HFSA
HEART FAILURE SOCIETY OF AMERICA
Phone 301-718-4800 • 5425 Wisconsin Ave. Suite 600 Chevy Chase, MD 20815

September 2, 2014

Marilyn B. Tavenner
Administrator
Centers for Medicare and Medicaid Services
Attention: CMS-1612-P
P.O. Box 8013,
Baltimore, MD 21244-8013.

RE: [CMS-1612-P] RIN 0938-AS12 -- 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.

Submitted electronically via www.regulations.gov

Dear Administrator Tavenner:

The Heart Failure Society of America (HFSA) is pleased to have the opportunity to comment on the proposed rule: 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.

HFSA is a non-profit, multi-disciplinary association of over 1500 physicians, researchers, nurses, Pharm Ds and other interested parties. We are dedicated to improving the outcomes and quality of life of patients with heart failure and those who are at risk of developing heart failure.

We are particularly concerned with two provisions of the proposed rule: the provision pertaining to chronic care management services (CCM), and the proposal to delete the exception under the Physician Payments Sunshine Act for

reporting of indirect payments by industry to physicians serving as faculty for accredited and/or certified continuing medical education (CME).

Chronic Care Management Services

In the CY 2014 Medicare Physician Fee Schedule (PFS) final rule with comment period, CMS finalized a policy to pay separately for non-face-to-face chronic care management services furnished to Medicare beneficiaries with two or more chronic conditions, beginning in CY 2015. CMS created the following code to report this service:

> GXXX1 Chronic care management services furnished to patients with multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; 20 minutes or more; per 30 days.

To value this code, CMS looked for services similar in work (time and intensity) to that of the non-face-to-face portion of transitional care management (TCM) services (CPT code 99495). This code contains the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge; medical decision making of at least moderate complexity during the service period face to face visit, within 14 calendar days of discharge).

For chronic care management services, CMS proposes a physician work relative value unit (RVU) of 0.61, the remaining RVU after subtracting for the portion of the face-to-face visit under 99495. CMS also proposes a clinical staff time of 20 minutes.

Elements of the chronic care management service include:

- Access to care management services 24-hours-a-day, 7-days- a-week, which means providing beneficiaries with a means to make timely contact with health care providers in the practice to address the patient's urgent chronic care needs regardless of the time of day or day of the week.

- Continuity of care with a designated practitioner or member of the care team with whom the patient is able to get successive routine appointments.

- Care management for chronic conditions including systematic assessment of the patient's medical, functional, and psychosocial needs; system-based approaches to ensure timely receipt of all recommended preventive care services; medication reconciliation with review of adherence and potential interactions; and oversight of patient self-management of medications.

- Creation of a patient-centered care plan document to assure that care is provided in a way that is congruent with patient choices and values. A plan of care is based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports. It is a comprehensive plan of care for all health issues.

- Management of care transitions between and among health care providers and settings, including referrals to other clinicians, follow-up after a beneficiary visit to an emergency department, and follow-up after discharges from hospitals, skilled nursing facilities, or other health care facilities.

- Coordination with home- and community-based clinical service providers as appropriate to support a beneficiary's psychosocial needs and functional deficits.

- Enhanced opportunities for a beneficiary and any relevant caregiver to communicate with the practitioner regarding the beneficiary's care through, not only telephone access, but also through the use of secure messaging, internet or other asynchronous non-face-to-face consultation methods.

Billing requirements for chronic care management services include:

- Use of a certified EHR vendor
- Inform the beneficiary about the availability of the CCM services from the practitioner and obtain his or her written agreement to have the services provided, including the beneficiary's authorization for the electronic communication of the patient's medical information with other treating providers as part of care coordination.
- Document in the patient's medical record that all of the CCM services were explained and offered to the patient, and note the beneficiary's decision to accept or decline these services.
- Provide the beneficiary a written or electronic copy of the care plan and document in the electronic medical record that the care plan was provided to the beneficiary.
- Inform the beneficiary of the right to stop the CCM services at any time (effective at the end of a 30-day period) and the effect of a revocation of the agreement on CCM services.
- Inform the beneficiary that only one practitioner can furnish and be paid for these services during the 30-day period.

While we very much appreciate CMS' commitment to moving forward with acknowledging the critical importance of chronic care management services, we are concerned that the proposed RVU is too low to enable practitioners and clinical staff to furnish these services. As documented above, provision of this type of care can entail substantial time and effort. We encourage the Agency to review the American Medical Association (AMA) Relative Value Scale Update Committee (RUC) recommendation for values for these services. We submit that the proposed RVU of 0.61 will not match the time and effort needed to supply these important chronic care management services to Medicare beneficiaries. We respectfully request that the RVU value of 0.61 be revisited and revised upward.

Physician Payments Sunshine Act

Under the proposed rule, CMS proposes to delete the exception in the Open Payments Program (Physician Payments Sunshine Act) for reporting of indirect payments by industry to physicians serving as faculty for accredited and/or certified continuing medical education. CMS believes strongly that eliminating the exemption for payments to speakers at certain accredited or certifying continuing medical education events will create a more consistent reporting requirement, and will allow for better and more consistent communication with consumers who will ultimately have access to the reported data.

HFSA urges CMS to reconsider the removal of the exception to reporting for faculty of accredited Continuing Medical Education (CME) programs. We are very concerned about how this will affect our ability to recruit top faculty for our meetings, as some may be reluctant to participate in activities that will put them on lists suggesting they have been given "gifts" by industry, when in fact they are just being paid to take time away from their practice to speak and reimbursed for travel, lodging, and meal expenses.

Industry-supported CME must adhere to ACCME Standards for Commercial Support (or another accrediting organization). These standards help ensure the integrity of CME programs and allow for the necessary flow of educational events and the expert faculty needed to ensure that advances in medical education are communicated fully and appropriately to attendees of CME events.

CME is fundamental to HFSA's mission to disseminate state-of-the-art information to heart failure care providers. We are very concerned that this new proposal will make it much more difficult to recruit outstanding clinicians and investigators to provide this critical information to our physicians, nurses, nurse practitioners, and PharmD's. Further, we respectfully submit that there is little rationale to consider expense reimbursement for CME activities as a "transfer of value" from industry.

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For all these reasons, we urge the Agency to maintain the exception for reporting of payments by faculty members of accredited CME events.

We thank you for your consideration of these views. If you have any questions or require further information, please contact Michele Blair, HFSA's Chief Executive Officer (mblair@hfsa.org).

Sincerely,

Thomas Force, MD
President