



September 11, 2017

Seema Verma  
Administrator  
Centers for Medicare and Medicaid Services  
U.S. Department of Health and Human Services  
Attn: CMS-1676-P  
Room 445–G, Hubert H. Humphrey Building  
200 Independence Avenue SW  
Washington, DC 20201

**Re: Medicare Program: Revisions to Payment Policies Under Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (CMS-1676-P)**

Dear Administrator Verma:

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the proposed rule for the Calendar Year (CY) 2018 Medicare Physician Fee Schedule (PFS). The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 152,000 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.

**I. Summary of ACP Recommendations**

Throughout this letter, ACP provides a number of comments in support of proposals made by the Centers for Medicare and Medicaid Services (CMS) as well as recommendations to CMS in order to improve the final CY 2018 Medicare PFS. Our top priority comments and recommendations are summarized below and discussed in greater detail within this letter.

**Evaluation & Management (E/M) Guidelines Comment Solicitation**

- **ACP agrees with CMS that any revisions made to the E/M documentation guidelines should not result in a revaluation of the entire E/M code set.**
- **ACP agrees with CMS and recommends it remove the auditing requirements associated with the history and physical exam elements of both the 1995 and 1997**

E/M documentation guidelines. Documentation of the history and physical exam should continue to be a key component of the patient visit but they should not be associated with the auditing requirements.

- ACP proposes all relevant stakeholders, including medical specialty organizations, work with both the Current Procedural Terminology (CPT) Editorial Panel and CMS to create frameworks outlining general principles of care that are beneficial and appropriate for medical specialties in describing the varying approaches to patient care for the current levels of E/M codes. These general principles of care would incorporate the existing medical decision making elements of the 1995 and 1997 E/M documentation guidelines in order to determine the level of service for the existing E/M codes, thus having clinical documentation tied to program integrity and auditing practices. The College looks forward to the opportunity to work with CMS on developing these frameworks and collaborating further on E/M documentation reform.

#### Care Management Services Comment Solicitation

- ACP recommends CMS clarify that the CCM planning code (G0506) can be billed on a day separate from an E/M date of service.
- ACP recommends CMS allow for a properly done Annual Wellness Visit (AWV) conducted by a physician, with all of the required elements along with a review of the chronic medical conditions, to count as a CCM Plan as long as it was done within the past year.
- ACP recommends CMS simplify the documentation requirements necessary to bill CCM services in order to ease the burden of documenting each separate minute of care management over the course of the month.
- ACP reiterates our recommendation from previous comment letters for CMS to develop add-on codes for time increments greater than 20 minutes – such as 21-40 min and 41-60 min.
- ACP recommends that the Department of Health and Human Services (HHS) Secretary to designate CCM services as “additional preventive services” available under Medicare Part B through its waiver authority outlined in Section 1115A(d)(1) of the Social Security Act in order to eliminate any beneficiary co-payment associated with CCM services.
- ACP further recommends that the HHS Secretary also waive the requirements (under Section 1861 (ddd)(2)) to use the national coverage determinations (NCDs) process to avoid creating unforeseen implementation problems or any further delay in beneficiaries with chronic conditions receiving appropriate care due to payment barriers.

#### Determination of Proposed Practice Expense RVUs

- ACP recommends CMS improve the accuracy and reliability of the resource inputs for derivation of the PE RVUs by:
  - more accurately pricing expensive equipment items and disposable supplies and performing another physician practice expense survey.

### Medicare Telehealth Services

- **ACP supports the proposed code additions to the list of Medicare-approved telehealth services.**
- **ACP appreciates CMS' review of the remote patient monitoring codes and believes these codes should be paid separately under the appropriate circumstances.**
- **ACP recommends these codes need be taken through the CPT process in order to establish up-to-date and accurate code descriptors and guidance prior to separate payment.**

### Physician Payment Update & Misvalued Codes Target

- **ACP strongly opposes this proposal and is disappointed that CMS did not achieve the full misvalued code target resulting in an across-the-board reduction of 0.19 percent in the fee schedule. Therefore, ACP strongly recommends that CMS incorporate the decreases in Practice Expenses that were submitted to CMS by the RUC's Practice Expense (PE) Subcommittee and Health Care Professional Advisory Committee (HCPAC) Review Board.**

### Proposed Payment Rates under the Medicare PFS for Nonexcepted Items and Services

- **ACP is pleased to see CMS taking action to create better payment alignment to benefit Medicare beneficiaries and protect community-based care practices.**
- **ACP does not support provider-based billing for care delivered in an outpatient, hospital-system-owned practice when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College's high-value care initiative, the College supports delivery of care in the most efficient setting, while maintaining quality of care.**

### Initial Data Collection and Reporting Period for Clinical Laboratory Fee Schedule

- **ACP recommends CMS provide information related to data collected and publish preliminary CY 2018 CLFS rates as soon as possible to allow the physician community adequate time to review and assess the potential impacts on near patient testing services.**
- **ACP recommends CMS modify the existing PAMA regulations through issuance of an interim final rule that provides for CMS to conduct targeted market segment surveys (reference laboratories, physician office-base laboratories, independent laboratories, and hospital outreach laboratories) to validate and adjust the final amount calculated based on the data collection to ensure Congressional intent—payment rates that accurately reflect private market payments across all market segments—is achieved.**
- **ACP urges the Agency to consider the potential increased burdens on patients caused by loss of physician office-based testing services as it continues its work in this area. We look forward to working with the Agency to ensure that patient access to critical clinical testing services at the point of care is maintained.**

### Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

- **ACP strongly supports the proposed delay of implementation of the AUC consultation and reporting requirements to January 1, 2019. ACP recommends that CMS consider a**

delay beyond 2019 while ECs and groups are learning the evolving policies of QPP and gaining increasing experience reporting for the program.

- ACP recommends that the AUC consultation and reporting requirements be initially implemented as a pilot, with an evaluation of the AUC program occurring before moving to this complex and expensive system including:
  - A review of whether the program leads to more appropriate use of advanced imaging and/or better or different billing code selection.
  - An analysis of whether the MIPS requirements make this program largely unnecessary.
- ACP recommends that CMS consider initially limiting the AUC program to a smaller subset of the priority clinical areas, working to phase in additional priority clinical areas over time.
- ACP recommends that the work associated with the additional consultation and communication time between the ordering and furnishing physicians and their teams be separately billable for the purposes of the AUC requirement.
- ACP recommends that CMS make information available to allow ordering clinicians to make an informed decision when selecting a qualified CDSM.

#### Medicare Shared Savings Programs (MSSP)

- ACP supports the majority of CMS' proposals related to MSSP ACOs, which will largely serve to reduce the administrative burdens associated with various aspects of the Shared Savings Program.
- ACP recommends that CMS only exclude a TIN if the primary care services are billed during a significant portion of the performance year (e.g., primary care services are billed more than half of the performance year).

#### Physician Quality Reporting System Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS and EHR Incentive Program Payment Adjustments

- ACP supports CMS' proposal to better align PQRS satisfactory reporting requirements with the Quality Performance Category requirements in the first year of MIPS.
- ACP strongly encourages CMS to consider finalizing additional changes to better align the final year of PQRS with the pick your pace options. Therefore, the College urges CMS to allow any clinician who submitted any PQRS data for 2016 to be held harmless from any downward adjustments associated with PQRS and the VM for the 2016 performance period (2018 payment adjustment period).
- ACP urges CMS to consider providing relief from penalties associated with the Medicare EHR Incentive Program (Meaningful Use) for the 2016 performance period for ECs who tried but were unsuccessful at reporting MU.
- ACP recommends that CMS hold clinicians and groups harmless from negative payment adjustments for the final year of PQRS if they fall below the MIPS low-volume threshold criteria ( $\leq$ \$30,000 in Part B allowed charges or  $\leq$ 100 Part B patients).

#### Value-Based Payment Modifier and Physician Feedback Program

- **ACP supports the proposal to hold Category 1 clinicians harmless from negative payment adjustments (i.e., those clinicians who met satisfactory reporting criteria for PQRS).**
- **ACP recommends that CMS consider any clinicians or groups that submit any quality data for PQRS as Category 1 and be held harmless from any potential VM penalties.**
- **ACP appreciates that CMS accepted our previous recommendation to reduce the maximum negative payment adjustment to negative 2.0 percent for groups of 10 or more ECs in Category 2.**
- **ACP recommends that CMS hold solo clinicians and small groups in Category 2 harmless from any negative payment adjustments.**
- **ACP urges CMS to hold these clinicians harmless from any negative payment adjustments associated with the VM.**

#### MACRA Patient Relationship Categories and Codes

- **ACP previously recommended that CMS use modifiers to determine the relationship that each clinician has with the patient when multiple clinicians are billing on a single claim and therefore supports the current proposal to use such modifiers.**
- **ACP urges CMS to ensure the utmost transparency in how the Agency attributes cost, based on the use of these patient relationship categories and modifiers, along with the codes for care episodes and patient conditions.**
- **ACP recommends that CMS conduct a voluntary pilot program on the overall episode-based cost measures – which include the patient relationship categories described above as well as the proposed patient conditions groups.**
- **ACP recommends that clinicians should receive full credit within the Improvement Activities Performance Category of MIPS for participating in the pilot.**

#### Proposed Changes to the Medicare Diabetes Prevention Program (MDPP)

- **ACP is pleased that CMS finalized the expansion of the MDPP and further outlined specific payment policies for implementation of the program.**
- **ACP reiterates the recommendation from our 2017 PFS comment letter that CMS should allow beneficiaries that previously failed the program to attempt the program again. We believe that any patient that meets the criteria, even if he/she failed the program previously, should be allowed to enroll in the MDPP.**

#### Request for Information: CMS Flexibilities and Efficiencies

##### 1) Update Regulatory Impact Analyses for New and Existing Regulations

- **ACP urges CMS to incorporate into the regulatory impact analysis a standard assessment of cost, time, and quality of care for public review and comment.**
- **ACP strongly recommends CMS consider using ACP's framework for identifying and classifying new or existing requirements or tasks and incorporate the following questions into the regulatory impact analysis (outlined in detail in next section of letter).**

- 2) *Simplify the Merit-based Incentive Payment System (MIPS) Scoring System*
  - ACP recommends that CMS simplify the MIPS scoring system via the following approaches (outlined in detail in the next section of the letter) (additional QPP recommendations can be found in our [Comment Letter to CMS Regarding MACRA/Quality Payment Program \(QPP\) Proposed Rule for CY 2018](#)).
- 3) *Simplify and Align the Quality Measurement System to Ease the Burden of Reporting, Enhance Patient Care, and Build a Learning Health Care System*
  - ACP strongly recommends that CMS use ACP's Performance Measurement Committee (PMC) recommendations first when considering what measures to use for reporting by internal medicine specialists.
  - ACP recommends CMS focus any additional performance measure proposals on the core sets of measures identified by the Core Quality Measures Collaborative and measures recommended by the Measure Application Partnership (MAP).
- 4) *Align Varying Policies, Procedures, and Contracting Arrangements in the Medicare Advantage (MA) Program with Traditional Medicare to Promote Transparency and Reduce Excessive and Burdensome Administrative Tasks.*
  - ACP calls on CMS to collaborate with Medicare Advantage Organizations (MAOs) in order to identify and analyze contracting arrangements and associated administrative tasks required for participation in their plans and either align varying arrangements and tasks, streamline duplicative tasks, or remove entirely tasks that are deemed excessive and burdensome using the comprehensive framework developed in ACP's position paper "Putting Patients First by Reducing Administrative Tasks in Health Care

## II. Detailed ACP Comments on Proposed Rule

### Evaluation & Management (E/M) Guidelines Comment Solicitation

#### **Background:**

CMS currently maintains guidelines developed in 1995 and 1997 specifying the kind of information that is required to support Medicare payment for each of the five levels of E/M codes. There are three key elements to selecting the appropriate level of E/M service: History of Present Illness (History); Physical Examination (Exam); and Medical Decision Making (MDM). CMS agrees with stakeholders' longstanding concerns that the guidelines are unnecessarily burdensome and, given that the guidelines have not been updated in over 20 years, do not align with the current practice of medicine or incorporate advances in technology and electronic health records (EHRs).

In the 2018 proposed rule, CMS seeks comment from stakeholders on specific changes the Agency should undertake to update the guidelines, to reduce the associated burden, and to better align E/M coding and documentation with the current practice of medicine. CMS acknowledges that E/M documentation reform will be a multi-year process but requests feedback on some initial changes they can make to documentation requirements as a "first step" in the longer process. Specifically, the Agency proposes to focus initial changes and potential simplification of requirements on the history and exam portions of the E/M guidelines and allow MDM and time to serve as the key determinant of level of E/M service.

#### **ACP Comments:**

ACP would first like to thank the Agency for their acknowledgment of and focus on the need to simplify and reform the 1995 and 1997 E/M documentation guidelines in the CY18 Medicare PFS proposed rule. The College has long advocated for the simplification of these overly burdensome documentation requirements and developed extensive policy recommendations for clinical documentation reform<sup>1</sup> as well as recommendations for reducing unnecessary and burdensome administrative tasks in health care<sup>2</sup> so physicians can focus their time on providing high-value care to their patients. The College applauds CMS' efforts to address these issues and appreciates the opportunity to provide the following feedback on the current state of E/M documentation guidelines as well as recommendations for what we agree will be a multi-year process for reforming the documentation requirements.

#### *Current State of E/M Documentation*

The College's main concerns with both sets of E/M documentation guidelines is that they are outdated and specify the required contents of the medical record in excruciating – and often irrelevant – detail. This level of unnecessary detail within the guidelines has redefined the cognitive office visit to focus on what was *documented*, rather than what service is actually

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<sup>1</sup> <http://annals.org/aim/article/2089368/clinical-documentation-21st-century-executive-summary-policy-position-paper-from>

<sup>2</sup> <http://annals.org/aim/article/2614079/putting-patients-first-reducing-administrative-tasks-health-care-position-paper>

provided. The detailed guidelines often cause clinicians to over-document, creating “note bloat” and making the medical record an ineffective source of communication. To address the required elements specified in the guidelines, some clinicians are tempted to engage in extraneous clinical activity to justify using higher code levels when in fact deciding not to provide a clinical service or order a certain test is just as complex and important of a decision.

Moreover, the E/M codes themselves are a “one-size-fits-all” set of codes used by all specialties of medicine and premised on taking an extensive history from the patient and performing a physical examination based on requirements for documentation and provision of payment. However, caring for patients with multiple chronic illnesses does not require repeated, extensive physical exams or the taking of a traditional history once the information is initially captured. Physical examinations may be brief and focused and the history may revolve around functional issues. For cognitive specialties, the intensity of the visit requires making complex medical decisions for their patients and the E/M documentation guidelines as currently defined do not appropriately capture the work involved with the type of care provided in the modern era of health care. As the health care system continues to shift focus from volume of services to high-value care, it is imperative that the documentation guidelines focus on the narrative within the clinical note and what is needed to capture the intensity and complexity of the medical decisions that were made as well as promote capturing the value in not performing a clinical service based on thoughtful and complex medical decisions by the physician.

#### *ACP Recommendations for E/M Documentation Reform*

**First and foremost, ACP agrees with CMS that any revisions made to the E/M documentation guidelines should not result in a revaluation of the entire E/M code set.** This process is an effort to reform the documentation guidelines to make them consistent with current medical practice and does not relate to the established values of the E/M services. The College is not proposing any changes to the E/M codes and coding structure and seeks assurance that any changes to the E/M documentation requirements will not result in referral to the Relative Value Scale Update Committee (RUC) for review or an independent review of the code set by CMS.

**As an initial step in the multi-year process, ACP agrees with CMS and recommends it remove the auditing requirements associated with the history and physical exam elements of both the 1995 and 1997 E/M documentation guidelines.** The College understands that the history and physical exam does provide valuable information in connection with patient care.

**Documentation of the history and physical exam should continue to be a key component of the patient visit but they should not be associated with the auditing requirements.** Once these elements are no longer required for auditing purposes, the level of service should be determined by the complexity of the medical decision making for that encounter and allow physicians to focus on documenting what is necessary based on the unique needs of their individual patients. Concurrent to the removal of the history and physical examination requirements, CMS must ensure that the auditing guidelines and procedures also are updated and aligned to focus on the medical decision making elements of the visit and the College is willing to work with CMS and other stakeholders to ensure that these auditing guidelines and procedures are appropriately redesigned while reducing the documentation burden for clinicians. The College believes this short-term step will provide the immediate administrative

relief needed by clinicians so they can focus on providing high-value care to patients – ultimately benefiting the patient and improving patient care overall. Meanwhile, CMS should work with all necessary stakeholders to further restructure and improve E/M documentation.

**For a potential long-term approach, ACP proposes all relevant stakeholders, including medical specialty organizations, work with both the Current Procedural Terminology (CPT) Editorial Panel and CMS to create frameworks outlining general principles of care that are beneficial and appropriate for medical specialties in describing the varying approaches to patient care for the current levels of E/M codes. These general principles of care would incorporate the existing medical decision making elements of the 1995 and 1997 E/M documentation guidelines in order to determine the level of service for the existing E/M codes, thus having clinical documentation tied to program integrity and auditing practices. The College looks forward to the opportunity to work with CMS on developing these frameworks and collaborating further on E/M documentation reform.** Once these frameworks and underlying principles are developed and agreed upon, electronic health record (EHR) vendors would be required to build in an attestation based on the principles of care and the information captured within the EHR would be tracked to support the care delivered by the clinician relieving burdensome and duplicative documentation requirements.

#### Care Management Services Comment Solicitation

##### **Background:**

CMS is interested in continuing to develop and refine the set of codes describing care management services through collaborating with clinician stakeholders and the medical community. The Agency proposes to adopt Current Procedural Terminology (CPT) codes for several care management services that were finalized as G-codes last year to align CMS requirements and CPT guidance. The Agency is seeking comments on ways to further reduce burdens associated with reporting these types of codes as well as ideas on how to further align CMS and CPT guidance.

##### **ACP Comments:**

###### *Chronic Care Management Service Codes*

**The College would first like to thank the Agency for proposing to adopt the CPT codes for several care management services that were finalized as G-codes last year to align CMS requirements and CPT guidance and recommends finalizing that proposal.** ACP appreciates CMS' continued work on the refinement of the care management services codes and its recognition and work to reduce the administrative burdens associated with the service elements and billing requirements for CCM. However, some ACP members continue to report that they do not participate in the CCM program because of the onerous administrative burden and those who do participate in the program still feel that administrative burdens are too high. In general, the College believes that the CCM payment system should allow for and promote non-visit based management between visits, time spent where time is needed, but also a less costly, low-touch approach that helps to keep the majority of patients in contact with the health system where needed, but without necessitating expensive one-to-one care. In order to reach that goal, promote enrollment in the important program, reduce administrative burden, and align requirements between CMS and CPT, ACP offers the following recommendations:

- **ACP recommends CMS clarify that the CCM planning code (G0506) can be billed on a day separate from an E/M date of service.** The rationale is that for many situations where the physicians know the patient well, they may perform or develop the chronic care plan on a day different from when they enroll the patient.
- **ACP recommends CMS allow for a properly done Annual Wellness Visit (AWV) conducted by a physician, with all of the required elements along with a review of the chronic medical conditions, to count as a CCM Plan as long as it was done within the past year.** ACP members have expressed concerns around bringing the patient back into the office for the creation of a care plan via a separate CCM visit, even though it is a separately reimbursed service. This is an administrative barrier for physicians to sign patients up for CCM, but more importantly, it is a burden for patients, who would need to make yet another trip to see the physician.
- **ACP recommends CMS simplify the documentation requirements necessary to bill CCM services in order to ease the burden of documenting each separate minute of care management over the course of the month.** There is a significant resource cost involved in maintaining time logs to demonstrate 20 minutes of time over the course of a month for a specific subset of a physician's patient panel that is enrolled in the program. One possible solution to address the burdensome time logs would be to use a summary attestation statement in the medical record to account for the time spent providing CCM services (e.g., "I spent greater than 20 minutes providing these services [list out services] in the past calendar month for these chronic conditions [list out chronic conditions].") The College looks forward to collaborating with CMS on this or other ideas for simplifying these burdensome documentation requirements.

As another avenue to address the underutilization of the CCM code (CPT code 99490), **ACP reiterates our recommendation from previous comment letters for CMS to develop add-on codes for time increments greater than 20 minutes – such as 21-40 min and 41-60 min.** These add-on codes provide the ability to capture the unquestionable amount of time spent with patients that reaches between 21 and 60 minutes. In order to meet the needs of physician practices, particularly small practices, as well as encourage and capture further involvement in chronic care management services, it is important to have these codes available.

Further, the College believes that CCM services are generally consistent with the types of additional preventive services that are appropriate for Medicare beneficiaries and should not have a copayment associated with the provision of service. It can also be argued that the provision of CCM services reduce hospital readmission rates (as with Transitional Care Management services) therefore reducing overall Medicare spending, which therefore should offset the need for beneficiary cost sharing. The copayment associated with enrollment in the CCM program provides a cost burden on patients in need of these preventive services and additional administrative burden for physicians and their staff to collect this separate copayment on a monthly basis. **ACP recommends that the Department of Health and Human Services (HHS) Secretary to designate CCM services as "additional preventive services"**

**available under Medicare Part B through its waiver authority outlined in Section 1115A(d)(1) of the Social Security Act in order to eliminate any beneficiary co-payment associated with CCM services.** ACP believes that deeming CCM as an “additional preventive service” and thus removing the beneficiary copayment will incentivize beneficiaries to receive these important CCM services. **ACP further recommends that the HHS Secretary also waive the requirements (under Section 1861 (ddd)(2)) to use the national coverage determinations (NCDs) process to avoid creating unforeseen implementation problems or any further delay in beneficiaries with chronic conditions receiving appropriate care due to payment barriers.**

#### Determination of Proposed Practice Expense RVUs

##### **Background:**

Practice expense (PE) is the portion of the resources used by a clinician when providing clinical services such as office rent and personnel wages. CMS uses a resource-based system for determining PE Relative Value Units (RVUs) for each specific physician service and develops PE RVUs by considering the direct and indirect practice resources involved in furnishing each service. Direct expense categories include clinical labor, medical supplies, and medical equipment. Indirect expense categories include administrative labor, office expense, and all other expenses.

##### **ACP Comments:**

**ACP recommends CMS improve the accuracy and reliability of the resource inputs for derivation of the PE RVUs by:**

- **more accurately pricing expensive equipment items and disposable supplies and;**
- **performing another physician practice expense survey.**

##### *More Accurate Pricing of Expensive Equipment and Disposable Supplies*

Current pricing of expensive equipment items and disposable supplies depends upon submission of paid invoices from specialty societies. The small number of submitted invoices, and the potential for highly biased, non-representative invoices, makes these cost inputs relatively unreliable and possibly highly inaccurate. Prior review of both governmental pricing (e.g., from the Government Accountability Office or Department of Veterans Affairs), hospital acquisition costs (from Medicare cost reports), and commercially available proprietary databases (e.g., Veterans Health Administration and others) suggests that the invoice submission process for these expensive equipment items and disposable supplies in fact overestimates the costs used for derivation of the PE RVUs. This overestimation augments the reimbursement disparities between proceduralists and primary care physicians and other physicians providing cognitive services, inappropriately rewards procedural physicians, and provides an improper incentive for overuse of these services.

ACP recognizes the critical need for transparency in all CMS processes. ACP also understands the difficulty of using 1.) governmental pricing, 2.) hospital acquisition costs, or 3.) commercially available databases – each of these sources of more accurate cost data have unique limitations. In aggregate, all three of these sources of more accurate cost data may not be completely applicable to the more limited purchasing power of physician practices; however, these data

sources do underscore the existence of an inequity in the current PE RVU calculation methodology.

**ACP recommends that CMS correct this inequity in the current PE RVU calculation methodology, demonstrated by the three sources of more accurate cost data discussed above.** Expensive equipment items and disposable supplies, beyond a specific threshold (e.g., \$250,000 for equipment, \$250 for disposable supplies) could be subject to a fixed discounting of the costs inaccurately estimated by the current, submitted invoice process. This fixed discounting would be in addition to the direct adjustment of the aggregated pool of direct PE costs, and follows logically with the same rationale of more accurately scaling the direct to the indirect practice expenses. The fixed discounting would be an arbitrary percentage (e.g., 8%), created by any among several methods from review of the three sources of more accurate cost data (governmental pricing, hospital acquisition costs, and commercially available databases). ACP notes that CMS already implements unique rules for expensive items of equipment in the derivation of PE RVUs, such as: a) the location of certain clinical staff activities outside of expensive imaging rooms; and b) the assumed utilization rates for expensive equipment.

#### *Need for a New Physician Practice Expense Survey*

Maintaining the relationship between direct and indirect practice expenses is entirely dependent upon the relationship between these expenses in the Physician Practice Information Survey (PPIS) survey. The PPIS survey was conducted more than a decade ago. In addition to simply being outdated, the practice of medicine has significantly and substantially evolved in this past decade including advances in health IT and incorporation of EHRs in the majority of physician practices. Immense numbers of advanced practitioners now provide a large range of services, previously performed by physicians or clinical practice staff. Clinical staff perform a wide array of non-face-to-face services, and only a small number of these services are reportable with existing CPT codes, representing an unreimbursed and unmeasured expense borne by physician practices (e.g., expenses associated with expanding staff to provide CCM services, maintaining time logs for providing CCM services, updating EHR modules, etc.). Many specialties (e.g., cardiology) have had extensive changes in physician employment models, such that the physicians currently in private practice and reimbursed for their technical services represent a different group of physicians experiencing different direct and indirect costs than actually surveyed more than a decade ago. Finally, participation of practices in a wide variety of new, advanced payment models (including Comprehensive Primary Care [CPC] and CPC+, as well as Accountable Care Organizations [ACOs], advanced Alternative Payment Models [AAPMs], and gain-sharing arrangements) have required new forms of practice support and operational implementation that result in higher indirect practice expenses; none of these indirect expenses were captured in the decade-old PPIS.

**Therefore, ACP believes that continued use of the outdated PPIS survey leads to an inappropriate and inaccurate distortion of the PE RVUs for current, modern practice. ACP recommends that CMS proceed with another physician practice expense survey, utilizing available funds dedicated to improving the relativity and allocation within the Resource-based Relative Value Scale (RBRVS).**

## Medicare Telehealth Services

### **Background:**

#### *New Telehealth Service Code Proposals*

CMS received several requests in calendar year (CY) 2016 to add various Medicare telehealth services effective for CY 2018. The Agency proposes to add the following three services to the list of telehealth Medicare services on a Category 1 basis beginning in CY 2018: Counseling visit to discuss need for lung cancer screening using low dose CT scan (G0296); Psychotherapy for crisis, first 60 minutes (90839); and Psychotherapy for crisis, each additional 30 minutes (90840). Category 1 involves services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.

Although not specifically requested, CMS also proposes to add the following four add-on codes that describe additional elements of services currently on the telehealth list on a Category 1 basis beginning in CY 2018: Interactive complexity (90785); Administration of patient-focused health risk assessment instrument with scoring and documentation (96160); Administration of caregiver-focused health risk assessment instrument with scoring and documentation (96161); and Comprehensive assessment of and care planning for patients requiring chronic care management services (G0506). CMS notes that these add-on services will only be considered Medicare telehealth services when billed with a base code that is listed on the Medicare telehealth services list. The Agency recognizes that these add-on services are not necessarily furnished in-person (which is typical of services included on the Medicare telehealth list) but felt it would be administratively easier for clinicians to report these add-on services in association with a base telehealth service so they both would be reported with the telehealth place of service.

CMS declined to add codes for physical, occupational, and speech therapy because they believe they do not have the statutory authority as these types of clinicians are not included in the list of telehealth clinicians within the law. The Agency also declined to add services for initial hospital care and online Evaluation & Management (E/M) and did not change the requirements for end-stage renal disease (ESRD) procedure codes furnished via telehealth. Requests for services to be considered during the PFS rulemaking for CY 2019 must be submitted and received by December 31, 2017.

#### *Elimination of Required Use of GT Modifier*

Since the place of service (POS) code is required on all professional claims and serves to indicate both the provision of the service via telehealth and certification that the requirements have been met, the Agency proposes to eliminate the requirement for distant site clinicians to also use the GT modifier when reporting telehealth services.

#### *Payment for Remote Patient Monitoring Comment Solicitation*

CMS seeks input from stakeholders on whether to make separate payment for CPT codes that describe remote patient monitoring and specifically interested in comments regarding CPT code 99091 (Collection and interpretation of physiologic data [e.g., electrocardiogram, blood pressure, glucose monitoring] digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education,

training, licensure/regulation [when applicable] requiring a minimum of 30 minutes of time) and 99090 (Analysis of clinical data stored in computers [e.g., electrocardiograms, blood pressures, hematologic data]). Both CPT codes are currently assigned a procedure status of B (bundled) and CMS has assigned RVUs for 99091 based on existing RUC recommendations; however, they do not have a RUC value recommendation or assign RVUs for 99090.

In addition to comments on the valuation of 99091 (\$57.06) and payment status in general for both codes, CMS seeks information about the circumstances under which these codes might be reported for separate payment, including how to differentiate the time related to these services from other services, including care management services. For example, PFS payment for analysis of patient-generated health data is considered included in chronic care management (CCM) services (CPT codes 99487, 99489, and 99490) to the extent that this activity is medically necessary and performed as part of CCM. The Agency is also looking for utilization estimates for these types of services.

**ACP Comments:**

**The College supports the proposed code additions to the list of Medicare-approved telehealth services.** The services described by these codes will better serve the needs of patients in areas where telehealth services are an important access point of care. Patients in rural settings should not be denied access to needed care due to the absence of codes within the list of Medicare telehealth services. With the increasing lack of ideal access to care that can occur in rural areas, it is important that these services be allowed to be provided both as in-person or reimbursable telemedicine services. As CMS is considering removing the required use of the GT modifier by distant sites providing telehealth services, the College would like to point out that the GT modifier does capture additional information outside of what is captured in the POS code including whether the telehealth service was synchronous vs asynchronous. The GT modifier also serves as a useful research tool for understanding the overall utilization of telehealth services.

**ACP appreciates CMS' review of the remote patient monitoring codes and believes these codes should be paid separately in the appropriate circumstances. Moving forward, these codes need be taken through the CPT process in order to establish up-to-date and accurate code descriptors and guidance prior to separate payment.**

Physician Payment Update & Misvalued Codes Target

**Background:**

CMS proposes an overall payment rate update of +0.31 percent, which incorporates the +0.5 percent update required by MACRA and a -0.19 reduction for failing to reach the misvalued code target. The misvalued code target for 2018 is 0.50 percent, and CMS only identified 0.31 percent in code changes, resulting in the -0.19 percent reduction in the fee schedule update.

**ACP Comments:**

**The College strongly opposes this proposal and is disappointed that CMS did not achieve the full misvalued code target resulting in an across-the-board reduction of 0.19 percent in the fee schedule. Therefore, ACP strongly recommends that CMS incorporate the decreases in**

**Practice Expenses that were submitted to CMS by the RUC’s Practice Expense (PE) Subcommittee and Health Care Professional Advisory Committee (HCPAC) Review Board.** The results of a comprehensive review of the direct PE inputs was performed on a family of codes by the RUC PE Subcommittee and HCPAC Review Board yielded significant decreases in PE that were submitted to CMS—and, if put in place, would have helped in a significant way to reach the target. However, the Agency has proposed to leave the overvalued direct PE inputs in place for 2018, which will subject all clinicians to a 0.19 percent decrease to the Conversion Factor because the misvalued target was not met.

#### Proposed Payment Rates under the Medicare PFS for Nonexcepted Items and Services

##### **Background:**

CMS proposes to set payment rates for services provided at non-excepted off-campus provider-based departments (PBDs) at 25 percent of the Outpatient Prospective Payment System (OPPS) payment rate effective January 1, 2018. CMS states they are focused on ensuring they do not overestimate appropriate overall payment for these services in order to eliminate the Medicare payment incentive for hospitals to purchase physician offices, convert them to off-campus PBDs, and bill under the higher OPPS rates for the items and services they furnish there.

##### **ACP Comments:**

**The College is pleased to see CMS taking action to create better payment alignment to benefit Medicare beneficiaries and protect community-based care practices.** By better aligning outpatient hospital and private practice payment rates, Medicare can ensure more options for cost-effective healthcare services for all patients.

**The College does not support provider-based billing for care delivered in an outpatient, hospital-system-owned practice when that care is not dependent on the hospital facility and its associated technologies. Rather, in line with the College’s high-value care initiative, the College supports delivery of care in the most efficient setting, while maintaining quality of care.** Further, hospitals and hospital-owned outpatient practices should be transparent about their billing policies with patients prior to providing care, particularly if the patient and/or their health plan will be responsible for both the physician service and hospital facility fees. Moreover, provider-based billing should not be used as a mechanism for hospitals to recoup/stabilize funding or as a means of ensuring access to care. Ensuring adequate hospital funding and patients’ access to care can be better addressed and supported through other means, such as increased/improved health insurance coverage, strengthened workforce policies, and delivery system reforms.

#### Initial Data Collection and Reporting Period for Clinical Laboratory Fee Schedule

##### **Background:**

CMS is soliciting comments on the initial data collection and reporting periods established to determine rates under the new private-payer based Medicare Clinical Laboratory Fee Schedule (CLFS). This new Medicare CLFS private-payer-based system was created by the Protecting Access to Medicare Act of 2014 (PAMA) and requires applicable labs performing clinical diagnostic laboratory tests (CDLT), including certain physician office-based labs (POLs), to participate in an extensive data collection and reporting exercise to determine weighted,

median private-payer rates for CDLTs. These new rates will be posted by CMS by November 1, 2017 and will go into effect January 1, 2018.

The data required for submission by applicable labs includes the specific code associated with the CDLT, each private payer rate for which final payment has been made for each CDLT, and the associated volume of tests performed corresponding to each private payer rate. This data collection and reporting exercise included a 6-month data collection period beginning January 1, 2016 through June 30, 2016 and a 3-month data reporting period beginning January 1, 2017 through March 31, 2017. CMS later extended the reporting period through the end of May 2017 due to feedback from reporting labs on data quality and insufficient time to collect and report the data.

**ACP Comments:**

ACP would first like to thank CMS for its efforts to implement the laboratory provisions of the Protecting Access to Medicare Act of 2014 (PAMA). ACP estimates a small percentage of our membership having POLs that meet the “applicable lab” definition and therefore most are not required to report the pricing information to CMS. For this reason, we do not have specific feedback on the data collection questions posed in the proposed rule; however, the College, along with many other physician organizations, is very concerned about the potential impacts of PAMA and the subsequent pricing cuts on patient access to critical rapid clinical testing services offered to patients while they are receiving medical care in their physician’s office.

As written in a joint letter from multiple medical specialty organizations including ACP, rapid and accurate patient testing in a physician’s office is invaluable to early diagnosis of a range of conditions and plays a critical role in the treatment of acute illness, as well as in the ongoing management of chronic disease. It can also help avoid emergency care situations resulting in hospitalization. However, given the data integrity issues due to the retroactive data collection period and the difficulties with the Agency’s beta test for submission of data, we are concerned that the new payment rates will not actually reflect the weighted median of private payer payments as Congress intended.

Should reimbursement for physician office-based testing services fall below the costs to physicians providing these tests, it will become increasingly difficult for patients to receive timely diagnosis of acute conditions and ongoing management of chronic conditions will become significantly more burdensome. Initial projections on the impacts of PAMA on patient testing show significant cause for concern that this scenario may become reality when new PAMA payment rates are implemented on January 1, 2018. Where before PAMA, patients could receive testing results at the time of a first visit to their physician, after PAMA, testing results and diagnosis may require a second follow-up visit—a potentially costly and burdensome ask for a number of patients, particularly the vulnerable patients comprising the Medicare and Medicaid populations. Patients in rural areas will also face increasing challenges in accessing testing services, as a significant number of Americans live in areas where the nearest laboratories can be 80 to 100 miles away. Instead of one visit to their local clinic for services such as testing for common illness such as influenza, infectious disease testing, cholesterol screening, pregnancy testing, and rapid cardiac marker diagnostics, patients may be forced to

take additional time off work, find child care, find transportation, or travel significant distances in order to receive necessary testing, which raises issues not only of increased burden, but increased concerns of whether patients will follow-up to receive these critical services at all.

While working to implement PAMA, we recommend, that CMS carefully consider Congressional intent, as well as the potential impacts of loss of near-patient testing services on patients. In order to help mitigate potential negative impacts on patient care, we urge CMS to:

- **Provide information related to data collected and publish preliminary CY 2018 CLFS rates as soon as possible to allow the physician community adequate time to review and assess the potential impacts on near patient testing services; and**
- **Modify the existing PAMA regulations through issuance of an interim final rule that provides for CMS to conduct targeted market segment surveys (reference laboratories, physician office-base laboratories, independent laboratories, and hospital outreach laboratories) to validate and adjust the final amount calculated based on the data collection to ensure Congressional intent—payment rates that accurately reflect private market payments across all market segments—is achieved.**

Loss of physician office-based laboratories will undoubtedly affect all patients at some point in time, but the impacts will likely be felt by our sickest, elderly, and other vulnerable populations the most. **While we thank CMS for its ongoing efforts to implement PAMA, ACP urges the Agency to consider the potential increased burdens on patients caused by loss of physician office-based testing services as it continues its work in this area. We look forward to working with the Agency to ensure that patient access to critical clinical testing services at the point of care is maintained.**

#### Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

##### **Background:**

Section 201(b) of PAMA requires CMS to implement a program that utilizes appropriate use criteria (AUC) for advanced diagnostic imaging services. In previous fee schedule rules, CMS has established a process for the development of AUC by defining provider-led entities (PLEs) that may be qualified to develop, modify, or endorse AUC. The Agency also identified the criteria for qualified clinical decision support mechanisms (CDSMs) that clinicians may use to consult AUC. An initial list of priority clinical areas that will require AUC to be consulted was also established. After several years of implementation of the AUC program, CMS required to identify ordering clinicians who are outliers and implement a prior authorization process for advanced diagnostic imaging services for these clinicians.

##### *Consultation by Ordering Professional and Reporting by Furnishing Professional*

CMS proposes that clinicians ordering certain advanced diagnostic imaging must consult specified AUC through a qualified CDSM beginning on or after January 1, 2019. This represents a delay from the previous physician fee schedule rule, which would have required implementation of the AUC requirements beginning on January 1, 2018. CMS believes that delaying implementation of reporting requirements until 2019 will allow needed time for education and outreach efforts, time for clinicians to prepare, and time for CDSMs to become

more user-friendly and less burdensome. The Agency also proposes to require furnishing clinicians to include information on claims submitted on or after January 1, 2019, including which qualified CDSM was consulted by the ordering clinician, whether the service ordered adheres to the applicable AUC, and the NPI of the ordering clinician. Unless an exception applies, AUC must be consulted for every order for an applicable imaging service. AUC may not be available in every CDSM for every applicable service. Therefore, CMS will allow furnishing physicians to meet the requirement by indicating that AUC is not applicable to the service ordered.

In order for payment to be made for a specified advanced diagnostic imaging service, the claim for the furnishing clinician must contain the information in the paragraph above. To implement this requirement, CMS proposes to establish level 3 HCPCS codes, using G-codes to describe the specific CDSM that was used by the ordering clinician. Each qualified CDSM will have its own G-code. For newly qualified CDSMs, CMS will establish a generic G-code that can be used until such time that a unique G-code can be added for the CDSM and incorporated into the claims processing system. There will also be a G-code created to identify circumstances where no AUC consultation through a qualified CDSM occurred. One G-code should be reported for each advanced diagnostic imaging service, so if there are two codes billed for advanced diagnostic imaging on a single claim there should be two G-codes included.

CMS will also develop a series of modifiers to provide information on whether, when a CDSM is used to consult AUC, the imaging service adheres to criteria, does not adhere to criteria, or the criteria are not applicable to the imaging service. There will also be modifiers available to identify exceptions to the requirement to consult AUC through a CDSM for advanced diagnostic imaging such as for emergency medical conditions and significant hardships. CMS specifically seeks comments on whether any additional HCPCS modifiers are needed to separately identify allowable scenarios for which a qualified CDSM was not consulted.

The Agency believes that the 2019 start date will allow adequate time for CMS to operationalize the claims-based procedures and systems changes needed to process Medicare claims with AUC consultation information. Billing systems will also need to be able to translate AUC consultation information onto Medicare claims in the form of G-codes and HCPCS modifiers, which leaves room for potential error. To address this issue, CMS proposes to use an educational and operational testing period during which ordering clinicians would consult AUC and furnishing clinicians would report the AUC information on claims, but claims would continue to be paid regardless of whether the information is included correctly. This testing period would occur during the first year of the AUC program, which is 2019 under the current proposals. CMS may allow voluntary reporting prior to the testing period (such as beginning July 2018) if technically feasible. However, applicable imaging services ordered on or after January 1, 2019, would be required to have an AUC consultation with information reported on the claim. CMS seeks comment on whether the program should be delayed beyond the January 1, 2019, start date and whether a longer testing period is needed.

### *Alignment with Other Programs*

In the proposed rule for the Quality Payment Program for year 2, CMS proposed to allow ECs to receive credit in the Improvement Activities Performance Category in MIPS for ordering clinicians that consult AUC using a qualified CDSM for advanced diagnostic imaging services. Consultation with AUC would be considered a high-weighted improvement activity beginning in 2018, which would allow clinicians that do voluntary AUC consultation in 2018 to begin receiving credit in MIPS. CMS is also considering how AUC could support a quality measure in MIPS and seeks feedback on this concept.

### *Significant Hardship Exceptions to Consulting and Reporting Requirements*

CMS is proposing to align hardship exceptions with the Advancing Care Information (ACI) Performance Category under MIPS by allowing exceptions for ECs who qualify for re-weighting of ACI. The Agency proposes to allow hardship exceptions for AUC consulting and reporting due to:

- Insufficient Internet Connectivity
- Extreme and Uncontrollable Circumstances
- Lack of Control over the Availability of CEHRT
- Lack of Face-to-Face Interaction

For the purposes of AUC consultation, the Agency proposes to remove the criterion for a significant hardship exception for clinicians practicing less than 2 years. This exception for MIPS is unlikely to trigger reweighting of the performance category because newly enrolled Medicare clinicians are exempt from MIPS in their first year. Therefore, CMS does not believe that it should carry over to the AUC program. Clinicians qualifying for a reweighting of the ACI performance category to zero in MIPS for a year would be excepted from the AUC consultation requirement for the payment adjustment year associated with the reweighting. CMS proposes to establish a process to identify ordering clinicians who may need a significant hardship exception to the AUC program requirements that is outside of the MIPS reweighting process. In these instances, a significant hardship exception could be granted for no longer than 1 year. Additional information on these processes will be available in future rulemaking. CMS seeks comments on whether there are additional circumstances for which it might be appropriate to grant a significant hardship exception from AUC consultation requirements.

### **ACP Comments:**

**The College strongly supports the proposed delay of implementation of the AUC consultation and reporting requirements to January 1, 2019.** Given that there have been few to no education and outreach efforts on the existence of this program, let alone the actual requirements of the program itself, it is clear that implementing this program in 2018 would be problematic and burdensome. ECs will be reporting in MIPS for the first performance period in the first three months of 2018, which is when this program was slated to begin. Given the complexities of learning the reporting requirements of MIPS, layering on the AUC program simultaneously would only add to the confusion. **Therefore, ACP recommends that CMS consider a delay beyond 2019 while ECs and groups are learning the evolving policies of QPP and gaining increasing experience reporting for the program.**

**We recommend that the AUC consultation and reporting requirements be initially implemented as a pilot, with an evaluation of the AUC program occurring before moving to this complex and expensive system including:**

- **A review of whether the program leads to more appropriate use of advanced imaging and/or better or different billing code selection.**
- **An analysis of whether the MIPS requirements make this program largely unnecessary.** This is because MIPS is intended to move clinicians into a value-based payment system that is focused on tying quality and cost to performance, so clinicians will already be incentivized to ensure that the services they order and provide are appropriate and necessary. Quality and cost measures based on the AUC program requirements could also be developed and incorporated into MIPS to allow physicians the option of having their performance evaluated based on AUC.

**The College further suggests that CMS consider initially limiting the AUC program to a smaller subset of the priority clinical areas, working to phase in additional priority clinical areas over time.** This will allow ordering and furnishing physicians to gain experience using AUC through a qualified CDSM and establish the necessary workflows for a smaller set of advanced diagnostic imaging services prior to implementing the program more broadly. There will be many complex interactions that will be required to implement the AUC requirements including incorporating AUC with existing EHRs and billing systems, capturing the codes and modifiers associated with the CDSM and result of the AUC consultation, and transmitting the appropriate information to the furnishing physician to report on the claims. If the AUC program is implemented with a broad set of priority clinical areas simultaneously, the administrative burden, complexity, and cost of acquiring a CDSM may cause some physicians to stop ordering advanced diagnostic imaging for services that require consultation of AUC through a CDSM. This will be to the detriment of the patient, who may be forced to see additional physicians solely to get an order for imaging.

As CMS notes in the proposed rule, this program could have a significant impact on primary care physicians given the broad scope of their practice. Often times the radiologist or other furnishing physicians would have the more relevant expertise that is needed to determine which diagnostic test is most appropriate for a given patient. Because the AUC consultation must be done by the ordering physician, there may be communications back and forth between the ordering and furnishing physicians to identify the appropriate test and information to include in the AUC consultation before the test can be ordered. Additionally, time may be required to formally communicate the relevant pieces of the AUC consultation to the furnishing physician to add to the claim for payment purposes. **ACP recommends that the work associated with the additional consultation and communication time between the ordering and furnishing physicians and their teams be separately billable for the purposes of the AUC requirement.** ACP along with other stakeholders will explore the options for developing codes for payment that describe the services provided by the ordering physician. We further recommend that CMS not make the AUC program mandatory until a code that can be billed and paid by Medicare for the communications necessary to implement this complex system is available for at least 1 year.

**We also recommend that CMS make information available to allow ordering clinicians to make an informed decision when selecting a qualified CDSM.** This includes adding information on which AUC is incorporated into a CDSM, the platform the CDSM uses, the estimated cost of the mechanism, and a link to a website with additional information. It would also be useful to know whether the CDSM can be used to meet requirements that other payers may have in place. Significant education efforts will also be necessary to ensure that physicians understand the requirements of the AUC program and can make changes to their practices and workflows.

#### Medicare Shared Savings Programs (MSSP)

##### **Background:**

*Modifications to Beneficiary Assignment Methodology:*

*Revisions to the Definition of Primary Care Services*

The Affordable Care Act left CMS broad discretion to determine what should count as a primary care service for the purposes of beneficiary assignment to a MSSP ACO. CMS For the purposes of beneficiary assignment to an ACO, CMS currently defines primary care services based on the following:

- 99201 through 99215,
- 99304 through 99318 (excluding claims including the POS 31 modifier),
- 99319 through 99340,
- 99341 through 99350,
- Transitional Care Management (99495 and 99496),
- Chronic Care Management (99490),
- Welcome to Medicare visit (G0402), and
- Annual Wellness Visits (G0438 and G0439).

CMS proposes to add additional codes to the list of primary care services for the purposes of beneficiary assignment:

- Complex Chronic Care Management (99487, 99489, and G0506), and
- Behavioral Health Integration (BHI) (G0502, G0503, G0504, and G0507).

These proposed codes would be used for beneficiary assignment beginning in 2018 for the 2019 performance period. CMS seeks comment on whether there are any additional HCPCS/CPT codes that the Agency should consider adding to the list of primary care services used in beneficiary assignment to MSSP ACOs.

##### *Reducing Shared Savings Program Application Burden*

*SNF 3-day Rule Waiver Application Requirement that ACOs Report Their Financial Relationships*

CMS policy on the skilled nursing facility (SNF) benefit in Medicare requires beneficiaries to have a prior inpatient hospital stay of at least three days in order to be eligible for Medicare coverage of inpatient SNF care. Beginning on January 1, 2017, CMS is allowing additional flexibility with regards to SNF coverage for Track 3 ACOs by allowing them to apply for a waiver of the SNF 3-day rule. This waiver will apply to a Track 3 ACO's prospectively assigned beneficiaries when they are admitted to a SNF that has an affiliate agreement with the ACO.

In evaluating experiences in implementing the SNF 3-day stay waiver for Next Gen and MSSP ACOs, CMS has identified two requirements in the application process that impose unnecessary burden on applications without sufficient benefit to justify it. CMS proposes to remove the requirement that ACOs applying for the SNF 3-day rule waiver must submit a narrative describing any financial relationships between the CAN, SNF affiliate, and acute care hospitals. The Agency has determined that the narratives are not useful in determining whether to approve a waiver request. CMS also proposes to eliminate the requirement that an ACO document that each SNF on its SNF affiliate list has an overall rating of 3 or higher on the CMS 5-star Quality Rating System. The Agency is able to obtain the required information directly from the Nursing Home Compare website, so it is not necessary for an ACO to submit documentation. The requirement that SNFs have at least a 3-star rating is retained.

#### *Modifications to the Shared Savings Program Initial Application*

CMS currently requires ACOs applying to the Shared Savings Program to submit supporting documents and/or narratives that outline the processes that the ACO has in place in a number of areas including promoting evidence-based medicine, beneficiary engagement, and care coordination. The Agency has determined that the specific details of the processes that the ACO has established are not particularly relevant or important for the purposes of assessing whether the ACO is eligible to participate in the program. Therefore, CMS proposes to remove the requirement that these documents be submitted with the application and instead allow ACOs to certify that it has the processes in place at the time of the application and provide documentation only upon request. This includes documentation of processes, organization and management structure, and distribution of shared savings payments; however, ACOs will still need to publicly report information on their website about their shared savings and shared losses.

#### *Addressing Compliance with ACO Participant TIN Exclusivity*

Under the Shared Savings Program, TINs are permitted to participate in more than one ACO unless the TIN submits claims for primary care services that are used as part of the beneficiary assignment process. As ACO participation grows, CMS is concerned that there will be increased TIN participation in multiple ACOs, which CMS deems “overlapping.” Some TINs that are specialists only and have not previously billed primary care services may have a change in status mid-year due to hiring of an NP who then bills for primary care services.

CMS proposes to address situations in which a change in TIN status occurs as follows. If, during a benchmark or performance year (including the 3-month claims run out period for such a benchmark or performance year), an ACO participant that participates in more than 1 ACO begins billing for services that would be used in assignment, CMS would not consider any of the services billed through that TIN during the relevant performance year when performing beneficiary assignment for the applicable benchmark or performance year. The affected ACOs would be required to resolve the overlap prior to recertification of their ACO participant lists for the subsequent performance year. If the overlap remains unresolved, CMS would remove the TIN from all ACO participant lists seeking to include the TIN. CMS believes that this policy will ensure a uniquely assigned beneficiary population for each ACO.

### *ACO Quality Reporting*

CMS proposes to provide additional flexibility to address substantive changes to CMS web interface measures that are made under QPP. Specifically, the Agency proposes to allow for redesignation of a measure pay-for-reporting when a substantive change to a CMS web interface measure is made under QPP. This proposed change will supplement the authority that the Agency already has to redesignate a measure as pay-for-reporting when the measure owner determines that the measure no longer aligns with clinical practice or causes patient harm. Three quality measures in the web interface had substantial changes proposed in the QPP year 2 rule. However, CMS determined that these changes would not impact the information that must be collected to report the measure and therefore a change in the phase-in of the reporting is not necessary.

In the final rule for CY 2017, CMS made changes to the data validation process to assess the ACO's overall audit match rate rather than assessment at the individual measure level. The Agency believed that this change was necessary to minimize the number of records that must be requested to achieve the desired level of statistical certainty and better align with the methodology used in other CMS quality program audits. For ACOs that have an audit match rate of less than 90 percent, CMS will adjust the ACO's overall quality score proportional to its audit performance and use that audit-adjusted overall quality score in determining shared savings/losses for which the ACO is accountable. Additionally, those ACOs with an audit match rate of less than 90 percent may be required to submit a corrective action plan. These policies will be applied to quality validation audits beginning in 2017 with quality reporting data for the 2016 performance period. In this rule, CMS proposes to lower the threshold for the audit match rate to 80 percent as the Agency determined that the 90 percent match rate may inappropriately penalized ACOs. CMS proposes that for each percentage point difference between the ACO's match rate and the match rate considered passing the audit, the ACO's overall quality score would be adjusted downward by 1 percent.

### **ACP Comments:**

**The College supports the majority of CMS' proposals related to MSSP ACOs, which will largely serve to reduce the administrative burdens associated with various aspects of the Shared Savings Program.** We appreciate the proposals to reduce the documentation associated with the SNF 3-day Stay Waiver applications as well as to minimize the additional documentation that must be submitted with initial MSSP ACO applications. Requiring ACOs to submit documents that have little value to CMS in the assessment of an application should be avoided when at all possible. ACP supports reducing the audit match rate for MSSP ACOs to 80 percent. This will more closely align the match rate with the Hospital Inpatient Quality Reporting Program and help mitigate unnecessarily penalizing ACOs for minor quality reporting errors that are not indicative of poor quality of care. ACP supports the addition of complex CCM and BHI codes to the list of codes that are considered primary care services for beneficiary assignment to an MSSP ACO.

ACP has some concerns with the proposal related to compliance with ACO TIN exclusivity. Specifically, we are concerned some TINs may be excluded from having their billing counted for assignment when the addition of a primary care clinician has very limited impact on the services

billed for the performance year. **Therefore, we recommend that CMS only exclude a TIN if the primary care services are billed during a significant portion of the performance year (e.g., primary care services are billed more than half of the performance year).**

Physician Quality Reporting System Criteria for Satisfactory Reporting for Individual EPs and Group Practices for the 2018 PQRS and EHR Incentive Program Payment Adjustments

**Background:**

Physicians and other eligible clinicians were required to satisfactorily report quality measures through the Physician Quality Reporting System (PQRS) and meet certain criteria or be subject to a negative payment adjustment. Payment adjustments under PQRS are applied in payment years 2015 through 2018 based on the submission of quality data from the year two years prior.

When Congress enacted the Medicare and CHIP Reauthorization Access Act (MACRA) in 2015, the flawed sustainable growth rate formula was repealed and the penalties associated with PQRS, along with the value-based payment modifier (VM) program and the EHR Incentive Program (aka Meaningful Use), were sunsetted beginning in 2019. These three legacy programs (PQRS, VM, and MU) were combined to form three of the four performance categories under the Merit-Based Incentive Payment System (MIPS) under the Quality Payment Program (QPP) that was created by MACRA. The 2018 payment adjustment year will be the last year that is based on the legacy reporting programs before the QPP adjustments kick in for payment year 2019.

The CY 2016 reporting period was the last year the ECs were required to satisfactorily report PQRS data to avoid a negative payment adjustment, with the final adjustments occurring in payment year 2018. For most reporting mechanisms for 2016, ECs were required to report on 9 quality measures across at least 3 National Quality Strategy (NQS) domains including at least one cross-cutting measure. Data for each measure was required to be submitted for at least 50 percent of the Part B patients to which the measure was applicable.

While the data submission period for the final PQRS reporting period (2016) has already concluded, CMS recognizes that ECs found the requirements complex and had difficulty understanding what was necessary to meet satisfactory reporting requirements. Therefore, CMS is revisiting the finalized policies for 2016 to make satisfactory reporting simpler and better align the policy with requirements for the quality performance category in MIPS.

The determination of ECs that meet the proposed revised satisfactory reporting criteria will be based off of the data submitted during the data submission period for the 2016 performance period. CMS is not reopening data collection and will not apply these policies to any reporting periods prior to 2016. For the special reporting option for clinicians in an ACO that failed to report quality on behalf of its participants for 2016, CMS will apply these proposed satisfactory reporting criteria for both the 2017 and 2018 payment adjustment periods. This exception is only applicable to select ECs in ACOs that fail to report.

### *Individual Reporting*

The Agency proposes to revise the previously finalized satisfactory reporting criteria for the CY 2016 reporting period to lower the requirement from 9 measures across 3 NQS domains, where applicable, to only 6 measures with no domain or cross-cutting measure requirement. For individual ECs, this would apply to the following reporting mechanisms: claims, qualified registry (except for measures groups), QCDR, direct EHR product and EHR data submissions vendor product. QCDR reporters will also not be required to meet the outcome or other high priority measures requirements to meet the satisfactory reporting criteria. If less than 6 measures are applicable to an EC for the 2016 performance period, the EC must report every applicable measure to be considered as satisfactorily reporting and thus avoid a negative payment adjustment.

#### **Individual Measures Reporting Criteria and Proposed Changes for Reporting Year 2016**

<b>Measure Type</b>	<b>Reporting Mechanism</b>	<b>Original Reporting Criteria</b>	<b>Proposed Reporting Criteria</b>
Individual measures	Claims	Report 9 measures across at least 3 NQS domains including 1 cross-cutting measure. Report for at least 50 percent of Part B patients to which the measure applies.	Report at least 6 measures for at least 50 percent of Part B patients to which the measure applies.
Individual measures	Qualified Registry	Report 9 measures across at least 3 NQS domains including 1 cross-cutting measure. Report for at least 50 percent of Part B patients to which the measure applies.	Report at least 6 measures for at least 50 percent of Part B patients to which the measure applies.
Individual measures	EHR data submission vendor/direct EHR product	Report 9 measures across at least 3 NQS domains. At least one reported measure must contain Medicare patient data.	Report at least 6 measures for at least 50 percent of Part B patients to which the measure applies.
Measures groups	Qualified registry	Report on every measure in 1 measures group for at least 20 patients, the majority of which must be Part B patients.	No proposed changes.
Individual PQRS/non-PQRS measures	QCDR	Report on at least 9 measures available for reporting under a QCDR covering at least 3 NQS domains. Measures must be reported for at least 50 percent of all patients to which the measure applies. At least 2 measures must be	Report at least 6 measures available for reporting under a QCDR for at least 50 percent of all patients to which each measure applies.

Measure Type	Reporting Mechanism	Original Reporting Criteria	Proposed Reporting Criteria
		outcome measures. If 2 outcome measures are not available, at least 1 outcome and one high priority measure are required.	

*Group Reporting*

For group practices, CMS proposes to revise the previously finalized satisfactory reporting criteria for the CY 2016 reporting period to lower the requirement from 9 measures across 3 NQS domains, where applicable, to only 6 measures with no domain or cross-cutting measure requirement. For individual ECs, this would apply to the following reporting mechanisms: qualified registry, QCDR, direct EHR product and EHR data submissions vendor product. QCDR reporters will also not be required to meet the outcome or other high priority measures requirements to meet the satisfactory reporting criteria. If less than 6 measures are applicable to an EC for the 2016 performance period, the EC must report every applicable measure to be considered as satisfactorily reporting and thus avoid a negative payment adjustment.

For group practices with 25 or more ECs reporting via the CMS Web Interface, CMS does not propose any changes to the satisfactory reporting criteria. Therefore, Web Interface reporters are required to report on the first 248 consecutively ranked and assigned beneficiaries for each measure in the Web Interface. Group practices with 100 or more ECs were required to report the CAHPS for PQRS survey for 2016 using a CMS-certified survey vendor. Smaller groups had the option of reporting the CAHPS for PQRS survey for a portion of their quality measures. Group practices that reported CAHPS for PQRS either voluntarily or as required will need to report an additional 3 measures under the proposed rule, rather than the 6 measures that were required for 2016, to meet satisfactory reporting requirements. For groups with 100 or more ECs, CMS proposes to drop the requirement to report the CAHPS for PQRS survey and make it a voluntary option consistent with MIPS.

**Group Practice Reporting Criteria and Proposed Changes for Reporting Year 2016**

Practice Size	Measure Type	Reporting Mechanism	Original Reporting Criteria	Proposed Reporting Criteria
25+ ECs	Individual GPRO measures in Web Interface	Web Interface	Report on all measures included in the web interface; populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the group’s sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is	No proposed changes.

Practice Size	Measure Type	Reporting Mechanism	Original Reporting Criteria	Proposed Reporting Criteria
			less than 248, then the group practice must report on 100 percent of assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.	
25+ ECs	Individual GPRO measures in Web Interface + CAHPS	Web Interface + CAHPS for PQRS	Report on all measures included in the web interface; populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100 percent of assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data. The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor.	No proposed changes.
2+ ECs	Individual measures	Qualified Registry	Report 9 measures across at least 3 NQS domains including 1 cross-cutting measure. Report for at least 50 percent of Part B patients to which the measure applies.	Report at least 6 measures for at least 50 percent of Part B patients to which the measure applies.
2+ ECs	Individual measures + CAHPS	Qualified Registry + CAHPS Survey	The group practice must have all CAHPS for PQRS survey measures	The group practice must have all CAHPS for PQRS survey measures

<b>Practice Size</b>	<b>Measure Type</b>	<b>Reporting Mechanism</b>	<b>Original Reporting Criteria</b>	<b>Proposed Reporting Criteria</b>
		Vendor	reported on its behalf via a CMS-certified survey vendor. Report at least 6 additional measures across at least 2 NQS domains including 1 cross-cutting measure.	reported on its behalf via a CMS-certified survey vendor. Report at least 3 additional measures using a qualified registry for at least 50 percent of Part B patients to which the measure applies.
2+ ECs	Individual measures	Direct EHR Product or EHR Data Submission Vendor	Report 9 measures across at least 3 NQS domains. At least one reported measure must contain Medicare patient data.	
2+ ECs	Individual measures + CAHPS	Direct EHR Product or EHR Data Submission Vendor + CAHPS Survey Vendor	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. Report at least 6 additional measures across at least 2 NQS domains using a direct EHR product or EHR submission vendor. At least 1 measure reported via EHR must contain Medicare patient data.	The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. Report at least 3 additional measures using a direct EHR product or EHR submission vendor. At least 1 measure reported via EHR must contain Medicare patient data.
2+ ECs	Individual PQRS/Non-PQRS measures	QCDR	Report on at least 9 measures available for reporting under a QCDR covering at least 3 NQS domains. Measures must be reported for at least 50 percent of all patients to which the measure applies. At least 2 measures must be outcome measures. If 2 outcome measures are not available, at least 1 outcome and one high priority measure are required.	Report at least 6 measures available for reporting under a QCDR for at least 50 percent of all patients to which each measure applies.

**Physician Compare:**

CMS finalized in the CY 2016 rule that the Agency would publicly report three VM data points in Physician Compare in late 2017:

- The VM quality tiers for 2016 noting whether an EC or group is high, low, or average on cost and quality per the VM.
- An indication of the payment adjustment received for each EC or group in the form of upward, downward, or neutral.
- An indication of whether the EC or group was eligible to report PQRS quality measures but did not.

Based on the proposed changes to PQRS satisfactory reporting criteria and the VM, CMS proposes not to report this specific VM data. CMS believes that the changes in the number of measures may make the data confusing to the public. The Agency will continue to publish a Public Use File that contains VM performance results of de-identified practices.

**ACP Comments:**

**The College supports CMS' proposal to better align PQRS satisfactory reporting requirements with the Quality Performance Category requirements in the first year of MIPS.** This will allow some additional physicians to avoid a negative payment adjustment for the final year of PQRS reporting.

**ACP strongly encourages CMS to consider finalizing additional changes to better align the final year of PQRS with the pick your pace options. Therefore, the College urges CMS to allow any clinician who submitted any PQRS data for 2016 to be held harmless from any downward adjustments associated with PQRS and the VM for the 2016 performance period (2018 payment adjustment period).** This hold harmless policy should be applied regardless of how much data or how many measures were submitted as long as something was submitted, as this would better align with the transition year policies in the first year of MIPS. Under the test option in the MIPS transition year, ECs that try to submit any quality data are held harmless from negative payment adjustments. This same policy should be applied for the final year of PQRS to ensure that more ECs are not hit with reduced payments in 2018 at the same time as they are trying to submit their first year of performance data for MIPS. **Additionally, ACP urges CMS to consider providing relief from penalties associated with the Medicare EHR Incentive Program (Meaningful Use) for the 2016 performance period for ECs who tried but were unsuccessful at reporting MU.** Due to the changes that will occur with EHR reporting in MIPS, the College believes that ECs that attempted to submit some MU data should be held harmless from negative payment adjustments in 2018.

**The College further recommends that CMS hold clinicians and groups harmless from negative payment adjustments for the final year of PQRS if they fall below the MIPS low-volume threshold criteria ( $\leq$ \$30,000 in Part B allowed charges or  $\leq$ 100 Part B patients).** This change will better align with MIPS policies by allowing ECs and groups that will be ineligible for payment adjustments in MIPS due to their low Medicare volume to avoid application of PQRS and VM penalties in 2018, the final year of participation in the legacy reporting programs prior

to QPP. ACP also reiterates its comments<sup>3</sup> from the QPP proposed rule for year 2 that CMS allow ECs and groups below the low-volume threshold to opt-in for MIPS reporting and be allowed to receive payment adjustments.

### Value-Based Payment Modifier and Physician Feedback Program

#### **Background:**

CMS previously finalized using quality tiering to determine payment adjustments associated with the value-based payment modifier (VM) program. CMS will continue to use a two category approach for the CY 2018 VM based on participation in PQRS by groups and solo ECs during performance year 2016, as outlined below.

#### *Category 1:*

- Solo ECs that meet the criteria to avoid the PQRS payment adjustment;
- Groups that meet the criteria to avoid the PQRS payment adjustment as a group practice participating in PQRS GPRO; and
- Groups that have at least 50 percent of the ECs meet the criteria to avoid the PQRS payment adjustment as individuals, regardless of whether the group registers for PQRS GPRO. In previous years, this option was only available to groups that did not register to participate in PQRS GPRO.

*Category 2:* groups and solo ECs that are subject to the 2018 VM and do not fall in Category 1 (e.g., those that do not meet the PQRS satisfactory reporting/participation criteria).

Under the current policy, CMS will apply the quality-tiering methodology to groups and solo ECs in Category 1. For the CY 2018 VM (based on performance in CY 2016), solo ECs and groups in category one could receive a maximum upward adjustment under the quality-tiering methodology for the CY 2018 VM to: +4.0 times an upward payment adjustment factor (to be determined after the performance period has ended) for groups with 10 or more EPs; +2.0 times an adjustment factor for groups with between 2 to 9 EPs and physician solo EPs; and +2.0 times an adjustment factor for groups and solo EPs that consist of non-physician EPs who are PAs, NPs, CNSs, and CRNAs. The amount of payment at risk under the CY 2018 VM is 4.0 percent for groups with 10 or more EPs, 2.0 percent for groups with between 2 to 9 EPs and physician solo EPs, and 0 percent for groups and solo clinicians that consist only of non-physician EPs who are PAs, NPs, CNSs, and CRNAs.

CMS proposes to modify this policy to hold harmless from negative payment adjustments any solo clinicians and groups in Category 1. This will protect clinicians who satisfactorily reported PQRS but would have been subject to a negative payment adjustment based on their quality composite score and/or cost composite score. CMS also proposes to reduce the potential positive payment adjustments to a maximum of +2.0 times an upward adjustment factor. The Agency notes that the upward adjustment factor has resulted in adjustments that are

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[https://www.acponline.org/acp\\_policy/letters/cms\\_comment\\_letter\\_re\\_cy\\_2018\\_macra\\_qpp\\_proposed\\_rule\\_2017.pdf](https://www.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf)

significantly higher than the adjustments that will be available in MIPS, so this proposed change will ensure a smoother transition from the VM to MIPS policies.

**Proposed VM Quality Tiering Methodology for All ECs & Groups for the 2016 Perf. Period**

<b>Cost/Quality</b>	<b>Low Quality</b>	<b>Average Quality</b>	<b>High Quality</b>
Low Cost	+0.0%	+1.0x *	+2.0x *
Average Cost	+0.0%	+0.0%	+1.0x *
High Cost	+0.0%	+0.0%	+0.0%

\*Under existing policy, these clinicians are eligible for an additional +1.0x if their average beneficiary risk score is in the top 25 percent.

For Category 2 ECs (i.e., non-PQRS reporters), the finalized CMS would apply an automatic 4.0 percent downward payment adjustment VM to groups of 10 or more ECs and a 2.0 percent downward adjustment VM for solo ECs and groups of 2-9 for payment adjustment year 2018. These VM payment adjustments are in addition to the 2.0 percent downward payment adjustment for failing to satisfactorily report PQRS data for payment adjustment year 2018 (performance year 2016). In this rule, CMS proposes to reduce the negative payment adjustment from negative 4.0 percent to negative 2.0 percent for clinicians in groups of 10 or more ECs. For solo clinicians and groups of 2-9 ECs, the Agency proposes to reduce the negative payment adjustment from negative 2.0 percent to negative 1.0 percent for the 2018 payment adjustment year.

**ACP Comments:**

**The College supports the proposal to hold Category 1 clinicians harmless from negative payment adjustments (i.e., those clinicians who met satisfactory reporting criteria for PQRS).** This will protect these clinicians from negative payment adjustments while they are learning the new policies under QPP. **However, in line with our comments above pertaining to PQRS, ACP further recommends that CMS consider any clinicians or groups that submit any quality data for PQRS as Category 1 and be held harmless from any potential VM penalties.** Allowing ECs and groups submitting any amount of quality data to be held harmless from negative payment adjustments associated with the VM will better align the program with the MIPS transition year policies. We further recommend that ECs and groups of any size that fall below the low-volume threshold for MIPS be held harmless from negative payment adjustments associated with PQRS and the VM, regardless of whether they submit quality data, in order to align the final year of reporting in the legacy programs with MIPS.

**ACP appreciates that CMS accepted our previous recommendation to reduce the maximum negative payment adjustment to negative 2.0 percent for groups of 10 or more ECs in Category 2.** This will make the potential penalties associated with the VM more aligned with MIPS policies. **We further recommend that CMS hold solo clinicians and small groups in Category 2 harmless from any negative payment adjustments.** The small practice threshold for the VM should be expanded to include those groups with 15 or fewer ECs in a shared TIN to be consistent with MIPS policies. Additionally, as we recommended in our comments on the QPP

year 2 proposed rule,<sup>4</sup> loosely held TINs with multiple practice sites that are not owned and operated as part of an organization should meet this definition if individual practice sites meet the small practice definition. As CMS acknowledges, many of these clinicians will fall below the low-volume threshold in MIPS and will therefore be considered excluded from payment adjustments in MIPS. **Due to the low PQRS participation rate among small practices and solo clinicians and the fact that many of these practices will be excluded from reporting in MIPS, we urge CMS to hold these clinicians harmless from any negative payment adjustments associated with the VM.**

The College also reiterates its comment from the QPP proposed rule that we have significant concerns with the claims-based measures from the VM as well as the newly developed episode-based measures that will be used to calculate the Cost Performance Category score. The total per capita cost measure and the Medicare Spending Per Beneficiary (MSPB) measure, which will be used in both the VM and MIPS calculations, lack sufficient attribution methodology and inappropriately attribute broad-based costs to physicians for services that are outside of their control and that they do not have the ability to impact, such as costs associated with hospitalizations and other care settings that occur outside of the physician’s practice. The cost measures also lack proper risk adjustment methodologies such as adjustments for socioeconomic status. Due to these concerns and other issues, CMS has weighted the Cost Performance Category at zero percent for the first year of MIPS while providing feedback on the flawed measures used in the VM calculations. We recommend that CMS assert its full authority to minimize any negative payment adjustments associated with the VM for all clinicians for the 2018 payment adjustment period.

MACRA Patient Relationship Categories and Codes

**Background:**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) directed CMS to create new patient relationship codes that physicians would be required to report on claims starting in 2018 for the purposes of determining which physician would be held accountable for a patient’s cost of care. Public comments indicated that modifiers would be the best way to operationalize the reporting of patient relationship codes. CMS proposes five patient relationship categories that would be identified by Level II HCPCS modifiers and are listed in “Table 26” below beginning January 1, 2018. Given the learning curve associated with using these modifiers, the Agency further proposes that reporting these modifiers on Medicare claims will initially be voluntary and not a condition of payment.

**Table 26: Proposed Patient Relationship HCPCS Modifiers and Categories**

No.	Proposed HCPCS Modifier	Patient Relationship Categories
1x	X1	Continuous/broad services
2x	X2	Continuous/focused services
3x	X3	Episodic/broad services
4x	X4	Episodic/focused services
5x	X5	Only as ordered by another clinician

<sup>4</sup>

[https://www.acponline.org/acp\\_policy/letters/cms\\_comment\\_letter\\_re\\_cy\\_2018\\_macra\\_qpp\\_proposed\\_rule\\_2017.pdf](https://www.acponline.org/acp_policy/letters/cms_comment_letter_re_cy_2018_macra_qpp_proposed_rule_2017.pdf)

**ACP Comments:**

**ACP previously recommended that CMS use modifiers to determine the relationship that each clinician has with the patient when multiple clinicians are billing on a single claim and therefore supports the current proposal to use such modifiers.** Because clinicians and their staff are already familiar with modifiers in general, this will make the transition to using patient relationship codes on a claim smoother. However, even if CMS uses a documentation format with which practices are familiar by utilizing modifiers, we reiterate that implementing a new code set to document something that previously has not been included on claims will be a significant challenge, and we urge the Agency to take steps to make the burden that this transition places on practices as minimal and automated as possible.

**ACP urges CMS to ensure the utmost transparency in how the Agency attributes cost, based on the use of these patient relationship categories and modifiers, along with the codes for care episodes and patient conditions.** It must be made clear how the cost for an episode of care will be attributed across the multiple clinicians that may be involved— and also when physicians may be caring for a patient on behalf of another physician who is temporarily unavailable (e.g., due to vacation or illness), as well as for physicians providing care to patients who co-locate (e.g., “snowbirds” who primarily reside in the north, but may also spend several months in a southern state during the winter). Prioritizing transparency in the approach to measuring resource use and involving participating clinicians in the testing and implementation is critical to building trust—and trust in all of the data to be used for determining a physician’s cost score and composite score within MIPS is paramount to achieving success in the implementation of MACRA and meeting the true intent of the law.

**In order to test the system prior to implementation, ACP recommends that CMS conduct a voluntary pilot program on the overall episode-based cost measures – which include the patient relationship categories described above as well as the proposed patient conditions groups.** The pilot would use an operational set of episode groups and subgroups and include a representative sample of practice types, sites, geographic regions, etc. Clinicians who volunteer to test the episode-based cost measures would receive feedback reports on the cost measures but it would not be counted toward their composite performance score in the Merit-based Incentive Payment System (MIPS). **Additionally, clinicians would receive full credit within the Improvement Activities Performance Category of MIPS for participating in the pilot.** The pilot would provide the opportunity for CMS to collect and review data over the course of a year (or multiple years) to help further answer some of the outstanding questions for how to best develop and implement these episode-based cost measures without inappropriately penalizing physicians.

**Proposed Changes to the Medicare Diabetes Prevention Program (MDPP)****Background:**

In 2017 CMS finalized the expansion of the Medicare Diabetes Prevention Program (MDPP) which is a structured health behavior change program delivered in community and health care settings by trained community health workers or health professionals. The MDPP consists of intensive “core” sessions of a CDC-approved curriculum in a group-based setting that provides

practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. After completing the “core” sessions, less-intensive, monthly maintenance sessions are provided to help ensure health behaviors with the primary goal of at least five percent average weight loss by participants.

In the 2018 PFS proposed rule, CMS proposes policy updates to the expanded MDPP including:

- **New Start Date:** In order to ensure that MDPP suppliers have sufficient time to enroll in Medicare, CMS proposes a new start date of April 1, 2018 instead of the previous January 1, 2018.
- **Updates to Eligibility Criteria:** If the Medicare beneficiary develops diabetes during the MDPP services period, this would not make the beneficiary ineligible to continue to receive MDPP services.
- **Updates to Ongoing Maintenance Sessions:** CMS proposes a 2-year limit to the ongoing maintenance sessions provided after the initial year of “core” sessions. The beneficiary must attend at least three sessions and maintain five percent weight lost during the ongoing maintenance session intervals to be eligible to continue with future maintenance sessions.
- **Payment Structure Proposals:** CMS proposes a performance-based payment structure based on two main goals – attendance and/or weight loss. The below table provides a breakdown of the payment structure

Performance Goal	Proposed Performance Payment Per Beneficiary (with at least 5 percent weight loss)	Proposed Performance Payment Per Beneficiary (without at least 5 percent weight loss)
First core session attended	\$25	
Four total core sessions attended	\$30	
Nine total core sessions attended	\$50	
3 sessions attended in final core maintenance session interval (months 7-9 of the MDPP core services period)	\$60*	\$10
3 sessions attended in second core maintenance session interval (months 10-12 of the MDPP core services period)	\$60*	\$10
5-percent weight loss achieved	\$160	\$0
9-percent weight loss achieved	\$25	\$0
3 sessions attended in ongoing maintenance session interval (8 consecutive 3-month intervals over months 13-36 of the MDPP ongoing services period)	\$50*	\$0**
<b>Total performance payment</b>	<b>\$810</b>	<b>\$125</b>

Reference: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-3.html>

\* = The required minimum weight loss from baseline must be achieved or maintained during the core maintenance session 3-month interval or maintained during the ongoing maintenance session 3-month interval

\*\* = A beneficiary must achieve or maintain the required minimum weight loss at least once during the final core maintenance session 3-month interval to have coverage of the first ongoing maintenance session interval.

### *Virtual Diabetes Prevention Program (DPP)*

CMS is proposing to include a limited number of virtual make-up sessions in the MDPP; however, the Center for Medicare and Medicaid Innovation (CMMI) DPP model test that met the statutory requirements for expansion did not include diabetes prevention services furnished 100 percent remotely and CMS decided not to include any proposals for the virtual DPP program at this time. The Agency intends to develop a separate virtual model under CMMI authority to test and evaluate DPP services that are exclusively furnished virtually and CMS will release additional details about model through guidance outside of the PFS rulemaking cycle.

### **ACP Comments:**

ACP is pleased that CMS finalized the expansion of the MDPP and further outlined specific payment policies for implementation of the program. The College understands CMS must ensure program integrity; however, **ACP would like to reiterate our recommendation from our 2017 PFS comment letter that CMS should allow beneficiaries that previously failed the program to attempt the program again.** The proposal gives the impression that beneficiaries who meet the coverage criteria would only be able to enroll in the MDPP once. Evidence shows that even a modest amount of weight loss improves health outcomes. **We believe that any patient that meets the criteria, even if he/she failed the program previously, should be allowed to enroll in the MDPP.**

The College believes that the virtual DPP program has the opportunity to expand access to these important preventive services. ACP policy<sup>5</sup> highlights how certain telemedicine programs have shown to “aid in extending the range of primary care physicians and subspecialists to patients they could not reach otherwise, provide care equitable to that of in-person visits, and reduce costs through heightened efficiency.” We are encouraged that CMS is developing a separate virtual DPP model through the appropriate CMMI demonstration process and hope that it can be expedited in order to expand access to this program even sooner.

### Request for Information: CMS Flexibilities and Efficiencies

#### **Background:**

CMS is requesting public comment and specific ideas for regulatory, subregulatory, policy, practice, and procedural changes to improve the health care system by reducing unnecessary burdens for clinicians, other health care providers, patients and their families. The Agency highlighted the following topic areas to focus feedback and comments:

- payment system redesign,
- elimination or streamlining of reporting, monitoring and documentation requirements,
- aligning Medicare requirements and processes with those from Medicaid and other payers,

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<sup>5</sup> <http://annals.org/aim/article/2434625/policy-recommendations-guide-use-telemedicine-primary-care-settings-american-college>

- operational flexibility,
- feedback mechanisms and data sharing that would enhance patient care,
- support of the physician-patient relationship in care delivery and facilitation of individual preferences,
- and recommendations regarding when and how CMS issues regulations and policies and how CMS can simplify rules and policies for beneficiaries, clinicians, physicians, providers, and suppliers.

**ACP Comments:**

ACP greatly appreciates the opportunity to provide CMS with specific ideas for how to reduce unnecessary regulatory and administrative burden for clinicians and their patients. **The following are a set of detailed recommendations listed in order of priority to the College:**

*1) Update Regulatory Impact Analyses for New and Existing Regulations*

The growing number of excessive administrative tasks diverts time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may prevent patients from receiving timely and appropriate care or treatment. These tasks can stem from federal health care requirements, as well as from private payers, vendors, and suppliers. Often administrative tasks are added without any formal assessment of why the task is being proposed, what is intended by the task, and its actual impact on physicians and patients (such as diverting physicians from spending time with patients to complying with unnecessary administrative tasks), and whether the tasks could be eliminated, streamlined, or modified to reduce the burden on physicians without harming quality, safety, or program integrity. **Therefore, ACP urges CMS to incorporate into the regulatory impact analysis a standard assessment of cost, time, and quality of care for public review and comment.** These analyses should occur for existing and new regulations and associated administrative tasks. Those regulations and tasks that are determined to have a negative effect on quality and patient care, unnecessarily question physician and other clinician judgment, or increase cost should be challenged, revised, or removed entirely.

In a recent position paper, [Putting Patients First by Reducing Administrative Tasks in Health Care](#), ACP proposes a cohesive framework for analyzing administrative tasks to better understand any given task that a clinician and his/her staff may be required to perform and then potentially be revised or removed entirely, by government and other external entities. **The College strongly recommends CMS consider using this framework for identifying and classifying new or existing requirements or tasks and incorporate the following questions into the regulatory impact analysis:**

- a. Could the requirement interfere with or enhance the ability of clinicians to provide timely and appropriate patient care (both in-person and remotely, in real time and asynchronously)? What are the expected or potential opportunity costs of the requirement in terms of its effect on time spent by clinicians providing care for patients and on any time spent by patients to address the requirement?
- b. Does the requirement improve the quality of care delivered to the individual patient and/or to the population? If so, how?

- c. Does the requirement have a financial impact on the physician practice, provider organization, patient and his/her family, and/or the health system that diverts resources from patient care? To what extent can this impact be quantified?
- d. Does the requirement call into question physician judgment in terms of expertise, training, education, and experience? If so, what are the reasons these questions are being raised?
- e. Overall, can stakeholders propose alternative approaches to accomplish their goal for consideration by the public?

## 2) Simplify the Merit-based Incentive Payment System (MIPS) Scoring System

When Congress sunsetted the payment adjustments associated with Physician Quality Reporting System (PQRS), the value-based payment modifier, and the EHR Incentive Program through MACRA, the intent was that these programs would be rolled into one streamlined program – MIPS – that combines the piecemeal approach to assessing clinicians into a single program with a single payment adjustment attached to it. CMS made modifications to the overall scoring methodology through rulemaking; however, ACP still has concerns with the scoring structure for MIPS, including proposed revisions, because overall it continues to allow each performance category to operate within its own fragmented silo. Most significantly, there are still different scoring systems across the performance categories, and while all of this may have been well-intentioned, the inconsistent construction adds significant and unnecessary complexity to the already complicated Quality Payment Program (QPP).

In the 2018 QPP Proposed Rule, CMS proposes modifications to the methodology to create a final MIPS composite performance score (CPS):

- Zero out the weight of the Cost Performance Category – which was initially set at ten percent of the overall CPS for 2018.
- Increase the weight of the Quality Performance Category from 50 to 60 percent of the CPS.
- Increase the overall performance threshold for the CPS from three points to 15 points, which fails to align sufficiently with most participation options for the 2018 performance period.
- Add a complex patient bonus of 1-3 points based on average HCC risk score.
- Add a small practice bonus of 5 points for practices with 15 or fewer ECs that submit data in at least one performance category.
- Propose a methodology for scoring improvement in the quality and cost performance categories.
- Create a lower scoring standard for quality measures that are identified as topped out, allowing them a maximum of 6 points rather than 10.
- Allow 1 point for failing to meet data completeness criteria for quality measures, while allowing small practices 3 points.

**ACP recommends that CMS simplify the MIPS scoring system via the following approaches (additional QPP recommendations can be found in our [Comment Letter to CMS Regarding MACRA/Quality Payment Program \(QPP\) Proposed Rule for CY 2018](#)):**

- Further simplify and standardize the scoring approach within MIPS in order to allow the point value for each measure or activity to be fully reflective of its value within in the overall composite performance score (CPS). Currently, there is still a different methodology for the weight of points in each performance category that does not fully align with the value of the category in contributing to the overall CPS. Alternatively, ACP proposes that CMS modify the point values to reflect a more unified approach:
  - The available points within the quality component should add up to a total of 60 points – counting for 60 percent;
  - The points within improvement activities would add up to 15 – counting for 15 percent;
  - The points within ACI would add up to 25 – counting for 25 percent (and not 155, with only 100 of those points actually “counting,” as described in this proposed rule); and
  - When cost is eventually recalculated into the overall CPS, the points would add up to however much it is weighted in the overall score (10 points if 10 percent; 30 points if 30 percent).
- Modify the base score component of the Advancing Care Information (ACI) performance category and remove the threshold requirements of 1 or “yes” for all proposed base measures except for the protecting patient health information attestation, which ACP believes is integral to the use of health IT. When considering our move to a value-based and learning health care system and exploring ways to further advance the use of health IT, there is an opportunity to be less prescriptive.
- Continue to consider additional options in rulemaking to promote taking on quality improvement activities that crossover into multiple performance categories to strengthen MIPS and make the program more comprehensive rather than siloed.
- Remove the weighting of Improvement Activities, as it adds unnecessary complexity and it is unclear what evidence might indicate why certain activities might be considered medium versus highly weighted.

3) *Simplify and Align the Quality Measurement System to Ease the Burden of Reporting, Enhance Patient Care, and Build a Learning Health Care System*

There is an opportunity provided within the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation for the Centers for Medicare and Medicaid Services (CMS) to actively build a learning health and health care system that incorporates clinically relevant and accurate quality measurement. It is critically important that the new payment systems that are designed through the implementation of MACRA and the Quality Payment Program reflect the lessons from the current and past programs and also effectively allow for ongoing innovation and learning. Overall, quality measurement must move toward effective approaches of measuring clinically relevant care and patient outcomes. Additionally, as ACP noted in our [comments](#) to CMS on the draft Quality Measure Development Plan (MDP), it is important to constantly monitor the evolving quality measurement system to identify and mitigate any potential unintended consequences, such as increasing administrative burden and clinician burn-out,

adversely impacting underserved populations and the clinicians that care for them, and diverting attention disproportionately toward the things being measured to the neglect of other critically important areas that cannot be directly measured (e.g., empathy, humanity).

**The College strongly recommends that CMS use ACP’s Performance Measurement Committee (PMC) recommendations first when considering what measures to use for reporting by internal medicine specialists.** ACP’s PMC has reviewed and provided detailed [recommendations](#) on performance measures that are particularly applicable to internal medicine—and soon will have recommendations available for all internal medicine-relevant Merit-based Incentive Payment System (MIPS) measures. The PMC recommendations are based upon a scientific review process that involves four domains: purpose and importance to measure, clinical evidence base, measure specifications, and measure implementation and applicability.

**Additionally, ACP recommends CMS focus any additional performance measure proposals on the core sets of measures identified by the Core Quality Measures Collaborative and measures recommended by the Measure Application Partnership (MAP).** We would also like to reiterate our support for CMS using measures that have undergone the National Quality Forum (NQF) consensus-standards endorsement process, which entails measures being evaluated against four criteria— importance to measure, scientifically acceptable, usable and relevant, and feasible to collect. Consistent implementation of these sets of quality measures will align and simplify the quality measure reporting process, reduce the burden associated with reporting, and most importantly focus on clinically relevant and accurate measures that improve quality and patient outcomes.

4) *Align Varying Policies, Procedures, and Contracting Arrangements in the Medicare Advantage (MA) Program with Traditional Medicare to Promote Transparency and Reduce Excessive and Burdensome Administrative Tasks.*

Medicare Advantage Organizations (MAOs) – as well as other private payers – have their own approaches and rules related to their business operations, billing requirements, prior authorizations, reporting of quality measures, referrals and treatment plans, and so on. These varying requirements across Medicare programs result in excessive administrative burden for participating physicians. For example, different Medicare Advantage (MA) plans may send guidance to participating physicians on certain services to provide to a patient based on the patient’s specific MA plan and what the physician can bill for – even if that service is not entirely necessary at the time of the visit. These varying processes and guidelines make it difficult for a physician practice to manage and capture the appropriate charges (e.g., some MA contracts may allow physicians to bill for an Annual Wellness Visit [AWV] even though the patient received an AWV three months prior, whereas other MA plans allow an AWV to be billed 11 months apart, and others 365 days plus one day). Physicians should be clear on the intent of contracting arrangements and associated policies and procedures for participating in the MA plan so the appropriate and timely care of the beneficiary is at the forefront.

Additionally, aligning and streamlining the performance measurement system across Medicare programs and the commercial insurance market should be a priority in the efforts to decrease

excessive and burdensome administrative tasks in the health care system. In addition to the complexities involved with contracting with multiple payers, navigating the differing data collection mechanisms and performance metrics systems across individual plans can become extremely time consuming and burdensome and take away from providing the high-quality care the metrics seek to capture.

**The College calls on CMS to collaborate with Medicare Advantage Organizations (MAOs) in order to identify and analyze contracting arrangements and associated administrative tasks required for participation in their plans and either align varying arrangements and tasks, streamline duplicative tasks, or remove entirely tasks that are deemed excessive and burdensome using the comprehensive framework developed in ACP's position paper "[Putting Patients First by Reducing Administrative Tasks in Health Care.](#)"**

ACP believes the quality measurement systems for both Medicare Advantage plans and traditional Medicare should align in a way that promotes high-value care for all beneficiaries, streamlines quality reporting across Medicare programs, and promotes administrative simplification. A key approach in addressing the issues with the performance measurement system is for all stakeholders, including CMS, MA plans, other payers, electronic health record (EHR) vendors, and physicians, to collaborate in better utilizing existing and innovative health information technology (health IT) to seamlessly extract information from EHRs and address issues of burdensome data collection and performance measure reporting.

Thank you for considering ACP's comments. Please contact Brian Outland, PhD, Director, Regulatory Affairs, by phone at 202-261-4544 or e-mail at [boutland@acponline.org](mailto:boutland@acponline.org) if you have questions or need additional information.

Sincerely,

A handwritten signature in black ink that reads "Jacqueline W. Fincher MD". The signature is written in a cursive, flowing style.

Jacqueline W. Fincher, MD, MACP  
Chair, Medical Practice and Quality Committee  
American College of Physicians