September 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; CMS 1654-P

Dear Acting Administrator Slavitt:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR), and other supporting organizations, appreciate the opportunity to comment on the proposed rule, *Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model*. CPR is a coalition of national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities and chronic conditions may regain and/or maintain their maximum level of health and independent function.

CPR is pleased to comment on the following priority issues under the proposed rule for Medicare beneficiaries with injuries, illnesses, disabilities, and chronic conditions who require access to physician services and have other health care and rehabilitation needs.

1. **Proposed HCPCS G-code to Improve Payment Accuracy for Care of People with Mobility-Related Disabilities**

The proposed rule seeks to address a long-standing problem related to health disparities of people with disabilities by establishing a new add-on "G" code that physicians could use to receive accurate payment for the extra clinical time, accessible equipment, and expertise required to provide access and quality care to people with disabilities, particularly Medicare beneficiaries with mobility impairments. The proposed rule cites the National Healthcare Disparities Report produced by the Agency for Healthcare Research and Quality for the proposition that access and quality disparities derive from a "range of payment challenges, accessibility issues with equipment and facilities, communication obstacles, and sometimes lack of practitioner understanding of how to assess and fully address the needs and preferences of people with disabilities." CMS-1654-P, page 193.

We agree with the proposed rule's broad statement of disability disparities. We applaud CMS and the HHS Office of Minority Health for offering a concrete proposal with significant funding to meaningfully address this problem. Twenty six years after passage of the Americans with Disabilities Act, it is alarming that physical and communication barriers in physicians' and other health care professionals' offices still exist across the country. These, of course, lead to disability-based disparities in health care. Our member organizations represent millions of Medicare beneficiaries who receive physician and other health care services every day.

While we appreciate CMS' efforts to address health disparities based on disability, we cannot support this proposal in its current form for two reasons. First, the proposal is narrowly focused on beneficiaries with mobility impairments and favors one disability subgroup over another.[1] This is inequitable at best and potentially discriminatory at worst. Second, granting a physician the ability to bill the Medicare program an additional fee in order to provide accessible health care services creates a copayment obligation on the beneficiary. Surcharges of this nature on individuals otherwise protected by federal disability nondiscrimination laws are prohibited.

In addition, the United States Access Board issued a final report of the Medical Diagnostic Equipment Accessibility Standards Advisory Committee in December 2013 with detailed recommendations on minimum height standards for transfer surfaces and accessibility considerations for diagnostic imaging equipment. The Board developed accessibility standards for examination tables and chairs, weight scales, radiological equipment, and mammography equipment to be incorporated into the Patient Protection and Affordable Care Act.[2] The CPR Coalition recommends that CMS and the Office of Minority Health include the Access Board's medical diagnostic equipment recommendations into their review of mitigating healthcare disparities and "accessibility issues with equipment and facilities." CMS-1654-P, page 193.

The proposal in its current form is intended to meaningfully address the serious problem of health care disparities in access and quality experienced by Medicare beneficiaries with disabilities. But the proposal focuses narrowly on beneficiaries that use "specialized mobility-assistive technology (such as adjustable height chairs or tables, patient lifts, and adjustable padded leg supports)." CMS-1654-P, page 196. CPR asks why, in addition to this particular G-code for mobility impairments, similar G-codes could not be established to cover the following situations:

a. A patient with severe cognitive issues who requires additional staff time to treat in the context of a routine physician office visit;
b. A person with communication disorders who requires additional time and, perhaps, technology, to effectively communicate; or
c. An individual with severe mental health/behavioral health issues who requires greater than average time and resources during a physician office visit.

[1] We appreciate the fact that CMS is proposing the creation of additional codes to reflect additional payment for patients with cognitive impairments who need care planning services, and patients with behavioral health conditions who require collaborative care management. While CPR supports the creation of these codes as noted later in this comment letter, these codes will not address the time and resource needs of patients in the context of a routine physician office visit. In addition, there is no proposal to establish a new code for patients with communication disorders who require additional time, resources or technologies to effectively communicate with medical staff.

[2] https://www.access-board.gov/guidelines-and-standards/health-care/about-this-rulemaking/advisory-committee-final-report, accessed 9/5/2016.

In short, while we admire and support the intent of the proposal, we believe it is fundamentally unfair as written, in that it selects winners and losers among the beneficiary population. Worse yet, all of the individuals cited herein have supposedly been guaranteed equal access to health care services for the past several decades.

With respect to the additional fee that would flow to the physician from the Medicare program under this proposal, the patient would be obligated, as with most Medicare Part B services, to cover a 20 percent copayment. This would impose a "surcharge" on Medicare beneficiaries with mobility impairments to obtain accessible health care services, even though they are already entitled to them under federal law. Imposing a surcharge on individuals with disabilities violates federal civil rights laws that prohibit such fees on individuals with disabilities in order to receive equal access to services provided by a place of public accommodation under Title III of the Americans with Disabilities Act of 1990). For instance, Title III of the ADA states:

> "Charges. A public accommodation may not impose a surcharge on a particular individual with a disability or any group of individuals with disabilities to cover the costs of measures, such as the provision of auxiliary aids, barrier removal, alternatives to barrier removal, and reasonable modifications in policies, practices or procedures, that are required to provide that individual or group with the nondiscriminatory treatment required by the Act or this part." See, 28 CFR Sec. 36.301

This additional copayment may also serve as a disincentive for beneficiaries with mobility impairments to seek out physician care if their financial resources do not permit them to pay an additional copayment of approximately $9 every time they visit a physician.[3]

Recommendation: Unless the proposed G code is reconsidered and additional codes are created to ensure that all beneficiaries with disabilities are treated in an equitable manner, and unless CMS agrees to cover this G code(s) at 100 percent cost-sharing the way preventive services are treated, thereby eliminating any additional payment obligation on the patient, CPR cannot support this proposal. However, we commend CMS for its efforts in seeking ways to address this intractable problem and we look forward to continuing to work together to find ways to address health care disparities of all kinds, especially disability-based disparities.

2. Behavioral Health Services

We are pleased that CMS has proposed to pay for behavioral health integration services focused on collaborative care management through the addition of several new G-codes. These codes will provide for a more team-based approach to addressing behavioral health issues. Many beneficiaries, in particular, those with traumatic brain injuries and mental health conditions have behavioral health needs that must be managed, coordinated, and addressed. This proposal has CPR's strong support because it will increase access to care for these Medicare beneficiaries.

[3] This figure represents approximately 20 percent of the proposed valuation of this new billing code, which is approximately $44 per visit.

3. Payment for Cognitive Care Planning and Assessment

We support CMS' proposal to create a new G code for assessment and care planning for beneficiaries with cognitive impairments. Many of our organizations represent beneficiaries with cognitive impairments, in particular impairments resulting from stroke or traumatic brain injury. Assessing these patients and developing a plan of care involves obtaining detailed histories from the patient and family members and can be very time consuming. We are pleased that CMS will recognize separate payment for this service by a physician or other health care professional.

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We greatly appreciate your attention to our concerns and your interest in our participation in this process. Should you have further questions regarding this information, please contact Peter Thomas or Steve Postal, CPR staff, at (202) 466-6550 or by emailing Peter.Thomas@ppsv.com or Steve.Postal@ppsv.com.

Sincerely,

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Supporting Organizations

ACCSES
American Association on Health and Disability
American Congress of Rehabilitation Medicine
American Music Therapy Association
American Speech-Language-Hearing Association
American Therapeutic Recreation Association
The Arc of the United States
Association of Rehabilitation Nurses
Association of University Centers on Disabilities
Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Disability Rights Education and Defense Fund
Disability Section of the American Public Health Association
Easterseals
Epilepsy Foundation
Falling Forward Foundation
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Lakeshore Foundation
Michael J. Fox Foundation for Parkinson's Research
National Association for the Advancement of Orthotics and Prosthetics
National Association of State Head Injury Administrators
National Council for Behavioral Health
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association