that are "high value" and meaningful to beneficiaries, clinicians, and to CMS itself. In the past, we have urged CMS to select measures that will strengthen and improve the program, both in AARP-initiated letters, as well as those we have joined with other groups. We continue to urge CMS to bolster the current PQRS requirements, which in our view rely too heavily on measures of basic competencies and other processes that are not necessarily close to or related to an outcome. We also want to reiterate that many measure gaps (particularly in the area of outcomes) must be filled for PQRS to effectively and accurately assess physician performance. We urge CMS to fill these gaps at the earliest opportunity by working with medical societies and other measure developers.

Physician Compare

CMS expects to publish performance information on *Physician Compare* by 2013, by posting information collected through the GPRO web interface for group practices that submit data under the PQRS in 2012.

AARP members consistently tell us they are most interested in information to help them find "a good doctor." We know that the individual physician-level is most salient to consumers and will be most useful to beneficiaries in making health care choices. While we understand the emphasis in the

proposed rule on reporting at the practice level, we hope that CMS will be able to overcome the methodological challenges to offer beneficiaries information on *Physician Compare* at the physician level as soon as possible, without compromising the validity of the information presented. As with any information intended for beneficiaries, it should be suitable for the target population and take into account their health literacy, decision making skills, and cultural and linguistic preferences.

We also urge CMS to require that data, including results from patient experience surveys, be stratified in order to address disparities in care and to target interventions to eliminate them. Many studies show minority patients often receive different treatments for the same underlying condition as non-minority patients. Stratifying data from quality measures can, over time, help gauge reductions in health disparities and provide useful consumer information. We recognize that there are measure gaps that need to be filled for CMS to accomplish this goal. However, we strongly support a requirement for providers to participate in a survey of patient experience. Collecting patient experience data at the physician-level has already been demonstrated to be feasible. We know that consumers value information from other consumers, and obtaining patient reports on their experience with their physicians is a necessary and feasible component for *Physician Compare*.

We hope these comments are helpful. If you have any questions about our comments or need more information, please feel free to contact Andrew Scholnick of our Government Affairs staff at 202-434-3770 or ascholnick@aarp.org.

Sincerely,



David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs

ⁱ Brown, R et al. "Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions of High-Risk Patients", *Health Affairs*, 31:6(2012);1156-1166.
Coleman, E et al. "The Care Transitions Intervention", *Arch Intern Med*, 166(2006);1822-1828.
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ⁱⁱ Naylor, M et al.

ⁱⁱⁱ Brown, R Et al. Naylor, M et al.