



February 28, 2020

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) notice of final rulemaking regarding changes to the Medicare Physician Fee Schedule (PFS), Quality Payment Program (QPP), and other federal programs for Calendar Year (CY) 2020 and beyond. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

We are confident that our comments and recommendations will improve the strength of these policies and help to promote access to affordable care for Medicare patients, while supporting physicians in their ability to deliver innovative care and protecting the integrity of the Medicare trust funds. We appreciate this opportunity to offer our feedback and look forward to continuing to work with the Agency to implement policies that support and improve the practice of internal medicine.

Payment and Documentation for Evaluation and Management (E/M) Services

ACP expresses our strong support for the policies finalized by CMS to address the historic undervaluation of Evaluation and Management (E/M) codes (office visits) utilized by internal medicine physicians who deliver care to millions of Medicare patients. These changes increase physician work relative value units (RVUs) for new and established office visit codes and will result in additional resources to enable physicians to provide care for their patients. We applaud CMS for recognizing the value of cognitive services in providing quality patient care. ACP is encouraged by these improvements to E/M codes and we look forward to working with our members to help them understand these changes.

Additionally, the College strongly supports the agency's decision to eliminate the use of history and/or physical exam for purposes of determining the level of E/M code, and we encourage the agency to implement this policy without delay. ACP also supports CMS' decision to allow the choice of medical decision making (MDM) or time to decide the level of office/outpatient E/M visit, along with updated CPT documentation guidelines for both options.

The College remains committed to working with CMS and other key stakeholders, including private payers, EHR vendors, clinician organizations, and patients, to improve clinical documentation and reduce burden. Since CMS's initial proposals in the 2019 PFS proposed rule, ACP formed a task force focused on developing resources to promote clinical documentation that tells the patient's story in a meaningful manner as well as developing strategies for the effective dissemination and uptake of best practices in documentation. Another component of ACP's work in this area, led by an ACP member advisory group, is to develop recommendations for modifications to electronic health records (EHRs) and health information technology (IT) that leverage CMS's recent documentation proposals in the service of improving documentation clarity and value, decreasing documentation burden, and furthering EHR usability, interoperability, and better care.

CMS's proposals have presented a unique opportunity to reexamine clinical documentation requirements to lower the burden of documentation creation while simultaneously improving its usefulness to clinicians and patients. The College applauds the Agency for their efforts to move the needle forward. While these proposals are an important first step, the College believes there are a number of critical next steps needed to operationalize these regulatory updates, and for these updates to truly reduce the burden of clinical documentation and improve the value of clinical notes. A key concept to consider when addressing documentation reform is that the guidelines themselves are burdensome, but there is also a great deal of burden associated with the lack of clarity and differing interpretations on what is required. A recent article¹ published in *the Journal of the American Medical Association* discussed the disconnect between the actual physician-patient encounters and what is documented in the note – concluding that payers should consider removing financial incentives that promote lengthy and verbose notes. Removing requirements for history and physical exam, as well as providing the option to document based on time or MDM, will address these issues to a certain extent. However, there is still a lack of clarity and consistency around what will actually be accepted for these various options and the College fears that these updates will not be utilized due to fear of audits and financial penalty – resulting in the same lengthy and verbose notes. **Therefore, ACP recommends CMS provide additional clarity, through sub-regulatory guidance, on what will be accepted for both time-**

¹ Berdahl CT, Moran GJ, McBride O, Santini AM, Verzhbinsky IA, Schriger DL. Concordance Between Electronic Clinical Documentation and Physicians' Observed Behavior. *JAMA Netw Open*. Published online September 18, 2019;2(9):e1911390. doi:10.1001/jamanetworkopen.2019.11390
<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2751388>

based and MDM-based documentation. Useful clarification from CMS includes a clear understanding of what is needed within the note to qualify to bill a certain level of code (and whether data stored within other areas of the EHR will qualify) – as well as a baseline for what will be considered clinically appropriate. Moreover, ACP recommends CMS work to ensure that the auditing guidelines and procedures are updated and aligned to focus on both time-based and MDM-based notes – and applied consistently by all auditing organizations.

With that additional clarity, the College and other medical professional societies, can begin to provide resources to members on low-burden, valuable documentation practices – and work with EHR vendors to build technology that supports and enhances the documentation process.

Clarifying Questions:

- For time-based documentation, must the note itself include the time audit or meta-data features from the EHR? Alternatively, could the time-based note that includes a physician attestation of time and describe the data that exists in other sections of the EHR (without replicating it in the note) suffice?
- For MDM-based documentation, what will CMS accept as information within other sections of the EHR that could substantiate an MDM-suggested code level, without the need for physicians to manually click a box?
- Will CMS permit EHR vendors to develop and build functionalities that capture both time-based and MDM-based requirements simultaneously? For example, a clinician cares for a patient and writes their note based on what is clinically important. Ideally, an EHR could indicate, “based on your use of the EHR during the visit, this visit would qualify for a 99213 based on time OR a 99214 based on MDM; click to choose, or click to modify note or attestation.”

Visit Complexity (GPC1X)

ACP is encouraged by the agency’s decision to implement a Medicare-specific add-on code for E/M office visits describing the complexity associated with visits that serve as a focal point for all medical care for ongoing care related to a patient’s single, serious, or complex chronic condition. The College recommends that this code move forward as CMS has proposed with the recommended values. At the same time, we encourage the agency to work with ACP, other medical specialties and the CPT Editorial Panel to better define this service to meet its intended purpose as we transition away from the Medicare specific G code to a CPT code. This new code will give physicians a way to identify outlier patients where additional payment is warranted.

Care Management Services

The College supports the changes CMS made to the Care Management code set, including allowing concurrent billing with Transitional Care Management (TCM) services, the addition of a non-complex CCM code to reflect each additional 20 minutes of service in providing non-complex Chronic Care Management (CCM) services, the addition of two new G codes to bill for Principal Care Management (PCM), and revisions to Chronic Care Remote Physiologic Monitoring Services. **ACP continues to recommend that the Agency issue very clear guidance to assist physicians in understanding the**

changes to Care Management codes to avoid the use of codes that describe the same service. The College remains ready to assist CMS with developing this guidance. Additionally, ACP applauds the Agency's recognition of the value of TCM services by finalizing the RUC-recommended values for TCM services. The acceptance of the RUC's recommendations, as well as the additional changes to the care management code set has the potential to increase the utilization of care management services and lead to improved outcomes and lower healthcare costs. ACP looks forward to working with CMS and specialty societies to fully implement and educate our members about these changes.

Revocation/Enrollment Denial

The College continues to note that it is excessively severe to revoke or deny a physician's or eligible professional's enrollment if he or she has been subject to any prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. **Although CMS has unfortunately decided to finalize this policy with a few changes, the College continues to strongly encourage CMS to consult with the physician community prior to finalizing policies that would establish broad criteria for revocation or denial of a clinician's ability to participate in the Medicare program.**

Review and Verification of Medical Record Documentation

The College is encouraged by and applauds CMS' decision to amend existing regulations to specify that when furnishing their professional services, clinicians in all settings, not just teaching, may review and verify (sign/date) notes in a patient's medical record made by other physicians, residents, nurses, students, or other members of the medical team, rather than fully re-documenting the information. This policy expands on previous burden reduction proposals focused on teaching physicians and is intended to apply more broadly to documentation requirements for professional services furnished by physicians, physician assistants (PAs), and advanced practice registered nurses (APRNs) in all settings, regardless of whether they are acting in a teaching capacity.

Immunization Administration (CPT Code 90460)

ACP commends CMS for reversing its proposal to crosswalk PE RVUs from CPT code 96372 to codes 90471/90460, which would have brought about a 60 percent reduction in PE RVUs. **The College continues to encourage CMS to explore vaccine administration codes and decouple them from the therapeutic injection codes.**

ACP noted in the proposed rule that CMS's proposal could impact vaccine access. We are encouraged by the agency's statement in the final rule that "given our concern about public access to vaccines and in light of recent public health events, we are maintaining the CY 2019 national payment amount for immunization administration services for CY 2020." The College supports this decision and is available to work with CMS to determine appropriate valuations for vaccine administration codes to ensure that patients continue to have appropriate access.

Treatment for Opioid Use Disorder

ACP welcomes the new bundled payment arrangement finalized by CMS that will describe the care and management of patients with an opioid use disorder. Additionally, the addition of these new codes to the list of designated telehealth services will expand the availability of these codes and increase treatment options for patients. **The College also looks forward to educating our members about the availability of these new services, as well as those to bill for services delivered in an Opioid Treatment Program (OTP) to ensure that treatment access continues to expand for patients impacted by opioid use disorder.**

Remote Patient Monitoring (RPM)

The College welcomes the agency's adoption of new codes to report time spent beyond the initial 20 minutes for evaluating patient-generated health data (PGHD) obtained through RPM and the revision of supervision requirements which will increase patient access to these services. These changes will help to relieve physician burden and allow physicians more time to treat the more complex patient issues that require more than remote monitoring.

Merit-Based Incentive System (MIPS) Value Pathway (MVP)

ACP strongly supports the goals of the MVP to reduce burden while improving the effectiveness of MIPS by creating more alignment across performance categories, reducing the number of metrics, providing more regular, actionable performance feedback, and helping clinicians transition to Alternative Payment Models (APMs). Many of these reflect long-term ACP advocacy priorities.

We commend the agency for being responsive to concerns raised by ACP and other stakeholders and recognizing the need for a transition period or pilot, which will help to ensure a smoother transition to the MVP. Doing so allows practices and clinicians who have an applicable MVP and are ready to transition to do so, while not forcing other practices who are not prepared or do not have an applicable MVP available to transition prematurely, particularly certain specialists and subspecialists. It allows CMS to start with a smaller set of MVPs—such as those built off of the current specialty measures sets—while allowing time to develop and review submissions of additional MVPs. Importantly, it also allows for clinician education on the new requirements and specific MVP options, which is critical to successfully navigating any transition, especially one of this magnitude.

We appreciate CMS' desire to solicit input from physicians and other stakeholders on a number of elements related to the design, feedback, and implementation of the MVP. **Stakeholder input will be paramount to the success of the MVP.** To be effective, stakeholders must be given ample opportunities to provide feedback on the MVP design and implementation plan throughout development, both within and outside of the rulemaking process. ACP looks forward to providing more detailed feedback and potentially helping to design MVPs of its own. To assist in developing MVPs, stakeholders will need to know the basic structure of an MVP, as well as methodologies for patient attribution, risk adjustment, and measure requirements, including but not limited to case minimums, numerator/denominator requirements, scoring requirements, and data completeness criteria.

Supporting private sector development of MVPs and accompanying new measures and activities will be critical to developing a diverse array of MVP options in a short timeframe. Funding to develop MVPs and accompanying measures and activities would help to speed the development of MVPs and cover existing gaps, particularly for certain specialties or subspecialties whose societies may have more limited resources. CMS could also act as a conduit to connect vendors that are interested in developing similar MVPs and may be interested in collaborating and sharing resources. Allowing vendors access to Medicare claims data could help to spur development of new measures that could support MVPs, particularly condition- or specialty-specific cost measures. ACP also supports aligning the MIPS update cycle with the eCQM update process to minimize burden and confusion. **Above all else- stakeholders need a transparent, sufficient timeline for development that takes into consideration the impact of new vendor requirements (discussed below). The earlier CMS clarifies the timelines and processes for MVP implementation the better, for clinicians and vendors alike.**

CMS recently finalized several new criteria for QCDR and qualified registry vendors, including that all measures be fully tested and developed prior to submission, and that a measure's approval may be contingent on the extent to which it is available from other vendors. While ACP recognizes the intent behind these policies to protect and minimize burden on clinicians, we continue to have concerns that these policies may unintentionally deter or delay measure development, which will be especially important in the work to develop new MVPs. **ACP recommends mandatory MVP implementation no sooner than 2024, to allow three years to develop, test, and submit MVPs and any accompanying measures or activities. Moreover, CMS should only move forward with mandatory implementation after there are a sufficient number of reliable, valid MVPs available to cover the majority of specialties, which will require close monitoring and may take several years.** CMS should also bear in mind that if the MVP reduces burden and provides robust performance data as intended, clinicians will want to transition to this new reporting option without it being mandated at all. **CMS should also consider adopting policies that encourage the development and testing of a limited set of patient-centered, actionable, appropriately attributed, and evidence-based measures for public reporting and payment purposes.** This could include ensuring that measures are available for a minimum number of years, awarding credit for reporting new measures, or setting a scoring floor for new measures.

Performance measurement is only as useful as the accuracy of the individual metrics used. CMS should establish transparent, independent standards for robust performance measurement. All measures should be statistically valid, clinically relevant, and subject to feedback and evaluation by independent third-party reviewers with clinical expertise. CMS should prioritize measures that have been proven to have the most meaningful impact on patient care and that have been independently vetted by a third-party organization such as ACP's Performance Measurement Committee (PMC), the Measures Application Partnership (MAP), or Core Quality Measures Collaborative. Measure attribution should occur at a level that a clinician or practice has a reasonable ability to impact and patients should be assigned voluntarily and prospectively when possible to maximize accuracy and effectiveness. **ACP supports the development of more targeted cost measures, rather than attributing broad downstream costs, particularly at the individual clinician level.**

CMS should look to retain elements of consistency and key elements of flexibility where possible, including self-selecting MVPs, choice in measure selection, collection types, and reporting level. Choice is critical to accommodating a diverse range of practices of varying sizes, locations, and specialty types. Restricting the number of measures or reporting methods does not reduce burden, it

limits certain clinicians' abilities to fully participate in the program. Retaining certain elements of consistency will help to minimize the level of disruption.

CMS should award points toward multiple categories for reporting a metric that is applicable to both, including the Promoting Interoperability (PI) Category. Clinicians who report data for other categories using Certified EHR Technology (CEHRT) should be awarded credit toward the PI Category because they are actively demonstrating their use of CEHRT to improve their practice. Awarding cross-category credit will have a direct, immediate effect on the burden of reporting. CMS should award points corresponding to their weight for the overall MIPS composite score to make the point system more meaningful and intuitive.

Providing detailed, frequent performance and financial data will empower practices to meaningfully improve quality of care for the patients they serve and give them confidence to transition to APMs. Receiving performance data up to 18 months after-the-fact is not an effective way to drive performance improvement in an industry as fast-moving as healthcare. Practices need frequent feedback on consistent metrics over time to be able to track their progress, target areas for improvement, develop improvement strategies, and evaluate their success. Annual snapshots of data makes this difficult, if not impossible. If practices are expected to join APMs, particularly those that are risk-bearing, they need the financial data to be able to perform the necessary cost benefit analyses to see if a model is financially viable. Without that data, they simply cannot warrant the risk. **ACP has long advocated for performance feedback on a quarterly basis at a minimum, working up to a real time claims data feed.**

Cost Category Weight

ACP appreciates CMS being responsive to stakeholder concerns over the numerous changes to the Cost Category and agreeing to retain the weight of the Cost Category at 15%. It is important that before increasing the weight of this category, clinicians have an opportunity to familiarize themselves with the sweeping changes to that category, including the redeveloped Total Per Capita Cost and Medicare Spending Per Beneficiary measures.

Advanced APMs

ACP supports CMS' decision to reverse its proposal and continue applying Partial Qualified Participant (QP) status designations at the National Provider Identifier (NPI) level to all of a clinician's TIN/NPI combinations, which will continue rewarding clinicians who meaningfully participate in Advanced APMs. CMS' proposal to only apply Partial QP status designations to TINs through which a clinician achieved Partial QP status would have effectively subjected clinicians to MIPS payment penalties under non-APM TINs, thereby undermining the intent of the Partial QP status designation to reward participation in APMs. To address CMS' underlying concern about allowing clinicians to earn positive MIPS adjustments even if their APM Entity opts out of MIPS, we reiterate our recommendation for CMS to mirror its policy for facility-based scoring, in which it would simply apply the most advantageous score.

In general, ACP continues to support the development of additional Advanced APM options and urges CMS not to implement policies that unnecessarily restrict the types of models that qualify, particularly

as QP and Partial QP thresholds are set to increase and meeting them will become increasingly difficult in the years to come.

Thank you for considering our comments. ACP looks forward to continuing to work with CMS to strengthen our health care system and continue the transformation towards improved patient access and higher quality of care at reduced costs. Please contact Brian Outland, PhD, Director, Regulatory Affairs, by phone at 202-261-4544 or e-mail at boutland@acponline.org if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read 'R. Mire', enclosed within a hand-drawn oval.

Ryan D. Mire, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians