JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

September 6, 2016

Submitted electronically to https://www.regulations.gov

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1654-P
P.O. Box 8013
Baltimore, MD 21244-8016

Re: CMS-1654-P Physician Fee Schedule

Justice in Aging appreciates the opportunity to provide a response to the above-referenced proposed Medicare Physician Fee Schedule.

Justice in Aging is an advocacy organization with the mission of improving the lives of low income older adults. Justice in Aging uses the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries, including those dually eligible for both programs.

Our comments are limited to a few sections of the proposal.

Assessment and care planning for patients with cognitive impairment –Part II(E)

Justice in Aging supports the creation of G-code for separate payment which recognizes the value of assessment and care planning services for patients with cognitive impairment, noting particularly the value of identifying caregiver needs, limitations and supports. We also appreciate that this separate code recognizes the broad range of experiences of people with cognitive impairments such as dementia, including particularly: women, people in medically under-served areas or ethnically and culturally diverse communities, those with intellectual and developmental disabilities, or with younger-onset disease.

Improving payment accuracy for care of people with disabilities -- Part II (E)(6)

The prior fee schedule did not reflect the additional time and services required to serve individuals with disabilities and is one of the factors that has made access to care a challenge for persons with disabilities. We are very appreciative that CMS is attempting to address this problem by creating of an add-on G-code. We ask, however, that CMS consider ways to protect beneficiaries from additional co-insurance charges that could result from this change. While the cost to the provider is higher serving some persons with disabilities, the benefit to the individual being served is the same as that to a person without the disabling condition. The co-insurance for the person with disabilities should therefore not be higher.

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Section 1557 of the Affordable Care Act prohibits heath care providers, including CMS, from disability discrimination in insurance design, including co-insurance. To be consistent with the non-discrimination mandate of Section 1557 and specifically with 42 C.F.R. Sec. 92.207, which applies those requirements to insurance design, we ask that CM protect people with disabilities from any additional discriminatory cost sharing in connection with this G-code, while at the same time ensuring access to needed providers. To fully implement the nondiscrimination mandate of Section 1557, both elements are essential.

Diabetes self-management training (DSMT) -- Part II (F)

Person-centered care requires the engagement and empowerment of individuals. For consumers living with diabetes, DSMT is a particularly important element in that process. We appreciate and support the current proposal but wish to point out two areas where it could be strengthened:

- Co-insurance: For low-income individuals, the imposition of co-insurance, even if a modest amount, can be an impediment to access. Low income beneficiaries are reluctant—and often unable—to stretch their budgets for any health care that is not urgent. Treating DSMT as a zero-co-insurance preventive service would be a good step to increase utilization of this important service.

- Restriction on payment for DSMT and Medical Nutrition Therapy (MNT) on the same day: We ask that CMS consider removing this restriction. Low income Medicare beneficiaries and those in rural areas have persistent problems in obtaining reliable transportation to non-emergency health care. Problems with Medicaid NEMT availability and quality are widespread. Any same-day restriction, including this one, exacerbates the problem. Further, for individuals who are frail and especially those with anxiety or other common mental health conditions, the energy and effort needed to leave the house are considerable, and more so when distances are significant. Allowing individuals to combine appointments in a single day is one common sense way to address some of these issues. It lessens the burden on the beneficiary and increases access to needed services.

Bid pricing data for MA organizations -- Part III (E)

We strongly support the release of Medicare Advantage bid pricing data. Roughly one in three Medicare beneficiaries is enrolled in Medicare Advantage and it is critically important that data about of this massive program are transparent. Information released will be relevant to many important issues of public policy including the relative costs incurred in Medicare Advantage versus traditional Medicare, the value of added benefits financed by rebate amounts, the transfer of Part C benefit dollars to reduce Part D premiums, geographic variation in Medicare costs, and many others.

We believe, however, that a five year data lag is unjustified and negates much of the value of data release. Informed policy discussions and decisions need to be made on reasonably recent data. We are confident that CMS can protect genuinely proprietary information while still releasing information that is timely and useful. We urge the agency to do so.

Bid pricing data for Part D organizations -- Part III (E)

As with Medicare Advantage, we strongly urge CMS to maximize transparency with respect to Part D pricing data. While we recognize that the agency faces some statutory constraints, we ask the CMS find

appropriate mechanisms so that researchers and policy makers can have access to the tools they need to make informed analysis of program performance.

Prohibition on billing Qualified Medicare Beneficiary (QMB) individuals for Medicare cost-sharing -- Part III(F)

We very much appreciate that the proposal includes a strong reminder to physicians of the prohibition on illegal balance billing of low income beneficiaries, both in fee-for-service and in Medicare Advantage. We also recognize and support the multiple efforts that CMS has made to highlight this persistent problem, particularly through the work of the Medicare-Medicaid Coordination Office. Balance billing continues to be a significant problem for beneficiaries, reducing access to care and increasing financial instability, and we hope CMS will continue to use multiple avenues to make sure that the prohibitions are well understood by providers and that beneficiaries are protected.

Medicare Advantage provider enrollment -- Part III(I)

We ask for clarification of how this provision would affect providers of supplemental services that are not covered by Medicare Part A or Part B. One example is dental services, which in many cases are part of a supplemental services package. Would CMS require that dentists who are in-network with Medicare Advantage plans be enrolled in Medicare?

We recognize that eventually many dentists will enroll in Medicare because of the Part D prescriber enrollment requirements, enforcement of which has been delayed. We expect however that lack of information and/or a reluctance of many dentists to engage with Medicare could mean a significant lag in dentist enrollment, which could negatively affect the pool of dentists available to Medicare Advantage plan enrollees and thus their access to oral health services. We ask CMS to carefully consider whether extending its proposed Medicare enrollment requirement to dentists and other affected supplemental service providers is in the best interest of beneficiaries. To ensure continued access to oral health and other supplemental services, we suggest that CMS consider delaying any enrollment requirement for providers of supplemental services until CMS gains experience and understands the effects of the enrollment requirement on Part A and Part B providers, and can make any adjustments needed to ensure access.

Thank you for the opportunity to submit comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,

Jennifer Goldberg
Directing Attorney