

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

September 10, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8011

Baltimore, MD 21244-1850

Submitted electronically via Regulations.gov

RE: CMS-1693-P: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Justice in Aging appreciates the opportunity to comment on the above referenced proposed rule and accompanying requests for information. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use 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 and populations that have traditionally lacked legal protection such as women, people of color, LGBT individuals, and people with limited English proficiency.

Our comments below focus on the Evaluation and Management Documentation and Payment, the Quality Payment Program, and the Requests for Information on Price Transparency and Interoperability.

A. Evaluation and Management (E/M) Documentation and Payment

CMS is proposing to condense payment for office and outpatient visits and develop a single set of relative value units (RVUs) under the Physician Fee Schedule (PFS) for Level 2 through Level 5 E/M for both office-based and outpatient visits for new and established patients. Under the proposal, payment for office visits Levels 2 through 5 would be blended into a single \$135 payment for new patients and a single \$93 payment for established patients.

The proposed changes attempt to solve the longstanding problems of burdensome documentation guidelines and upcoding under the Medicare Physician Fee Schedule. Although we agree that these problems need to be addressed, we do not support CMS's proposed approach.

First, the proposed changes to E/M documentation and payment would create barriers to care, especially for low-income beneficiaries and those dually eligible for Medicaid, as well as beneficiaries with limited English proficiency, disabilities, or any complex healthcare needs. These individuals already face difficulties finding providers who will treat them because of the

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

perverse incentives in the fee schedule that reward doctors for volume of patients and services rather than time and quality.

These access problems are even more pronounced for Qualified Medicare Beneficiaries who are protected from improper billing for Medicare services. Because providers are prohibited from collecting Medicare copays from QMBs and rarely receive any additional payment from state Medicaid programs, they usually only receive 80% of what they would be reimbursed for a non-QMB.¹ The proposed fee schedule would further disincentivize physicians from accepting QMB patients. The prohibition on improper billing is a critical consumer protection that removes a barrier to care for QMBs, but it is not useful if providers are unwilling to see QMBs at all because the payment system discriminates against QMBs and others with more complex needs.

Under the proposed rule, Medicare would reimburse physicians the same amount, regardless of how much time the physician spends with the patient or the effort and personalized attention the patient's condition(s) and circumstances demand. This flat per visit payment structure not only incentivizes physicians to spend less time with a patient in order to see as many patients as possible, but it fails to promote person-centered care. This means Medicare beneficiaries who have complex needs or conditions that require the physician's time and would benefit the most from attention to person-centered care planning will have more difficulty finding doctors who will treat them or getting the time with the doctor that they need. This will burden many Medicare beneficiaries. Nearly 9 out of 10 adults age 65 and older have at least one chronic condition: over half have high blood pressure, nearly a quarter have diabetes, and more than 10% suffer from cancer or mental illness.² Moreover, among Medicare beneficiaries, over a third have a functional impairment or a cognitive/mental impairment; 30% have five or more chronic conditions; and over a quarter are in fair/poor health.³

Similarly, individuals with limited English proficiency or a disability might not be able to find a doctor willing to make the effort to use an interpreter or make the necessary accommodations for effective care.

The proposed fee schedule fails to acknowledge these needs and is inconsistent with CMS's goals of fostering a culture of person-centered care and addressing health disparities. At the same time that the agency is focusing on measurement areas that include care that is personalized and aligned with patient goals, includes patients' experience of care, advances equity of care, and increases community engagement, CMS is proposing a fee schedule design that fails to take into account the time and effort needed to achieve those goals. The proposed fee schedule would have the effect of exacerbating health inequities and work at cross purposes with the Meaningful Measures Initiative.

¹ CMS, Access to Care Issues Among Qualified Medicare Beneficiaries (July 2015), available at www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Access_to_Care_Issues_Among_Qualified_Medicare_Beneficiaries.pdf

² AARP Public Policy Institute, *Chronic Care: A Call to Action for Health Reform* 11–12, 16 (March 2009), available at www.aarp.org/health/medicare-insurance/info-03-2009/beyond_50_hcr.html.

³ Kaiser Family Foundation, *An Overview of Medicare* (Nov. 22, 2017), available at www.kff.org/medicare/issue-brief/an-overview-of-medicare/.

Furthermore, paying providers the same fee, regardless of the time spent with a patient or special factors, also incentivizes providers to increase the number of visits with a patient and to address concerns separately that could be addressed during a single longer visit. The rule also proposes to reduce payment for multiple procedures or visits by the same physician or a physician in the same practice in a single day. These incentives, which will require patients to make multiple appointments on different days, subject beneficiaries to additional Part B cost-sharing because they will be charged for multiple visits instead of one. Additionally, they create a barrier for low-income seniors and people with disabilities who need transportation and other assistance to attend appointments. These individuals may not be able to find or afford the necessary transportation and caregiving multiple times in a week or month. And their health conditions or disability may limit their ability to leave their home more frequently. For dual eligible beneficiaries relying on the Medicaid Non-Emergency Transportation (NEMT) to get to appointments, the proposed rule would impose more costs to state Medicaid programs and, even more importantly, tax a system that already struggles to meet current needs.⁴ Person-centered care ensures an individual's needs are met and minimizes burden on the individual. This proposal would have the opposite effect.

Second, the proposal would not address the existing perverse incentives found in the Medicare Physician Fee schedule that encourage physicians to increase the volume of services, resulting in increased spending and often poor health outcomes for patients. In fact, it would exacerbate the problem by financially rewarding physicians who spend the least time with patients and schedule the most separate appointments. Rather, changes to the Medicare Physician Fee Schedule should focus on efforts to improve the quality of services by holding providers accountable for the quality, cost and outcomes. Finally, because this change has not been thoroughly studied or tested, this change would be made system-wide without evidence that there will also be an improvement in quality and health outcomes.

B. Updates to the Quality Payment Program--Alignment with Meaningful Measures Initiative

We strongly support CMS's stated goal of addressing cross-cutting criteria of eliminating disparities, as well as its measurement areas that include care that is personalized and aligned with patient goals, includes patients' experience of care, advances equity of care, and increases community engagement. Explicitly including health equity in the QPP is consistent with the Department of Health and Human Services Action Plan to Reduce Racial and Ethnic Health Disparities⁵ and CMS' Health Equity Plan.⁶

⁴ See, e.g., Justice in Aging, *Medicaid Non-Emergency Medical Transportation : An Overlooked Lifeline for Older Adults* (October 2016) available at www.justiceinaging.org/wp-content/uploads/2016/11/NEMT-Medicaid-Transportation.pdf; Center for Health Care Strategies, *Disruptive Innovation in Medicaid Non-Emergency Transportation* (Feb. 2017), available at www.chcs.org/media/NEMT-Issue-Brief-022317.pdf.

⁵ U.S. Department of Health & Human Services, *Action Plan to Reduce Racial and Ethnic Health Disparities* (2011), available at http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf.

⁶ CMS, *Equity Plan for Improving Quality in Medicare* (2015), available at www.cms.gov/About-CMS/Agency-Information/OMH/OMH_Dwnld-CMS_EquityPlanforMedicare_090615.pdf.

In its 2015 National Quality and Disparities Report, the Agency for Healthcare Research and Quality (AHRQ) noted that disparities in health care quality persist based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location. Specifically, about 60% of quality measures show that people in poor households received worse care than people in high-income households. About 40% of quality measures show that Blacks, Hispanics, and American Indians and Alaska Natives and about 20% show that Asians received worse care than Whites. Disparities were common for Person-Centered Care and Care Coordination, and improvement in care coordination lagged behind other priorities.⁷

Accordingly, we strongly support the inclusion of specific Improvement Activities related to health equity in the Merit-Based Incentive Payment System (MIPS). We support the inclusion of the criteria "importance of an activity that could lead to improvement in practice to reduce health care disparities" in the Annual Call for Improvement Activities. Moreover, we suggest that elements of existing nationally-recognized quality and practice transformation standards, such as the National Committee for Quality Assurance (NCQA) PCMH recognition,⁸ could be considered as new Improvement Activities. For example, a practice could demonstrate that it has met specific NCQA PCMH elements and factors as a MIPS Improvement Activity, including knowing and managing patients' diversity, language, comprehensive health assessment, social determinants of health, population needs, patient materials, and assessing health disparities using performance data stratified for vulnerable populations.

In developing and aligning these measures and improvement activities, we urge CMS to use a broad definition of health equity and underserved populations. We support the proposed rule's definition of health equity populations as including persons with behavioral health conditions, racial and ethnic minorities, sexual and gender minorities, people with disabilities, people living in rural areas, and people in geographic HPSAs. However, we urge CMS to also explicitly include persons with limited English proficiency, persons with primary languages in addition to English, persons with lower levels of health literacy, persons living in Medically Underserved Areas (MUAs), and persons with other relevant social and behavioral characteristics identified by the Institute of Medicine.⁹

We urge CMS to support the identification and/or development of measures to address measurement gaps, including qualitative measures for family and caregiver experience of care and measures of community engagement and collaboration and partnerships with other providers outside of health care systems. While we support the addition of the four patient-

⁷ AHRQ, *2015 National Healthcare Quality and Disparities Report & 5th Anniversary Update on the National Quality Strategy: Quality and Disparities in Quality of Health Care*, available at www.ahrq.gov/research/findings/nhqdr/nhqdr15/quality.html.

⁸ NCQA, Patient-Centered Medical Home Recognition Evaluation Program, www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

⁹ Institute of Medicine, *Capturing Social and Behavioral Domains in Electronic Health Records, Part 2* (2014), available at www.nationalacademies.org/hmd/Activities/PublicHealth/SocialDeterminantsEHR.aspx.

reported outcome measures in MIPS, we are disappointed in the absence of meaningful measures for diverse and medically underserved patients' experience of care.

We also encourage CMS to work closely with the AHRQ to further develop the Consumer Assessment of Health Providers and Systems (CAHPS) surveys for use in MIPS and in APMs. We recommend the incorporation of the Patient-Centered Medical Home, Health Literacy, and Cultural Competence Supplemental Item Sets into the Clinician and Group Survey in order to measure patient experience of care more comprehensively.¹⁰ This is an opportunity for CMS and AHRQ to model and lead the alignment and harmonization of measures across health care settings, and the coordination and sharing of work across measure developers and stewards.

Finally, we commend CMS for making the Physician Quality Reporting System CAHPS survey available in Spanish, Cantonese, Mandarin, Korean, Vietnamese, and Russian¹¹ and the Medicare Accountable Care Organization CAHPS survey available in Spanish, Cantonese, Mandarin, Korean, Vietnamese, Russian, and Portuguese.¹² We strongly encourage CMS and AHRQ to work together to develop validated translations of all CAHPS surveys used in MIPS and APMs in at least the top ten primary languages among Medicare beneficiaries.

C. Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange

CMS is requesting feedback on how best to accomplish the goal of fully interoperable health IT and EHR systems for Medicare- and Medicaid-participating providers and suppliers, including possible revisions to the patient health and safety requirements for hospitals and other providers. All the requirements for hospitals and LTC facilities set out in 42 CFR 483.15(c)(2)(iii) are critically important in ensuring safe transitions for beneficiaries leaving those facilities. We strongly endorse those requirements and urge CMS to design its interoperability requirements in a way that supports early, full and effective implementation of those requirements.

We appreciate CMS' efforts in developing Blue Button 2.0 and its efforts to provide beneficiaries with health information in ways that they can understand and use. We urge CMS to ensure that this and other EHR and health IT systems are designed from the outset to be fully accessible to individuals with disabilities and individuals with limited English proficiency. Integrating accessibility at the outset is the most effective way to ensure that all beneficiaries are able to see their health information and participate fully in their care. In creating regulations and guidance around interoperability and access and in designing consumer-facing platforms, CMS should work closely with the disability community and provide ample opportunity for field testing and feedback from consumers, particularly those with disabilities and those with limited English proficiency.

¹⁰ AHRQ, Consumer Assessment of Health Providers and Systems, Supplemental Items, www.cahps.ahrq.gov/surveys-guidance/item-sets/index.html. We note that NQF has endorsed both the Cultural Competency and Health Literacy Supplemental Item Sets, but neither has been widely used.

¹¹ CAHPS for Physician Quality Reporting System (PQRS) Survey, www.pqrscahps.org/en/survey-instruments/

¹² CAHPS Survey for Accountable Care Organizations Participating in Medicare Initiatives, <http://acocahps.cms.gov/en/faqs/faqs-for-vendors/>

D. Request for Information on Price Transparency

CMS requested comments on how to provide better price transparency and improve beneficiary access to provider and supplier charge information. The request discusses the issue in the context of broader efforts by the agency to use transparency and consumer-friendly communications to address rising concerns about “surprise billing” faced by beneficiaries.

Justice in Aging supports price transparency in health care. Transparency alone, however, does not fully address surprise billing. Without other protections, attempts to address surprise billing or other issues with health care access and costs through price transparency alone puts additional and unfair burdens on consumers to navigate even more information in an already complex system.

The Medicare “limiting charge” policy is one critical piece of surprise billing protection for Medicare beneficiaries and we urge CMS to maintain this important safeguard. In Medicare Advantage, the requirement that plans only charge in-network co-insurance for emergency services, even if providers are out-of-network, also provides some important, though limited protection.

Particularly for Medicare Advantage plan members, however, much more is needed to address the underlying cause of surprise billing, a delivery system design in which services embedded in in-network facilities are provided by out-of-network providers not chosen by or even known to the beneficiary. When beneficiaries visit in-network facilities, it is impossible and unworkable for them to navigate the labyrinth of contracted doctors, radiologists, anesthesiologists and other providers to determine which specific providers who serve patients in the in-network facilities are themselves out-of-network. Further, the pharmacy section of facilities that are otherwise in-network may not be considered in-network for purposes of Part D drugs that an individual may need during an out-patient or observation visit. These issues exist whether or not a situation meets the definition of an “emergency.” This situation is simply irrational, and providing a beneficiary, who likely is sick and under stress, with a piece of paper describing the situation and predicting the charges that may ensue, does not provide sufficient billing protections for the older adults and people with disabilities who rely on Medicare.

It is imperative that CMS impose order on this situation so that Medicare Advantage beneficiaries may always be confident that when they follow the rules and choose an in-network facility and in-network treating provider, there will be no surprise bills and all the “behind the scenes” providers whom they had no role in choosing will be treated as in-network. There are different ways to achieve this result by placing the responsibility on the facility, the plan or some combination. But CMS needs to address the issue head-on and ensure that the responsibility lies with the facility/provider/health plan and not the beneficiary. Merely being transparent about a hopelessly confusing and unfair situation is insufficient. With a third of Medicare beneficiaries in Medicare Advantage plans and that number growing, it is imperative that CMS ensure that the operation of the Medicare Advantage program is coherent and fair to beneficiaries.

The RFI also asks how CMS can help beneficiaries better understand how co-pays and co-insurance are applied to services and what state-specific requirements or programs help

educate Medigap patients about their out-of-pocket costs prior to receipt of care. While we support engaging plans and providers in educating Medicare beneficiaries and providing them with complete and accurate information about their out-of-pocket costs, we cannot overstate the important role of in-person assistance available through the State Health Insurance Assistance Programs (SHIPs). Medicare beneficiaries are faced with an enormous amount of information about their coverage and often need assistance with understanding that information and navigating their options, whether they get coverage through Original Medicare and Medigap or through Medicare Advantage. This assistance is most effective if it is from a neutral party who can provide personalized attention. The SHIPs offer this and should be expanded to ensure they can reach all Medicare beneficiaries.

We also recommend CMS invest in greatly improving Plan Finder and other tools that can provide customized information about coverage and costs. These sorts of tools not only help beneficiaries who are trying to navigate coverage on their own, but also are a valuable asset for SHIP counselors and others who are assisting beneficiaries.

E. Conclusion

Thank you for considering our comments. If any questions arise concerning this submission, please contact me at jgoldberg@justiceinaging.org.

Sincerely,



Jennifer Goldberg
Directing Attorney