

October 5, 2020

Ms. Seema Verma  
Administrator, Centers for Medicare and Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, SW  
Washington, DC 20201

**Re: CMS-1734-P  
Medicare Program; CY 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD plan; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; and Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy**

Dear Ms. Verma,

On behalf of the Coalition to Transform Advanced Care (C-TAC), we appreciate the opportunity to provide comments on this proposed rule in regard to its effects on those living with advanced illness.

C-TAC is a national non-partisan, not-for-profit organization dedicated to ensuring that all those living with advanced illness, especially the sickest and most vulnerable, receive comprehensive, high-quality, person- and family-centered care that is consistent with their goals and values and honors their dignity. C-TAC is composed of over 140 national and regional organizations including patient and consumer advocacy groups, practitioners, health plans, faith-based and community organizations, and others who share a common vision of improving care for advanced illness in the U.S.

### **Telehealth services**

We support the following proposed telehealth changes with specific comments below. We would also encourage CMS to work with providers to ensure that telehealth is used when it is both clinically appropriate *and* in line with the patient's wishes and needs. While we support access to telehealth for those with advanced illness, for whom travel

to clinic appointments can be burdensome to them or their loved ones, we are also concerned that the pendulum not shift in the other direction, such that telehealth services do not come to replace clinical interventions for those with advanced illness that should in fact be delivered in-person, and/or such that a patient remains free to choose the care modality (i.e. virtual or face-to-face) that they feel is appropriate and best-suited to meet their unique needs. People with advanced illness have complicated medical and social situations and sometimes need literal hands on care by a provider that cannot be done via telehealth.

- Telehealth changes- Category 1 service additions- We support the addition of services to the telehealth list on a Category 1 basis to identify or monitor services that should or could become permanently available to use via telehealth. The particular services on the Category 1 list, Visit Complexity Associated with Certain Office/Outpatient E/Ms, Prolonged Services, Neurobehavioral Status Exam, Care Planning for Patients with Cognitive Impairment, Domiciliary, Rest, Home, or Custodial Care Services, and Home Visits, are of use to teams providing care to those with advanced illness and allowing them to be permanently billable via telehealth will be helpful. We would also recommend that CMS should include all levels of service for the home and domiciliary CPT code range under Category 1 for CY 2021, New Patient Home Visit CPT range 99341-99345 and Established Patient Home Visit Range CPT 99347-99350 and New Patient Domiciliary CPT range 99324-99328 and Established Patient Domiciliary Range CPT 99334-99337. This will ensure that those with advanced illness have continued access to telehealth services beyond the pandemic if and/or when there is a legislative change to revise the originating site and geographic restrictions so patients can receive care where they are.

We also request clarification on other services whose telehealth status was changed during the pandemic, but which are not in these categories. We speak specifically about the two advance care planning CPT codes, 99497 and 99498. These appear on a list CMS published back in April<sup>i</sup> as being already allowable via telehealth and as being audio-only, but that list does not clarify whether their via audio-only use, or with the patient's home as an allowable origination site, are permanent or not. We have advocated in the past for both the home as an originating site and audio-only as these have been two of the most helpful changes made in the pandemic.

However, these changes are not only useful in this crisis but will be on an on-going basis. If patients can receive telehealth services in their homes, then we will need to also allow providers the flexibility to use readily available modalities to interact with them there. Some beneficiaries lack access to smart phones, computers, and even broadband or cell phone service, and we therefore recommend allowing audio-only telehealth services to be permanent. This is also an equity issue and those in lower socioeconomic groups should not be penalized for not having access to technology with video capabilities<sup>ii</sup>.

- Nursing facility Telehealth frequency- We support the change from limiting visit frequency from once every 30 days to now once every 3 days and would ask that CMS consider removing visit limitations altogether. The residents our providers see in these facilities are usually frail and medically fragile. Being able to visit them as often as needed via telehealth allows for assessment and reassessment as often as is necessary to address a new or acute issue. More frequent telehealth visits could identify, treat, and avoid emergency department (ED) visits or an escalating health crises that could result in an avoidable hospitalization. We do recognize, however, the need to monitor such loosened frequency limits to ensure they are being used appropriately.
- Other team member assessment/management services via telehealth- We support this proposed change as well since the kind of care our providers provide to those with advanced illness is team-based. Allowing other team members to furnish brief online assessment and management services as well as virtual check-ins and remote evaluation could improve patient care and also avoid unnecessary ED or hospital visits.
- Additional telehealth opportunities- We strongly support continuing to allow a patient's home as a qualifying originating site, although we recognize that making this change permanent will require a statutory solution. As noted above, we also strongly support efforts to make Medicare ACP services allowable via audio-only technology beyond the pandemic. We also support CMS developing coding and payment for a service similar to the virtual check-in but for a longer unit of time and subsequently with a higher value. While we have no recommendations on the duration of the services and the resources in both work and practice expense associated with furnishing this service, we know that such a check-in with a person living with advanced illness could need to be 30 minutes long or even longer. We also recommend that it be PFS payment policy permanently since the barriers to accessing in-person and/or video-only care existed before the pandemic and will continue to exist after it.
- Remote Physiologic Monitoring (RPM) Services- Allowing auxiliary personnel to furnish CPT codes 99453 and 99454 services permanently under a physician or non-physician practitioner's (NPP) supervision is helpful as ideally care for those with advanced illness is team-based and allowing some team members to furnish these supervised services is helpful. While we support limiting such services to an established patient, we would ask that the consent process be streamlined so as to not be burdensome to either the patient or the provider/practice.

We also understand that after the pandemic, CMS will revert to requiring that these services be furnished to established patients and require that 16 days of data be collected within 30 days to meet the requirements for CPT codes 99453 and 99454. We have an issue with requiring 16 days of data to be collected within a 30-day period and urge CMS to adopt a different standard that takes into account

populations with cognitive and physical issues, such as those with dementia and frailty. Unless a device is continuously running, it is unlikely to be able to collect enough data to meet this requirement, especially for the advanced illness patient population. These patients often require assistance with activities of daily living and may either forget to put or turn on their medical device on a consistent basis within a 30-day period. However, the data collected through RPM is still valuable and informative for patient care and monitoring, and still needs to remain an option for this population.

### **Payment for Office/Outpatient Evaluation and Management (E/M) and Analogous Visits**

We appreciate the rebalancing to increase the value of office-based E/M codes 4 and 5, since these are the code levels often used when caring for patients with advanced illness due to their multiple issues and medical complexity. However, we also understand that this payment increase is being balanced by a substantial decrease (roughly 8%) in the rates for other PFS codes, including those for home visits (CPT codes 99341-99350) and domiciliary visits (CPT codes 99324-99337). While we acknowledge that a fee schedule rebalancing must be carried out in a budget-neutral way, we feel that reducing payment rates for home-based care at a time when it has never been more important is problematic and has the potential to disincentivize care in the setting that most individuals with advanced illness prefer. Both patients and providers have learned the benefit of home-based care during the pandemic and that will not change for those living with advanced illness when this health emergency ends. We therefore suggest that CMS find other ways to balance the E/M increases. We would also suggest that the RVUs for advance care planning and complex care management be reviewed and possibly increased. These can be labor-intensive services and should be valued in such a way as to promote their use.

### **Supervision of Diagnostic tests by Certain Nonphysician Practitioners**

We support this expansion of these practitioners' scope of practice. Many of the teams providing care to those with advanced illness include NPPs and allowing them to supervise any needed diagnostic testing will increase both access to and efficiency of patient care.

### **Pharmacists Providing Services Incident to Physicians' Services**

We are also in support of allowing pharmacists to bill incident to physician services. Teams caring for those with advanced illness fortunate enough to include pharmacists on them have learned that such pharmacists can sometimes be the most effective team member to see the patient for services like medication reconciliation and even medication for symptom management. Allowing this billing change will let interdisciplinary teams better deploy pharmacists and improve care delivery.

### **MSSP- CAHPS**

We support the proposed changes to integrate telehealth item into the CAHPS for MIPS Survey, to include a reference to care received in telehealth settings. We also support changes for performance year 2020 to provide automatic full credit for CAHPS patient experience of care surveys. These are all needed changes. However, we would recommend that CMS also address the steadily declining CAHPS response rate since at some point it will

be too low to be meaningful, along with the fact that it does not accurately represent the experience of diverse populations<sup>iii</sup>. Both are important enough that there needs to be a specific effort to address them going forward. We would be happy to participate in such a process.

### **MSSP – Advance care planning**

We are always gratified to see advance care planning addressed in Medicare regulations. In this case, we appreciate the concern that codes billed in an inpatient setting in the beneficiary assignment methodology may result in beneficiaries being assigned to the ACO based on inpatient care, rather than on primary care. Our only concern is that removing them from the definition of primary care services not inadvertently discourage them from taking place. Evidence shows that usage of these billing codes is low<sup>iv</sup> while most Americans do not have advance directives<sup>v</sup>. Therefore, this process should be promoted, not in any way diminished.

### **New Specialty Measures Sets and Modifications to Previously Finalized Specialty Measure Sets Finalized for the 2023 MIPS Payment Year and Future Years- Clinical Social Work**

We appreciate the recognition of the important role clinical social workers play in patient care. This is particularly the case for those with advanced illness who often have significant social issues in addition to multiple medical ones. We also appreciate the addition of advance care planning on this specialty measure set since clinical social workers are trained to have counseling and other important conversations with patients and so are often very effective at discussing advance care planning<sup>vi</sup>. We would also recommend that given the inclusion of advance care planning on this measure set, that license clinical social workers be added to the list of those Medicare providers who can bill CPT codes 99497 and 99498 for advance care planning conversations.

Thank you for the opportunity to comment on this proposed rule. If you have any questions, please contact Dr. Marian Grant, Senior Regulatory Advisor, C-TAC, at 443-742-8872 or [mgrant@thectac.org](mailto:mgrant@thectac.org).

Sincerely,

*Marian Grant*

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<sup>i</sup> <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

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- ii [https://www.modernhealthcare.com/information-technology/tech-access-tied-health-disparities-emblemhealth-finds?utm\\_source=modern-healthcare-covid-19-coverage&utm\\_medium=email&utm\\_campaign=20200706&utm\\_content=article5-readmore](https://www.modernhealthcare.com/information-technology/tech-access-tied-health-disparities-emblemhealth-finds?utm_source=modern-healthcare-covid-19-coverage&utm_medium=email&utm_campaign=20200706&utm_content=article5-readmore)
- iii <https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/about-cahps/research/survey-administration-literature-review.pdf>
- iv <https://onlinelibrary.wiley.com/doi/abs/10.1002/hast.848>
- v <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0175>
- vi Wang, C., Chan, C.L.W. & Chow, A.Y.M. Social workers' involvement in advance care planning: a systematic narrative review. *BMC Palliat Care* **17**, 5 (2018). <https://doi.org/10.1186/s12904-017-0218-8>