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Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: Medicare Program; Revision 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

Dear Administrator Verma:

The American Geriatrics Society (“AGS”) greatly appreciates the opportunity to comment on the Physician Fee Schedule (“PFS”) and Quality Payment Program (“QPP”) Proposed Rule for Calendar Year (“CY”) 2019 (CMS-1693-P) [hereinafter the “Proposed Rule”]. The AGS is a not-for-profit organization comprised of nearly 6,000 physician and non-physician practitioners (“NPPs”) who are devoted to improving the health, independence and quality of life of all older adults. The AGS provides leadership to healthcare professionals, policy makers, and the public by implementing and advocating for programs in patient care, research, professional and public education, and public policy. Our mission is to advance efforts that promote high quality of care, quality improvement, and increased payment accuracy for physicians and other professionals paid under the PFS and through the QPP. The AGS shares CMS’s commitment to the overall goal of reforming Medicare payment structures to improve patient outcomes and the quality of care provided, and we appreciate the efforts CMS has made in this rule to reduce reporting burden so that healthcare providers can spend more time focusing on patients.

The AGS strongly supports the “Patients Over Paperwork” initiative. We appreciate that CMS understands the administrative burden attributable to the current documentation guidelines for the new and established outpatient Evaluation and Management (“E/M”) service codes and applaud CMS for its desire to address these issues. However, the AGS has significant concerns with the specific payment changes that CMS proposes for 2019 and believes that the payment changes should not be finalized in the CY 2019 Final Rule. Instead, we recommend that CMS work with the AGS and other stakeholders to create revisions to E/M that better meets the Agency’s goals of improving patient care and reducing burden, without the undesirable consequences described below. We urge CMS to not finalize any of its E/M payment proposals, including the proposed modifier 25 reimbursement reduction policy and to withdraw any changes in outpatient visit coding or payment until a consensus on equitable E/M revisions is achieved. We believe that a step-wise and open approach that includes a sophisticated

data analysis and involves all stakeholders will help CMS achieve an E/M payment structure that allows accurate reporting of physician work and practice expenses for office visits.

I. Recommendations

The AGS recommends that CMS adopt the following recommendations with regard to the PFS and QPP portions of the 2019 Proposed Rule:

- CMS should withdraw all of its proposals related to payment for E/M services including the proposed collapsing of payment for 99202-99205 and 99212-99215, the proposed multiple procedure reduction, and the proposed G codes for primary care and specialty adjustments and prolonged services.
- CMS should finalize several of its proposals to reduce documentation burden including allowing physicians to choose among time, medical decision-making, or the existing documentation guidelines for use in their practice(s).
- CMS should broaden the scope of its advanced virtual check in code proposal (GVCI1) to include all patient initiated communications irrespective of whether the communication results in an office visit within 24 hours. CMS should also consider allowing for a single advanced consent for this service, rather than requiring the physician to obtain consent each time a service is initiated. CMS should also clarify how it intends to determine that a communication is patient initiated, what documentation is required to support billing, and how it will conduct audits for this service.
- CMS should finalize the proposal to pay separately for interprofessional internet consultations (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449).
- CMS should adopt the RUC recommended work value of 0.70 for 994X6.
- CMS should not finalize the proposed work RVUs for chronic care management services (CPT code 994X7) of 1.22 and instead adopt the RUC recommended value of 1.45 RVUs.
- CMS should finalize its proposal to add additional codes (G0513 and G0514) to the list of services that may be provided via telehealth.
- Prior to implementing facility-based scoring, CMS should conduct modeling analysis to determine how non-facility-based clinicians' performance in the quality and cost performance categories changes when facility-based clinicians are scored through the alternative methodology and share that information for public comment.
- CMS should expand facility-based scoring to post-acute care settings, beginning with skilled nursing facilities. CMS should convene a group of post-acute/long-term care specialists and measure scientists to test the feasibility and impact of applying Skilled Nursing Facility Quality Reporting Program and IMPACT measures to clinicians practicing in these settings.

- CMS should finalize its proposal to recognize those MIPS eligible clinicians who provide a sufficient amount of patient care through Qualifying Payment Arrangements under the Medicare Advantage Qualifying Payment Arrangement Incentive (“MAQI”) Demonstration and to exclude those clinicians from MIPS requirements and payment adjustments; however, we urge CMS to adopt the proposed MAQI Demonstration with an amended, and more inclusive, definition of “nominal financial risk.”
- CMS should finalize the Geriatrics specialty measure set. However, CMS should consider revising the proposed new Zoster (Shingles) Vaccination (MUC17-310) measure, which is included in the measure set, so that eligible clinicians receive credit for discussing the vaccine with their patients, irrespective of whether the patient ultimately receives it.
- CMS should not remove Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (measure # 048) from the MIPS program.
- CMS should proceed with a slow and thoughtful process for removing topped out measures and finalize its proposal to begin with only six topped out measures.
- CMS should be extremely cautious when removing process measures. CMS should add an additional criterion regarding the availability of other MIPS quality measures that cover the same condition or procedure to the list of criteria considered when evaluating whether to remove a process measure. CMS also should remove process measures only where there is an alternative MIPS quality measure available. Finally, CMS should weigh the criterion related to availability of measures for a specific specialty heavily as part of this process to avoid unfair implications for clinicians.
- CMS should not implement a multi-weight scoring methodology.
- CMS should replace the existing two-step attribution process for the measure “Total per capita Medicare Part A and B costs/year.” Specifically, a patient and his associated Part A and Part B costs should be attributed to a provider who attests to having a continuous/broad relationship through claims data.
- CMS should explore ways to incorporate frailty into the risk adjustment methodology for cost measures.
- CMS should maintain the Cost performance category weight at 10% for the 2021 MIPS payment year. Additionally, CMS should establish scoring policies to allow for a more gradual impact of these cost measures on a clinician’s overall performance, as well as time for CMS and stakeholders to evaluate their effectiveness and any unintended consequences.
- For the 2021 payment year, CMS should establish a minimum floor of 3 points for cost measures, as it has for quality measures. All new episode-based cost measures should be

assigned a score of zero for at least the first year of inclusion in the Cost performance category so that they can be beta-tested.

- CMS should not finalize its proposed changes to the scoring methodology for the Promoting Interoperability performance category. This performance category should be scored like the others, where clinicians and groups are scored on each measure reported and if one is not reported, the clinician receives a zero only for that measure.
- CMS should adopt a more inclusive definition of “financial risk of monetary losses” by designating as Advanced APMS those models that take on one-sided risk and otherwise meet the statutory and regulatory requirements and lowering the applicable percentage of risk required for both the revenue-based standard and the benchmark-based standard.
- CMS should lower the nominal risk amount for both the revenue-based standard and the benchmark-based standard across all clinicians.

More detailed comments on specific proposals in the Proposed Rule are set forth below.

II. Provisions of the Proposed Rule

A. Physician Fee Schedule

1. Evaluation & Management (“E/M”) Payment and Documentation Requirements

CMS proposes to apply a minimum documentation standard under which practitioners would only need to meet documentation requirements currently associated with a level 2 visit for history, exam, and medical decision-making (“MDM”). In addition, CMS proposes to allow practitioners to choose to use time as the single factor in selecting the level for office/outpatient E/M visits, instead of using the documentation framework or MDM.

CMS also proposes to pay a single rate for level 2-5 E/M visits (99212-99215 for established patients, 99202-99205 for new patients). The proposed single payment amount for established patients is a little more than the current payment amount for 99213 and a single payment amount for new patients that is a little more than the current payment amount for 99203. CMS also proposes to require physicians to continue to report the level of service they “believe” they furnished using existing CPT codes 99212-99215 and 99202-99205, even though the code choice would not affect payment.

The single level payment amounts were determined by (1) weight averaging the work RVUs based on specialty utilization for levels 2-5 and (2) establishing a new E/M practice expense pool. This proposal resulted in an extremely negative impact on specialties that predominantly bill level 4 and 5 services and an extremely positive impact on specialties that bill mostly level 2 and 3 services. CMS attempted to mitigate these impacts by creating complexity adjuster codes for primary care and selected specialty care. These payment amounts are \$5.41 and \$13.70 respectively and, when billed with the new single payment level, would still pay significantly less than the current payments for 99214 and 99204. CMS, realizing that it was paying the same amount for a 40 minute visit as for a 10 minute

visit, also proposed to establish a new prolonged services code that could be reported in addition to the underlying visit code if the visit lasted 15 minutes beyond the typical time for the visit.

Due to the way CMS structured its proposal with its interconnected parts, CMS has described it as a take it or leave it, “all or nothing” proposal.

AGS strongly urges CMS to withdraw all of its proposals related to payment for outpatient/office visits (i.e., the proposed collapsing of 99202-99205 and 99212-99215, the proposed multiple procedure reduction, and the proposed G codes for primary care and specialty adjustments). Instead, we invite CMS to engage with stakeholders over the next year to develop a refined approach that will achieve CMS’s goal of burden reduction while also ensuring the best possible outcome for patients. We believe that this collaborative effort will more effectively address the needs of the Agency to have accurate pricing for the outpatient E/M services consistent with the Congressionally mandated resource based nature of the work, the appropriate practice expense support and calculated malpractice costs. The accurate pricing of outpatient E/M services is integral to all efforts at healthcare payment reform. In addition, implementation of any new coding structure requires substantial physician and office staff education and changes to our electronic health records systems, as well as changes for Medicare contractors, commercial payers, and auditors. CMS must allow ample time for education and implementation. With an eye to minimizing confusion, we urge that consideration be given to the role of the CPT editorial process in developing consistent codes for use by all payers.

AGS recommends that for CY 2019 CMS finalize the following changes to documentation requirements while retaining the existing five level coding structure:

1. Allow physicians to document visits based solely on the level of medical decision-making or the face-to-face time of the visit as an alternative to the current guidelines.
2. If physicians choose to continue using the current guidelines, limit required documentation of the patient’s history to the interval history since the previous visit (for established patients).
3. Eliminate the requirement for physicians to re-document information that has already been documented in the patient’s record by practice staff or by the patient.
4. Eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.
5. Remove the need to justify providing a home visit instead of an office visit.

In addition to the above comments and recommendations, the AGS is part of a multi-specialty coalition, group of diverse medical societies, that provided separate more detailed comments in response to CMS’s E/M proposals and we adopt those and incorporate them by reference into this letter (see Appendix A). The coalition recommends that CMS not finalize any of its E/M payment proposals, including the proposed modifier 25 reimbursement reduction policy, and withdraw any changes in outpatient visit coding or payment until a consensus on an equitable coding structure is achieved. The coalition believes that a step-wise and open approach that includes a sophisticated data analysis and

involves all stakeholders will help CMS achieve an E/M payment structure that allows accurate reporting of physician work and practice expenses for office visits.

2. Communication Technology-Based Services

a. Virtual Check-in (HCPCS Code GVC11)

CMS proposes to establish a code for a brief check-in with a patient using communication technology to evaluate whether or not an office visit or other service is warranted. This service would not be separately billable if it originates from a related E/M service provided within the previous seven days or leads to an office visit in the next 24 hours. The service could be provided only to established patients and the beneficiary would be liable for cost-sharing for this service.

AGS appreciates CMS's ongoing efforts to recognize the significant changes in how health care is practiced and particularly steps CMS has taken to develop coding and payment for the active management and ongoing care of chronically ill patients. Our members care for the sickest and most complex Medicare beneficiaries so we greatly appreciate CMS's recognition that management of those patients is an important service that should be valued and paid for under the PFS. We believe that Medicare should support innovative care models that encourage development of strong physician-patient relationships and better meet patient needs. We see the virtual check-in code as another potential improvement in payment for patient interaction and care that occurs outside of a traditional office visit and applaud CMS for recognizing these services.

However, we also note that there are other virtual services that are included in the proposal but are equally as valuable and should be included. For example, CMS proposes to limit use of the new code to situations in which the physician determines that follow up care is not needed in the next 24 hours. Calls in which the physician determines additional care is needed rapidly are just as, if not more, important because they can result in timely interventions that avoid emergency department visits or hospitalizations. The current proposal provides a financial incentive for physicians to send patients to the emergency room or to delay an office visit (e.g., for 48 hours). We believe CMS should expand its proposal to include all virtual check-ins. All these calls involve the same amount of medical decision-making whether or not they lead to an in-person visit and represent a separate service in addition to the in-person care. We ask that CMS also consider providing separate payment for all calls to recognize the cost of such virtual care.

In addition, because beneficiaries will have to pay a co-pay for this service, we agree that it is important that beneficiaries are aware of the cost associated with the service and that the service only be provided when medically necessary. However obtaining consent at the time of service may not be appropriate since the service will already have been initiated before consent can be obtained. **We recommend that CMS consider allowing for advance consent, similar to the HIPAA Authorization to Disclose Medical Information, to facilitate access to the service. That is, the practitioner should be required to obtain consent once and not every time the service is performed. We also ask that CMS clarify how it intends to audit for this service and keep documentation requirements at a minimum, to avoid undermining CMS's broader efforts to reduce physician burden.**

- b. Interprofessional Internet Consultation (CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449)

CMS proposes to recognize a series of codes for interprofessional internet consultation that would reimburse assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when a patient's treating physician requests the opinion and/or treatment advice of a consulting physician with specific specialty expertise to assist with the diagnosis and/or management of the patient's problem without the need for the patient's face-to-face contact.

AGS concurs with CMS's proposal to make separate payment for the interprofessional internet consultation codes. We agree with CMS that these services represent an important element of care for complex patients, such as those treated by AGS members, and that providing Medicare payment for the internet consultation codes will facilitate team-based care. **We urge CMS to finalize the proposal to pay separately for CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449.**

Several of the interprofessional consultation codes (99446, 99447, 99448, and 99449) already have RVUs established under the PFS. However, two codes are new: 994X0 *Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes* and 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 Relative Value Scale Update Committee ("RUC") recommended physician work RVUs of 0.50 for 994X0 and 0.70 for 994X6. CMS accepted the recommendation of 994X0 but proposed to reduce the work RVUs for 994X6 to 0.50, because CMS believes the two codes have similar intra-service times and therefore should have equal values for physician work.

The RUC concluded that code 994X6 is equivalent in intensity to code 99447, which requires 11-20 minutes of medical consultative discussion, as well as both a written and verbal report. When the RUC valued code 99447 in October 2012, it used 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 its key reference service, concluding that code 99447 is a more intense procedure due to the fact that the patient is typically unknown to the consulting physician, making the service provided in a complex/urgent situation and the medical decision-making required more intense than code 99442. These same concepts apply to code 994X6.

We concur with the RUC's assessment and urge CMS to adopt the RUC recommended work value of 0.70 for 994X6.

- c. Chronic Care Services Code (CPT Code 994X7)

CPT created a new code to describe CCM services provided by billing practitioner: 994X7 *Chronic care management services, provided personally by a physician or other qualified health care*

professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored. CMS proposes to recognize this new code for Medicare payment. **We appreciate that CMS is proposing to recognize this service and concur that 994X7 should be priced under the PFS.**

However, we recommend that CMS adopt the RUC recommendation for physician work RVUs rather than the proposed value. The RUC recommended work RVUs of 1.45 for 994X7. CMS proposed to reduce the value to 1.22, based on the work RVUs assigned to CPT code 99490 *Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.* The proposed work RVUs for 994X7 are twice the work RVUs of 0.61 assigned to 99490 because 994X7 has 30 minutes of intra-service time compared to 15 minutes for 99490. CMS also stated that its proposal would resolve a rank order anomaly with CPT code 99487 *Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, establishment or substantial revision of a comprehensive care plan, moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month* which has 26 minutes intra-service and work RVUs of 1.0.

We disagree with CMS. Both 99487 and 99490 are performed by clinical staff under the supervision of a physician. The patient acuity criteria for all these services are the same but the physician work is different and more intense for code 994X7. There is a significant difference in intensity when a physician performs all the care management services (as for 994X7) as opposed to when the physician supervises clinical staff who perform the care management services (as in 99487 and 99490). When a physician personally performs CCM activities for a patient, he or she does so because the patient and the patient's condition(s) requires a level of knowledge and skill that only the physician can provide. Mental effort and judgment and technical skill are all elements of intensity. The value recommended by the RUC recognizes that when a physician's mental effort and judgment and technical skill are personally brought to bear on behalf of a patient, the intensity of the service is greater than when the physician is simply supervising the efforts of the clinical staff. In addition, we believe the CMS proposal creates a significant rank order anomaly. The RUC recommended value of 1.45 is consistent with the work RVUs for other E/M codes personally provided by physicians. For example, a level 4 established patient office visit (99214) has 25 minutes intra-service time and work RVUs of 1.50. A work RVU of 1.22 for 994X7 would create a significant rank order anomaly with 99214.

Therefore, the AGS strongly recommends that CMS not finalize the proposed work RVUs for 994X7 of 1.22 and instead adopt the RUC recommended value of 1.45 RVUs.

3. Telehealth

The AGS supports CMS’s proposal to add additional codes (G0513 and G0514) to the list of services that may be provided via telehealth. The ability to provide services via telehealth expands the tools available to geriatricians to effectively and efficiently care for patients. We urge CMS to finalize the proposed additions to the telehealth list.

B. Quality Payment Program

1. Facility-Based Scoring Option

CMS previously finalized a facility-based scoring option for CY 2019 and, in this Proposed Rule, proposes some modifications and additional policies related to the implementation of this option. AGS is generally supportive of providing facility-based clinicians the option of using facility-based measures to assess their quality and cost performance because it will ease the reporting burden on clinicians. As we noted in last year’s comments, however, it is difficult to provide meaningful feedback on the specific proposal without better understanding the impact of these policies on non-facility-based clinicians. For instance, it is unclear whether facility-based clinician’s data will be included in measure benchmarks. Will facility-based clinicians’ costs be included in establishing the cost measure benchmarks? To the extent these clinicians have submitted quality measures during the benchmark period, will those scores be incorporated into the benchmarks used for the MIPS quality measures? Additionally, because facility-based clinicians and groups who submit quality data will receive the benefit of whichever score is higher between the facility-based score and the combined quality and cost performance score, this may advantage them compared to other clinicians against whom they are evaluated for purposes of determining total performance score and payment adjustments.

Prior to implementing facility-based scoring, CMS should conduct modeling analysis to determine how non-facility-based clinicians’ performance in the Quality and Cost performance categories changes when facility-based clinicians are scored through the alternative methodology and share that information for public comment. Similarly, once finalized, CMS should carefully monitor and assess the impact of its facility-based measurement policies on non-facility-based clinicians to ensure that these clinicians are not unfairly disadvantaged.

Additionally, CMS requests comments on expansion of facility-based measurement into post-acute care (PAC) and the end-stage renal disease (“ESRD”) settings. **The AGS supports expanding facility-based measures to PAC settings.** Several quality measures reported pursuant to the IMPACT Act and under the Skilled Nursing Facility Quality Reporting Program (“SNF QRP”) are potentially influenced by clinicians, such as SNF QRP measures of functional status, medication reconciliation, spending per beneficiary, discharge to the community, and hospital readmissions. Allowing clinicians to be scored for MIPS using these measures would increase alignment between facility and clinician performance incentives. **We recommend that CMS convene a group of post-acute/long-term care (“PA/LTC”) specialists and measure scientists to test the feasibility and impact of applying these measures to clinicians practicing in these settings.** CMS should begin with SNFs, but consider expanding to other settings, as efforts under the IMPACT Act harmonize the data reported across PAC settings.

Because clinicians and groups who see patients in PAC settings typically practice in multiple PAC facilities, as well as in other practice settings, we recommend that CMS establish an attribution

methodology that accounts for the nature of this work. Specifically, eligible clinicians and groups who see 40% of Medicare patients in PAC settings should be provided the opportunity to receive scores based on facility measurement. Eligible clinicians and groups should be given the highest score among the three facilities with their highest percentage of Medicare patient encounters.

The AGS would be pleased to work with CMS in developing facility-based measurement in PAC settings, including participating in any relevant stakeholder advisory groups.

2. Exclusion of MIPS Eligible Clinicians Participating in the Medicare Advantage Qualifying Payment Arrangement Incentive (“MAQI”) Demonstration

CMS proposes that, under the Medicare Advantage Qualifying Payment Arrangement Incentive (“MAQI”) Demonstration, beginning in CY 2018, MIPS eligible clinicians who participate in Qualifying Payment Arrangements (i.e., participation to a sufficient degree in certain Medicare Advantage Organizations (“MAOs”) arrangements) would be excluded from the MIPS reporting requirements and payment adjustment. To be a Qualifying Payment Arrangement, the arrangement must be consistent with the criteria CMS has established to be an Other Payer Advanced Alternative Payment Model (“APM”), including 1) the arrangement must require at least 50% of participants to use Certified EHR Technology (“CEHRT”) to document and communicate clinical care; 2) the arrangement must apply quality measures comparable to measures under the MIPS Quality performance category; and 3) the arrangement must require the entity to “bear more than nominal financial risk” if actual aggregate expenditures exceed expected aggregate expenditures, as CMS defines that term for Other Payer Advanced APMs.¹

AGS supports CMS’s proposal to recognize those MIPS eligible clinicians who provide a sufficient amount of patient care through Qualifying Payment Arrangements and to exclude those clinicians from MIPS requirements and payment adjustments. If finalized, this proposal will reduce the reporting burden and eliminate the compounded financial risk for clinicians who participate in these types of MAO arrangements. AGS agrees with CMS that MIPS eligible clinicians who participate in MAOs and who meet the specified criteria should be treated in a manner that approximates the treatment of eligible clinicians who meet the criteria to be a Partial Qualifying APM Participant.

As described in detail below in Section 6 of this comment letter, AGS believes that the CMS’s proposed definition of “more than nominal financial risk” is overly burdensome and restrictive. AGS strongly believes that CMS should define “nominal financial risk” through a broader definition that allows clinicians to take on a lower percentage of financial risk, and includes other types of potential monetary losses, such as the costs incurred when establishing the delivery model necessary to meet the requirements of the alternative financial arrangement. **We urge CMS to adopt the proposed MAQI Demonstration with an amended, and more inclusive, definition of “nominal financial risk.”**

¹ To bear “more than nominal risk,” the total amount an entity potentially owes a payer or forgoes under the payment arrangement is either 1) at least 8% of the total combined revenues from the payer to providers and other entities under the payment arrangement is revenue-based; or 2) at least 3% of the expected expenditures for which the entity is responsible under the payment arrangement.

3. Quality Performance Category

a. Geriatrics Specialty Set and Zoster (Shingles) Vaccination Measure

The AGS greatly appreciates CMS's support of measure development and promoting ways to develop new, more applicable measures, such as by proposing to add a Geriatrics specialty set for use in the Quality performance category. We encourage CMS to continue to facilitate and sponsor measure development for the very population CMS expends the most resources upon—that is, the multi-morbid patient with functional impairment who is not institutionalized. We recommend that CMS prioritize measures that specifically address care of the geriatric population and the AGS looks forward to working with CMS on the development of future metrics based on the care episode groups, patient condition groups, and physician-patient relationship categories.

To that end, the AGS recommends that CMS finalize the Geriatrics specialty measure set. We do, however, want to draw your attention to a concern our members have raised regarding the proposed new Zoster (Shingles) Vaccination (MUC17-310) measure, which is included in the Geriatrics specialty measure set.

The Zoster (Shingles) Vaccination is not presently covered under Medicare Part B; the only Part B covered vaccines are influenza, hepatitis, and pneumococcal pneumonia. Because the Zoster (Shingles) vaccine is not covered under Part B, it is covered by Part D. However, coverage under Part D means that patients may have cost-sharing obligations, and may be required to pay for the vaccine upfront and be reimbursed by their Part D plan retroactively.² The added costs and complications for patients of obtaining coverage for the Zoster (Shingles) vaccine under Part D means that some patients may forgo receiving the vaccine. In fact, the AGS's members report that, although they encourage patients to receive the vaccine, patients on fixed incomes are foregoing the vaccination due to an inability to pay. **CMS should consider amending the Zoster (Shingles) Vaccination (MUC17-310) measure so that eligible clinicians are not unfairly penalized because their patients cannot afford the vaccine. The AGS recommends that CMS revise the measure requirements so that eligible clinicians receive credit for discussing the Zoster (Shingles) vaccine with their patients, irrespective of whether the patient ultimately receives the vaccine.**

b. Removal of the Urinary Incontinence (Measure # 048) Measure

The AGS disagrees with CMS's proposal to remove Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older (Measure # 048) as a quality measure from the MIPS program. Removing the Urinary Incontinence measure will result in excluding up to half of women with urinary incontinence from quality measurement, resulting in loss of opportunity to improve outcomes.

CMS states that its rationale for proposing to remove the measure is that "it is duplicative in concept and covers the same patient population as currently adopted Measure 050: Urinary

² See *Medicare Part D Vaccines and Vaccine Administration*, MLN Fact Sheet (Jan. 2018), available at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Vaccines-Part-D-Factsheet-ICN908764TextOnly.pdf>.

Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older[.]” This is incorrect; the two measures are not duplicative either in concept or in the populations they cover. The intent of the two measures is conceptually different:

- Measure 048 is intended to promote screening for urinary incontinence, recognizing that urinary incontinence is under-reported by patients and under-evaluated by providers.
- Measure 050 is intended to ensure that women who have identified as having urinary incontinence are the evaluated and offered treatment, based on literature showing that patients reporting urinary incontinence are often not evaluated for what is otherwise a treatable condition.

Additionally, Measure 050 is applicable to patients that comprise a subpopulation of those included in Measure 048 and, therefore, do not truly “cover the same patient population.” The denominator for Measure 048 is all women aged 65 years and older, whereas the denominator for Measure 050 is all eligible women already diagnosed with urinary incontinence. Removal of Measure 048 undermines the intent of quality measurement related to urinary incontinence — it is not possible to effectively assess quality and clinical outcomes for this highly prevalent, morbid and treatable condition if it remains undetected. In order for Measure 050 to have value, there must also be measurement to assure improved screening for urinary incontinence in the first instance. Relying on Measure 050 alone for quality measurement related to urinary incontinence will exclude nearly half of women over age 65 that have urinary incontinence but have not been diagnosed. Measures 048 and 050 go hand-in-hand because interventions to increase urinary incontinence screenings (as measured by 048) results in higher numbers of women receiving urinary incontinence treatment (as measured by 050). Having Measure 050 without Measure 048 undermines the purpose of improving outcomes for women with urinary incontinence. **For these reasons, CMS should not remove Measure 048 from the MIPS program.**

c. Removal of Topped Out Measures and Process Measures

In addition to the four year removal process for topped out measures that CMS previously finalized, CMS proposes that once a measure has reached an extremely topped out status, CMS may propose the measure for removal within the next rulemaking cycle, regardless of whether or not it is in the midst of the topped out measure lifecycle.

As we noted last year, given the large percentage of topped out measures, we advise extreme caution in removing topped out measures. We are concerned that removing these measures may lower quality of care related to them. Given the limited resources and time available to many eligible clinicians, we believe it is naïve of CMS to assume that the practices associated with those measures will be maintained without financial incentives. Moreover, without clinicians reporting those measures, CMS will have limited ability to monitor and assess whether there have been changes in the quality of care as a result of removing the measures. Additionally, there is very limited experience with the behavioral responses to removing a quality of care measure. CMS should not assume that the activities associated with a removed measure will continue to be performed at the same rate after its removal. Removing a measure changes the financial incentives associated with reporting that measure and there could be a

drop in quality due to lack of performing the measure activity. We also are concerned that certain specialties, including those without a relevant registry/QCDR like geriatricians, may be disadvantaged by CMS's proposal.

Given these concerns, we appreciate CMS's proposal to begin with only six topped out measures. We believe a slow and thoughtful process for removing topped out measures, rather than a blanket policy for all topped out measures, is the appropriate approach. CMS should carefully consider the potential effects of removing a particular measure, including through soliciting feedback through notice and comment rulemaking, before identifying it for this process. CMS should also work with measure stewards to adopt new MIPS quality measures to replace measures being removed, especially if the removed measures are going to disproportionately affect a particular specialty. We urge CMS to support measure development as smaller societies do not have the resources to invest in this activity.

CMS also proposes to implement an approach, beginning with the 2019 MIPS performance period, to incrementally remove process measures based on the following criteria: (i) whether the removal of the process measure impacts the number of measures available for a specific specialty; (ii) whether the measure addresses a priority area highlighted in the Measure Development Plan; (iii) whether the measure promotes positive outcomes in patients; (iv) considerations and evaluation of the measure's performance data; (v) whether the measure is designated as high priority or not; and (vi) whether the measure has reached a topped out status within the 98th to 100th percentile range.

The AGS urges the Agency to be extremely caution when removing process measures to avoid unintended consequences for patients and MIPS eligible clinicians. CMS has established an overarching approach to quality that focuses on outcomes. While we understand that CMS's intention is to ensure that its policies are ultimately driving improved patient outcomes, we believe that processes remain incredibly important, whether following clinical guidelines or performing activities associated with quality process measures. Not every service or intervention lends itself to an outcome measure. As with the removal of topped out measures, there is a risk that the practices associated with process measures will not be maintained without the financial incentives associated with reporting the process measure.

Additionally, for certain specialties, such as geriatricians, who treat the oldest and frailest Medicare beneficiaries, the outcome may not reflect the quality of care the patient received. Unfortunately, the geriatric patient population can face poor clinical outcomes even when they have received optimal care. Moreover, for specialties like ours there are very few applicable outcome measures available. For instance, of the 21 proposed measures for the Geriatrics specialty set, only two are outcome measures and these apply to a very limited subset of patients — those with cancer who spend time in the ICU during their last month of life (which may be appropriate) and those with new depression who show remission within 12 months.

If CMS does finalize this proposal, the AGS believes that CMS's proposed criteria for considering whether to remove a process measure are appropriate, if seriously considered. However, we recommend that CMS add an additional criterion regarding the availability of other MIPS quality measures that cover the same condition or procedure to the list of criteria considered when evaluating whether to remove a process measure. We urge CMS to remove process measures only where there is an alternative MIPS quality measure available. Finally, we recommend that CMS weigh

the criterion related to availability of measures for a specific specialty heavily as part of this process to avoid unfair implications for clinicians.

d. Categorizing Measures as Gold, Silver, or Bronze

CMS proposes to implement a system where measures are classified as a particular value (gold, silver, or bronze) and points are awarded based on the value of the measure. **The AGS opposes a multi-weight scoring methodology as it will further complicate the MIPS program and undercut CMS's efforts to reduce burden and promote simplification.**

In setting forth its proposal, CMS purports to “acknowledge that not all measures are created equal.”³ By way of example, CMS states that “the value or information gained by reporting on certain process measures does not equate that which is collected on outcome measures.”⁴ The AGS disagrees; whether a measure is an outcome measure or a process measure is not an accurate reflection of a measure’s value. Measures have varying applicability and value to the populations that particular specialties serve, so a one-size-fits-all value system would be inappropriate. To assign differential weights based on whether a measure is an outcome measure or process measure oversimplifies the value and importance of a given measure.

Furthermore, this methodology would disadvantage certain specialties who, for instance, do not have as many applicable outcome measures available to them. Particularly disadvantaged would be providers who treat frail older adults with multiple chronic conditions, such as geriatricians. A significantly broader portfolio of outcome measures for complex older adults with multiple chronic conditions is required for a multi-weight scoring methodology to be viable. At this point in time, and for the foreseeable future, the AGS believes such an approach is untenable.

4. Cost Performance Category

a. Measuring Costs for Primary Care Physicians

Most geriatrics clinicians identify themselves as primary care providers. Geriatricians provide primary care to the sickest and most complex Medicare beneficiaries, a population characterized by the presence of multiple, co-existing chronic conditions and a high prevalence of frailty. Patients with multiple chronic diseases cannot be treated as though these conditions exist independently of one another.

A “whole patient” orientation is a core principle of geriatric primary care, indeed of all primary care. We treat patients, not diseases. It is our job to provide and/or coordinate substantially all the medical care our patients need. We aspire to deliver “person-centered care.” By understanding the full picture, taking into account the complexity of multiple diseases, medications, and symptoms, as well as the patient's values and preferences, we strive to balance the benefit and burden of recommendations across the whole of an older person's well-being. Ultimately, this supports patients and their families and caregivers in making informed medical decisions that are consistent with their health and life goals.

³ 83 Fed. Reg. at 35900.

⁴ *Id.*

The nature of our work corresponds to the “continuous/broad” patient relationship category that CMS has proposed. An approach to evaluating cost performance that looks at the cost of treating patients, rather than diseases, will align better with the mission and goals of geriatric care.

Payments to primary care providers account for only about 5% of the Medicare dollars, making these payments an unlikely source of significant savings. However, high quality primary care is associated with overall healthcare cost savings. Accordingly, episode payments for primary care would be unlikely to achieve cost goals and might adversely affect overall costs. Incentives that promote reduction in payments for primary care services would result in less primary care engagement with patients and higher overall costs, and would be inconsistent with the expectations and roles of primary care in health reform.

Primary care providers have an outsize influence on overall costs through the downstream impact of their decisions. Incentives that reward good stewardship of system resources, efforts to avoid unnecessary high cost and/or low value services, and more effective chronic disease care and management would address the sphere of influence of primary care on cost. Although primary care providers do not directly control downstream costs like hospitalization, imaging, and procedures, there can be no doubt that they exert substantial influence on utilization. Most importantly, incentives must be sufficient to support necessary investment in transforming primary care to best serve population management.

The diagnosis and procedure-focused model of defining episodes proposed in this year’s Proposed Rule is relatively well-suited to the procedural and acute medical episode types that have been the focus of the cost measure development work thus far. We believe that extending this concept to chronic disease care will be exceptionally challenging, especially when most beneficiaries have multiple chronic conditions, and often interrelated diseases. We previously shared our thoughts on these challenges with CMS in our April 24, 2017, letter regarding episode-based cost measure development so we will not reiterate them here.

The AGS believes that the measure “Total per capita Medicare Part A and B costs/year,” which CMS previously finalized as a cost measure for the MIPS Cost performance category, is the best initial metric for assessing the cost-effectiveness of primary care providers, including their care for patients with multiple chronic diseases. We believe this measure is the most accurate way to fulfill MACRA’s mandate to evaluate a primary care provider’s cost performance. This approach offers multiple advantages:

- It is consistent with the “whole patient” orientation of primary care.
- It is a measure that, if adequately risk-adjusted, reflects the influence of both the provider’s clinical effectiveness and his or her stewardship of taxpayer dollars. It encourages more effective chronic care, care coordination, and prudent use of costly downstream resources.
- It covers virtually the entirety of a provider’s practice and serves to ameliorate to a degree the small numbers problem.

- It avoids entirely difficult issues of attribution of costs to individual disease-specific episode groups in patients with multiple chronic diseases. It permits the application of the HCC risk adjustment system, which, although not a perfect approach in that it does not adequately account for frailty, has proven utility in Medicare Advantage and in CMS population-based payment environments, and proven capability to provide meaningful risk adjustment.
- Similar measures of primary care cost influence have been used extensively by provider groups participating in Medicare Advantage, and enjoy widespread acceptance by providers as useful measures of performance.

With the advent of patient relationship codes, however, we recommend that the existing two-step attribution process for this measure be replaced. Specifically, a patient and his associated Part A and Part B costs should be attributed to a provider who attests to having a continuous/broad relationship through claims data. This methodology will more accurately attribute patient costs to the provider—usually a primary care provider—that has a real, ongoing relationship with a patient rather than to the provider that merely has the largest share of allowed charges for primary care services. Primary care providers that have a continuous/broad relationship to their patients are much more likely to be able to influence those patients’ quality of care and the prudent stewardship of associated resources. Therefore, it is both fairer and more effective as a cost-containment approach to attribute a patient’s total Part A and Part B costs to those physicians.

b. Episode-based Cost Measure Risk Adjustment

Proper risk adjustment for cost measures is critical to ensure that the measures are both meaningful and unbiased with regard to patient complexity. Without effective risk adjustment, cost measures can have the unintended consequence of encouraging clinicians to inappropriately stint on care and avoid caring for the oldest and frailest patients, who require more resources. The AGS has concerns about CMS’s proposed risk adjustment methodology for the proposed episode-based cost measures. CMS’s current proposed approach includes factors that are included in the CMS Hierarchical Condition Categories (HCCs) Version 22 2016 Risk Adjustment Model, additional standard variables such as beneficiary age and original reason for enrollment in Medicare, and additional risk adjustors (in the form of ICD-10 codes) that were recommended by Clinical Subcommittees for each episode group.

First, using HCCs risk scores in this fashion has not been properly validated. The use of HCCs risk scores for risk adjustment generally have been validated with respect to their effect on the total cost of care for a one year period across all causes of care. For instance, CMS uses this model when determining Accountable Care Organizations’ benchmark expenditures, capitation rates for Medicare Advantage (“MA”) plans, and the MIPS complex patient bonus. However, this model may not be an accurate basis for risk adjustment for individual episodes of care and, thus, the use of HCCs for risk adjusting individual condition- or procedure-specific episodes of care requires independent validation.

Additionally, the proposed risk adjustment methodology does not account for frailty, where frailty is generally defined in terms of functional impairment. Frailty is a key determinant of health status and outcomes of health care interventions in older adults, but except in rare circumstances (e.g., the Program of All-Inclusive Care for the Elderly (“PACE”)), it is not incorporated into the risk adjustment

methodologies used by CMS. Expenditures for the frail elderly are considerably higher than the average beneficiary, and HCC risk scores do not adequately account for the higher cost of their care.

The PACE program, as well as recently studies aimed at developing and validating methods to measure frailty in Medicare, suggest that including frailty in the risk adjustment methodology for MIPS cost measures is achievable. For instance, in PACE, frailty adjustment is applied in conjunction with the HCCs risk adjustment model. CMS calibrates the frailty factors by regressing the residual, or unexplained, costs from the CMS-HCC risk adjustment model on counts of activities of daily living (“ADLs”). CMS obtains ADLs from surveys of the general Medicare population and currently uses the Fee-For-Service (FFS) Consumer Assessment of Health Providers & Systems (“CAHPS”). Additionally, researchers have developed and validated a Medicare claims-based frailty indicator⁵ and a Medicare claims-based frailty index.⁶

We recommend that CMS explore ways to incorporate frailty into the risk adjustment methodology for cost measures. Including a frailty in the risk adjustment methodology for cost measures would increase the accuracy of these measures and help protect clinicians that care for the frailest patients from financial risk, ensuring that these vulnerable beneficiaries have access to the care they need.

c. Weight of Cost Performance Category Score in the Final Score

As amended by the Bipartisan Budget Act of 2018, the Medicare Statute requires that for each of the second, third, fourth, and fifth years of MIPS, the weight of Cost performance category must be not less than 10% and not more than 30% of the MIPS final score. In light of these amendments, CMS is proposing that the Cost performance category would make up 15% of a MIPS eligible clinician’s final score for the 2021 MIPS payment year. CMS invited comments on whether it should consider an alternative weight for the 2021 MIPS payment year.

The AGS recommends that CMS maintains the Cost performance category weight at 10% for the 2021 MIPS payment year. Additionally, as CMS incorporates new, untested cost measures into this category, we recommend that CMS establish scoring policies, as described below, to allow for a more gradual impact of these cost measures on a clinician’s overall performance, as well as time for CMS and stakeholders to evaluate their effectiveness and any unintended consequences.

For the 2021 payment year, CMS should establish a minimum floor of 3 points for cost measures, as it has for quality measures. Additionally, all new episode-based cost measures should be assigned a score of zero for at least the first year of inclusion in the cost performance category so that they can be beta-tested.

⁵ Segal JB, Chang H-Y, Du Y, Walston JD, Carlson MC, Varadhan R. Development of a Claims-based Frailty Indicator Anchored to a Well-established Frailty Phenotype. *Med Care.* 2017;55(7):716-722; Segal JB, Huang J, Roth DL, Varadhan R. External Validation Of The Claims-Based Frailty Index In The National Health And Aging Trends Study Cohort. *Am J Epidemiol.* 2017;186(6):745-747.

⁶ Kim DH, Schneeweiss S, Glynn RJ, Lipsitz LA, Rockwood K, Avorn J. Measuring Frailty in Medicare Data: Development and Validation of a Claims-Based Frailty Index. *The Journals of Gerontology: Series A.* 2017:glx229-glx229. *See, also* Kim DH, Schneeweiss S, Glynn RJ. Comparing Approaches to Measure Frailty in Medicare Data: Deficit-Accumulation Frailty Index Versus Phenotypic Frailty. *The Journals of Gerontology: Series A.* 2018:gly054-gly054.

These policies will not only allow additional time for eligible clinicians to become more comfortable with the cost measures, but also allow CMS time to analyze clinicians' performance on the measures to better understand whether they inappropriately favor or harm particular specialties, as well as determine if certain specialties or clinician types have such insufficient numbers of attributed patients for the cost measures that they aren't being measured on costs at all. As CMS develops new episode-based measures, it should conduct modeling and analysis and maintain a zero score for each measure until CMS is confident that the measure is properly structured, with appropriate risk adjustment and attribution, so that it is not disproportionately harming particular specialties or encouraging scrimping on necessary care. The results of this analysis should be published prior to cost measures being scored for purposes of the Cost performance category percentage score to allow all stakeholders an opportunity to provide meaningful feedback. Additionally, as cost measures are implemented and eventually scored, CMS must closely monitor their effects to prevent inappropriate reductions in services and negative consequences for patient care.

5. Promoting Interoperability Performance Category

The AGS supports CMS's focus on promoting interoperability of health information technology and aligning the MIPS program requirements with regard to use of CEHRT with the changes to the Promoting Interoperability program finalized in the FY 2019 Medicare Hospital Inpatient Prospective Payment System and Long Term Acute Care Hospital Prospective Payment System Final Rule. As CMS is aware, interoperability is important for the patient population treated by geriatricians because frail older Medicare patients are often seen in multiple care settings, including long term care ("LTC") facilities, skilled nursing facilities ("SNFs"), hospitals, and physician offices. The ability to see and access medical documentation across these care settings will reduce errors and redundancies, allow for medication reconciliation, improve quality of care, and reduce costs. This is currently very challenging because EHRs are not fully interoperable across these many care settings, particularly between LTC facilities and physician offices. Alignment of the requirements applicable to use of CEHRT in different care settings will further the transition to full interoperability and the AGS supports CMS's efforts in this regard.

However, the AGS disagrees with CMS's proposed changes to the scoring methodology for the Promoting Interoperability performance category, which AGS believes suffer from the same flaws that stakeholders criticize about the current scoring methodology. In response to comments and criticisms of the previous scoring methodology for the Advancing Care Information performance category, which included a base, performance and bonus score methodology, CMS proposes a new scoring methodology for the renamed Promoting Interoperability performance category. Under the new scoring methodology, CMS proposes to reduce the number of objectives to four: (1) e-Prescribing, (2) Health Information Exchange, (3) Provider to Patient Exchange, and (4) Public Health and Clinical Data Exchange. Clinicians and groups would be required to report on all of the measures (excluding bonus measures) from each of the four objectives, with performance-based scoring occurring at the individual measure-level. Failure to report any required measure, or reporting a "no" response on a "yes or no" response measure, unless an exclusion applies, would result in a score of zero for the entire performance category.

We respectfully disagree with CMS that this proposal would increase clinician flexibility. While we appreciate the reduction in the reporting burden, this proposal is still all-or-nothing scoring in a slightly different format. Thus, the proposal does not address the concerns that the Agency noted in the Preamble — that “MIPS eligible clinicians have indicated that they dislike the base score because it is a required set of measures and provides no flexibility because the scoring is all or nothing. If a MIPS eligible clinician cannot fulfill the base score, they cannot earn a performance and/or bonus score.”⁷ **The Promoting Interoperability performance category should be scored like the other performance category, where clinicians and groups are scored on each measure reported and if one isn’t reported, they receive a zero only for that measure.**

6. Advanced APMs

The AGS continues to be disappointed with CMS’s approach to defining the financial risk criterion for Advanced APMs,⁸ which has now expanded to the MAQI Demonstration, as well. **We believe that CMS’s interpretation of the financial risk criterion for Advanced APMs is inconsistent with the plain language of the statute and with the statutory intent to encourage proliferation of, and participation in, Advanced APMs.** One of the primary goals of MACRA is to give physicians incentives to adopt APMs, but those options are unavailable to most geriatricians given the limited geographic reach and specialization of the current Advanced APMs.

The Medicare Access and CHIP Reauthorization Act of 2015 (“MACRA”) defines an “eligible APM entity” as an entity that participates in an APM that (1) requires participants to use certified EHR technology, (2) provides for payment based on quality measures that are comparable to MIPS, and (3) “bears financial risk for monetary losses under the APM that are in excess of a nominal amount,” or is a medical home expanded under CMMI. The statute does not define “financial risk for monetary losses” or “excess of a nominal amount.”

CMS’s current regulations provide that an APM bears financial risk in excess of a “nominal amount” if the amount the APM Entity potentially owes CMS or forgoes is equal to at least either (1) 8% of the average estimated total Medicare Part A and Part B revenue of [providers and suppliers in] participating APM Entities (the revenue-based standard), or (2) 3% of the expected expenditures for which an APM is responsible under the APM for all QP Performance Periods (the benchmark-based standard). Additionally, CMS interprets this statutory requirement to only encompass “losses” that could be incurred through either direct repayments to CMS or withholdings/reductions in payments for services.

The AGS believes that, consistent with the statute, CMS should adopt a more inclusive definition of “financial risk for monetary losses” — designating as Advanced APMs, those models that take on one-sided risk and otherwise meet the statutory and regulatory requirements and lowering the applicable percentage of risk required for both the revenue-based standard and the benchmark-based standard.

⁷ 83 FR 35914.

⁸ Given that our members’ patients are primarily Medicare beneficiaries, our comments focus on Medicare Only Option, but are generally applicable to the All-Payer Combination Option, as well.

Financial Risk for Monetary Losses. The term “financial risk for monetary losses” in MACRA, by its plain language, refers to any losses in the operations of the APM entity and is not limited to losses or increased spending in the Medicare program. The gains or losses of the APM entity are a function of both costs that the entity incurs to implement the model and the revenues it receives under the model. If an entity hires or pays for new staff to deliver services to patients under the model, acquires new or different equipment to deliver services, or incurs other kinds of expenses to implement the APM, and those expenses are not automatically or directly reimbursed by Medicare, then the entity is accepting financial risk for monetary losses.

Under a one-sided shared savings model, an entity incurs financial risk if it incurs costs to implement programs that are designed to reduce Medicare spending, since the provider could fail to qualify for the shared savings payment needed to pay for those costs.

These investments can be quite significant. A 2013 survey by the National Association of ACOs found the average start-up costs for an ACO were approximately two million dollars, and described the associated risks as follows:

Estimates in the published literature of ACO start-up costs have ranged widely, with \$1.8 million estimated by CMS in the draft regulations being the most often quoted. [The American Hospital Association] estimated in 2011 that they would range from \$11.6 to \$26.5 million. The average actual start-up costs of the [survey] respondents in the first 12 months of operations were \$2.0 million with a range from \$300,000 to \$6,700,000. Since savings are slow to flow as a result of data and complex reconciliation process, ACOs will have almost a second full year of operations until their cash flow can be replenished with shared savings from CMS (if any). This means that the average ACO will risk \$3.5 million plus any feasibility and pre-application costs. We estimate that in total, ACOs on average will need \$4 million of startup capital until there is a chance for any recoupment from savings.⁹

Additionally, APM entities are bearing real financial risk associated with potential reductions in “bonus payments,” such as shared savings payment incentives that vary based on quality performance. Now that the intent is to tie payments to quality or value as much as possible, providers are unable to sustain their practices on base payments alone and “bonus payments” tied to quality become essential to a provider’s business model. In fact, CMS recognizes that these one-sided risk models are bearing risk of financial losses by allowing Patient Centered Medical Homes to qualify as Advanced APMs by assuming only one-sided risk, such as reductions in bonus payments. Other APMs that put participants at financial risk through potential reductions in quality- or value-based payments should similarly be recognized.

In Excess of a Nominal Amount. The AGS believes that CMS’s definition of “nominal amount” should better reflect the plain language and intent of the statute, and be more inclusive of APM

⁹ National Association of ACOs, National ACO Survey, conducted November 2013, Final report January 1, 2014, at 1 (emphasis added).

structures. CMS has said that “nominal amount” means “an amount that is lower than optimal but substantial enough to drive performance.”¹⁰ This standard has no foundation in the statutory language. The common dictionary definitions of nominal are: “existing as something in name only,” “not actual or real” and “very small in amount.”¹¹ There is nothing in the plain meaning of the word “nominal” to suggest that it would be appropriate to interpret nominal to mean “lower than optimal” or “substantial enough to drive performance.” If Congress had wanted Advanced APM entities to accept substantial financial risk, it would have explicitly required that.

APMs are still a relatively new structure paradigm and most clinicians have little experience with taking on significant financial risk. Many clinicians would be financially challenged to provide sufficient care or even remain a viable business if they were faced with the kinds of substantial disruptions in revenue that can accompany financial risk arrangements. These very real concerns, especially given the magnitude of risk CMS requires for participation in an Advanced APM, prevent many clinicians from considering participation in the limited Advanced APMs available. CMS seems to recognize these concerns in the context of Medical Home Models. CMS had originally finalized a much more incremental approach, using much small percentages of revenue, to establishing nominal risk for Medical Home Models. In the CY 2018 Final Rule, however, CMS finalized a plan to increase the percentage of revenue at stake even more gradually. We disagree with CMS that these models have such special characteristics that this approach is appropriate only for them, but not other APMs.

Consistent with the plain language of the statute and the intent to encourage APM participation, CMS should lower the nominal risk amount for both the revenue-based standard and the benchmark-based standard, across all clinicians. As currently structured, the magnitude of risk required makes participation in an Advanced APM an impossibility for many clinicians, including most geriatricians, other than those in the largest multi-specialty group practices, academic medical centers, and integrated health systems. CMS should be encouraging APM participation not only for large health care networks that can take on significant financial risk immediately, but for smaller organizations and a variety of provider types, who, relative to their size and structure, are taking on substantial risk in their own right. As both clinicians and CMS gain experience with APMs, in subsequent years, CMS could look to set forth gradually increasing financial risk criteria that would reflect the state of APMs at that time. Such an approach would allow CMS to develop appropriate criteria for identifying Advanced APMs while encouraging APMs entities to craft innovative designs that allow them to succeed through care transformation and the provision of high-value care, and maximize clinician participation in APMs. High quality, patient-centered care can come in all shapes and sizes, and CMS should not limit its ability to promote transformative care by so narrowly defining payment models that will meet the definition of Advanced APMs.

* * *

Thank you for your attention to these comments. Please contact Alanna Goldstein at 212-308-1414 or agoldstein@americangeriatrics.org if you have any questions.

¹⁰ 81 Fed. Reg. at 28306.

¹¹ Merriam-Webster (online edition), available at <http://www.merriam-webster.com/dictionary/nominal>.

Sincerely,

Handwritten signature of Laurie Jacobs in black ink.

Laurie Jacobs, MD, AGSF
President

Handwritten signature of Nancy E. Lundebjerg in black ink.

Nancy E. Lundebjerg, MPA
Chief Executive Officer

Appendix A: Coalition Letter in Response to PFS Proposed Rule for CY 2019

September 10, 2018

SUBMITTED ELECTRONICALLY VIA

<http://www.regulations.gov>

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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 undersigned members of The Patient-Centered Evaluation and Management Services Coalition [hereinafter “the Coalition”] write to comment on the Centers for Medicare and Medicaid Services’ (“CMS”) proposed changes to Evaluation and Management (“E/M”) documentation guidelines and payment policies as set forth in the above captioned proposed rule,¹ which is intended to update the Physician Fee Schedule (“PFS”) for CY 2019. **The Coalition appreciates the intent behind CMS’s proposals to reduce documentation burden and we strongly urge the agency to finalize several of its proposals to reduce that burden. However, we are very concerned about the payment proposals and strongly urge CMS to withdraw all of its payment proposals and work closely with the coalition and other stakeholders to consider whether there are alternatives that will improve upon the current structure.**

The Coalition strongly supports the “Patients Over Paperwork” initiative and we appreciate that CMS understands the administrative burden attributable to the current documentation guidelines for the new and established outpatient E/M service codes and applaud CMS for its desire to address these issues. However, the Coalition has significant concerns and believes that waiting at least one year to finalize any payment proposals (e.g., until 2020) will allow CMS to work with the undersigned and other stakeholders to create a coding structure that better meets the agency’s goals of improving patient care and reducing burden but without the undesirable consequences described below. In other words, the coalition urges CMS to not finalize any of its E/M payment proposals, including the proposed modifier 25 reimbursement reduction policy and to withdraw any changes in outpatient visit coding or payment until a consensus on an equitable new coding structure is achieved.

We believe that a step-wise and open approach that includes a sophisticated data analysis and involves all stakeholders will help CMS achieve an E/M payment structure that allows accurate reporting of physician work and practice expenses for office visits. By accurately capturing the breadth and depth of current E/M work, we can assure appropriate payment is in accord with the current statute while minimizing unintended consequences.

¹ 83 FR 35704 (July 27, 2018) [Hereinafter, “Proposed Rule”]

To support this effort, the Coalition has engaged an independent consultant to perform additional data analysis of CMS's current proposal and to model alternatives. However, we believe that the limited duration of the comment period does not permit adequate analysis of CMS's proposals or possible alternatives in the context of this year's rule-making cycle and that finalizing these proposals for CY 2019 would be premature. While it is not possible to complete this analysis by the comment period deadline of September 10, 2018, we expect to be able to share our analysis and conclusions with CMS in time to inform discussion among stakeholders so the agency can develop refined proposals for the CY 2020 or 2021 rulemaking cycles.

Summary of Recommendations

Documentation: For CY 2019, the Coalition proposes that CMS finalize the following changes to documentation requirements while retaining the existing five level coding structure:

1. Allow physicians the option to document visits based solely on the level of medical decision-making or the face-to-face time of the visit as an alternative to the current guidelines.
2. If physicians choose to continue using the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients).
3. Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.
4. Eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.
5. Remove the need to justify providing a home visit instead of an office visit.

Payment: We request that CMS withdraw finalizing any of its proposals related to payment for outpatient/office visits (i.e., the proposed collapsing of 99202-99205 and 99212-99215, the proposed multiple procedure reduction, and the proposed G codes for primary care and specialty adjustments and prolonged services). Instead, we invite CMS to engage with stakeholders over the next year to develop a refined approach that will achieve CMS's goal of burden reduction while also ensuring the best possible outcome for patients. We believe that this collaborative effort will more effectively address the needs of the agency to have accurate pricing for the outpatient E/M services consistent with the Congressionally mandated "relativity" of service payment based on physician work, practice expense, and malpractice costs. The accurate pricing of outpatient E/M services is integral to all efforts at health care payment reform, especially those arising from MACRA. In addition, implementation of any new coding structure requires substantial physician and office staff education and changes to our electronic health records systems, as well as changes in the procedures of Medicare contractors, commercial payers, and auditors. CMS must allow ample time for education and implementation.

The proposed changes in CMS' coding structure will not apply to E/M services other than outpatient visits and therefore will not necessarily be followed by commercial payers. With an eye to minimizing confusion, we urge that consideration be given to the role of the CPT editorial process in developing consistent codes for use by all payers.

Comments Related to E/M Documentation Reduction Proposals

In an effort to “simplify and change our documentation requirements to better align with the current practice of medicine and eliminate unnecessary aspects of the current documentation framework,” CMS proposed to apply a minimum documentation standard under which practitioners would only need to meet documentation requirements currently associated with a level 2 visit for history, exam, and medical decision-making (“MDM”). CMS explains that it “believe[s] [the] proposed documentation changes for E/M visits are intrinsically related to our proposal to alter PFS payment for E/M visits . . .” For that reason, and because the current documentation guidelines have been in effect for so long, CMS suggests that it chose the rulemaking process to create new documentation standards, even though it has done so through sub-regulatory guidance in the past. Finalizing these proposals is consistent with the discussion of the documentation guidelines in the preamble of the proposed rule, where CMS stated, among other things, it would permit practitioners to document E/M services, regardless of the level of service provided based on the CPT code descriptors, by choosing to use either current documentation guidelines, documenting by time only, or documenting by medical decision-making only. We are convinced that this can be done without collapsing the code levels. Since each code descriptor contains an estimated visit time (which is advisory unless more than 50% of the visit is for counseling and coordination of care) and a level of medical decision-making, physicians are already very familiar with how to use time and decision-making to support a level of service. Finalizing these proposals would not require extensive re-education.

In this connection we note that private payers have their own documentation requirements and allowing a specified interval for new code development and vetting would amplify the agency’s commitment to burden reduction. If implemented as proposed, physicians will need to juggle between different documentation requirements based on site of service and payer policy. The development interval will also allow electronic health record (“EHR”) systems to be updated in an incremental manner. We are very concerned that if CMS finalizes its payment proposal to collapse code levels and establish complexity adjusters, documentation workflows will not mirror the new CMS requirements, commercial insurers will continue existing requirements, meaning practitioners will be relegated to documenting E/M services as they always have because creating two entirely different documentation systems for patients with different insurance is not feasible. Furthermore, the proposed primary care and complexity adjusters are inherently vague and will likely require their own, entirely new documentation guidelines (if so, these must be carefully developed to avoid adding unnecessarily to the burden on providers).

More significantly, although CMS has acknowledged that Recovery Audit Contractors (“RACs”) and the Office of Inspector General (“OIG”), which conduct pre- and post-payment documentation audits, will need to be trained on the new proposed documentation guidelines, the Coalition has significant concerns that fear of over-zealous audits could affect whether and how physicians use these (i.e., physicians may not use the complexity adjuster codes or the prolonged service codes due to potential audits and overpayment demands).

Lastly, we wish to note that there are many other important reasons why all visits need to be appropriately documented. These include: (1) providing sufficient information for other healthcare

professionals to care for patients. The amount of documentation required for this purpose will vary based on the acuity and complexity of the patient's medical condition(s), and (2) the need to document in accordance with the standards required for professional liability considerations. CMS's proposals address Medicare's documentation requirements related to claim audits, which are only one reason that documentation is necessary.

Once a consensus new coding structure is in place, additional reduction in E/M documentation burden, consistent with a new simplified coding structure, as well as education of physicians and other qualified health practitioners on the new codes and documentation requirements can be initiated and can be made consistent across all stakeholders.

Comments Related to the Single Payment Level and Adjuster Proposals

We applaud the leadership role CMS has taken in suggesting simplification of the coding structure for office visits. However, we believe the proposed collapsing of levels 2-5 for new and established patient visits along with the proposed multiple procedure reduction, the savings from which would fund two codes for complexity adjustments, could have extremely negative effects on patient care. For the reasons described below, we recommend that CMS not finalize any of these proposals and instead work with us and other stakeholders to come up with a better solution – one that achieves the goals of coding and documentation simplification but does not negatively impact patient care.

CMS proposes a single payment amount for established patients that is a little more than the current payment amount for 99213 and a single payment amount for new patients that is a little more than the current payment amount for 99203. The single level payment amounts were determined by (1) weight averaging the work RVUs based on specialty utilization for levels 2-5 and (2) establishing a new E/M practice expense pool. As expected, this proposal resulted in an extremely negative impact on specialties that predominantly bill level 4 and 5 services and an extremely positive impact on specialties that bill mostly level 2 and 3 services. CMS attempted to mitigate these impacts by creating complexity adjuster codes for primary care and selected specialty care. These payment amounts are \$5 and \$13.70 respectively and, when billed with the new single payment level, would still pay significantly less than the current payments for 99214 and 99204.

Unfortunately, because the original single payment level proposal was budget neutral to existing payments, CMS had to fund the complexity adjusters in order to not add additional cost to the system. CMS found this money by proposing a reduction to encounters when a procedure is performed on the same day as an E/M visit. (E/M visit codes are only billable on the same day as procedure codes when the billing professional indicates that the visit is separately identifiable from the procedure in which case the visit is paid at the full amount. To indicate that the visit is separately identifiable from the procedure the line item for the E/M is appended with modifier 25.)

CMS proposes to reduce payment for the least expensive service performed during the encounter (the procedure or the E/M visit) by 50% even though a physician uses modifier 25 to identify a visit as separately identifiable from the procedure. Importantly, CMS does not propose to limit the reduction to only those procedures with a 0-day global; as we understand it, the reduction would be tied to all 0, 10, and 90 day global codes. CMS indicates that this proposed modifier 25 reimbursement reduction policy is an extension of the Multiple Procedure Payment Reduction (MPPR). The MPPR is a reduction in

reimbursement by 50% for each additional procedure when multiple procedures occur during the same encounter. The existing MPPR policy recognizes the efficiencies gained when two or more procedures are performed during the same encounter (e.g., there is overlap in the physician work for the procedures). However, the proposed modifier 25 reimbursement reduction policy is unlike the MPPR because the medical community and CMS have worked for several years to remove any overlap in the physician work and practice expense for procedures commonly performed during the same encounter as an office visit. Therefore, the proposal would result in an excessive, unjustified reduction in reimbursement because the overlap in physician work and practice expense has already been accounted for in the valuation of these services.

CMS also created a new set of specialty specific codes for podiatrists explaining that the new “consolidated E/M structure” does not accurately represent podiatric E/M visits. The Coalition believes this is a back-end fix to the problem of winners and losers resulting from the proposal to collapse E/M services. In this regard we note that CMS’s own impacts showed a positive 12% impact on podiatry based on the code consolidation proposal which became a -4% impact after creation of the new podiatry G codes.

Lastly, CMS, realizing that it was paying the same amount for a 40 minute visit as for a 10 minute visit, proposed to establish a new prolonged services code that could be reported in addition to the underlying visit code if the visit lasted 15 minutes beyond the typical time for the visit. We believe the CMS proposal on the new prolonged services code is very unclear and more information is needed on how the prolonged service code will be used with other codes. We are also concerned that as proposed, the new code may be subject to a lot of miscoding. This is an area that needs further work.

Discussion of Policy and Legal Issues

The Coalition believes CMS should withdraw its payment proposals relating to outpatient E/M service coding and payment for the following reasons:

Patient Care Concerns

- The significant reduction in payment expected for providers of the frail elderly and patients with complex chemotherapies or several concurrent chronic complex and chronic conditions could result in practitioners providing shorter, more frequent visits for these patients resulting in additional coinsurance amounts for the additional visits and additional patient inconvenience. It is not clear that CMS has anticipated this result in this context, but this type of response is well described in documentation prepared by CMS’ Office of the Actuary.² The single payment rate could create patient access issues because it will incentivize physicians to avoid treating the sickest patients who require additional time and resources that will no longer be recognized by Medicare.
- CMS’s proposal will create an incentive for hospitals and health systems employing physicians to reduce the scheduled time for all visits to 5-10 minutes and to instruct practitioners to address

² See, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PhysicianResponse.pdf>

only one medical problem per visit. Physician practice can be heavily influenced by enterprise financial need. Such a pattern would reduce the quality of care, especially for patients with multiple illnesses or those with age-related issues such as dementia. In addition, shorter visits are antithetical to the generally accepted notion that spending more time with patients improves quality of care and helps foster shared decision-making and doctor patient relationships.

- Establishing a single payment irrespective of the code being reported (i.e., the existing outpatient visit codes describe different levels of physician work) will likely result in a disconnect for physician practices where compensation is based on physician work RVUs and it is assumed that payments correlate with work. In other words, because a single payment irrespective of visit length means that high volume providers will generate more income than lower volume providers, practices will need to determine how to value providers whose patient mix allows them to reduce time per visit on the one hand and, on the other hand, providers whose patient mix will not allow them to do that. One unintended consequence could be that providers and medical centers may not be financially able to care for older patients with multiple chronic conditions who require highly intensive team oriented care. It may also discourage physicians in training from entering specialties with older and/or highly complex patients.
- The flat rate will produce beneficiary cost sharing that is the same regardless of the length or content of the visit.

Analytic Concerns and Unintended Consequences

- CMS proposes a poorly explained change in the calculation of practice expense RVUs that will have a significant impact on codes with high practice expense, such as those for oncology. To determine the practice expense RVUs, CMS calculates an indirect practice expense index (IPCI) for most specialties and uses the IPCI to adjust the practice expense costs for a service based on the specialties that perform the service. A percentage reduction in the service-level IPCI for a CPT code would result in the same percentage reduction in the indirect practice expense component of Medicare payment, all else held equal (i.e., a -25% reduction in service-level IPCI would result in a -25% reduction in indirect practice expense payment).

CMS's proposal to collapse payment for office visits included creating a new IPCI solely for office visits, overriding the current methodology for these services by treating Office E/M as a separate Medicare Designated Specialty. This change also excludes the indirect practice costs for office visits from the derivation of all the other specialty IPCIs. CMS justifies this proposal because in the absence of this adjustment, "establishing a single PFS rate for new and established patient E/M levels 2 through 5 would have a large and unintended effect on many specialties." Significant swings of more than 10% in the IPCI occurred for roughly a quarter of all physician specialties, a result CMS does not explain in the preamble.

The proposed methodology change would also result in large swings in payment for many services predominantly performed by those specialties. There are 1,100 CPT codes that are proposed to experience a non-facility practice expense payment reduction, which cannot be explained by any other factor other than the change in their service level IPCI predominantly due to the E/M payment collapse. The RUC estimates that the change in the specialty-level IPCI

will result in a redistribution of almost \$1 billion between Medicare specialties. For example, the payment rates for chemotherapy administration codes would be reduced by well over 10% solely because the practice expense RVUs for E/M were removed from all specialty pools to create the new E/M pool.

CMS did not isolate the impact of the E/M payment collapse on indirect practice expense for other services in the CY 2019 Proposed Rule and the impact analyses presented do not appear to account for these large changes. Therefore, most stakeholders may not even be aware of the impact of the IPCI policy change and have not been provided with an opportunity to comment. With the additional impact on the indirect practice expense for all services, it is unclear whether the proposed E/M payment collapse and E/M MPPR are even budget neutral.

The Coalition believes the development of an E/M IPCI distorts the relativity of Medicare physician payments. We strongly recommend that this proposal should not be implemented and believe that the need for this methodological change undermines all of CMS's payment proposals. The unintentional consequences of this policy alone are sufficient to demonstrate that all of CMS's payment proposals should be withdrawn.

- In determining how the proposals will impact clinician payment, the Coalition believes that CMS is placing too great reliance on the use of the proposed prolonged services code (GPRO1) to mitigate the financial impact of the single payment proposal. It is unlikely any individual physician will be able to use GPRO1 more than once or twice a day. Patients are seen based on an overall office schedule that does not include prolonged visits – prolonged visits are unexpected; if physicians have a prolonged visit with one patient, other patients are kept waiting. Prolonged visits will only occur when it is completely unavoidable. While GPRO1 might allow practitioners to report occasional outliers with very long visits, it does not address the distribution of usual patients, which includes patients that require longer (e.g., 40-45 minutes) base visits because of the complexity of their condition. The Coalition also notes that discussion of GPRO1 omits any explanation of how it would be billed in conjunction with the single level payment and that CMS offered no projections on utilization and did not include it in the impact analysis, but CMS did use it in its “examples” of what “typical” payment would look like if the payment proposals were finalized. The Coalition finds the “examples” to be extremely optimistic as they make it appear that an outlier case (i.e., use of GPRO1) that would be used perhaps once a day, is really the “typical” case.
- The Coalition has been unable to recreate the analytic methodology CMS applied in determining the proposed RVUs for 2019. In this rule, CMS appears to have deviated significantly from the standard methodology it uses to incorporate the most recent available claims data into the practice expense RVU calculation. Since 2007, CMS has provided a detailed step-by-step description of exactly how the practice expense RVUs are calculated and has posted on the CMS website the data files needed to replicate the RVUs by following that methodology. In the proposed rule, CMS provides the same description of the methodology used in previous years and does not explain the substantial adjustments required to implement the proposed E/M policy changes. CMS appears to have made assumptions about utilization of outpatient E/M services under the proposed documentation and payment policies, including utilization by specialty of the proposed adjusters and other G codes, without acknowledging or describing

those assumptions in any way. Nor does CMS describe the assumptions used to create the new “EM” specialty added to the practice expense per hour file nor the impact that the creation of the “EM” specialty has on the practice expense pool. The sum effect of these assumptions can be seen in the data files released with the rule but the origin of and logic behind the assumptions is wholly unclear and it is not possible to isolate the impact of individual elements of the proposal on the RVU calculations or on payments for E/M services for different specialties. In addition, as a result of these apparent methodology changes, the IPCI calculated for many specialties is significantly different than the IPCIs used in previous years, as noted above. The change in the IPCIs means that the assumptions related to the outpatient E/M services also affect the practice expense RVU calculation for all other codes under the PFS. There was no discussion in the rule about the IPCI changes or the impact these changes would have on the PFS payment rates.

Because of the lack of transparency about the assumptions and changes in methodology required to implement the proposed payment policies and the scope of the impact that those changes have on RVU calculation for outpatient E/M visits and other services, the Coalition believes that CMS must withdraw those proposals. CMS should also release additional information describing the process and assumptions it used in each step of the rate-setting methodology, as it typically provides, to allow stakeholders to effectively analyze the proposals.

Legal Concerns

- As presented in the proposed rule, it appears the primary care adjuster, the specialty care adjuster, and the podiatry codes violate the legal prohibition on creating specialty specific payment rates. The statute states that “the Secretary may not vary the conversion factor or the number of relative value units for a physicians’ service based on whether the physician furnishing the service is a specialist or based on the type of specialty of the physician.”³ CMS has previously interpreted this language to require the same payment regardless of specialty, stating that it “prohibits the Secretary from making differential payments by physician specialty for the same service.”⁴ The descriptors for those proposed codes state which specialties are allowed to report the code and would vary the PFS payment rate for the E/M visit based on the type of specialty of the physician.
- The single payment proposal for all established and new patient visits and the payment proposal for the primary care and specialty specific adjuster appear to violate the statutorily mandated requirement that the PFS be based on the relative resources required to furnish a service. The statute requires that for each physician service, the Secretary determine work RVUs based on the “relative resources incorporating physician time and intensity required in furnishing the service”⁵ and practice expense RVUs “based on the relative practice expense resources involved in furnishing the service or group of services.”⁶ Creating a payment rate based on the weighted averaged utilization of a code set eliminates the connection between the resources needed to provide outpatient E/M services relative to those needed to furnish other physician services.

³ SSA § 1848(c)(6).

⁴ 58 Fed. Reg. 63856, 63861 (Dec. 2, 1993)

⁵ SSA §1848(c)(2)(C)(i).

⁶ SSA §1848(c)(2)(C)(ii)

Because outpatient E/M service comprise such a significant share of physician services, severing the mandated connection to relative resource use for those services undermines the integrity of the entire fee schedule.

- The relativity of the PFS is further weakened by the proposal to establish the primary care and specialty care adjusters based on money from the multiple procedure reduction. The proposed RVUs for the adjusters are not derived from the resources needed to provide specific E/M services but are simply a means of redistributing money to certain specialties.
- The single payment rate for established and new patient office visits results in a payment reduction for level 5 services (99205 and 99215) that is well over 20% and the law prohibits HHS from reducing the payment rate for an existing code by more than 20% in a single year.⁷

Coding and Valuation Concerns

- The proposed multiple procedure reduction is not resource based and not justified. As noted above, the RUC has worked closely with CMS to remove any overlap in physician work, clinical staff time, supplies, and equipment between office procedures and visits. If finalized, this proposal will create an incentive for physicians to perform procedures on days when there is no visit being billed, with resulting inconvenience for patients.
- The Coalition strongly opposes the proposed primary care and complexity adjuster codes for several reasons. The definitions appear arbitrary and are not reasonable from a clinical perspective; the proposed payments for the complexity adjuster codes are far too low to be meaningful and they are not resource based because CMS has designed them to be budget neutral with respect to the savings generated from the multiple procedure reduction proposal.
- CMS does not explain how it determined that 1.75 minutes and 0.07 work RVUs accounts for the “extra” time and effort required to provide GPC1X and why it determined that the adjuster should not be applied to new patient visits. The Coalition believes that the proposal vastly underestimates the actual time and effort required to deliver primary care services and does not understand why it should not be applied to new patient visits where the time and intensity of a primary care visit is even higher.
- The specialty adjuster GCG0X is not clinically reasonable (e.g., there is no basis for excluding psychiatry, infectious disease or nephrology as those patients are just as complex as rheumatologic or urologic patients); use of this code should not be guided by a physician’s specialty designation but rather the level of work performed.
- CMS provides no explanation as to how it concluded that GCG0X should be valued at 75% of the psychiatric interactive complexity code (90785). Further, reliance on 90785 appears misplaced because 90785 can only be added on to specific psychiatric services, primarily psychotherapies. E/M services are specifically excluded as the primary service to which 90785 is added. Therefore 90785 describes a completely different type of complexity and psychiatrists should be able to

⁷ SSA §1848(c)(7).

report GCG0X. Further, the Coalition opposes the proposal that would prohibit psychiatry from using GCG0X appended to E/M services delivered in the care of complex psychiatric patients.

- The Coalition believes it would not be appropriate to limit use of GCG0X to “stand-alone” E/M services. Why are E/M services provided on the same date as procedures any less complex than those provided on dates without procedures? CMS offers no explanation for this, but the proposal would result in additional incentives to request patients return on a different date for minor procedures.
- The descriptors proposed for GPC1X and GCG0X are inherently vague. They will necessitate the creation of new documentation guidelines that could undermine this proposals attempt to simplify documentation, and will require extensive education to providers and auditors to assure compliance. We are concerned that the documentation requirements that will be required to assure appropriate reporting of these codes (and the proposed prolonged services code) could actually be more onerous than the current requirements. This concern has been amplified because even though the proposed rule indicates these codes are specialty specific, in meetings CMS has stated that they are not specialty specific and can be billed when any of the “topics” included in the codes are addressed during the visit. Unfortunately, this makes the codes even more problematic. For example, this suggestion could be interpreted as meaning that GCG0X could be reported for any visit in which a patient complains of chest pain or nerve pain. Similarly, GCG0X could be reported if the primary care doctor rewrites a prescription during the office visit for gabapentin, a drug initially prescribed by a neurologist for diabetic neuropathy, or GPC1X could be reported if a provider inquires about a screening mammogram.

The Coalition’s Concerns About the Payment Impacts of CMS’ Proposal

As we discussed above, the Coalition believes strongly that additional modeling is needed to obtain more accurate estimates of the true payment impacts of the proposals on clinicians because there is a discrepancy between the payment analysis performed by the American Medical Association (AMA) and the impacts that CMS published in the proposed rule. CMS looks at the impact on specialties at a high level, without evaluating the impact on subspecialties or types of physicians that may be more significantly affected by the proposal, such as physicians who see patients in office settings (rather than in facilities) or physicians who practice in academic medical centers and who may specialize in particularly complex cases. The Coalition finds the AMA analysis to be much more useful because it isolates the effects of the E/M proposals, including the effect of the 50% multiple procedure reduction. The AMA analysis shows that there are over 20 specialties that will face unsustainable decreases in payment, including specialties such as geriatrics whose practices are limited to the Medicare population.

In summary, even with the primary care and complexity adjusters, the total payment will still fall well short of the current payment for levels 4 and 5, which are the services billed for visits involving high complexity care and medical decision-making and which are typically needed to treat sicker and the most complicated Medicare beneficiaries.

For all of these reasons, the Coalition strongly opposes CMS’s proposals regarding single payment for E/M levels 2 through 5 and the primary care and complexity adjusters, and prolonged services add-on code.

The Coalition's Vision for a Pathway Forward

We propose that CMS collaborate with all stakeholders and as a coalition we will fully engage and support this effort. We believe that the definition, valuation and documentation expectations of the MPFS should be as accurate as possible and reflect the breadth and depth of the services provided across the full range of physician specialties. CMS has powerfully identified longstanding issues with the current coding documentation expectations, now over two decades old. Clearly, updating is an appropriately essential activity, especially as we embark on new and more value focused payment models. We believe that there is a range of changes that must be considered, thoughtfully analyzed and modeled as part of the process of determining whether any are feasible and achieve dependability for the pricing of E/M services in the MPFS.

The Coalition will consider a number of coding options as alternatives to the CMS proposal. Our process will include data and impact analysis and be driven by consensus of all those involved. To the extent possible we will coordinate our efforts with the AMA CPT/RUC workgroup and we intend to meet with CMS to discuss our findings and recommendations. We acknowledge that any options with more levels of service than the CMS proposal, including maintaining the current code set, will need to be accompanied by clear descriptors and/or criteria to use when selecting each code level. Finally, should none of these options be superior to the current system, we would recommend focusing on documentation that does not require coding or payment changes.

Recommendations

We strongly urge CMS to take action on the following:

Finalize several of its proposals to reduce documentation burden for CY 2019 including:

1. Allow physicians the option to document visits based solely on the level of medical decision-making or the face-to-face time of the visit as an alternative to the current guidelines.
2. If physicians choose to continue using the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients).
3. Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.
4. Eliminate the prohibition on billing same-day visits by practitioners of the same group and specialty.
5. Remove the need to justify providing a home visit instead of an office visit.

Withdraw all of its payment proposals and work closely with the coalition and stakeholders over the next year to develop a refined approach that will achieve CMS's goal of burden reduction while also ensuring the best possible outcome for patients.

* * *

The Patient-Centered Evaluation and Management Services Coalition is a coalition of medical societies across a range of specialties formed in response to the CMS proposal to revise the Evaluation and Management documentation guidelines and payment policies as outlined in the CY 2019 Medicare Physician Fee Schedule Proposed Rule.

We greatly appreciate your attention to our concerns. For additional information or if you have questions, please contact Dr. Paul Rudolf by emailing Paul.Rudolf@arnoldporter.com or by calling 202-942-6426.

Sincerely,

Supporting Organizations within The Patient-Centered Evaluation and Management Services Coalition

American Geriatrics Society
AMDA - The Society for Post-Acute and Long-Term Care Medicine
American Academy of Allergy, Asthma & Immunology
American Academy of Child and Adolescent Psychiatry
American Academy of Dermatology Association
American Academy of Home Care Medicine
American Academy of Hospice and Palliative Medicine
American Academy of Neurology
American Academy of Otolaryngic Allergy
American Academy of Ophthalmology
American Association for Geriatric Psychiatry
American Association for the Study of Liver Diseases
American Association for Thoracic Surgery
American Association of Clinical Endocrinologists
American Association of Neurological Surgeons
American College of Cardiology
American College of Chest Physicians
American College of Physicians
American College of Rheumatology
American Gastroenterological Association
American Osteopathic Association
American Podiatric Medical Association
American Psychiatric Association
American Society for Blood and Marrow Transplantation
American Society for Clinical Pathology
American Society of Addiction Medicine
American Society of Hematology
American Society of Nephrology
American Society of Pediatric Nephrology
American Thoracic Society
American Urological Association

College of American Pathologists
Congress of Neurological Surgeons
Digestive Health Physicians Association
Heart Rhythm Society
Infectious Diseases Society of America
North American Neuromodulation Society
Renal Physicians Association
Society of General Internal Medicine
The Endocrine Society
The Society of Thoracic Surgeons