Telehealth

The proposed rule notes the conditions that must be met to receive Medicare payment for telehealth services. These conditions include that the service must be on the list of Medicare telehealth services and:

- The service must be furnished via an interactive telecommunications system
- The service must be furnished by a physician or other authorized practitioner
- The service must be furnished to an eligible telehealth individual
- The individual receiving the service must be located in a telehealth originating site

When all of these conditions are met, Medicare pays a facility fee to the originating site and makes a separate payment to the distant site practitioner furnishing the service.

The Centers for Medicare & Medicaid Services (CMS) is proposing several new services to the list of Medicare payable telehealth services for calendar year (CY) 2017 including:

- End-stage renal-disease related services for dialysis less than a full month of service, per day
- Advanced care planning
- Critical care consultations

While HAP is pleased with Medicare’s willingness to increase the number of payable telehealth services, the limited nature of the expansion continues to constrain the broad adoption of cost-effective health technology. HAP urges the agency to take a more expansive approach to the coverage for telehealth services similar to Medicaid. It is also important to note that, in particular, the underlying condition that an individual must be located in a telehealth originating site is and will increasingly be problematic as technology improves and beneficiaries demand to receive care as conveniently as possible.

New Payment for Primary Care, Care Management, and Behavioral Health

Primary Care

The rule proposes two new Current Procedural Terminology (CPT) codes and payment for two additional CPT codes (99358 and 99359 for prolonged evaluation and management services before and/or after direct patient care) acknowledging that current reimbursed evaluation and management (E/M) codes do not reflect all of the services and resources necessary to provide comprehensive, coordinated care for complex Medicare patients.
Specifically:

- GPPP6 will cover time spent assessing and creating a care plan for patients with cognitive impairment
- GDDD1 will pay for resource-intensive services for patients who require use of specialized mobility-assistive technology during an E/M visit

HAP supports this proposal and appreciates CMS’ consideration for the services and resources required to provide much needed care management for the Medicare beneficiary population.

Care Management

CMS also proposed several changes to chronic care management (CCM) payment including payment for two new complex CCM service codes, 99487 and 99489. Rules for billing these new codes are similar to those of the existing CCM code 99490 and include billing once per calendar month, by only one practitioner. Additionally, in response to the significant stakeholder feedback received since implementing payment for CCM in the CY 2015 Physician Fee Schedule (PFS) regarding the burdensome billing requirements, CMS proposes the following changes to the CCM scope of service requirements:

- An initiating visit must precede billing for CCM services only for new patients or patients not seen within a year, rather than for all beneficiaries receiving CCM services.
- Removal of the requirement that practices providing CCM services must make the care plan available remotely to other professionals providing CCM services after hours, and replacement with the requirement that the practice must provide the means to contact health care professionals in the practice to address urgent needs, regardless of the time of day or day of the week.
- Removal of the requirement that access to the electronic care plan be available on a 24/7 basis but, instead, require timely electronic sharing of care plan information within and outside the billing practices.
- Modification to the requirement that practitioners must create and exchange/transmit continuity of care documents in a timely manner. CMS proposes removing the specific requirement on how the exchange or transmittal must occur.
- Modification to the requirement that a beneficiary or caregiver must receive a hard copy or electronic copy of the care plan. CMS proposes removing the specification of the format.
- Removal of the requirement for written agreement from the beneficiary to receive CCM services. Instead, the practitioner must document that information was shared regarding CCM services and whether the beneficiary accepted or declined the services.
- Removal of the requirement for use of a qualifying certified electronic health record (EHR) for documentation.
While HAP appreciates CMS’ efforts to minimize the administrative burden of providing CCM services, the proposals still do not sufficiently account for the billing complexities for these codes, which is one of the most significant reasons for their underuse in actual practice. HAP encourages CMS to attempt to alleviate the complexities associated with billing for these codes in the final rule to better enable providers to be paid for the services they are providing.

**Behavioral Health**

CMS also proposes three new G-codes to pay for services under the Psychiatric Collaborative Care Model (CoCM). The CoCM promotes the collaboration of a primary care provider and behavioral health care manager with a psychiatric consultant.

An additional G-code is also proposed to provide payment for primary care practices treating patients with behavioral health conditions under behavioral health integration models other than the CoCM.

**HAP applauds CMS’ continued commitment to improving care for Medicare beneficiaries with behavioral health conditions. We support CMS’ proposal to improve payment for behavioral health integration in the primary care setting. Recognizing that CMS has already finalized CPT codes for such services in future calendar years, we appreciate CMS’ proposal to make payment available for these services in CY 2017 through temporary G-codes—thereby improving access to essential services in the near-term.**

Pennsylvania hospitals welcome the opportunity to expand access to effective, evidence-based services and appreciate CMS’ acknowledgment that providing high-quality care for Medicare beneficiaries with behavioral health conditions—care that is truly collaborative and integrated—requires resource commitment overlooked in the existing outpatient payment structure. We encourage CMS to continue to look for additional opportunities to provide appropriate payment that will encourage greater integration of physical and behavioral health services.

**Appropriate Use Criteria (AUC)—Imaging**

CMS began implementation of AUC for advanced imaging with the CY 2016 PFS rule by defining AUC and specifying the process for developing them, including the requirement of physicians ordering certain imaging services (magnetic resonance, computed tomography, nuclear medicine, and positron emission tomography imaging services) to consult appropriate use criteria using a qualified clinical decision support mechanism (CDSM). CMS also states its intent to use CY 2016 to work through the details of the program for inclusion in CY 2017’s rulemaking process.
The CY 2017 proposed rule proposes the definition of and requirements for CDSMs as well as the timeline for this policy. Additionally, CMS proposes eight clinical areas for AUC implementation—chest pain, abdominal pain, headache, low back pain, suspected stroke, altered mental status, cancer of the lung, and cervical or neck pain. These clinical areas accounted for approximately 40 percent of Part B advanced diagnostic imaging services in 2014.

The rule also proposes exceptions including:
- Imaging for patients with an emergency medical condition
- Inpatients for whom payment is made under Part A
- Ordering professionals who the Secretary determines on a case-by-case basis that consultation with AUC would result in a significant hardship (defined as those who are granted a hardship exception for purposes of the Medicare EHR Incentive Program)

The proposed rule also notes that it will not meet the statutory requirement that ordering professionals must consult with qualified CDSM effective January 1, 2107. The timeline proposes that qualified CDSMs will begin being specified on June 30, 2107, with full implementation of the policy possible January 1, 2018.

**While HAP supports CMS’ step-wise implementation approach, it continues to have concern with the impact of this policy on hospitals. While hospitals will bear the financial ramifications if there is failure to consult AUC, they have little control over ordering professionals. HAP appreciates the CMS proposal to limit implementation to the eight clinical areas above.**

**Changes to Quality Programs**

*Physician Quality Reporting System*

CMS proposed only minor changes to the Physician Quality Reporting System (PQRS) and value-based payment modifier (M) programs, as these programs wind down by the end of CY 2018 and transition to the Quality Payment Program (QPP).

One change proposed is relevant for eligible professionals participating in a Medicare Shared Savings Program (MSSP). Currently, eligible professionals are not permitted to participate in PQRS separately from their ACO and, thus, are penalized in the event that an ACO fails to submit quality data. The proposed rule would allow eligible professionals within the MSSP to report quality data for purposes of PQRS and use this data should their MSSP ACO fail to report.

**HAP supports the flexibility CMS is proposing by allowing eligible professionals to report independently of the MSSP ACO in the event that their ACOs fail to submit quality data.**
Physician Value-based Payment Modifier (VM)

Similar to the PQRS proposal, CMS proposes that eligible professionals may use their separately reported PQRS data for VM performance determination in the event that an ACO fails to report performance.

CMS also proposes revisions to the informal review process for VM performance determination. Currently, policies provide that CMS would re-calculate quality and cost composite scores when the informal review process found errors in calculations. This process has proved to be operationally complex per CMS and the following “updates” were proposed:

- Providers that successfully appeal a determination of being in Category 2 (i.e., did not submit PQRS data) for VM, will have their quality composite score reclassified from “low” to “average”. CMS will also calculate a cost composite score for these groups.
- If an informal review finds that CMS did not include some of the eligible professionals that successfully met PQRS reporting requirements within a TIN, CMS will re-class “low quality” performers as “average quality”; leave the quality score unchanged for “average and high quality” performers; and allow the initial cost composite to remain unchanged.
- In the event of systemic quality data issues, CMS proposes classifying providers as “average quality”, re-classifying “high cost” providers as “average cost”, and leave “average or low cost” providers unchanged.
- In the event of systemic claims data issues, CMS proposes re-classifying “high cost/low quality” providers as “average” for both cost and quality and providers classified as “average or high” quality and “average or low” cost will retain their initial classification.

HAP agrees that CMS should not penalize providers unfairly due to the complexity of the reporting process. Should an error on CMS’ part occur, it would be reasonable for CMS to move low cost or quality providers to an average category, thereby eliminating a potentially erroneous negative value. HAP urges CMS to assure that it attempts to prevent any systemic data issues with quality or claims data to prevent confusion with the VM program.