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Via electronic submission (www.regulations.gov)

September 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201
Attention: CMS-1693-P

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program (CMS-1693-P)

Dear Administrator Verma:

The Association of American Medical Colleges ("the AAMC" or "Association") welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS') 2019 Physician Fee Schedule and Quality Payment Program (QPP) proposed rule (83 Fed. Reg. 35704). The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members are all 151 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Together, these institutions and individuals are the American academic medicine community.

Teaching physicians who work at academic medical centers (AMCs) provide care in what are among the largest physician group practices in the country. Teaching physicians at AMCs are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of which require highly specialized care. Often care is multidisciplinary and team-based. These practices frequently are organized under a single tax identification number (TIN) that includes many specialties and subspecialties, such as burn care, cardiac surgery, and general surgery, to name a few. A large percentage of the services provided at AMCs are tertiary, quaternary, or specialty referral care. A patient may be transferred to or seek care at an AMC because the care needed is not available in a patient's neighborhood or region.

The AAMC commends CMS for its efforts to increase the amount of time that physicians and other clinicians spend with their patients by reducing the burden of paperwork. We strongly support CMS' initiatives to modernize Medicare payment policies by allowing payment for the use of telecommunications technology. **However, we have major concerns with the proposals to change payment for evaluation and management services, which could limit access to care for complex patients.** We are committed to working with CMS to ensure that Medicare payment policies are not overly burdensome to clinicians, ensure access to care, improve quality of care, and accurately reflect the resources involved in treating patients.

The AAMC's key recommendations on the 2019 proposed rule include the following:

Physician Fee Schedule:

- ***E/M Payment Changes:*** CMS should not finalize the proposal to establish single payment rates for outpatient/office visits (99202-99205 and 99212-99215), the proposed multiple procedure payment reduction (MPPR) and the proposed G-codes for primary care, inherent complexity, and prolonged services. CMS should work with stakeholders on implementation of a new approach.
- ***E/M Documentation and Medical Decision-Making:*** CMS should retain the existing 5 level code and payment structure and allow physicians to document visits based solely on the level of medical decision-making (MDM), time in some cases, or the 1995 or 1997 E/M guidelines. CMS should not finalize the proposal that practitioners would only need to meet documentation requirements associated with a level 2 visit.
- ***Other Documentation Changes:*** CMS should finalize the following changes for January 2019: eliminate the requirement that information that has already been documented by practice staff be re-documented; remove the need to justify the home visit; limit required documentation of the patient's history and exam to the interval changes since the previous visit; allow presence of the teaching physician for E/M services to be demonstrated by the notes in the medical record made by a physician, resident, or nurse.
- ***Removal of Prohibition on Same Day Visits:*** CMS should eliminate the prohibition on billing same day visits by practitioners of the same group and specialty**.**
- ***Interprofessional Internet Consults:*** CMS should finalize its proposal to pay for Interprofessional Internet Consultations (CPT codes 994X0, 994X6, 99446, 99447, 99448, and 99449). We commend CMS for recognizing the effort of both the treating and consulting provider in completing the interprofessional consult and urge CMS to accept the RUC-recommended work RVUs of 0.50 for CPT code 994X0 and 0.70 for 994X6.
- ***Appropriate Use Criteria:*** CMS should address concerns with the unreasonable burden that the Appropriate Use Criteria program for advanced diagnostic imaging services may place on providers by simplifying the tracking and reporting system for consultations. CMS should consider allowing additional time to engage providers and their staffs about the guidelines, introduce them to the CDSM software, modify their work flow pattern, update their EHRs, and test their systems.

- ***HOPD payment and PFS Relativity Adjuster***: CMS should set the PFS Relativity Adjuster at 65% instead of 40% of the OPPS rate for services provided in non-excepted off-campus hospital outpatient departments. This amount would be a more accurate representation of payment relativity between the applicable MPFS rates and the OPPS rates. CMS' 40% Relativity Adjuster sets the payment rates below the hospital's costs of providing care.

Quality Payment Program:

- ***Risk Adjustment***: As appropriate, CMS should risk-adjust outcome, population-based measures, and cost measures for clinical complexity and sociodemographic factors.
- ***MIPS Identifiers:*** In addition to using the taxpayer identification numbers (TINs), national provider identifiers (NPIs), APM Identifiers, and Virtual Group Identifiers, CMS should create an option for a MIPS subgroup identifier that would allow large multi-specialty groups to elect to have sub-groups under the same TIN assessed in the quality payment programs in a way that is meaningful.
- ***Quality Category:*** To reduce provider burden and ensure that measures under the program are meaningful, CMS should finalize the proposal to remove the six measures from the Web Interface program.
- ***Cost Category***: CMS should maintain the weight of the cost category at 10% instead of increasing it to 15%. For cost measures, CMS must address risk adjustment and attribution concerns before increasing the weight in the future. In future MIPS feedback reports, CMS should provide additional details in the cost category regarding patients and providers.
- ***Promoting Interoperability:*** CMS should finalize the proposal to score this category based on performance on individual measures as it simplifies scoring and provides increase flexibility to clinicians. CMS should include the two new opioid measures as bonus measures only in the program until they are more adequately defined and there is sufficient time to integrate them into systems.
- ***Complex Patient Bonus:*** CMS should extend the complex patient bonus beyond the 2019 performance year and increase the cap so that it is higher than 5 points.
- ***Nominal Financial Risk Definition:*** CMS should finalize the proposal to maintain the generally applicable revenue-based nominal amount standard at 8% of the average estimated total Medicare Part A and B revenue of providers participating in APM entities through 2024.
- ***Qualifying Participant Threshold***: CMS should review and analyze information about physician participation in advanced APMs to determine whether a change in thresholds for QP status is warranted. CMS should consider reducing the Medicare threshold in the future to enable participants in these models to continue to qualify to receive the 5% bonus.
- ***Other Payer Determination:*** CMS should finalize the proposal that determination of Other Payer Advanced APM status would be effective for five years as long as no changes are made. CMS should reduce burdens associated with requiring eligible clinicians to submit information for Other APM determinations.

MEDICARE PHYSICIAN FEE SCHEDULE

The CY 2019 Physician Fee Schedule (PFS) rule proposes several policy changes which impact AMCs**.** Among the areas addressed by this letter are the significant changes to evaluation and management (E/M) documentation and payment, coverage and payment for communication technology-based services, appropriate use criteria for advanced diagnostic imaging services, bundled payments for substance-use disorder treatment and proposed payment rates for non-excepted off-campus hospital provider-based departments.

Evaluation and Management Documentation and Payment

In the 2019 Physician Fee Schedule proposed rule, CMS proposes major changes to documentation, coding and payment for outpatient/office evaluation and management (E/M) visits. We very much appreciate the proposals related to documentation as CMS recognizes the unnecessary administrative burdens physicians and other health care professionals experience. Excessive documentation requirements take away from important time that could be spent with the patient and often make it very difficult to find the information that is relevant for the patient's care in the medical record. The medical record has become bloated in order to meet billing rules, which has led to difficulties in following the care and proposed management of patients and has impeded quality care in some cases. Therefore, we strongly support the documentation proposals contained in this rule as they improve patient care and safety and believe that many of them can be implemented as of January 1, 2019. Unfortunately, the proposal to set the same payment rate for levels 2-5 outpatient/office visits would result in many negative unintended consequences and therefore we oppose adopting the new payment proposals. Our key recommendations include the following:

Payment Proposal Recommendations

- CMS should not finalize the proposal to establish single payment rates for outpatient/office visits (99202-99205 and 99212-99215), the proposed multiple procedure payment reduction (MPPR) and the proposed G-codes for primary care, inherent complexity, and prolonged services.
- Over the next year, CMS should engage with stakeholders to refine the payment and coding approach for outpatient/office visits to promote better patient care, achieve burden reduction, protect patient access, and ensure that payment accurately reflects the resources used to provide services.
- Working with stakeholders, CMS should consider implementation of a new approach to coding and payment that would reduce burden and minimize the impact on patient care.

Documentation Proposal Recommendations

In 2019 CMS should retain the existing 5 level code and payment structure for CPT codes 99201 - 99215 and finalize the following changes to documentation.

- Allow physicians to document visits based solely on the level of medical decision-making (MDM), time in some cases, or the 1995 or 1997 E/M guidelines.
- Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or the patient.

- Allow presence of the teaching physician for E/M services to be demonstrated by the notes in the medical record made by a physician, resident, or nurse. We also urge the Agency to extend this policy to medical students.
- Limit required documentation of the patient's history and exam to the interval changes since the previous visit.
- Remove the need to justify the home visit instead of an office visit.
- Eliminate the prohibition on billing same day visits by practitioners of the same group specialty and associated documentation.

These recommendations related to the documentation and payment changes proposed for outpatient/office visits are enumerated in further detail below.

Comments Related to E/M Documentation Reduction Proposals

The AAMC strongly supports CMS's "Patients Over Paperwork" initiative, which stresses the importance of reducing administrative burdens to allow physicians and other health care professionals to devote more time to patient care. Excessive documentation requirements have made it difficult for physicians and other health care professionals to locate important information about the patient's current condition, recent changes and the plan of care in the medical record. Several of the changes to documentation requirements that CMS proposes in this rule would help to alleviate these problems, lead to improved patient care, and better align with current medical practice and the use of electronic medical records. These are discussed below.

Remove Requirement of Documentation of Medical Necessity of Home Visit

We encourage CMS to finalize its proposal to remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office. As CMS states, the physicians are in the best position to determine in which setting the patient should be seen and therefore this requirement is unnecessary.

Eliminating Prohibition on Billing Same Day Visits by Practitioners of the Same Group and Specialty

Medicare Claims Processing Manual, Chapter 12, Section 30.6.7.B prohibits Medicare from paying for two E/M office visits billed by a physician or physician of the same specialty from the same group practice for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems that could not be provided during the same encounter. In the rule, CMS considers removal of this policy from the Medicare manual.

We strongly support elimination of this prohibition on the same day visits to better align with medical practice. In academic medicine, practices are often organized under one tax identification (TIN) number that includes many specialties and subspecialties. The number of specialties and subspecialties continues to grow. It can be beneficial to the patient to see more than one physician (designated in the same specialty in the Medicare enrollment system) in the faculty practice in the same day. As long as both visits are medically necessary, irrespective of whether the visits are for obtaining more expertise to treat the same condition or to treat a separately identifiable condition, full Medicare payment should be made for both visits.

For example, in a large, multi-specialty group practice a patient may come to a general cardiologist with atypical chest pain without evidence of ischemia but with arrythmia. This would lead to referral within the practice to an electrophysiologist, also enrolled as a cardiologist. Another example would be a patient seen by a gastroenterologist for abdominal pain who discovers that the patient needs to see a liver specialist (hepatologist), who is also enrolled in Medicare as a gastroenterologist. These physicians would be less likely to see the patient in the same day if they would not get paid for their services. This would lead to inconvenience for the patient, especially Medicare patients who generally come to the physician with a family member.

Removing Redundancy in E/M Documentation

We support CMS' proposal that the physician be required to focus their documentation only on what has changed since the last visit rather than re-documenting required elements of the history and exam. Many EHRs have documented allergies, history of prior medical conditions and surgical conditions, family history, social history and educational history. The review of systems also may not have changed or may not be germane to the problem at hand and have already been delineated in the medical record. None of these need to be repeated in a note unless there have been interval changes.

CMS solicits comments on whether analogous policies could be adopted for medical decision-making (MDM) and for new patients such as when prior data is available to the billing practitioner through an interoperable electronic health record (EHR). We believe that to the extent that data is available in EHRs, CMS should expand its policy so that what needs to be documented during each visit is the information that is relevant to the patient's diagnosis and treatment, allowing reliance on information that already is in the medical record.

We recommend CMS finalize its proposal to eliminate the requirement that the physician re-document information (chief complaint and history of present illness) that has already been documented in the patient's record by clinical practice staff or the patient. It would be sufficient for the practitioner to indicate in the medical record that they reviewed and verified this information. These changes will allow physicians to exercise their clinical judgment and discretion to document what is clinically relevant and medically necessary for the care of the patient.

Choice of Supporting Documentation

To reduce burden, CMS proposes substantial changes to E/M documentation for outpatient and office visits, by allowing physicians to choose their method of documentation among the following options: 1) current framework of 1995 or 1997 E/M guidelines; 2) medical decision making (MDM); or 3) time.

As a corollary to this documentation proposal, CMS would retain the current E/M codes but establish one payment rate for codes 99202-99205 for new patients and another payment rate for codes 99212-99215 for established patients. CMS explains that it believes the proposed documentation changes for E/M visits are intrinsically related to the proposal to alter payment for these services. Since there would be one payment rate for E/M visit levels 2-5, for the

purposes of PFS payment for an outpatient/office E/M visit, CMS is proposing that practitioners would only need to meet the documentation requirements currently associated with a level 2 visit for history, physician exam, and MDM. As will be explained below, we believe that many of the proposed documentation changes are separable from payment changes and can be adopted now while the payment changes can be postponed.

We commend CMS for its proposal to eliminate the requirement that physicians document in accordance with the 1995 or 1997 E/M guidelines. Use of the 1995 or 1997 E/M guidelines for documentation should be voluntary until CMS transitions to new documentation guidelines. These original guidelines were developed at a time when medical records were maintained on paper and clinicians worked largely independently. With the advent of the EHR, team-based care, and other changes over the past two decades, the E/M guidelines are outdated and have led to much of the "note bloat" that is seen in EHRs. The current documentation requirements (such as noting negative review of systems) impose an onerous burden on physicians while providing little benefit to patients. In some cases, the requirements impede patient care by making it difficult to locate the physician's differential diagnosis or plan of care. The physician spends less time with the patient since so much time is spent on ensuring the information to support billing is included in the medical record.

We believe that CMS should establish a policy that would allow physicians to elect documenting based on medical decision-making (MDM) only, and under some circumstances, using only time. This can be done without setting one payment rate for four levels of codes. Because each of the current E/M code descriptors contains a level of medical decision making and time, it is possible for physicians to continue to document the corresponding level of medical decision-making or time, as appropriate, to support the service.

Establishing a minimum level of documentation at a level 2 office visit puts in place a flawed policy that fails to recognize that MDM can vary substantially from patient to patient, as can resources used, the time spent with the patient, or the care coordination.

Such a policy would not result in the burden reduction anticipated by CMS for several reasons described below:

- Medical care for a patient frequently requires more than the care that is described by a level 2 office visit. For example, if a physician has diagnosed strep throat and has ordered antibiotics, a level 2 billing code may be appropriate. But if the patient has a heart transplant or is a 90-year-old with heart failure and COPD the same infection may lead to other decision making.

- The CMS proposal applies only to outpatient or office visits, meaning that in other settings, including inpatient, Medicare documentation requirements would be unchanged. A physician who follows a patient across sites of services (e.g. from office to hospital) would have to comply with different requirements for documenting, which would disrupt workflow. Further, private payers will continue to have their own documentation

requirements with which physicians would have to comply, requiring different workflows and billing processes.

- Physicians have a professional obligation to document all clinically relevant information irrespective of the code billed. It is important for the physician to provide sufficient information about their differential diagnosis and plan of care that will enable other health care professionals to coordinate and care for their patient. In many instances, this would result in more extensive documentation in the record than that associated with a level 2 visit.

- There would be concerns about potential audits and standards related to professional liability that make documenting all visits only to level 2 untenable.

In the future when a new coding structure is agreed upon and established, CMS could move forward with additional reductions in E/M documentation burden associated with that new coding structure. Until then, we recommend that CMS allow physicians to document MDM only in accordance with the appropriate level of service or time as appropriate.

Teaching Physicians

The AAMC appreciates that CMS has proposed burden reduction specifically directed at teaching physicians. The Agency proposed that "the presence of the teaching physician during procedures and evaluation and management services may be demonstrated by the notes in the medical records added by a physician, resident, or nurse." CMS also proposes deleting the requirement that the teaching physician document his/her participation in the review and direction of the services and adding that the extent of the teaching physician's participation in the service may be demonstrated by the notes in the medical records made by the physician, resident, or nurse. The AAMC strongly supports these proposals. We request that, consistent with changes made in the Medicare Claims Processing Manual (CR 20412), the regulations also recognize that the teaching physician's presence can be demonstrated by notes in the medical record made by a medical student. Finally, the AAMC asks that at a future time CMS revisit the regulations related to documentation by teaching physicians as those rules, which were first established in the December 8, 1995 Physician Fee Schedule final rule, no longer reflect either the way in which medical students and residents are educated, or the team-based care that patients receive at teaching institutions.

Comments Related to E/M Payment Proposals

CMS proposes a single payment rate for E/M visit levels 2 through 5 for new patients (99201-99205) and a separate single payment rate for level 2 through 5 visits for established patients (99212-99215). CMS also proposes three add-on codes to recognize additional relative resources for certain kinds of visits, including one for inherent complexity for specialty services, primary care, and prolonged visits. To fund the add-on payments, CMS proposes a multiple procedure payment reduction (MPPR) that would reduce payment by 50% for the least expensive procedure or visit when a procedure is performed on the same day as an office visit.

We strongly oppose implementation of these payment proposals as they would negatively impact physicians who treat the most medically vulnerable patients. Certain "non-procedural" specialties, such as oncology, hematology, and nephrology, who see patients with more complex conditions, would experience significant reductions in reimbursement as these specialties predominantly bill level 4 and 5 services. The negative impact is likely to be even larger for faculty physicians in academic medical centers who work in large multi-specialty practices that include all the specialties that patients with complex needs may require, including primary care, oncology, neurology, endocrinology and many others. These faculty practices also treat a disproportionate share of patients for whom social determinants of health, such as housing, nutrition, and transportation, are the root of additional health challenges, adding to complexity.

CMS attempts to mitigate the negative impact of the blended payment rates by setting forth add-on payments that could be used in certain situations. However, the small add-on payments for inherent complexity (approximately $13.70) and primary care (approximately $5.00) are insufficient to compensate for the substantial losses compared to reimbursement under the current system.

Unintended Consequences of Payment Reductions: Impact on Patient Care

While we appreciate CMS' goal to simplify the physician payment system, we are deeply concerned about the impact that these payment proposals would have on patient access to care. As discussed, the overall impact of these changes would vary based on specialty and patient characteristics, with physicians who see patients with more complex conditions receiving lower reimbursement. Faculty physicians in academic medical centers typically see more complex patients and therefore this payment policy will have an even greater negative impact for them. Although the CMS proposal pertains to Medicare payments for outpatient and office visits, it is likely that in the future it will be expanded by Medicare to other settings and also that commercial payers will set their payment rates in line with this model, as they historically have based their payment on Medicare rates. This expansion would further compound the negative impact of this proposal.

One of CMS' goals is to support primary care and patient-centered care management by improving payment accuracy to recognize the costs of primary care management, coordination and 'cognitive services. However, this current proposal does not recognize the work involved in the provision of these services, particularly for patients with complex conditions. It could potentially hurt specialties that provide comprehensive primary care, at a time when this care is considered a critical component of improving the quality of patient care and outcomes.

If the single payment rates are finalized, patient access to necessary health care services could be jeopardized. It may provide an incentive for some physicians to avoid treating more complex patients, meaning that many of these patients will go to academic medical centers that will continue to treat them but at a greater financial loss. Yet another unintended consequence is that the significant reductions in payment to providers with complex patients could result in providers giving patients shorter and more frequent visits. This would cause patient dissatisfaction and may increase costs to patients as there will be a co-pay for each visit. Perhaps more importantly, for complex patients, longer and less frequent visits often are the way to provide the best care.

Studies have shown that longer visits with more complex patients results in less hospital readmissions.

At a time when there are growing physician shortages, the shortages may be exacerbated for specialties that face significant cuts in payment. Medical school graduates could potentially be discouraged from entering into some of the "non-procedural" specialties that treat more complex patients.

Impact of E/ M Reductions on Specialties

In the proposed rule, CMS includes two impact tables: 1) Table 21-unadjusted estimated specialty specific impacts of the proposed single RVU amounts; and 2) Table 22-specialty specific impacts including the payment accuracy adjustments. Table 22 indicates that when the add-on payments are incorporated into the analysis, the specialty impacts range from -4% to +4%. There appears to be a discrepancy between CMS' impact analysis and analysis performed by the American Medical Association (AMA), which found much larger impacts on specialties as a result of the changes. For example, the AMA replicated CMS' analysis and found that hematology would experience a -16% decrease in payment from the E/M proposal and nephrology would experience a -13% while CMS reported an impact of less than 3% decrease in overall payment for hematology and for nephrology.

In addition, the AAMC and Vizient have a joint product, the Faculty Practice Solutions Center (FPSC), which collects claims data from over 90 faculty practice plans, reflecting approximately 70,000 physicians working in academic medical centers. Using the most recent 12 months of FPSC claims data, we spent considerable time and effort modeling the effects of the proposed payment changes (including the add-on codes for inherent complexity and primary care). Faculty physicians specialize in particularly complex cases and therefore the impact of the E/M proposal is even greater than the impacts found in the AMA analysis. This analysis showed that more than 20 specialties in academic medical centers would experience significant reductions in payment for E/M services, with the greatest reductions in payment for the following specialties: palliative care (-24.4%), nephrology (-22.6%); all medical oncology (-21.4%) and critical care (-18.6%). The table below shows the specialties with the most significant losses. Other specialties that typically bill predominantly level 2 and 3 E/M visits would experience gains. Our modeling differed from CMS' as it did not include the MPPR reduction due to the difficulty of taking the MPPR into account. Inclusion of the MPPR would result in even greater payment reductions. The significant shifts in reimbursement in specialties that we identified further brings into question the accuracy of CMS' modeling.

Specialty or Grouping	FPSC Variance	Specialty or Grouping	FPSC Variance
Palliative Care	-24.4%	Radiation Oncology	-13.3%
Nephrology	-22.6%	Geriatrics	-13.2%
All Medical Oncology	-21.4%	Transplant Surgery: All	-10.2%
Surgery: Cardiac	-19.4%	Neurology (All specialties)	-9.4%
Critical Care	-18.6%	Hematology	-8.9%
Pulmonary Disease	-18.6%	Surgery: Thoracic	-8.5%
Hospitalists	-17.3%	Physical Medicine	-7.4%
Gastroenterology / Hepatology	-14.5%	Psychiatry	-6.6%
Infectious Disease	-14.4%	Surgery: Breast	-4.0%

We are also concerned that CMS' analysis examines the impact on specialties at an aggregate level instead of evaluating the impact on subspecialties which are more likely to be found at academic medical centers. By performing analysis using a database of faculty physician practices, which include numerous subspecialties, we were able to identify numerous subspecialties that would experience significant losses from this payment proposal. For example, CMS does not include any information on palliative care, which would experience the largest reduction of -24.4%, according to our analysis.

Add-On Codes to Recognize Additional Relative Resources for Certain Kinds of Visits
CMS proposes add-on codes for primary care (GPC1X), inherent complexity (GCG0X), and prolonged visits (GRPO1) to more accurately account for the type and intensity of E/M work performed in certain types of visits. We have multiple concerns with implementation of these add-on codes. First, the payment amounts for these add-on codes of approximately $5 for primary care and $14 for inherently complex E/M services are inadequate and do not come close to compensating for the losses from the proposed reductions in payment for level 4 and 5 E/M services. These appear to be "workarounds" to mitigate the negative impact of collapsing the office E/M payment to two levels. They also add complexity to the system at a time when burden reduction is the goal. The proposed add-on codes are not resource based, as is required by law. For example, the add-on payment for primary care services relies on a partial crosswalk to another code that is unrelated and not comparable.

As proposed in the rule, there is significant confusion regarding when it would be appropriate to bill for these add-on codes. For example, the proposed rule indicates that the inherent complexity code is described as applying to the following specialties: endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care. However, in a "Listening Session" on August 22, 2018, CMS staff indicated that the inherent complexity visit code would not be limited to particular specialties. If the add-on code is limited to particular specialties, the "nonprocedural specialties" listed are those that typically treat more complex patients and tend to bill a high volume of level 4 and 5 E/ M visits. However, there are other specialties, such as nephrology and infectious disease specialists, that treat very complex patients

and were not included on the list provided by CMS. We question why these specialties would be excluded.

Further, section 1848(c)(6) of the Medicare statute does not allow physician payment to vary by physician specialty. If CMS were to establish a code that is limited to a particular specialty, it would appear to be in conflict with the statutory provision. Likewise, there is confusion over when the primary care add-on code could be reported and by which specialties. Further clarity is needed about when it is appropriate to use the prolonged service code since CMS has not indicated the amount of time that would be considered "typical" for the evaluation and management services. Nor is it clear whether the prolonged services add-on would only be billed in addition to a level 5 office visit or if it could be billed in addition to any office visit. If the prolonged services add-on can only be billed in addition to a level 5 office visit, its value is significantly limited. Further, in the 30 minutes that it takes to bill a prolonged services E/M code, the physician could receive higher payment for a short E/M visit ($93 for a level 2 office visit versus $67 for a prolonged services E/M) further discouraging comprehensive care.

Another point of confusion relates to whether these services can be reported simultaneously. For example, there could be instances when a complex patient is receiving primary care services. In such an instance, there is a question of whether the two add- on codes (inherent complexity and primary care) could both be reported. In the Listening Session, CMS indicated that both add-on codes could be billed which means it is incumbent on CMS to provide guidance and a description of what these services are and when they can be billed if CMS finalizes this policy.

The addition of the codes GPCIX and GCG0X, which have vague descriptions, is likely to increase administrative burden if there is a need to provide additional documentation to support payment for these add-on codes. These documentation requirements would require extensive education for providers to comply and could potentially be as onerous as the current documentation requirements.

Multiple Procedure Payment Reduction (MPPR)

In order to fund the proposed add-on payments, CMS proposes an E/M multiple procedure payment reduction (MPPR) that would apply when E/M visits and procedures with global periods are furnished together. Specifically, in cases where a physician furnishes a separately identifiable E/M visit to a beneficiary on the same day as a procedure, CMS would reduce payment by 50% for the least expensive procedure or visit by the same physician (or a physician in the same group practice).

The MPPR policy would result in an unjustified reduction in reimbursement because the overlap in physician work and practice expense is already accounted for when the Relative Value Update Committee (RUC) valued the codes. During the code valuation process, the RUC worked diligently to ensure that there are no duplicate resource costs in the procedure codes that are typically performed with E/M services. Therefore, CMS should not finalize the proposed MPPR policy to reduce payment when procedures are performed on the same day as an E/M service.

Practice Expense Issues (IPCI)

To compute the Medicare Physician Fee Schedule (PFS) payment CMS uses a formula that is based on the resource costs of physician work, practice expense and professional liability insurance. The practice expense component is divided into practice expense costs directly related to performing the physician service (e.g. clinical staff, supplies, equipment) and practice expense overhead costs that are indirectly related (i.e. rent, utilities). One component used to determine indirect practice expense payment is the Indirect Practice Cost Indices (or IPCIs).

The CMS proposal to collapse payments for office visits included creation of a new IPCI solely for office visits as a separate Medicare designated specialty with its own practice expense per hour. This proposal may be resulting in dramatic shifts in practice expense payment, independent of any other changes, for certain specialties in 2019, such as medical oncology (-27%) and vascular surgery (-10%). These shifts affect all codes billed by these specialties (not just E/M services).

For example, CPT 96409 (Chemo iv push sngl drug), a drug administration code, is primarily used by the specialties of medical oncology and hematology/oncology (specialties with 20% declines in their IPCI values). In 2019, this code would experience a decrease in practice expense RVUs of about 12% (with an overall payment decline of 11%), based on the proposed policies. Even though the direct inputs (supply and equipment prices) increased slightly, this code showed a decline in overall payment. It appears that these reductions are the result of the change in the proposed IPCI value being used for 2019 compared to 2018. There is no change in physician work or clinical labor inputs for this code. The table below demonstrates the impact on the IPCI of selected specialties.

Table Comparison of Indirect Practice Cost Index (IPCI) value for Selected Specialties, 2017-2019

Spec	Specialty Description	2017 IPCI	2018 IPCI	2019 IPCI	% Change 2017-2018	% Change 2018-2019
66	Rheumatology	0.9147	0.91404	0.557314	-0.07%	-39.0%
03	Allergy/immunology	0.87797	0.92911	0.59153	5.82%	-36.3%
90	Medical oncology	1.43162	1.44812	1.061953	1.15%	-26.7%
76	Peripheral vascular disease	0.57062	0.54518	0.417125	-4.46%	-23.5%
C0	Sleep Medicine	0.97093	0.94298	0.746586	-2.88%	-20.8%
83	Hematology/oncology	1.43432	1.45557	1.162304	1.48%	-20.1%
19	Oral surgery	1.58256	1.47756	1.189683	-6.63%	-19.5%

09	Interventional Pain Management	1.31204	1.29055	1.067121	-1.64%	-17.3%
04	Otolaryngology	1.14449	1.0842	0.917839	-5.27%	-15.3%
72	Pain management	1.12775	1.10653	0.944442	-1.88%	-14.6%
07	Dermatology	1.61206	1.57897	1.386336	-2.05%	-12.2%
34	Urology	0.90503	0.90628	0.812722	0.14%	-10.3%
77	Vascular surgery	0.47655	0.44711	0.402161	-6.18%	-10.1%

These impacts are neither presented nor explained in the proposed rule. This table confirms that there have been significant changes to the IPCI from CMS's proposals for 2019 and will have serious implications for certain specialties, such as oncology, that have high practice expenses. It will be extremely difficult for these practices to continue to treat patients when they are faced with such significant financial losses. It does not make any intuitive sense that CMS' E/M proposal should lead to these large reductions in practice expense RVUs for unrelated services. Before CMS finalizes this proposal, CMS must further investigate and explain why these changes are happening. Given that this large negative impact may be resulting from CMS' E/M proposal to create a separate E/M IPCI, AAMC urges CMS to not implement this change**.**

E/M Payment Proposal Violates Requirements in Statute

The payment policy proposal raises several legal issues. This single payment rate for established and new patient office visits would result in payment reductions for level 5 services (99205 and 99215) of approximately 36% and 38% respectively. We question the legality of such a reduction as section 1848(c)(7) prohibits HHS from reducing the payment rate for an existing code by more than 20% in a single year for "services that are not new and revised codes."

Further, the single payment for levels 2-5 also appears to violate the Congressionally mandated requirement that the Physician Fee Schedule be based on a "resource based relative value scale." A payment rate based on weight averaged utilization of a code set is not resource based. CMS's proposal would pay more for a level 2 or level 3 office visit than their required resources and less than the required resources for a level 4 or level 5 office visit. Section 1848(c)(2)(C) requires each relative value unit to be based on the "relative resources" required to furnish the service.

Consider Other Options for Revisions to E/M Payment and Coding Structure

We believe that there are other alternatives to CMS' payment proposal that would more accurately reflect the resources used to provide patient care as Congress intended when it put in place Medicare's resource-based relative value system. The AAMC encourages CMS to work with stakeholders to develop an approach that would reduce burden and protect patient access. The AAMC is committed to working with CMS on future refinement of the coding structure and payment for E/M services. There are a range of other options that could be modeled and

analyzed to determine their impact as part of this process. We plan to model the options along with some other organizations.

In addition, the AMA CPT Editorial Panel has developed a workgroup charged with providing CMS with concrete solutions that could be proposed in the 2020 Medicare PFS rule and implemented in January 2020. It is important to give this workgroup an opportunity to develop an alternative to the CMS payment proposal in the rule

Implementation of any new coding structure and payment system would involve substantial education of physicians, and other staff and sufficient time is needed to ensure this occurs. Also, vendors need adequate time to make changes to their EHR systems to incorporate any changes from refinements to E/M Therefore, to implement payment and coding changes on January 1, 2019 would be problematic as there would be insufficient time for provider education and EHR updates.

Telehealth and Communication Technology-based Services

The AAMC appreciates CMS' efforts to modernize Medicare physician payment by recognizing communication technology-based services. Communication technology-based innovations directly improve care coordination between providers and patients. Providers who work to enhance access to care for populations should be supported through the reduction of regulatory barriers and the adoption of appropriate reimbursement incentives. Use of communication technology-based services that bring providers into more effective collaboration but do not generate a face-to-face billable encounter warrant expanded use. The AAMC applauds CMS for proposing to pay for brief check-in visits using communication technology and remote professional evaluations of patient-transmitted information conducted by pre-recorded "store and forward" video or imaging technology. The AAMC appreciates CMS' recognition that the statutory restrictions on telehealth do not apply to physician services whereby a medical professional interacts with a patient via remote technology.

In the past, CMS has allowed waivers of some specific telehealth or communication technology-based requirements, such as the originating site limitation and the requirement that the patient present from a rural area, for certain alternative payment models. **The AAMC suggests that waivers be provided to additional alternative payment models to extend the reach of physician services**. CMS has already determined that there is clinical efficacy for currently covered Medicare telehealth services (but which are subject to statutorily imposed geographic and originating site restrictions). In addition, CMS and its Innovation Center should undertake demonstrations, through delivery reform models, to continue expanding coverage of telehealth and evaluate whether expanded telehealth services for specific patient populations is cost effective and improves care quality. The purpose of these demonstrations would be to enable health systems and other providers that have developed telehealth capabilities to provide these services to a critical mass of Medicare beneficiaries without geographic and originating site restrictions, allowing CMS to assess impact on utilization.

Interprofessional Internet Consultations

In this rule, CMS proposes to pay separately for six CPT codes that describe interprofessional internet consultations (CPT Codes 994X0, 994X6, 99446, 99447, 99448, and 99449). Four of the codes (99446, 99447, 99448 and 99449) are currently assigned a procedure code status of "bundled" by CMS and therefore not paid separately under Medicare. The CPT Editorial Panel revised these four codes to include electronic health record consultations and the RUC reaffirmed the work RVUs for these codes and CMS accepts the RUC recommendations. We commend CMS for its ongoing efforts to recognize the changing focus in medical practice toward primary care and patient centered care management. **The AAMC strongly supports CMS's proposal to pay for these interprofessional consultations performed via communications technology.**

Two CPT codes (994X0 and 994X6) created by the CPT Editorial Panel are new and describe additional consultative services, including a code describing the work of the treating physician when initiating a consult. These codes are:

- *CPT code 994X0 Interprofessional telephone/ Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes*
- *CPT code 994X6 Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time*

The RUC recommended work RVUs are 0.50 for CPT code 994X0 and 0.70 for CPT code 994X6. CMS proposes a work RVU of 0.50 for both CPT codes 994X0 and 994X6.
The decision to cover these interprofessional consults is consistent with the movement toward team-based approaches to care that are often facilitated by electronic medical record technology. These interprofessional consults simplify the process of seeking input from or between specialists, allowing treating physicians (typically a primary care provider) to ask specialists specific clinical questions when unsure of how to treat a problem that might not require a face-to-face visit with a specialist. **We commend CMS for recognizing the effort of both the treating and consulting provider in completing the interprofessional consult through the proposal to pay for the two new codes (994X0 and 994X6). The AAMC urges CMS to accept the RUC recommended work RVUs of 0.50 for CPT code 994X0 and 0.70 for CPT code 994X6 as the work is inherently different.**

Background on Project CORE and the Use of Interprofessional Internet Consults
The AAMC and its members have significant experience with interprofessional consults described by the two new CPT codes (994X0 and 994X6) that inform our comments below.

In September 2014, the AAMC received a CMMI Round Two Health Care Innovation Award (HCIA-2), which allowed AAMC to launch Project CORE: Coordinating Optimal Referral Experiences. Utilizing EHR-based communication tools (called eConsults and enhanced referrals), the CORE model aims to improve quality and efficiency in the ambulatory setting by reducing low-value referrals, improving timely access to specialty input, and enhancing the

patient experience through more effective communication and coordination between providers. Initially, implemented in 5 academic medical centers (AMCs) through the HCIA award, the CORE model has been implemented at more than 20 AMCs across the country in over 140 adult and pediatric departments. There have been over 25,000 eConsults completed through the CORE model, with more than 1,000 per month being sent. Over 80% of PCPs at our original CMMI sites are active eConsult users. It is important to note that eConsults volumes have leveled off at sites, as the tools' use has matured, with rates of 5.7-10.4 completed eConsults per 1,000 primary care visits in the final program year.

In the CORE model, eConsults are an asynchronous exchange in the EHR that are initiated by the PCP to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. The model utilizes specialty and condition-specific templates to enable high quality exchanges between providers. There is an expectation that the specialist will respond within 72 hours; however, response times have averaged closer to 24 hours. If the specialist deems the eConsult question to be inappropriate or too complex, he or she can decline the eConsult or recommend that the PCP refer the patient for an in-person consult. Overall, we found that 2.8% of Medicare beneficiaries with a completed eConsult had a visit with that specialty within 14 days. All CORE AMCs have instituted an RVU credit (or equivalent payment) to recognize both the PCP and the specialist for completed eConsults. To date, the majority of the eConsult payments have been self-funded by each AMC. However, a growing number of centers are beginning to engage and contract with their local commercial payers and state Medicaid plans.

Preliminary analyses of the CORE program of eConsults demonstrate a positive impact on utilization of services, access to care, costs and patient and provider experience. PCPs using greater than median rates of eConsults within each center had a 12% decrease in referral rates compared to those with less eConsult use. After eConsults were initiated, patients had a reduction in specialist utilization, with a greater impact over time as the program matured. Using a difference-in-difference regression analysis comparing participating specialties to all other specialties from the 5 sites in our CMMI-funded program, we calculate a savings of over $7 million from the reduction of nearly 50,000 specialty visits. Timely access to specialist input (defined as within 14 days of the PCP request) improved by 80% after eConsults were in place, with improvements driven by better access times for in-person visits as well as the timeliness of eConsult responses. In a national survey we conducted, patients that received an eConsult were equally satisfied with the specialist's recommendations as patients who had seen a specialist in person. 95% of patients felt that the specialist's eConsult advice was conveyed promptly and recommendations were clearly explained. 89% of primary care providers and specialists reported being highly satisfied with the quality of the eConsult question and response, respectively. In its report on the CORE program, CMMI's independent evaluator found that *"Clinician surveys demonstrate that providers overwhelmingly believe the program positively affects the delivery of patient care."*

CMS Should Accept the RUC Recommended Work RVU of 0.70 for CPT code 994X0

In the rule, CMS proposes a work RVU of 0.50 for CPT code 994X0 and CPT code 994X6. CMS does not accept the RUC recommendation of 0.70 for CPT code 994X6 based on their

belief that the CPT code for the treating/requesting physician or qualified healthcare professional and the CPT code for the consultative physician have equal values for work because they have similar intra-service times.

We urge CMS to accept the RUC recommended work RVUs, which are 0.50 for CPT code 994X0 and 0.70 for CPT code 994X6. These codes should not be valued the same. While the codes may have similar intra-service time, the work is different. The treating/requesting physician already has an established relationship with the patient and has determined the information that he/she is seeking from the specialist. The treating physician compiles the information about the patient for the specialist to review. In contrast, the patient is typically new to the specialist. The specialist has to integrate patient history and other factors shared by the treating/requesting physician, consider the diagnostic possibilities, and recommend a management plan or series of diagnostic tests. The specialist is providing clinical guidance to the requesting physician, in most cases in lieu of an in-person visit.

In addition, the RUC decided that 994X6 is equivalent in intensity to code 99447, which requires 11-20 minutes of medical consultative discussion, and a written and verbal report. When CPT code 99447 was valued in 2012, the RUC used CPT code 99442 *Telephone evaluation and management service provided by a physician to an established patient parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion* (work RVU = 0.50) as a key reference service. They concluded that CPT code 99447 is a more intense procedure than 99442 because the patient is typically unknown to the consulting physician, resulting in more complexity and intense medical decision-making. We believe that the same rationale applies to CPT code 994X6 (which more closely approximates 99447).

Recommendations for Minimizing Potential Program Integrity Issues with 994X0 and 994X6

While CMS proposes to make separate payment for interprofessional consults, CMS raises some concerns. Specifically, CMS has concerns about how these services can be distinguished from activities undertaken for the benefit of the practitioner, such as information shared as professional courtesy or as continuing education. CMS also notes that there are program integrity concerns around making separate payment for these interprofessional consult services, including around CMS' or its contractors ability to evaluate whether an interprofessional consultation is reasonable and necessary. CMS seeks specific comments on how best to minimize potential program integrity issues. Below are some specific recommendations to address these concerns.

Require the requesting practitioner to act on the interprofessional consultation to bill

For 994X0, there is an important opportunity for clarification about the service that is being billed. The treating physician should not bill for asking and submitting their clinical question alone. At the point where the consultation is made, there is a risk that the question is never answered, and thus there is no service being provided to the patient. We strongly believe that the benefit of the eConsult to the patient only occurs when the treating physician receives a response from the specialist, and then reviews the response and determines a course of action, and that the course of action be documented. Thus, the treating physician has "owned" the problem and used

the specialist's feedback to determine appropriate next steps for the patient. The service to be billed, and the time to be estimated in determining appropriateness for billing, comes from this "closing the loop" portion of the eConsult. Thus, we recommend that CMS clarify that 994X0 is for a treating physician (typically a primary care provider) who has sent a consultation to the specialist and receives a response that they review and incorporate into the patient's care plan as appropriate, including documentation of such an action.

Distinguishing interprofessional consults from activities undertaken for the benefit of the practitioner

To ensure that the interprofessional consults are not activities taken for the benefit of the practitioner, there should be a requirement that the interprofessional consult involves a specific question related to an individual patient's care with the intent that the treating provider will own and manage the patient's care in lieu of a referral. In the CORE model, this is addressed by tying eConsults to specific patient medical records, with clinical questions and related laboratory and test data pulled in through templates in the EHR, specific to the patient for whom the eConsult exchange takes place. All related information is thereby incorporated into the patient's medical record, which is critical not only to ensure that the question being asked is specific to a patient, but also to ensure that the full eConsult encounter is documented and retrievable as part of the official record of care of that patient. For program integrity, CMS might require that interprofessional consults being billed under 994X0 and 994X6 take place within the EHR, and/or that the exchange and associated follow-up be documented in the medical record by the treating provider as a prerequisite to billing for the service with the 994X0 code.

Establishing key components of high-quality interprofessional consult

CORE AMCs have adopted principles for what constitutes an appropriate high quality eConsult question and response. We recommend that CMS adopt some of these principles for providers billing these interprofessional consult codes to ensure that the services are reasonable and necessary.

Interprofessional consult questions raised by the treating provider should meet the following criteria:

- Be focused questions that a specialist can reasonably answer, with associated and relevant medical history also provided/ available.
- Be answerable using only the information available in the EHR (for interprofessional consults that take place within the EHR).
- Be answerable within three business days.

Questions that should <u>not</u> be asked as part of the interprofessional consult include the following:

- Administrative questions to a specialty practice (e.g. Who should I refer this patient to in your clinic?).
- Questions easily answered by consulting textbook or clinical guidelines.

If an interprofessional consult question results in the specialist indicating that an in-person visit is needed, the treating physician should not use code 994X0, as the service would not provide

added value for the patient, nor would the treating physician need to provide clinical effort to carry out the request.

The specialist should also include key components within their responses, which are:

- Restate the question and define the parameters to address based on the clinical question.
- Provide recommendations for next steps in evaluation, management and/or ongoing monitoring.
- Explain the rationale for the recommendation(s).
- Conclude with contingencies that provide guidance for next steps in evaluation and management of the patient, consistent with potential outcomes of the recommendation(s) provided.

Establishing Time Frames for Use of Interprofessional Consults

The CPT Panel set forth circumstances for when it is appropriate to report and bill the interprofessional consults, which we believe will also address some of CMS's program integrity concerns. These include: 1) no use of the codes if a patient sees a specialist within 14 days before or after the e-consult; 2) only one use of the code per patient per 7 days; and 3) no use when the "sole purpose" of the communication is to arrange a referral for an in-person visit.

We are very supportive of the requirement that there be no use of these codes if the patient sees a specialist within 14 days before or after the interprofessional consult. Based on the experience of our CORE AMCs, 2.8% of Medicare beneficiaries have a billed specialist visit within 14 days of the eConsult (increasing slightly to 5.3% within 30 days of the eConsult). We note that there will always be a small proportion of patients that will require a specialty visit after an interprofessional consult because their condition doesn't improve or there may be a new problem unrelated to the initial condition/question. Having the 14-day rule in place will also help minimize the use of the interprofessional consult for triaging purposes.

The requirement that there be only one use of the code per patient per 7 days will help to ensure that when a treating provider has a back and forth communication with the consulting provider on a specific case, the treating provider only bills once for each question (rather than multiple bills). However, we note that there could be circumstances when a treating provider needs to seek feedback from two different specialties to manage a patient's care (e.g. two interprofessional consults, one each to Cardiology and to Pulmonology). In this instance, the treating provider should be able to bill for each of these distinct consults as separate consults.

We strongly agree with the premise that interprofessional consults should not be reimbursed for the treating provider or consulting physician if the sole purpose of the exchange is to arrange for an in-person visit. We believe that this is one of the most important risks of misuse of these codes. To make this most clear for all involved, CMS could require that if the consulting provider's recommendation is an in-person specialty visit, then there be no reimbursement for the treating provider or the consulting provider.

Verbal Beneficiary Consent/ Copays with 994X0 and 994X6

CMS proposes to require the treating practitioner obtain verbal beneficiary consent that would be documented in the medical record in advance of the interprofessional consults since these codes describe services that are furnished without the beneficiary being present.

There are clinically appropriate scenarios where a treating provide might place an interprofessional consult after the patient has left the office (e.g. in response to an abnormal laboratory test or value). In this case, it creates inefficiencies and could further delay care if the treating provider has to reach the patient and obtain consent before placing the consult. It could also cause undue stress for the patient, particularly if the specialist deems that the abnormal value is not of concern or does not need any additional follow-up at that time. To address the need for patient consent in a way that is practical for providers and practices, and minimize efficiencies and confusion for beneficiaries, we recommend that practices be allowed to obtain blanket consent at the practice level for this service.

Patient Copayment Concerns with 994X0 and 994X6

In the current CORE model, the program has been structured such that patients are not charged a co-pay for this provider-to-provider service. The AAMC is very concerned about the inclusion of a patient co-pay with this service for several reasons. First, given the structure of 2 distinct codes, patients will receive two co-pays for a single completed interprofessional consult: one for the treating provider (994X0), and one for the consulting provider (994X6). eConsults are often used for patients with new problems who are not established within the consulting specialty's practice and therefore do not have an existing relationship with the consultant. A bill and co-pay for a service delivered from a provider that the patient has never seen or heard of could raise concerns about billing errors and place an undue burden on the practice's billing staff to address questions.

In addition, while most treating physicians engage their patients in the decision to obtain an eConsult, there are clinically appropriate scenarios where the treating physician might do so without first engaging the patient. As described above, the treating physician might receive an abnormal test or laboratory value that requires a specialist's input to determine what, if any, next steps are needed in the patient's management. At this point, the patient is no longer in the office and the administrative burden of reaching the patient to obtain consent and discuss the eConsult option would likely be too high and discourage use. It could also result in delays of care, undoing the benefits of a prompt response from the specialist.

Finally, if presented with the option of an interprofessional consult co-pay versus a visit co-pay, patients may elect to see the specialist in-person, which negatively impacts the potential savings of eConsults.

While the AAMC recognizes that there are typically limited scenarios where a co-pay is waived in the Medicare program, we believe co-pays will stifle use of these value-promoting, physician-to-physician services. Therefore, the Agency should explore a pathway to waiving the patient co-pays for 994X0 and 994X6. In particular, CMS should prioritize waiving the specialist copay (994X6) to minimize overall administrative complexity and confusion for beneficiaries who likely have no established relationship with the specialist consulting provider.

At a minimum, these co-pays should be waived in circumstances where there is a straightforward mechanism to do so, such as CMMI's ability to do so for specific services in alternative payment models (APMs) demonstrations.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

Section 218(b) of the Protecting Access to Medicare Act of 2014 (PAMA) directs CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging services. Under the law, as a condition of payment to a provider who furnishes imaging services, the health care provider ordering advanced diagnostic imaging services must consult AUC. This would involve entering patient clinical data into an electronic decision tool, referred to as a clinical decision support mechanism (CDSM), to obtain information on the appropriateness of the services. The AUC must be developed or endorsed by national medical professional societies or other provider-led entities. The results of the AUC consultation must be documented on the claim submitted by providers furnishing imaging services in order to be paid by Medicare. There are four major components of the AUC program, including: 1) establishment of the AUC; 2) mechanisms for consultation with AUC; 3) AUC consultation by ordering professionals and reporting on AUC consultation by furnishing professionals; and, 4) annual identification of outlier ordering professionals.

In the 2018 Medicare Physician Fee Schedule final rule, CMS stated that ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting and ordered on or after January 1, 2020.

CMS also proposed that furnishing professionals report the following information on Medicare claims for applicable imaging service, furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2020:

- Which qualified CDSM was consulted by the ordering professional;
- Whether the service ordered would adhere to specified applicable AUC, would not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered; and,
- The NPI of the ordering professional (if different from the furnishing professional).

In the 2019 proposed rule, CMS proposes to establish a set of G-codes and HCPCS modifiers to capture AUC consultation information on Medicare claims. CMS clarifies that AUC consultation information must be reported on all claims submitted by the furnishing provider, including the practitioner's claim for the professional component and the provider's or supplier's claim for the facility portion or TC of the imaging service.

While the AAMC supports the use of clinician-developed, evidence-based AUCs to improve the quality of care, and understands the statutory requirement, we are concerned about the unreasonable burden placed on providers. **The AAMC urges CMS to provide sufficient time for providers to learn and comply with this program. There is a need to engage providers and their staff about the guidelines, introduce them to the CDSM software, modify work flow patterns, update EHRs, and pilot test the systems to gradually build up the program.**

As CMS further develops this policy, we request that the following also be addressed:

- The impact this policy will have on providers who furnish imaging services. The imaging providers will have limited control over whether the ordering professional consulted a CDSM as required. Yet, if the ordering professional does not consult the AUC, the imaging professional would not get paid for the services. **We urge CMS to consider allowing the imaging provider to occasionally use the AUC themselves, if appropriate, to demonstrate that the test was warranted.** This will also allow CMS to pay those providers for the service and will avoid linking payment to the actions of another provider over whom they have no control.

- The need to phase in the implementation over time starting with a list of priority conditions that would be consulted rather than requiring consultation for all tests.

- Ensuring that CDSMs are designed to be easy to use. Providers would prefer CDSMs that can be used quickly and efficiently and that are integrated with their electronic health record system. It is frustrating to providers if they are required to exit their electronic health record system and enter an entirely new platform to order imaging services.

- A simplified tracking and reporting system. This proposal involves a complex system of tracking consultation of AUCs. CMS proposes G-codes and modifiers that must be included on the claim form in order for the furnishing provider to be paid. It can be difficult for the furnishing professional to supply the ordering physician's AUC-use information to CMS. In most cases, the ordering physician and furnishing professional will not share the same office space or EHR system. To share this information will require additional health IT interoperability between the ordering physician's EHR and the systems used by the furnishing physicians in their practices.

- Ensuring that claim forms are modified to capture all required information. It is also unclear as to whether the required information from the G-codes and modifiers can be incorporated into the current claim form without some modification on how they may interact with the other codes and modifiers included on the claim form. It is important to acknowledge that there are a number of MACRA-related provisions, such as the codes for physician-patient relationships, that also must be captured on the claim forms in the near future. There could potentially be errors and disruption in claims processing and payment, which is another reason that a phase in of this policy is necessary.

Bundled Payment for Substance Use Disorder Treatment

In the 2019 proposed rule, CMS proposes to make separate payment for a bundled episode of care for management and counseling for substance use disorders. CMS believes that making separate payment for bundled episode of care for management and counseling for substance use disorders could be effective in preventing the need for acute services. The AAMC appreciates CMS' focus on the opioid crisis, and willingness to explore ways to expand payment for treatment services.

However, the AAMC is concerned that an effort to develop a bundle within the strict confines of the Medicare Physician Fee Schedule will limit innovation and replicate current efforts within CMMI. We strongly encourage CMMI to continue work on payment bundles for substance use disorders as part of ongoing efforts to address the opioid crisis. CMMI has far greater flexibility when testing new payment models. Proposals within the Medicare Physician Fee Schedule must be budget neutral, and there is very limited flexibility in experimenting with payment models outside of CMMI.

Proposed Payment Rules Under the PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments

The Bipartisan Budget Act of 2015 included a provision (Section 603) that excluded from the definition of covered outpatient department (OPD) services "applicable items and services furnished on or after January 1, 2017 by certain off-campus outpatient departments of a provider" (generally those that did not furnish OPD services before November 2, 2015). It also provides payment for those services under a Part B payment system other that the Hospital Outpatient Prospective Payment System (OPPS). In the 2017 OPPS interim final rule with comment (81 FR 79729), CMS established initial payment policies under the PFS for non-excepted items and services furnished on or after January 1, 2017. In the current proposed rule, CMS proposes payment policies under the PFS for non-excepted items and services furnished during 2019.

Currently, Medicare recognizes that physician offices and hospital outpatient departments (HOPDs) are both essential care settings in the health care landscape and that they differ from each other in key ways that warrant different payment methods and rates. The AAMC believes the payment differential appropriately accounts for the differences in the types of patients treated, services provided, and regulatory burden at HOPDs. Additionally, HOPDs are frequently the sole sources of care for low-income and otherwise underserved populations of Medicare beneficiaries, accepting patients who otherwise face difficulty being seen in physician offices. HOPDs need to meet the myriad regulatory requirements, including compliance with hospital conditions of participation, and must provide stand-by care not provided in a physician's office. In short, HOPDs are comprehensive and coordinated care settings for patients with chronic or complex conditions. Many centers of excellence are based in hospital settings and provide outstanding team-based, patient-centered care and HOPDs provide wraparound services, such as translators and other social services.

The AAMC understands CMS' continued use of the PFS Relativity Adjuster until a more appropriate payment mechanism is identified, as well as CMS' willingness to allow nonexcepted off-campus provider-based departments to continue to bill for nonexcepted items and services on the institutional claim form. However, we have significant concerns with CMS' methodology in calculating the 2019 PFS Relativity Adjuster. **We strongly oppose the proposed PFS Relativity Adjuster of 40% and believe that it should be set at 65%.**

AAMC Recommends 2019 PFS Relativity Adjuster of 65% Instead of 40%

In 2017, CMS adopted a set of payment rates that are based on a 50% reduction to the OPPS payment rates (inclusive of packaging) for non-excepted items and services furnished by

nonexcepted off-campus PBDs. CMS arrived at the 50% reduction by comparing (i) the payment differential between the OPPS and the ASC payment rates (where covered surgical procedures in ASCs are paid at 55% of the rate under the OPPS) and (ii) the weighted average payment differential for overall payment under the OPPS and the MPFS for 22 frequently billed HCPCS codes reported by outpatient hospital departments. In the AAMC's comments on the interim final OPPS CY 2017 rule, we stated that the PFS Relativity Adjuster should be higher than 50% because CMS needs to account for the fact that the OPPS incorporates far more packaging into its payments for services than the Physician Fee Schedule. In addition, the AAMC commented that CMS should use the full PFS payment for practice expenses in the non-facility setting when making comparisons of payment rates because a hospital incurs both indirect costs and direct costs when services are provided at off-campus settings. Based on our analysis, done with Watson Policy Analysis, Inc. (WPA), when packaged costs are incorporated and the non-facility practice expense rates are used in the comparison, the ratio of PFS payments to OPPS payment amounts to 64%. Therefore, in 2017 we recommended a PFS Relativity Adjuster of 64%.

In 2018, the AAMC, repeated the analysis from CY 2017 using updated claims data to determine the appropriate rates for CY 2018. We found that the ratio of PFS payment to OPPS payment for CY 2018 is 65% and therefore recommended a Relativity Adjuster of 65% in 2018, stating that this amount would be a more accurate representation of payment relativity between the applicable MPFS rates and the OPPS rates.

For 2019, CMS proposes to continue to use the PFS Relativity Adjuster until code-specific reductions that represent the technical component of services furnished under the PFS can be established, or until the Agency can implement system changes that would enable these hospitals to bill for the services under the PFS directly. In the rule, CMS explains that they made several adjustments to the methodology for calculating the PFS Relativity Adjuster for CY 2019, including use of a full year of claims data for claims submitted with the "PN" modifier. CMS finds that their updated analysis supports maintaining a PFS Relativity Adjuster of 40% and therefore proposes to continue the PFS Relativity Adjuster at 40% for 2019. **As will be described below, the AAMC was unable to replicate CMS' analysis for 2019, and therefore we continue to rely on our analysis from last year, which supports a PFS Relativity Adjuster of 65%.**

CMS Did Not Provide Detailed Information Needed to Replicate Calculation of PFS Relativity Adjuster

Unlike in past years, CMS did not provide the data needed to allow commented to complete analysis of the proposed PFS Relativity Adjuster. This is an impediment to understanding how CMS derived the proposed adjustment, as well as allowing commenters to provide the most cogent comments. In prior years, the AAMC was able to replicate CMS' calculation of the PFS Relativity Adjuster because CMS provided detailed information about the methodology. Specifically, in past rules, CMS included a table that listed the codes it used for the analysis, the number of claims lines used for weighting and the methodology (either the full non-facility amount, technical component or difference between the non-facility and facility amounts) used to determine PFS rate as a proportion of the OPPS payment. Further, CMS provided the

outcome of its analysis and explained why it was using a rounded figure (e.g. 50%, 40% or 25%) rather than the precise percentage obtained from its analysis.

CMS also made changes to its methodology from past years for calculating the PFS Relativity Adjuster that are unexplained, which significantly and materially affects our ability to comment meaningfully. For instance, CMS is using all codes from 2017 with the "PN" modifier rather than 22 high expenditure codes plus a clinic visit that CMS used in past years. While this change may make sense, it would be helpful for CMS to explain why it made this methodological change instead of continuing past year's analyses of using the highest volume services furnished in off-campus outpatient departments. In addition, CMS imputes PFS values for contractor priced codes and codes that are statutorily excluded from the PFS. We do not understand why CMS made these changes nor did CMS explain how it imputed PFS values for these codes.

For future years, and in support of the CMS goal of transparency, CMS should again provide the same information in the proposed that is needed for analysis of the PFS Relativity Adjuster. We understand that CMS used a selection of the highest volume codes in past years based on the "PO" modifier as it did not have any data available with the "PN" modifier given that 2017 was the first year the "PN" modifier was in use. In this year's rule, CMS's analysis is based on all codes where the "PN" modifier was billed in the 2017 utilization data. The much larger universe of codes used in the analysis may make including a similar table to one included with past years' rules impractical.

As an alternative, we recommend that CMS include an electronic version of this table with the same information among the other information makes available on the CMS website with the rule. Such a practice will make CMS' policies more transparent and allow public commenters to replicate CMS' analysis without having to return to the agency for clarifying questions. It will also allow public commenters to understand the methodological issues earlier in the comment period and make more informed comments.

In the final rule, we request that CMS explain its reasoning for these changes and how it imputed PFS values for codes if the agency decides to continue with the same methodology. Finally, we are uncertain of whether CMS changed the utilization it used to determine the weights for services in the comparison. The rule indicates that CMS weighted by "HCPCS claims" as opposed to "total claims lines" that CMS identified as the weight previously (for example, see Table 10 of the November 15, 2017 Physician Fee Schedule final rule, page 5303). We are uncertain of the meaning of "HCPCS claims" and request CMS provide a more detailed explanation of what it used for the weight to determine that the PFS Relativity Adjuster should remain at 40%.

QUALITY PAYMENT PROGRAM

The AAMC appreciates that CMS recognizes the need to transition slowly to the framework for physician payment required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We urge CMS to use the flexibility provided under the MACRA statute to create a

longer transition period for the program and to reduce complexity and burden. While CMS has addressed issues raised by many stakeholders, the AAMC still has concerns with some of the components of the Quality Payment Program (QPP), which we discuss in this comment letter.

We are committed to working with CMS to ensure that MACRA promotes improvements in delivery of care and is not overly burdensome to clinicians and the organizations for which they work.

Consideration of Unique Challenges for Large, Multi-Specialty Group Practices

As CMS continues to refine the QPP, we urge CMS to consider the unique challenges posed by the QPP for large, multi-specialty group practices, such as those typically found in academic medical centers. These large multi-specialty practices face complex decisions about how to approach the options and pathways available under QPP. In academic medical centers, faculty physicians frequently are organized under a single tax identification number (TIN) and treat the most vulnerable patients, those individuals who are poor, sick, and have complex medical needs.

Data from the Faculty Practice Solutions Center (FPSC), a joint product of Vizient and the AAMC, is helpful for an understanding of the breadth, depth and complexity of these large faculty practice groups. Recent FPSC data on 91 practice plans shows that they range in size from a low of 128 individual NPIs to a high of 4,319, with a mean of 989 and a median of 816. FPSC also has data on over 70 adult and pediatric specialties which does not count the numerous subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. In some cases, faculty practice plans are highly integrated and make decisions about quality improvement and care coordination as a single entity. In other instances, such decision making occurs at the specialty level. In other words, these large groups are very different from small and solo physician practices. While they have learned how to report under the current quality programs, the choices under MIPS and APMs present a high level of uncertainty, complexity and risk for these large organizations.

MIPS Low-Volume Threshold and Opt-In Policy

To reduce regulatory burden, beginning with the 2018 performance period, CMS proposed to increase the low-volume threshold. Specifically, it defined individual eligible clinicians or groups who do not exceed the low volume threshold as an individual MIPS eligible clinician or group who, during the performance period has Medicare billing charges less than or equal to $90,000 or provides care for 200 or fewer Part B-enrolled Medicare beneficiaries. In the 2019 Medicare Physician Fee Schedule, CMS proposes adding an additional criterion to the low-volume threshold. Therefore, in 2019, CMS proposes that a provider who bills less than $90,000 in Medicare charges, or provides care for 200 or fewer Medicare beneficiaries, or provides 200 or fewer covered professional services, is excluded from reporting MIPS. CMS estimates that about 390,000 clinicians will be excluded from reporting MIPS under these criteria. CMS proposes to allow eligible clinicians to opt-in if they exceed one of the three criteria.

While the AAMC understands CMS's desire to reduce the participation burden under the MIPS program, we are concerned about the impact this proposal may have on patient care. The MIPS program is designed to hold eligible clinicians accountable for the quality of that care; with these

thresholds a significant number of eligible clinicians will be excluded from participating. It would be beneficial for all physicians to be able to participate in a program that improves quality of care for their patients. We urge CMS to finalize the newly-proposed MIPS opt-in policy, as we feel that this will allow additional providers to participate in the MIPS program and report performance measures. **CMS should develop approaches that enable broader participation in quality programs and provide education and resources to physicians so that they are able to be successful.**

MIPS Subgroup Identifier

CMS recognizes multiple identifiers that allow MIPS eligible clinicians to be measured as an individual or through a group's performance. In the 2019 proposed rule, CMS acknowledges that groups, including multi-specialty groups, have requested an option that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed based on performance of that subgroup. We are pleased that CMS intends to explore the establishment of group-related policies that would permit voluntary participation in MIPS at a subgroup level and create a new identifier.

The AAMC supports the CMS policy that allows providers to select whether they would be assessed as an individual (TIN/NPI), group (TIN), as an APM participant, or a virtual group participant. CMS currently uses separate identifiers for participants in an APM or a virtual group. **The AAMC encourages CMS to add a distinct subgroup identifier under MIPS, similar to the identifiers used for virtual groups or for Advanced Payment Models. This would allow a subset of physicians within a large TIN to form their own group for reporting and to select measures that are most appropriate for them.**

With evolving delivery and practice models, it is important for CMS to allow multiple options for identifying providers to assess eligibility, participation and performance under the MIPS program. Some faculty practices have multiple TINs for business or legal reasons but for all other purposes the physicians in the practice are part of the same group and want to be identified for reporting purposes under the same identifier. Use of a group MIPS identifier would enable these TINs to be measured as one group practice under the MIPS program. Some groups may be under a larger TIN but may want to break into sub-specialty components to allow for more accurate and meaningful measurement under the program. A subgroup MIPS identifier would be a mechanism for allowing smaller components under these large TINs to be measured separately from the TIN.

To allow participation in MIPS at a subgroup level, the AAMC recommends that CMS follow some of the policies set forth for virtual groups, which include:

- Establish a subgroup identifier.
- Require the subgroup to make an election prior to the start of the applicable performance period under MIPS to be a subgroup.
- Request that a list of participants who would be part of the subgroup identifier be provided to CMS. A subgroup would submit each TIN and NPI associated with the

subgroup, the name and contact information for a subgroup representative and a confirmation that each member of the subgroup is aware of their participation.
- Each MIPS eligible clinician who is part of the subgroup could be identified by a unique subgroup participant identifier which would be a combination of the subgroup identifier (established by CMS); 2) TIN and 3) NPI.
- Assess performance by a method that combines performance of all MIPS eligible clinicians in the subgroup across all four performance categories.

Depending on the practice, there are advantages and disadvantages to reporting under a subgroup MIPS identifier, an NPI, a TIN, or a combination. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option works best.

Facility-Based Scoring

Beginning with the 2019 performance period, CMS had previously adopted a facility-based measurement scoring option for the quality and cost performance categories for certain facility-based individual clinicians. This new scoring option for the quality and cost performance categories allows facility-based MIPS eligible clinicians to be scored based on their facility's performance in the 2020 Hospital VBP program. In last year's rule, CMS defined MIPS-eligible clinicians as those who furnished 75% or more of their services in the inpatient hospital or emergency room. In this rule, CMS proposes a change that would include professional services provided in the on-campus outpatient hospital setting in determining whether the 75% threshold is met. For a group to qualify for the facility-based scoring option, 75% of the eligible clinicians under the TIN must meet the eligibility criteria as individuals. CMS proposes to automatically apply facility-based measurement to eligible clinicians and groups and calculate a combined quality and cost performance category score. If CMS receives another MIPS data submission for the clinician or group, it would assign the higher combined quality and cost performance category score.

Overall, the AAMC is supportive of the facility-based scoring proposal as we believe it can reduce reporting burden on facility-based MIPS eligible clinicians by leveraging existing quality data sources and better aligning the incentives between facilities and the MIPS eligible clinicians who provide services there. CMS should consider expanding this approach for physicians who are employed in other facilities, such as skilled nursing facilities. With regard to the clinicians in the hospital setting, we support the use of the Hospital VBP program as the method for determining quality and cost and we support the approach outlined by CMS that would assign the highest score if CMS receives another MIPS data submission for the eligible clinicians.

While we believe that the facility-based scoring can benefit some hospital-based physicians, as proposed it will most likely not be feasible for physicians in large multi-specialty practices that bill under one TIN as they would not be able to meet the 75% threshold. We encourage CMS to develop other mechanisms for facility-based physicians in these large practices to elect to be scored under this approach. One option would be to allow a portion of the group under one TIN, such as the facility-based clinicians, to report as a separate subgroup on measures and activities.

MIPS Scoring Bonus for Complex Patients

In the proposed rule, CMS continues the use of a complex patient bonus of up to 5 points for eligible clinicians who care for complex patients, based on Hierarchical Condition Categories (HCC) risk scores and the percentage of dual-eligible beneficiaries treated. We applaud CMS for recognizing the need to provide a bonus for treating complex patients. Physicians at academic medical centers care for vulnerable populations of patients who are sicker, poorer, and more complex than many patients treated elsewhere. As a result, they may require higher resource utilization, which may impact their quality scores. **We urge CMS to extend the bonus beyond the 2019 performance year and to potentially increase the cap so that it is higher than 5 points.** The impact of the bonus on the final score, even when increased to five points (out of 100), is likely to be minimal.

In the 2018 Physician Fee Schedule final rule, CMS paired the average HCC risk score with the proportion of dual eligible to determine the complex patient indicator. We believe that this is a first step towards identifying complex patients; however, we recommend CMS consider and test additional variables when accounting for social risk factors for purposes of determining a bonus for treating complex patients. CMS should consider the four domains recommended by the National Academy of Medicine, which include: (1) income, education and dual liability; (2) race ethnicity, language, and nativity; (3) marital/partnership status and living alone; and (4) neighborhood deprivation, urbanicity and housing.

MIPS Performance Category: Quality

For the 2019 performance year, CMS proposes to set the quality performance weight at 45% due to a proposed increase in the cost category weight to 15%. In addition, the reporting period for the quality performance category would be a full year for the 2019 performance period. Quality reporting still requires reporting of six measures, including one outcome measure. If providers choose to report via Web Interface, all Web Interface measures must be reported. In addition, practices are scored on one additional population measure, the all-cause hospital readmission measure.

CMS is a proposing to remove 34 quality measures, including six web interface measures. The six web interface measures proposed for removal are:

- Medication Reconciliation Post-Discharge
- Pneumococcal Vaccination Status for Older Adults
- Diabetes Eye Exam
- Preventative Care and Screening: BMI Screening and Follow-up Plan
- Ischemic Vascular Disease (IVD) Use of Aspirin or Another Antiplatelet
- Falls: Screening for Future Fall Risk (this would be replaced will be a new combined measure)

The AAMC supports the agency's Meaningful Measures framework and its proposal to remove these measures in the Web Interface program or revise them as this is a good step toward reducing provider burden. It is important to ensure that measures under the program provide meaningful value to clinicians reporting the data, beneficiaries, and the program. We recommend

that measures be NQF-endorsed to ensure that the measure is scientifically valid, reliable, and feasible.

There are several other measures in the Web Interface that we recommend CMS remove or refine to ensure they are appropriate for large group practices and reflect current recommendations. One measure that has been a challenge for academic medical centers is the depression remission measure. The depression remission measure (MH-1) measures the number of patients with major depression as defined as an initial PHQ-9 score > 9 who demonstrate remission at twelve months as defined as a PHQ-9 score <5. The requirement for PHQ-9 use for evaluating patients combined with a follow-up evaluation is problematic for many large group practices. The measure must be recorded for 248 patients, a very difficult bar for large multi-specialty group practices which refer patients for treatment and follow-up to psychiatrists if they have a PHQ of 9. The measure seems to be designed for group practices that do not have this type of referral pattern. This is just one example of practice pattern differences between large academic medical groups and small and or/ rural practices. **The AAMC asks that the measure be removed, and that CMS determine if there may be other measures related to depression that would be more appropriate to use in the MIPS program.**

Another measure that should be revised to reflect recent national consensus about appropriate blood pressure measurements is the "controlling high blood pressure measure." A national consensus has developed that blood pressure should vary by age and diagnosis. However, the MIPS measure requires a strict policy of controlling to less than 140/90 for hypertensive patients, regardless of age, and 120/80 for screening purposes. These levels are not consistent with current medical evidence or opinion such as those noted in the Eighth Joint National Committee. There should be a mechanism for removal of a measure that is no longer consistent with clinical guidelines or current practice and adding the measure back to the program when re-specified. We continue to have concerns with the use of the 30-day hospital readmission measure in the program. CMS should remove the 30- day hospital readmission measure from the program as it will potentially penalize physicians who care for the most complex patients or those with low socioeconomic status. The impact of inadequate risk adjustment has been raised as a significant concern in the context of the hospital readmission quality program. This measure also is not appropriate as a physician quality measure because physicians may have limited control over sociodemographic factors which may be important contributors to a hospital readmission.

MIPS Performance Category: Cost

In the 2019 proposed rule, CMS proposes to increase the weight of the cost category to 15%, and to assess performance in the cost category by utilizing: 1) the Total Per Capita Measure, 2) the MSBP measure, and 3) 8 episode-based cost measures. CMS also proposes a new attribution method for 3 of the new episode cost measures. CMS also solicits feedback on whether cost scores should be based on two years of data rather than one.

Given the multiple undetermined factors under the cost category, including the need for risk adjustment, the need for better attribution methodologies, and further development of episode groups, the AAMC strongly urges CMS to continue the weight of the cost category at 10%. Our concerns are enumerated in further detail below.

Cost Category Measures

CMS plans to assess performance in the cost category by utilizing: 1) the Total Per Capita Measure, 2) the MSPB measure; and 3) 8 episode-based cost measures. The episode cost-based measures are:

- Elective Outpatient Percutaneous Coronary Intervention (PCI)
- Knee Arthroplasty
- Revascularization for Lower Extremity Chronic Critical Limb Ischemia
- Routine Cataract Removal with Intraocular Lens (IOL) Implementation
- Screening/Surveillance Colonoscopy
- Intracranial Hemorrhage or Cerebral Infarction
- Simple Pneumonia with Hospitalization
  ST-Elevation Myocardial Infarction (STEMI) with PC

All Cost Measures Must be Appropriately Adjusted to Account for Clinical Complexity and Sociodemographic Status.

The 8-episode cost measures risk adjust based on variables, such as age, and comorbidities by using HCC data and other clinical characteristics. While the total per capita cost measure and the Medicare Spend Per Beneficiary (MSPB) measure are risk adjusted to recognize the higher risk associated with demographic factors, such as age, or certain clinical conditions, these measures are also not adjusted for other sociodemographic factors. We are concerned that none of the cost measures are adjusted to account for sociodemographic status. In addition to differences in patient clinical complexity, sociodemographic status can drive differences in average episode costs. Recent reports from the National Academies of Science, Engineering and Medicine and Assistant Secretary for Planning and Evaluation (ASPE) have clearly acknowledged that SDS variables (such as low income and education) may explain adverse outcomes and higher costs. Without accounting for these factors, the scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their performance will not be adequately represented to patients. In particular, physicians at AMCs care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere.

The AAMC believes that there are ways to appropriately adjust for SDS by incorporating SDS factors in the risk adjustment methodology. **We request that these measures be appropriately adjusted to account for these risk factors.**

Attribution Method Should be Clear and Transparent and Accurately Determine Patient/Clinician Relationship

With regard to cost measures, it is critical that there be an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that most patients receive care from numerous clinicians across several facilities. The attribution method used should be clear and transparent to clinicians.

CMS proposes a different attribution approach than that previously established for acute inpatient episode groups. Specifically, CMS proposes to attribute episodes to each MIPS eligible

clinician who bills inpatient E/M claims lines during a trigger inpatient hospitalization under a TIN that renders at least 30% of the inpatient E/M claim lines in that hospitalization with the Medicare Severity Diagnosis Related Groups (MS-DRGs) for the episode group. We are concerned that the clinical panels that created the inpatient condition measures did not have any discussion about this new approach to attribution. It is unclear as to how many additional physicians or groups would have these 3 episode cost measures attributed to them due to this change in the attribution approach. We recommend that CMS provide more analysis before implementing this new attribution measure.

We believe that better data sources and analytic techniques should be explored in the future to support more accurate attribution of these episodes. Attribution is a key component of these cost measures. There has been a focus on identifying how information from claims could be used to inform the attribution of services to clinicians or any other information that could clarify the relationship between patient and clinician. CMS indicated that there is a belief in the future that attribution will be benefited by the development of patient relationship codes, which were just finalized in the 2018 Physician Fee Schedule rule. CMS stated that they plan to consider how to incorporate these patient relationship categories and codes into the cost measure methodology as clinician's gain experience with them. While use of these codes could have the potential to improve data and promote accurate assignment of accountability, there could also be concerns with their accuracy. Significant education and testing need to be completed before using this information for attribution.

Quality Payment Program Feedback Reports: Cost Category

In the past, our members have found the feedback reports to have a significant amount of information that is useful to clinicians. Information on the breakdown and utilization and cost by Medicare setting and service category is helpful and can be actionable if the clinician is able to have some control over the referral or provision of services in a particular setting. Clinicians need to understand why a patient was attributed to him or her. Therefore, it is important for providers to have the opportunity to review feedback reports in advance and determine whether the patient's attributed to them appear to be accurate.

In discussions with members, the AAMC has found that this year's feedback reports differ from past years, and contain very little, if any, actionable data related to the cost category. For example, members have reported that there is no information on patients, nor is there detailed information on each category. The reports simply show overall scores and do not provide detail about the numerator and denominator. Members have also reported that they believe cost scores in particular may be inaccurate, but the reports do not provide enough information to verify how the score was calculated or what data was used. The AAMC is concerned that without detailed information on the cost reports, specifically on the cost category, providers will be unable to determine how they are performing or how they compare to other providers, and ultimately will be unable to make improvements within the Quality Payment Program.

Feedback on Cost Performance Should be Timely

CMS questions whether cost scores should be based on two years of data rather than one. Although two years could result in more reliable data, we are concerned that this timeframe

would create a long gap between the performance and the payment years. It is difficult to improve performance without timely data.

MIPS Performance Category: Promoting Interoperability

In the rule, CMS proposes several scoring and measurement policies that increase the focus on interoperability and improving patient access to health information. To better reflect this focus, CMS renames the Advancing Care Information performance category to the Promoting Interoperability performance category. Beginning with the 2019 performance period, CMS proposes that MIPS-eligible clinicians must use EHR technology certified to the 2015 Edition certification criteria.

AAMC Supports a Scoring-Based Approach for Promoting Interoperability

CMS proposes a new scoring methodology based on performance on individual measures. The new scoring methodology would have four objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange. MIPS-eligible clinicians would be required to report certain measures from each objective, with performance-based scoring at the individual measure level. The score for each individual measure would be added together to calculate the Promoting Interoperability (PI) performance score of up to 100 points for each MIPS-eligible clinician, with each measure having a maximum number of points. The AAMC supports this change to scoring based on performance, as it simplifies scoring, provides increased flexibility to clinicians and will enable them to focus more on patient care and health data exchange through interoperability. It also is a positive step as it will align the requirements of the PI performance category in MIPS with the requirements of the PI program for eligible hospitals.

Measures Proposed for the Promoting Interoperability Programs Should Be NQF- Endorsed, Approved by the MAP, and be Transitioned Over a Period of Public Reporting Before Factored into Meaningful Use Scoring

CMS is proposing to add two new e-prescribing measures to e-prescribing objective: Query of the Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment. For 2019, CMS proposes that these two new measures would be optional, and clinicians would receive bonus points for reporting them. For 2020, the e-prescribing measures would be reweighted as these would no longer be bonus measures.

The AAMC recognizes the value of new tools to assist with the opioid addiction epidemic but cautions against making these measures required as early as 2020 due to the need for better integration of these tools with CEHRT. CMS should not consider including these measures in the program until they are more adequately defined and there is better evidence of integration of these tools into CEHRT by vendors and into clinical workflows by providers. We recommend implementing them as bonus measures until there is sufficient time to integrate them into systems.

Currently, CEHRTs do not have widespread integration of the PDMP tools. Providers often need to manually document a query of the PDMP to score the measure, adding considerable burden. The AAMC recommends that the Office of National Coordinator (ONC) consider adopting

standards and certification criteria to support the query of PDMP before the measure is required under the program. Adding to that burden is that in some states, providers are charged for each query. CMS should examine more closely the impact of the fees charged by states on the performance of this measure. Finally, we are concerned that the measure is not adequately defined, as it does not include measure limits to the number of queries during a hospital stay. The AAMC recommends further discussion with stakeholders before the measure is finalized and implemented in the program. If finalized, CMS should simplify the PDMP measure by scoring it as a yes/no measure instead of by a numerator and denominator.

Regarding the treatment agreement measure, the AAMC notes that there is a lack of clarity of what would constitute a treatment agreement sufficient for meeting the goals of the measure. There are also questions of precisely how electronic the agreement must be – does it require an electronic signature, or can it be a paper agreement that is scanned into the EHR? This is of concern as some of our members have considered investment in electronic agreement tools in the inpatient setting, such as electronic signature pads, and found the cost to be prohibitive. If such tools were necessary for meeting performance standards on the measure, providers would have to make a resource determination unrelated to the value of the agreements at the heart of the measure. Additionally, some hospitals have implemented treatment agreements into ambulatory care setting clinical workflows and would need time to redesign workflows and transition them into the inpatient setting.

Overall, we continue to strongly recommend that all new measures be NQF-endorsed to ensure that the measure is scientifically valid, reliable, and feasible. Measures under the Promoting Interoperability Programs should be approved by the MAP before the measure the measure is proposed. Finally, considering CMS's Meaningful Measures framework, any new measures should be evaluated within the framework and appropriate corresponding measure removals should be considered to balance a measure's addition. Until this occurs, relevant stakeholders do not have all the necessary information to make a critical assessment as to whether a measure is appropriate for the program.

CMS Should Align Interoperability Programs as Much as Possible

We commend CMS for aligning the MIPS Promoting Interoperability Program with the hospital PI program. In the future, we recommend that the state Medicaid programs also adopt similar scoring methodology and objectives and measures for meaningful use. This is necessary to reduce burden and meet the broader goal of greater interoperability. Eligible hospitals and physicians should be evaluated across the same standards for promoting interoperability.

Alternative Payment Models

The AAMC encourages CMS to continue to allow more opportunities for physicians to be qualified alternative payment model (APM) participants and receive the 5% incentive payments. The AAMC supports alternative payment model (APM) programs, such as accountable care organizations (ACOs) and bundled payment initiatives, that seek to promote high-quality, efficient care while retaining at their core the essential patient-physician relationship. Many AMCs are participating in new payment models, including Pioneer ACOs and Medicare Shared Savings Program (MSSP) ACOs, and BPCI. The AAMC strongly supports the work of our

members, as is evident from our role as a facilitator-convener for the Bundled Payments for Care Improvement (BPCI) initiative for 30 hospitals and 19 health systems. Our own and our members' experiences with such alternative delivery models largely inform our comments below.

Qualifying/Partial Qualifying APM Thresholds

To be considered a qualified participant in an advanced APM and receive the 5% bonus payment, certain threshold related to payments under the advanced APM or Medicare patients treated by the advanced APM must be met or exceeded. In the first two years of the program, CMS set the threshold at 25% of Medicare payments would need to be made from the advanced APM, or 20% of patients. This amount is gradually increased in future years of the program. In the 2021 payment year, CMS proposes that the threshold of Medicare payments would increase from 25% to 50%, and the patient threshold would increase from 20% to 35%. The AAMC has concerns that this threshold will be more difficult for APMs to meet as these thresholds to be a qualified participant in an advanced APM increase in the coming years. Over the next several years, CMS should review and analyze information about physician participation in advanced APMs to determine whether a change in these thresholds is warranted. If the thresholds are too high, it may discourage physician participation.

Financial Risk Standard Setting for QP Performance Periods 2021-2024

Advanced APMs are required to bear more than nominal risk for monetary losses. The generally applicable revenue-based nominal amount standard initially was set at 8% or greater for QP performance period and later extended through 2020. CMS proposes to retain the 8% standards for QP performance periods 2021-2024.

The AAMC supports CMS' decision that the generally applicable revenue-based nominal amount standard remains at 8% of the average estimated total Medicare Parts A and B revenue of providers participating in APM entities through 2024. CMS seeks comment on whether it should consider raising the revenue-based standard to 10% and the expenditure-based nominal amount standard to 4%, starting with QP performance periods in 2025. To preserve stability and clarity in the program, we believe it is important to maintain the standard at 8% and 4% in the future.

The current levels of risk are more than sufficient to promote accountability. In addition, eligible clinicians will already be taking on additional risk in advanced APMs as the thresholds to be a qualified participant in an Advanced APM will increase from 25% of Medicare payments to 75% of Medicare payments, and the patient count threshold increases from 20% of patients to 50% of patients over the next several years. CMS should review and analyze information about physician participation in advanced APMs over the next few years to determine whether a change in the amount of required financial risk should be made in the future. If CMS sets a downside risk that is too high, it will create a barrier to physician participation.

All-Payer Combination Option

Starting in the 2021 payment year, a clinician may achieve status as a qualified participant of an alternative payment model through the All-Payer Combination Option. Thresholds under this option can be met by combining payments or patients from Other Payer Advanced APMs with

those from Medicare advanced APMs. These processes involve either the payer or the eligible clinician submitting detailed information to CMS for a determination that would be made at the individual clinician level. The AAMC has significant concerns with the approach to the All Payer Combination Option. It presents major operational challenges for eligible clinicians as compared to the Medicare option. Reporting the information to CMS would be extremely burdensome for the eligible clinicians. CMS needs to work with stakeholders to develop mechanisms to simplify determination of the threshold.

In this proposed rule, CMS states that the determination of Other Payer Advanced APM status would be effective for five years as long as no changes are made. We support this extension to 5 years as it will reduce burden significantly from the existing policy which would have only allowed the status to be effective for one year.

Threshold Scores for QP Status Determinations Under the All-Payer Combination Option
CMS previously finalized that under the All-Payer Combination Option, clinicians may request their QP determinations to be made at the individual level while APM Entities may request assessment at the APM Entity (group) level. QP status will be assessed and awarded based on the higher of the two threshold scores. However, eligible clinicians for whom QP status is assessed individually under the Medicare option will also be assessed only at the individual level under the All Payer Combination Option.

CMS proposes to add an alternative under which TIN-level determinations could be requested in addition to those at group or individual levels. The TIN-level alternative would only apply when all clinicians who have reassigned their billing rights under the TIN participate in the same (single) APM entity. CMS proposes to use the most advantageous QP outcome (individual, TIN, or APM entity level). We support this alternative as it would add to QP determination flexibility, increase the number of APMs, reduce burden, and better reflect non-Medicare payer contracting practices.

REQUEST FOR INFORMATION: PROMOTING INTEROPERABILITY AND ELECTRONIC HEALTHCARE INFORMATION EXCHANGE THROUGH POSSIBLE REVISIONS TO THE CMS PATIENT HEALTH AND SAFETY REQUIREMENTS FOR HOSPITALS AND OTHER MEDICARE AND MEDICAID PARTICIPATING PROVIDERS AND SUPPLIERS

The AAMC appreciates the opportunity to provide feedback to this Request for Information on promoting interoperability and the electronic healthcare information exchange, as part of our broader comments on the Quality Payment Program. In the 2019 Physician Fee Schedule Proposed rule, CMS seeks input from stakeholders on how they could use health and safety standards that are required for providers and suppliers participating in the Medicare and Medicaid programs to further advance electronic exchange of information that supports safe, effective transition of care between hospitals and community providers.

CMS Should Not Create Additional Conditions of Participation (CoPs) as Part of the Agency's Efforts Towards Promoting Interoperability and Electronic Healthcare Information Exchange

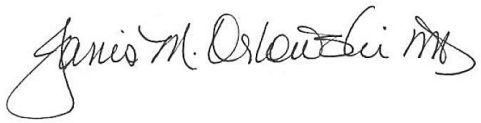
While the agency's goals of interoperability are increasingly important to transforming health care in the digital age, the **AAMC opposes any use of the conditions of participation (CoPs) for interoperability and electronic exchange of health information**. CoPs are not the right vehicle to encourage interoperability given the importance of CoPs and the significant consequences if not met, particularly since interoperability is still in progress. CMS has other policy levers to promote broader interoperability and use of electronic healthcare information exchanges, most notably the Promoting Interoperability Programs. Furthermore, requiring providers to meet interoperability requirements to comply with new CoPs in addition to the interoperability reporting requirements under the Promoting Interoperability Programs and the Inpatient Quality Reporting Program, while also participating in other Federal efforts, would be unnecessarily burdensome and duplicative.

The Office of the National Coordinator (ONC) explained that hospitals typically do not have the leverage to solve the obstacles of interoperability in its 2015 report to Congress on issues of information blocking, "Having made these investments, providers may be financially and otherwise unable to switch to superior technologies that offer greater interoperability, health information exchange capabilities, and other features. These switching costs make it easier for developers to engage in information blocking without losing existing customers."[1] **Revising CoPs is not likely to have an impact on the significant issue of information blocking, and the AAMC believes that CMS should instead identify other possible solutions that recognize the significant burden on providers with new interoperability requirements.**

CONCLUSION

The AAMC appreciates your consideration of the above comments. Should you have any questions, please contact Gayle Lee at galee@aamc.org or Kate Ogden at kogden@aamc.org.

Sincerely,



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cc:
Ivy Baer, AAMC
Gayle Lee, AAMC
Kate Ogden, AAMC

[1] "Report on Health Information Blocking," Office of the National Coordinator (April 2015), p. 23, https://www.healthit.gov/sites/default/files/reports/info_blocking_040915.pdf.