



August 29, 2014

Marilyn B. Tavenner
Administrator, Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Attn: CMS-1612-P
Mail Stop C4-26-05, 7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code-CMS-1612-P; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule; (July 11, 2014)

Dear Administrator Tavenner:

The American Academy of Pediatrics (AAP) appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on the Revisions to Payment Policies Under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015, published in the July 11, 2014 *Federal Register*. Although very few pediatric services are included in the Medicare program, payment policies introduced in Medicare are frequently adopted by the Medicaid program and eventually by private payers. Therefore, the Academy offers these comments on the proposed rule to ensure that new policies appropriately accommodate the unique aspects of health care services delivered by primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists.

Consideration for the Final Rule: New/Revised CPT Codes

While new CPT codes are not included in the proposed rule, the Academy expects that in its final rule, CMS will accept the RUC's recommended work relative value units (wRVUs) for the following codes:

Neonatal Selective Head and Total Body Hypothermia = 4.50 wRVUs

These relative values were recommended by the RUC during its January 2014 meeting, where survey results were analyzed to ensure that the recommended work values accurately account for physician resources expended with the typical patient.

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Topical Application of Fluoride Varnish = 0.20 wRVUs

These relative values were recommended by the RUC during its April 2014 meeting, where survey results were analyzed to ensure that the recommended work values accurately account for physician resources expended with the typical patient.

Brief Behavioral Assessment

Direct practice expense (PE) inputs were recommended for this new code during the April 2014 RUC meeting.

CPT/RUC Timeline

As outlined in the August 13, 2014 multispecialty sign-on letter to CMS, the Academy supports the American Medical Association (AMA) alternative proposal for modifications in CPT/RUC workflow to accommodate publication in the Proposed Rule to ensure that new technology is described and valued in an efficient and timely manner. While the CMS plan calls for changes as soon as 2016, the AMA proposal requests implementation of the new timeline and procedures for 2017.

If CMS adopts the AMA proposal, it will eliminate the need for CMS to create G codes, which essentially duplicate CPT codes. We believe that CMS' G code proposal is entirely unworkable and should not be considered in finalizing the new process. The creation and adoption of temporary G codes would unnecessarily add to the administrative burden of physicians who would be tasked with having to learn and implement new codes to be replaced within a relatively short period. When this applies to large families of codes, the burden is even greater, as is the risk for coding errors. Moreover, this threatens to create a situation of parallel but distinct coding between Medicare and private payers, as private payers are likely to implement new CPT codes as soon as they are published.

Therefore, we strongly urge CMS to begin implementing the new timeline and procedures for the CPT 2017 cycle and the 2017 Medicare Physician Payment Schedule.

Global Service Package

CMS proposes to transition all 010-day and 090-day global codes to 000-day global codes by 2017 and 2018, respectively. As support for this proposal, CMS references challenges it has experienced in obtaining available data to verify the number, level, and relative costs of post-operative visits included in global packages. CMS also expresses concern that 010-day and 090-day global packages may, in some cases, no longer accurately reflect the post-operative care provided to the typical patient.

While the Academy supports increasing the accuracy of physician payment and commends CMS for investigating methods to more accurately pay physicians for the services they provide, we are

concerned that the current proposal would not accurately account for physician work, practice expense, and malpractice risk for services performed within the current surgical global period.

In addition to an unrealistic timeline, the proposal also introduces several logistical hurdles, such as:

- 1) Post-operative physician work that is not part of separately-reported evaluation and management (E/M) codes would need to be separately-reported (eg, dressing changes, routine peripheral intravenous lines, local incision care);
- 2) There is a different mix of post-operative direct practice expense (PE) inputs for global period E/M services and separately-reported E/M services, including the fact that E/M services performed in a surgical global period often include additional, justifiably more expensive, supplies and equipment relative to standard, separately-billed E/M services;
- 3) The large redistribution of Physician Liability Insurance (PLI) payment away from the primary providers of surgical procedures and into a more diverse group of providers, given that the PLI relative value unit (RVU) for each service is calculated by multiplying the work RVU by the specialty risk factor of the specialty(ies) who perform the service;
- 4) Non-Medicare payers may choose to retain 010-day and 090-day surgical global packages, whereas many others would likely delay their transitions until several years after CMS made the change; such heterogeneous reporting mechanisms between payers would certainly result in additional administrative burden and confusion for all involved stakeholders, including patients.

Therefore, before the finalization of any proposal, CMS should work with the RUC and the CPT Editorial Panel to ensure physicians are accurately paid for these vital, routine patient care services. Toward this end, we recommend that CMS jointly work with the RUC Relativity Assessment Workgroup to collect and review existing, objective data in order to validate bundled post-operative visits.

Chronic Care Management (CCM)

The Academy applauds CMS for adopting a policy in 2013 to pay separately for transition care management (TCM) via CPT codes 99495-99496. While CMS did not include complex chronic care coordination (CCCC) along with its 2013 TCM proposal, it was expected that reconsideration would be given for CCCC in CY 2014.

In an effort to advocate for CMS recognition of CCCC services in CY 2014, the Academy participated in a multispecialty coalition to revise the CCCC CPT guidelines in order to allow consistency with Medicare payment policy, thereby allowing reconsideration for separate payment for CCCC in the Medicare program. Therefore, we were extremely disappointed to see

that CMS is proposing to develop its own HCPCS Level II G code for CCCC, with an anticipated implementation date of CY 2015.

Recommendations:

- The Academy strongly recommends that CMS not finalize the G code but instead recognize the three existing CPT codes (99487-99489), which will allow use for pediatric patients with chronic complex conditions who would not otherwise benefit under the G code.
- The Academy recommends that CMS recognize the CCCC CPT guidelines – and, if necessary, will work with CMS to revise the guidelines to allow greater clarity.

Complex Chronic Care Coordination CPT codes (99487-99489) represent services that support the outpatient management of patients whose diseases place them “at significant risk of death, acute exacerbation/decompensation, or functional decline.”¹ Such services can play an important role in the pediatric population where approximately 7 million US children suffer from chronic and complex conditions most of which fall under Medicaid eligibility.²

Studies demonstrate that outpatient integrated care coordination and management can prevent acute care utilization and improve family well-being in these complex pediatric populations.³ For such patients, the application of care coordination principles can especially benefit these children who are easily identifiable at hospital discharge, who go on to use multiple sources of health care services, and who account for an exceedingly disproportionate amount of child health spending in the post-discharge period.⁴

Improving coordination and reducing fragmentation can result in higher quality outcomes and reduced Medicaid expenditures in the care of these vulnerable children.⁵ Not only are chronically ill pediatric patients major users of acute inpatient care, but such care is frequently driven by high readmission rates, the reduction of which is a key strategy of robust complex care coordination.⁶ Furthermore, the complexity of chronic pediatric outpatient care is becoming increasingly challenging as demonstrated in a recently published assessment of patients with potentially lethal trisomy who are now surviving for months to years based on parental leadership in pursuing aggressive out-patient management and coordination.⁷

¹ 2014 CPT Professional Edition, American Medical Association.

² Randall O'Donnell. Reforming Medicaid for Medically Complex Children. Pediatrics 2013;131;S160

³ Cohen et al. Patterns and Costs of Health Care Use of Children With Medical Complexity. Pediatrics 2012;130;e1463

⁴ Ibid.

⁵ Randall O'Donnell. Op Cit.

⁶ Cohen et al. Op Cit.

⁷ McNee et al. Trisomy 18 and Complex Congenital Heart Disease: Seeking the Threshold. Pediatrics 2013;132;161.

While we value the role that CMS played during the initial development of the CPT CCCC codes, the proposed focus on development of a unique Medicare G code impedes the likelihood of appropriate reimbursement for the provision of chronic complex care coordination in the pediatric population. CMS would better serve the full spectrum of chronically ill patients -- including those most likely to benefit from Medicaid reimbursement -- by committing itself once more to full CPT development and valuation rather than to a unique code set that does not address one of society's most vulnerable patient populations.

Quality Measures in Accountable Care Organizations

The Academy strongly supports CMS' efforts to refresh and diversify the catalog of quality measures it uses to benchmark performance standards in Accountable Care Organizations (ACOs). Health care is not static and advances in health care technology and processes designed to improve the efficiency and effectiveness of health care delivery require corresponding changes in the metrics used to measure quality and performance. The Academy also pleased that the new mixture of performance and quality metrics tilts the focus more towards outcomes as opposed to processes of care. In addition, the addition of new measures that increase the emphasis on chronic conditions (eg, diabetes) is a welcome and needed change in the portfolio.

Also, in the proposal, CMS seeks to reward quality improvement more than the original MSSP design does. It will provide up to 2 bonus points in each of its 4 domains of performance specifically for improvement. The bonus points will raise the scores used to calculate how much each ACO receives from shared savings. The Academy agrees with this approach because it moves the system towards rewarding quality improvement successes and not just overall performance. Also, the Academy supports CMS' decision to reduce the minimum number of patients who whom ACOs must report on each quality measure from 411 to 248. This lessens the administrative burden to physicians and their office staff in having to access fewer charts to collect data for each measure as well as report out the measures through the Group Practice Reporting Option (GPRO) Web interface. While the Academy believes the current GPRO Web interface is adequate for reporting, it can be a very difficult tool for user-interface, particularly for inputting data.

CMS also is requesting input on additional measures that it should consider in future rulemaking. As echoed previously by the Academy, the Affordable Care Act (ACA) invests heavily in the future US health care system. One such policy is the Medicare Shared Savings Program (Section 3022.) However, Section 3022 is not the only ACO model contained in the ACA. Section 2706 authorizes DHHS to establish Pediatric ACO Demonstration projects, although to date this effort remains unfunded. Children and pregnant women deserve the opportunity to benefit from the quality and care coordination that ACOs hold the promise to improve. It is in this spirit that the Academy strongly urges CMS to begin introducing pediatric quality measures into the ACO

portfolio of measures. When policymakers view US health policy through the lens of the Medicare program, the results of this bias are not often positive for children.

The Academy is dismayed that the rule failed to reference any pediatric quality improvement measures in the inventory of measures proposed by CMS. Many ACOs, particularly those who collaborate with Medicaid programs, will be providing health care to children. The Child Health Insurance Program Reauthorization Act (PL 111-3) established a set of core voluntary pediatric performance measures designed to strengthen the quality of care provided and health outcomes of children in Medicaid and CHIP. In fact, CMS released the [2014 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP](#). This core set includes a range of children's quality measures encompassing both physical and mental health including chronic conditions, such as asthma, attention-deficit hyperactivity disorder, and diabetes. The Academy strongly encourages CMS to include an appropriate set of pediatric measures in future rules, particularly the Core Set of measures that have been developed and are under development.

Additionally, the Academy would urge that the CMS reference pediatric-specific experiences of care tools in future rulings. Numerous validated tools exist for soliciting satisfaction information from patients and families (eg, Parents' Perception of Primary Care, Starfield and Cassady's Child Health Systems Primary Care Assessment Survey, and Flocke's Components of Primary Care Index). In the case of children, it is imperative that ACOs use a tool that gauges a family's experience with the primary care their children receive.

Another option is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Item Set for Children with Chronic Conditions. In fact, the Academy worked with experts in the area in publishing a compendium that itemizes tools to evaluate the pediatric patient- and family-centered medical home. The resource "[Measuring Medical Homes: Tools to Evaluate the Pediatric Patient- and Family-Centered Medical Home](#)." Developed on behalf of the National Center for Medical Home Implementation, this monograph presents various tools available and in use to identify, recognize, and evaluate a practice as a pediatric medical home. Because no one tool is recognized as the *de facto* tool to assess pediatric practices, a review of the relative merits of existing tools will help inform purchasers, payers, providers, and patients in evaluating pediatric practices. The Academy strongly encourages CMS leadership to consult this timely and comprehensive resource.

The Academy encourages CMS to partner with the Academy and other leading child health organizations to explore the potential inclusion of self-reported health and functional status measures as part of the patient experience of care survey used in ACOs. As noted by researchers, the last decade has evidenced a dramatic increase in the development and utilization of pediatric health-related quality of life (HRQOL) measures in an effort to improve pediatric patient health and well-being and determine the value of health care services. In fact, the

emerging emphasis towards patient-reported outcomes in the health care field provides the fuel to expand and solidify a similar effort in pediatric care.

Pediatric Considerations: Proposed Discontinued ACO Measures

1) ACO #12, Medication Reconciliation after Discharge from an Inpatient Facility

CMS proposes to replace this measure with a new measure for documentation of current medications in the medical record since the medical community has indicated the importance of medication reconciliation at each office visit rather than only after an inpatient discharge.

For healthy children, this is burdensome. Every time a pediatric patient comes in for "routine" sick visit, such as for wart treatment or a cold, to have to completely reconcile the medication list is onerous and often does not improve care. Medication reconciliation is cumbersome in current electronic health record (EHR) technology and will add to the time it takes to see a patient efficiently without significantly improving care. However, for children with special health care needs, we agree that medication reconciliation is a necessary part of each office visit.

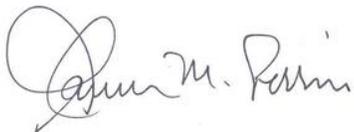
2) Percent of PCPs who Successfully Meet Meaningful Use Requirements

CMS proposes to modify the name and specifications for ACO #11 Percent of PCPs who Successfully Qualify for an EHR Incentive Program Payment so that it more accurately depicts successful use and adoption of EHR technology in the coming years.

This change would risk disenfranchising the majority of pediatricians who currently receive no Meaningful Use monies.

The Academy appreciates the opportunity to provide comments on the July 11th proposed rule and looks forward to working with CMS to ensure that the physician fee schedule accurately reflects the work value of physician practice and pediatric care.

Sincerely,

A handwritten signature in black ink that reads "James M. Perrin". The signature is fluid and cursive, with the first name being the most prominent.

James M. Perrin, MD, FAAP
President

JMP/ljw