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September 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201
Attn: CMS-1693-P

Re: Revision to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2019

Dear Administrator Verma:

On behalf of AARP, we welcome the opportunity to submit comments regarding the proposed rule relating to the calendar year (CY) 2019 Medicare Physician Fee Schedule and other matters. AARP, with its nearly 38 million members in all 50 States, the District of Columbia, and the U.S. territories, is a nonpartisan, nonprofit, nationwide organization that helps empower people to choose how they live as they age, strengthens communities, and fights for the issues that matter most to families, such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse. We appreciate the opportunity to comment on the Medicare PFS, and limit our comments in this letter to: Communication Technology-based Services; Evaluation and Management Services; Quality Measurement; and Transparency.

Recognizing Communication Technology-based Services

In general, AARP supports the continued expansion of telehealth services in Medicare. Considering the statutory limitations placed on Medicare by Section 1834(m) of the Social Security Act, we appreciate CMS's effort in finding ways to improve access and coordination through technology. We applaud the novel approach of developing a discrete set of services defined by the use of communication technology to allow more convenient telehealth interactions between provider and consumer.

Brief Communication Technology-based Services

AARP supports the use of a new code for a physician or other qualified health professional to have a brief non-face-to-face check-in with an individual. Used responsibly, such a check-in could improve treatment plan adherence, improve early detection of problems, and reduce unnecessary office visits. Audio-only telephone interactions would be sufficient for a check-in, but we caution against using text-messaging or chat functions unless necessary due to an individual's documented hearing impairment.

We urge appropriate documentation requirements, though, so that the check-in is fully incorporated in to the individual's medical history and to protect the beneficiary from both stinting on care and inappropriate utilization. Similar to in-office visits, documentation should at a minimum include the chief complaint and history of present illness, diagnosis, and treatment plans and follow-up. We also urge that verbal consent be required and noted in the medical record for each service. Part of the verbal consent should be the disclosure and acknowledgement that there is associated cost-sharing.

Remote Evaluation of Pre-recorded Patient Information

AARP supports the creation of specific coding that describes the remote professional evaluation of patient-transmitted information via "store and forward" technology. These codes should only be used, though, when voluntarily initiated by the individual. They should not be used instead of a face-to-face visit unless the individual is explicitly given the choice. This applies to both established patients and new patients seeking consultation from specialists.

Interprofessional Internet Consultation

AARP supports the ability for qualified clinicians to seek consultations via communication technologies. We agree that there should be verbal beneficiary consent in advance of these services, but urge CMS to waive cost-sharing for these codes. CMS correctly notes that these codes describe services which are furnished without the beneficiary being present. We believe it is inappropriate to charge the individual for a service they do not directly receive; and receiving a bill for such a service would be especially confusing.

Expanding the Use of Telehealth under 1834(m) and under the Bipartisan Budget Act of 2018

AARP supports the addition of the two codes, G0513 and G0514, for preventative services to be furnished via interactive telecommunications in Medicare. We also support monthly end-stage renal disease management via telehealth, so long as it is the individual's voluntary choice. Finally, we support the inclusion of mobile stroke units as originating sites for acute stroke telehealth services.

Evaluation & Management (E/M) Visits

AARP supports CMS's goal of updating the documentation requirements for clinicians to enable them to use their time more productively and focus on the things that are most important to each individual. For example, the proposal to eliminate extra documentation requirements for home visits may help individuals get care where they need it. This is especially important for seniors who want to live independently at home, and for their family caregivers, who often coordinate and manage their health care needs. The proposal includes Nurse Practitioners, who are the largest providers of home visits, particularly in rural areas.[1]

We are concerned, though, that the proposal to eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty would hinder the transition to more coordinated and accountable care. Allowing multiple same-day evaluation and management (E/M) office visits billed for the same beneficiary could undermine patient-centered care. We recommend retaining the existing policy until data is collected or a pilot is conducted to ascertain how removing the prohibition would impact care.

Additionally, AARP is strongly concerned that proposed changes in payments for evaluation and management services would have unintended harmful effects on Medicare beneficiaries. Specifically, CMS proposes replacing separate payment amounts for Level 2 through Level 5 office visits with a single payment amount set at an amount in between the current Level 3 and Level 4 amounts.

We have three significant concerns:

First, the proposed changes would impose unfair higher cost-sharing charges on individuals who have short visits. With the proposed single-payment level, payment for a visit will be approximately the average amount paid today across all E/M codes, and so would the associated cost-sharing amount. For shorter visits, individuals would be subject to higher cost sharing than they are now.

Second, the proposed change would likely reduce access to physician services for beneficiaries with complex needs, often stemming from multiple conditions, who frequently need longer visits, Levels 4 or 5, to address their needs. Physicians who serve a large proportion of patients with complex needs would receive a significant drop in total payments. For example, many specialists, such as geriatricians, neurologists, and endocrinologists, often have complex patient populations and need longer office visits to provide quality care to their patients. The proposed changes may lead to individuals with complex needs having their visits cut short (thus, reducing quality of care) or they may have difficulty finding physicians who will treat them.

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[1] Nengliang (Aaron) Yao, PhD, Christine Ritchie, MD, Thomas Cornwell, MD and Bruce Leff, MD, Use of Home-Based Medical Care and Disparities, *JAGS* (August 2018).

Third, an expected behavioral response to these financial incentives is that physicians will require individuals with complex needs, who now receive longer in-depth visits, to return for multiple visits instead, resulting in two or three visits in place of one longer visit today.[2] This would be very burdensome for individuals and the family members who accompany them. Especially for frail individuals, preparing for, and getting to and from an office visit, as well as the visit itself, can by quite physically taxing and stressful. Further, if two or three visits are required instead of one more-thorough visit, completeness and continuity would be lessened, reducing quality of care, while total cost-sharing and transportation expenses would increase.

We urge CMS to adopt an approach that updates and simplifies requirements for documentation, while retaining fees that are based on the relative resources used by clinicians to provide services. As described in recent publications, various approaches to doing so are possible and should be considered.[3]

Quality Reporting Measures

AARP supports the inclusion of two additional Consumer Assessment of Healthcare Provider and Systems (CAHPS) survey measures in the Medicare Shared Savings Program quality scoring for accountable care organizations. Consumer experience measures are an important component of quality measurement, and help hold providers accountable for person-centered care delivery.

We also support adding a new criterion for provider participation in the Merit-based Incentive Payment System (MIPS). In addition to the low-volume thresholds of $90,000 of billable charges or providing services to more than 200 Part B-enrolled individuals, creating a threshold of providing 200 or more covered services will allow more providers to be eligible for participation. We urge CMS, though, to make participation in MIPS dependent on *meeting any one* of these thresholds. *Not* meeting one of the criteria should not be an excuse to avoid participating in MIPS altogether.

Requests for Information on Promoting Interoperability and Price Transparency

Price Transparency

AARP believes individuals should know the financial costs of the health care they receive, and that price information can be a useful tool for consumers to make informed decisions about their care. A hospital's chargemaster or listed price menu is not a particularly useful source of information, however, because it does not reflect the person's actual out-of-pocket costs. We recommend that CMS require hospitals to post their hospital-specific Medicare rates and corresponding expected beneficiary out-of-

[2] Robert A. Berenson and Alan Lazaroff, "The False Choice of Burden Reduction Versus Payment Precision in the Physician Fee Schedule," *Health Affairs Blog*, August 15, 2018; and Zirui Song and John D. Goodson, "The CMS Proposal to Reform Office-Payments," *The New England Journal of Medicine*, August 15, 2018.
[3] Ibid.

pocket coinsurance amounts. This would offer more meaningful price transparency than hospital “standard charges”, which Medicare does not pay.

Promoting Electronic Interoperability

AARP supports the continued promotion of electronic health information exchange and interoperability that is aimed at improving patient care by making medical records readily available to providers, patients, and their family caregivers, as appropriate. Electronic data exchange among hospitals, physicians, hospices, skilled nursing facilities (SNFs), and other post-acute care providers is especially important during care transitions when information relevant to the individual’s next phase of care may be lost.

Having information useful to manage their own care when they are not directly interacting with their care team (e.g., after an encounter) is a critical support that individuals (and family caregivers, as appropriate) need, regardless of their condition or health status. Access to information electronically, such as discharge summaries and test results, greatly enhances opportunities to engage in one’s own care. By sharing information with providers, caregivers, or other members of the individual’s care team, it can help them better coordinate and manage their care needs. Under HIPAA privacy rules, health care providers must give individuals access, upon request, to the protected health information about them. People with the capacity to access their medical records and personal health information through patient portals or other electronic means should have the right and ability to do so without undue burden, as for many this can be easier than requesting and managing printed information. However, while AARP fully supports moving forward expeditiously on improved electronic access, many people will still need or prefer to access printed copies of their medical records or discharge/transfer summaries, or receive them by mail or fax, and CMS should ensure that this right continues. Not everyone has the technology for electronic access, including many older Americans.

Thank you for the opportunity to comment on the proposed rule. 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