September 27, 2019

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-1715-P

Re: Revision to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2020

Dear Administrator Verma:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, would like to thank you for the opportunity to submit comments regarding the proposed rule relating to the calendar year (CY) 2020 Medicare Physician Fee Schedule and other matters. Our comments focus on the consumer and beneficiary impact of various payment and coverage policies. Specifically, our comments will be limited to: telehealth; provider scope of practice; chronic care management services; colorectal cancer screening; bundled payments; and home infusion therapy services.

Telehealth

CMS proposes to add the face-to-face portions of three services (GYYY1, GYYY2, and GYYY3) pertaining to opioid treatment to the list of covered telehealth services. AARP supports the continued addition of telehealth to Medicare’s covered services, particularly for mental health and substance abuse treatment. We further urge CMS to consider coverage addressed in H.R. 1301, the Mental Health Telemedicine Expansion Act. We believe that a range of services can effectively and efficiently be furnished via telehealth technology, thereby increasing access to health care for many beneficiaries. We regret that current Medicare telehealth coverage policies remain narrow in scope (e.g., limited to certain geographic regions and originating sites) and lag behind many private payer and Medicaid programs, but we recognize that some of these restrictions flow from the statute. Nonetheless, we urge CMS to enhance the use of telehealth, and urge the Congress to expand coverage of telehealth services so that the technology can
achieve its full potential. However, CMS should also make clear that telehealth services should not be mandated by the provider, and that the consumer should retain the choice of face-to-face visits when possible.

Provider Scope of Practice

AARP supports all clinicians’ ability to provide care to the fullest extent of their education and training. To this end, AARP supports revising the regulation at § 410.74(a)(2) to provide that the statutory physician supervision for physician assistant (PA) services would be met when a PA furnishes their services in accordance with state law.

AARP also supports the recommendation that advanced practice registered nurses (APRNs) and PAs review and verify (sign/date) student notes rather than having to re-document the information. This would reduce extraneous, duplicative entries, make it easier for clinicians to quickly and efficiently find needed information about a patient without searching through redundant notes, and allow clinicians to spend more time with patients. Review and verify, rather than re-enter, could also reduce errors arising from miscommunication and loss of reliability from the original entry.

AARP supports revising the Ambulatory Surgical Center regulations to be in line with the Medicare hospital Conditions of Participation (CoPs) by allowing CRNAs to perform the pre-anesthesia evaluation. The proposed change would also ensure that patients benefit from the advice of the relevant expert. AARP further recommends that the procedure risk and anesthesia risk evaluations be separate regulations. Evaluation of the procedure risk should be performed by the surgeon. Evaluation for anesthesia risk should be performed by anesthesia professionals – certified registered nurse anesthetists (CRNAs) or anesthesiologists. Allowing CRNAs to perform this evaluation in Ambulatory Surgical Centers, as they do in hospitals, would promote efficiency and reduce costs. In addition, AARP recommends amending the Medicare hospital CoPs to allow CRNAs to direct the provision of anesthesia services in hospitals. Doing so would reduce costs and greatly improve access to services in rural hospitals.

Lastly, AARP supports the proposed revision of § 418.106(b)(1) to permit a hospice to accept drug orders from a physician, nurse practitioner, or physician assistant.

Chronic Care Management (CCM) Services

AARP agrees with CMS about the importance of care management and care coordination services and supports ongoing efforts to ensure beneficiaries receive these services. Chronic care management services are currently only available to beneficiaries with two or more chronic conditions. We support CMS’ proposal to establish separate coding and payment for Principal Care Management (PCM) services, care management for a beneficiary with one serious chronic condition which required a recent hospitalization or places the beneficiary at significant risk of death, acute exacerbation/decompensation, or functional decline. The establishment of a disease-specific care plan, that is implemented and revised as appropriate, will facilitate the treatment of a complex chronic disease that requires substantial care management.
We agree with CMS that most PCM services would be billed by specialists focusing on a single complex chronic condition and support the proposals not to impose any restrictions on either the specialties or on the number of clinicians simultaneously providing PCM services. We are concerned, however, that without ongoing communication with the beneficiary’s primary care practitioner, the maximum benefits of PCM will not be achieved. We recommend that CMS require documentation of ongoing communication with the primary care clinician in the medical record. This communication is necessary to facilitate continuity of care and to prevent duplication of additional services.

CMS also proposes new language for a typical care plan under CCM, and seeks feedback from stakeholders and additional language to guide practitioners as they decide what to include in their comprehensive care plan for CCM recipients. AARP supports the continued inclusion of caregiver assessment as part of the typical care plan. This is an important element of a care plan, as family caregivers often provide critical assistance to their loved ones that can impact their health, well-being, ability to live at home, and quality of life. Family caregivers assist with tasks such as eating, bathing, dressing, medications, medical/nursing tasks, transportation, paying bills, and coordinating care across multiple providers and settings. Caregivers can impact health outcomes and reduce or delay nursing home use and hospital admissions.

Although family caregiving is usually undertaken willingly, and may bring deep personal satisfaction, it frequently takes a great emotional, physical, and financial toll on the family caregivers themselves.

It is important for practitioners to have a conversation with the Medicare beneficiary to determine if they have a family caregiver(s) (defined broadly). If so, the caregiver should be identified (including with contact information) in the beneficiary’s medical record or electronic health record and care plan when the individual wants a family caregiver involved and the caregiver consents. Communication with caregivers can be critical and identifying them is a vital first step. The care plan should note whether the family caregiver has voluntarily agreed to provide assistance to the beneficiary under the care plan. We note services provided by family caregivers should only be included in the care plan if family caregivers have agreed to provide these services and have indicated their ability to carry out the actual tasks.

A person- and family-centered plan of care should be developed based on an assessment of both the individual and the family caregiver. A caregiver assessment helps the practitioner understand the caregiving situation, tasks that are most problematic and stressful for the caregiver, and what supports might be most beneficial to the caregiver. When family caregivers receive needed supports, it can benefit not only the family caregiver but also the person they are assisting.

A caregiver assessment should include, at a minimum, asking family caregivers about their own health and well-being; employment status; level of stress and feelings of being overwhelmed and unprepared; and the types of training and supports they might need to continue in their role. Following the assessment, the family caregiver should be provided with or connected to the critical supports identified during the caregiver assessment process. Doing so could, among other things, provide much needed support to caregivers to continue in their caregiving role and delay the institutionalization of the beneficiary. Family caregivers may need supportive services (such as education, counseling, support groups, or respite care) to reduce caregiver strain, provide
higher quality care, and continue playing an active role in a beneficiary’s care plan. AARP urges CMS to incorporate these elements into the care plan that would assist the beneficiary and the family caregiver.

We understand that CMS is trying to streamline the typical care plan language. CMS proposes to insert the phrase “interaction and coordination with outside resources and practitioners and providers” and remove “community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention.” At the same time, the current language also provides additional specificity that may be helpful to some providers and ultimately to some beneficiaries. If CMS makes the proposed change, we encourage CMS to make the additional wording or similar guidance available in appropriate Medicare Learning Network or other resources for providers who may look for additional information and guidance on the comprehensive care plan.

Finally, CMS seeks comment on requiring consent for communication technology-based services. AARP previously expressed our support for the creation of codes for provider-consumer communications and inter-professional communications that facilitate care management. Our initial comments, in response to the CY2019 proposed rule, recommended that verbal consent be required for each service. We recognize that obtaining consent for each communication may not be practical, and would be supportive of providers obtaining consent for a defined period of time. We reiterate, though, that consent and documentation must ensure that the beneficiary is aware of what communication technology-based services are being provided, the anticipated frequency of their use, and what other providers will be consulted. Moreover, we urge CMS to waive cost-sharing for these services, particularly charges stemming from provider-to-provider communications. 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. In fact, burdensome and confusing cost-sharing may play a role in the underutilization of transitional care management (TCM) and CCM codes reported by CMS.

**Coinsurance for Colorectal Cancer Screening Tests**

In general, Medicare beneficiaries have cost-sharing obligations for health care services. Recognizing that cost-sharing creates a barrier to obtaining preventive services and screenings, the Affordable Care Act (ACA)1 eliminated the Medicare Part B deductible and coinsurance requirements for routine screening tests that receive an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF). As a result, there is no beneficiary cost-sharing for recommended colorectal cancer screening tests.2 Medicare beneficiaries have a cost-sharing obligation when during their screening colonoscopy a polyp or abnormal growth is removed or when a tissue biopsy is obtained during the procedure. When a polyp is removed or a tissue biopsy obtained, Medicare considers the colonoscopy as diagnostic and not screening, and beneficiary cost-sharing applies.

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2 Section 1861(pp)(1) of the Social Security Act.
AARP is concerned that the potential for beneficiary cost-sharing because a polyp is removed or a tissue biopsy is obtained during a screening colonoscopy is confusing to beneficiaries and presents a barrier to receiving appropriate medical care. We do not believe that requiring physicians, or their staff, to notify the patient that their colorectal cancer screening procedure could become a diagnostic procedure – and that cost-sharing will apply – will reduce beneficiary confusion. The only way to eliminate this confusion is for the definition of a screening colonoscopy to include polyp removals and tissue biopsies that are determined to be medically necessary during the screening colonoscopy. AARP already supports legislation (H.R. 1570/S. 668, the Removing Barriers to Colorectal Cancer Screening Act) to remove the cost-sharing obligation from these diagnostic procedures. We urge CMS to take appropriate steps to expand the current definition of colorectal cancer screening colonoscopies to include these procedures.

Opportunities for Bundled Payments under the Physician Fee Schedule

How Medicare reimburses providers greatly impacts how care is delivered – and a model that prioritizes the financial or administrative needs of the provider may do so at the expense of the physical, emotional, and financial needs of the individual. As Medicare transitions away from fee-for-service and towards alternative payment models, such as bundles, we are concerned that the design and implementation of bundled payments may promote savings over quality, and result in less-than-ideal care. Existing bundled payment demonstrations have not been evaluated, and implementing a new bundled payment demonstration without learning lessons from the existing demonstrations could be counterproductive and negatively affect beneficiaries. In designing a new bundled payment demonstration, it will be important to incorporate data and results from other demonstrations.

CMS should better understand the impact of existing bundled payment models on the quality of care before initiating new ones. In particular, many bundles place emphasis on cost-savings, thereby incentivizing providers and hospitals to use the least costly alternative rather than the option that is most appropriate for the beneficiary. For example, depending on the financial arrangement between the hospital and the post-acute provider, financial incentives could lead to beneficiaries being released from post-acute rehabilitation before they are fully rehabilitated.

Payment of Home Infusion Therapy Services

CMS seeks comment on the statutory requirement that prior to furnishing home infusion therapy, the physician establishing the plan of care must notify the beneficiary of the options available for infusion therapy, such as treatment at home, in the physician’s office, or in the hospital outpatient department.

AARP believes that decisions about patient care, such as where to receive infusion therapy, should be the result of a dialogue between the physician, patient, and any family caregiver chosen by the patient. In this way the patient (and family caregiver) can have immediate answers to questions that may not be addressed in written materials. Written materials may be a helpful supplement but should not be the sole means of beneficiary notification.
As part of the notification, beneficiaries should be informed about differences in out-of-pocket costs. Beginning in 2021, home infusion therapy is a new Medicare Part B benefit that has the standard 20 percent Part B coinsurance. The dollar amount of beneficiary out-of-pocket costs can vary based on the site of care chosen for treatment due to Medicare payment policy differences. The ordering physician should be aware of the beneficiary’s status with respect to supplemental coverage and therefore able to assist the beneficiary in considering how out-of-pocket costs might be affected by the chosen site for home infusion therapy. It is important for beneficiaries to understand their potential out-of-pocket costs, so they can make informed decisions about their care.

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 me or 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