September 10, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

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

Dear Administrator Verma:

On behalf of our members, America's Physician Groups (APG) appreciates this opportunity to comment on the CY 2019 Medicare Physician Fee Schedule Proposed Rule (proposed rule). We thank you in advance for your consideration.

APG represents over 300 medical groups and independent practice associations (IPAs) across 43 states, the District of Columbia, and Puerto Rico. Our tagline, "Taking Responsibility for America's Health," truly represents our members' vison and efforts to move away from the antiquated fee-for-service (FFS) reimbursement system where clinicians are paid "per click" for each service rendered rather than on the quality or outcomes of the care provided. Instead, our members are taking responsibility improving the health of the patients and communities they serve by holding themselves accountable for the cost and quality of care through alternative payment models (APMs). Our preferred model of capitated, coordinated care avoids incentives for the high utilization associated with FFS reimbursement. This model aligns incentives for physicians to provide the right care in the right setting, thus improving the health of entire populations, particularly chronically ill and fragile individuals.

That being said, we know that our nation's health care system has just begun this journey from volume to value, and some providers aren't yet ready to participate in such an advanced model. That is why it is so important that the Centers for Medicare and Medicaid Services (CMS) to take steps to continue to improve a Medicare Physician Fee Schedule (PFS) that governs traditional Medicare and to continue to build the on-ramp to more advanced APMs.

Our detailed comments on specific elements of the proposed rule are provided below.

I. APG supports efforts to modernize Medicare physician payment by recognizing communication technology based cervices

CMS is proposing to add payments for communication technology-based services, including Virtual Check-ins (HCPCS code GVCI1). Importantly, these services would not be subject to the limitations on Medicare telehealth services because CMS does not consider them to be a part of Medicare telehealth services; instead, they would be paid under the PFS like other physicians' services. APG applauds this move by CMS and we are hopeful that this indicates a willingness by CMS to recognize the shift in care from traditional, office-based face-to-face services to a more all-encompassing care plan which supplements office visits with virtual and home-based services.

As technology and medicine advance, so too must the Medicare payment infrastructure. It is critical that clinicians are able to offer their patients the type of services and responses they need, especially when the patient initiates the exchange of information or care, e.g. the proposed virtual check-in or patient generated still image. The addition of these services allow for care to be provided in a non face-to-face manner which leads to higher beneficiary satisfaction. We urge CMS to expand payment in additional areas to support the new way in which care can be delivered in the future.

II. Proposed changes to Evaluation and Management documentation requirements and reimbursement in the PFS

After many hours of discussion with our members, it is clear that the proposed changes to Evaluation and Management (E/M) reimbursement will be financially positive for some of our members and financially negative for others depending on specialty and specific local market conditions. We are thus declining to take a formal position either supporting or opposing the collapsing of the E/M codes as outlined in the proposed rule.

However, we do wish to supply comments that will inform CMS of the impact these changes will have on our model of risk based, integrated care. It is our hope and intention that these comments will inform the modifications that CMS will make in the final rule.

We appreciate that CMS has acknowledged, through numerous meetings with stakeholders, that changes are needed in E/M codes to be more reflective of the needs of the growing chronically ill population. The complex documentation needed for E/M codes for patients that experience multiple chronic conditions have resulted in increasing burnout and stress among clinicians. With physician burnout being a genuine national problem, almost any solution that would reduce it would be strongly supported by the industry. CMS is proposing to collapse the Level 2-5 E/M codes into a blended rate for established patients and another for new patients. These new blended rates would require documentation currently only required for a Level 2

visit and only for any new clinical information. It would eliminate the need to reenter any past information, thus conceptually allowing more time with the patient.

Unfortunately, we do not think the rule will achieve its intended effect of reducing the time spent in documentation. Physicians code thoroughly in Medicare for at least three reasons that probably will not be affected by the rule:

- To create a record explaining the analysis that led them to the treatment plan for the benefit of other physicians who subsequently see the patient,
- To defend against malpractice exposure, and
- To capture patient acuity as necessitated by risk adjustment in their Medicare Advantage (MA) and alternative payment model (APM) populations.

However, APG does strongly support CMS efforts to reduce the administrative burden on physicians, including the adoption of the following CMS proposals related to medical record documentation and billing:

- Allowing physicians to document what has changed since the last patient visit, rather than requiring re-documentation of information that has previously been documented.
- Allowing physicians to review and verify information entered by medical staff or the patient, rather than requiring re-documentation by the physicians.
- Streamlining the overall level of medical record documentation required of physicians for E&M codes.
- Eliminating extra documentation requirements for home visits.
- Allowing billing of same day visits by practitioners of the same group and specialty when it is in the best interest of the patient.

While APG supports the streamlining of medical documentation requirements, we have heard the following concerns from our members about unintended consequences related to CMS' proposal to change its reimbursement methodology :

- CMS is proposing to have add-on G codes to adjust for more complex patients such as longer visits. These additional G codes can increase reimbursement to the primary care physician, but does increase the level of complexity in their workflow by adding an extra step that CMS is trying to avoid with the proposed collapsing of the E/M codes.
- The consolidation of Level 2-5 E/M codes to one reimbursement amount will negatively affect physicians that provide care to the sickest and most complicated patients (those that bill Level 4 and 5 E/M codes).
- The proposed E/M compensation methodology does not support the industry transition from volume to value, which has a focus on treating patients with chronic diseases. Chronic disease management is more complex and time consuming, and is typically billed with higher level E&M codes. APG is concerned that such treatment would be reimbursed at a lower amount under CMS' proposal.
- The proposed E&M code reimbursement changes may result in primary care physicians referring more chronically ill patients to specialists due to payment reductions for higher level E/M codes.
- The proposed multiple service payment reduction policy may result in increased utilization if patients requiring multiple procedures are scheduled on multiple days, rather than one day based upon reimbursement methodology.

- It appears that some primary care specialties would be adversely affected by the proposed reimbursement changes. This is troubling given the increasing shortage of primary care physicians. We need reimbursement methodologies that incentivize physicians to pursue primary care.

The proposed E/M updates have generated vigorous discussion over the last few months in the physician community. However, most discussions, including those in print, have centered on the impact of this change on physician reimbursement rather than on work flow impact, thus negating the underlying goal of the administration in proposing this rule – to reduce administrative burden in order to facilitate "Patients over Paperwork".

Since 90 percent of the nation's healthcare spend is on seniors with multiple chronic conditions, our healthcare system is in the process of moving from an acute care system to a system focused on chronic care. Any analysis of the rule must evaluate whether the rule moves us towards a better chronic care system, or not. We are aware that CMS has also tried to implement other innovative population management codes like CCM (Chronic Care Management), TCM (Transition Care Management), and BHI (Behavioral Health Integration) to move to a prospective and population based payment system, but these codes are seen by many APG members as too cumbersome to administer as evidenced by low percent of billing by practitioners. In fact, many of our members are all together unfamiliar with these codes.

Even with the changes decreasing the amount of documentation, this rule will pay less for the lengthy visits associated with the complex needs of chronically ill seniors. The adage "you get what you pay for is" is apt. Paying less for these visits will mean these visits happen less, or get split up, or get referred out. Irrespective of what it means for physician income, it will be harmful for these vulnerable seniors with the highest need.

All of the strife and difficulty associated with the proposed rule illustrates why CMS should move to directly contracted models where the Agency capitates physician groups who in turn may pay physician groups in ways that align with their local circumstances. The tweaking of coding rules for all physicians across the entire country in seismic strokes of the pen will undoubtedly produce some unintended negative consequences and significant clinician backlash. Capitated physician groups on the other hand can be much more nimble and effective by paying physicians more or less for services that are seen as aligned with their local circumstances. For example, primary care physicians may be paid more than certain specialties if the physician group finds that necessary or appropriate under their unique local circumstances.

We urge CMS to spend time developing models moving away from E/M codes and towards a capitated type of payment model for primary care rather than tweaking a system built on FFS.

III. APG urges CMS to continue working closely with the Core Quality Measures Collaborative to update the Medicare Shared Savings Program quality measures

APG applauds and supports CMS' efforts to align quality measurement and reporting programs with the needs of physicians and physician groups to ensure accountability, reliability and

improved performance. APG is a part of the steering committee of the Core Quality Measures Collaborative (CQMC) and leads the quality measurement conversation with national stakeholders on the harmonization of parsimonious measures that provide value to those measuring them. We are grateful that CMS continues to work closely with the CQMC to help streamline quality reporting programs and promote alignment of quality measures across all payers—public and private. Further, we believe that reducing measurement collection and reporting for the provider is crucial if we are going to align incentives appropriately in value-based purchasing and value-based care.

APG applauds CMS' desire to reduce administrative simplification and enhance burden reduction for the provider and physician organization. However, this is done by reducing measures, along with aligning core measures across quality reporting programs. Many of the measures proposed for removal from the Medicare Shared Savings Program (MSSP) are currently being used in other public and private programs, including the CQMC Accountable Care Organization (ACO)/Patient-Centered Medical Home (PCMH)/Primary Care (PC) core measure set used by several health plans for provider contracting and value-based payment, the MA Star Ratings program, and the Quality Ratings System (QRS). This means not only that ACOs will continue to collect and report measures removed from the MSSP set, but also healthcare stakeholders continue to see room for improvement in these areas.

APG urges CMS to consider working closely with the CQMC to re-evaluate ACO quality measures. The CQMC will be reconvening workgroups to update the core measure sets and recommends that CMS maintain the existing measure set for CY 2019, unless there is overwhelming rationale and support from broad stakeholders to remove specific measures. Given time for re-evaluation, CMS and CQMC may jointly work on measure inclusion in the ACO/PCMH/PC core measure set. After this process is wrapped up, CMS should make every effort to update the CY 2020 MSSP ACO measure set. Specifically, we recommend CMS retain ACO-12, ACO-15, ACO-16, ACO-30, and ACO-41, and delay consideration of adding ACO-45, and ACO-46. In particular, we strongly urge CMS to maintain ACO-41 because it is not only part of the CQMC core set, but is also included in MA Star Ratings, the Exchange Quality Rating System, and NCQA's commercial, Medicare and Medicaid accreditation measures. Further, it is a part of the comprehensive examination for patients with diabetes, and to remove that as a core measure would seem senseless at this time. However, we agree that ACO-35, ACO-36 and ACO-37 measures overlap with other measures in the ACO set, and thus can be removed. Additionally, ACO-47 is a more evolved measure that extends beyond screening for falls, and we support this to replace ACO-13. Furthermore, we concur that ACO-44 should be removed due to a low denominator for the Medicare population.

APG urges CMS to utilize the CQMC more purposefully to help evaluate measures during this year's maintenance review of the ACO/PMH/PC core measure set. This will allow providers, payers, and other stakeholders to weigh in on the changes to the measurement conversation and most importantly, on their patients' quality of care.

IV. APG supports the proposed addition of a special rule on compensation arrangements, but notes that more can and should be done to modernize the Physician Self-Referral Law

The Physician Self-Referral Law: (1) prohibits a physician from making referrals for certain designated health services payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship and (2) prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third-party payer) for those referred services. The statute establishes several specific exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

In response to provisions included in the Bipartisan Budget Act of 2018, CMS is proposing a new special rule on compensation arrangements and proposing to amend existing regulations. The rule, which states that any for compensation arrangement to be in writing, the writing requirement may be satisfied by a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties, simply codifies existing CMS policy. APG supports this clarification but we note that a larger overarching reform to the law as a whole would be much preferable to these small, specific exceptions and fixes. These reforms include:

- Specifically, the Stark Law should not apply to referrals, or related collaborative actions, made by physicians, physician organizations, or transaction participants when:
    - The Medicare beneficiary/patient for whom payment is made is among the population covered by a financial risk bearing agreement;
    - The providers in the transaction are financially integrated, such financial integration to include, but not be limited to, capitated and other risk-based models where the sharing and/or capitated payment is at the physician group level
    - The physicians participating in the transaction all are subject to a quality measurement program equivalent to Medicare Star Ratings Data (Stars) or Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO) programs.

V. APG supports many of the proposed updates to the CY 2019 Quality Payment Program, but urges CMS to go further in the final rule

APG has and will continue to strongly advocate for the implementation of the Medicare Access and Chip Reauthorization act of 2015 (MACRA) as intended by Congress. The MACRA statute was intended, through a variety of incentives and mechanisms, to help move physicians and physician groups from traditional fee-for-service (FFS) to alternative payment models (APMs). However, recent rulemaking in 2016 and 2017 by CMS has slowed the implementation of MACRA and thus the movement from volume to value. While APG recognizes that in some

cases, exemptions and special rules for physicians are necessary, the amount of exclusions offered has significantly hampered MACRA's impact.

Proposed changes to the Merit-based Incentive Payment System (MIPS)

In the proposed rule, CMS updates the 2019 MIPS performance year weights as: quality 45 percent; cost 15 percent; promoting interoperability 25 percent; improvement activities 15 percent. APG supports the increase of the cost performance weight component. Marrying cost and quality is essential to truly impacting the Medicare dollar while also ensuring patients have access to the highest quality of care and outcomes. While we would have liked to see the weight for cost eventually increase to 30 percent, 15 percent is probably a better thoughtful increase that allows for an "on-ramp" for physicians and physician groups. We would like to see the performance weight for cost increased in future years.

CMS also proposed to retain the current low volume threshold. APG opposes this. The low volume threshold went from $30,000 and 100 patients (which, according to the Federal Register, would have exempted 380,000 providers) to $90,000 or 200 patients (exempting more than 540,000 providers). The current threshold excludes over half of physicians and undermines the spirit of the law. Because MIPS adjustments are revenue neutral, there is little to incent high performers to stay in the program because there is so little to fund their bonuses. For example, an APG member who scored 100 on MIPS received a 2.02 percent adjustment – far below the maximum allowed, or 7 percent for performance year 2019. CMS must consider lowering the low volume threshold.

However, APG does support the CMS proposal extending the option for clinicians to voluntarily participate in MIPS for a performance score and performance-based adjustment. APG also supports the policy as proposed to allow clinicians to "opt-in" to MIPS participation in the third year of the program. Finally, APG also supports the CMS proposal to increase the MIPS performance threshold from 15 to 30 and the exceptional performance threshold from 70 to 80. Both mark important steps to ensure physicians are considering both cost and quality.

All Payer Combination Option

CMS has established that in payment year 2021, a new track will be available referred to as the "All-Payer Combination" option. This allow providers to become Qualified Providers (in order to receive the 5 percent bonus) through participating in Advanced APMs in Medicare, MA, Medicaid, and Commercial arrangements. It does not replace or supersede the initial Medicare FFS threshold hurdle of 25 percent patient counts and 20 percent Medicare FFS revenue.

However, APG believes that with the growth of MA plans, and the research demonstrating the superiority of MA in both cost and quality, that MA arrangements in All Payer must be viewed as **equal** to Medicare FFS in terms of the initial threshold 20 percent revenue and 25 percent patient counts

The Integrated Healthcare Association (IHA) recently released its California Regional Health Care Cost & Quality Atlas 2.0, which tracks cost and quality measures across the state for over 29 million beneficiaries and compares different levels of integration on a multi-payer platform

with commercial insurance, Medicare and Medi-Cal data. Not only did the Atlas 2.0 study find that the average risk-adjusted cost per patient for coordinated products (HMOs) were 10 percent less that uncoordinated (PPO) products, they found that in MA the average risk-adjusted, per-member-per-year cost was 25 percent less than traditional Medicare.[1] MA also vastly outperformed traditional Medicare FFS on hospital utilization, and, most importantly, clinical quality. The data is clear – capitated MA delivers superior value with higher quality performance and overall lower cost.

Millions of Americans depend on MA for quality, patient-centered health care and that number is growing fast; over one-third of all Medicare beneficiaries are now enrolled in a MA plan. For the ultimate goal of MACRA to be realized, MA must no longer be excluded from the programs and incentives therein. Therefore, APG is **recommending** that MA arrangements should be viewed as identical to Medicare FFS in terms of the initial threshold counts that must be met before counting the "Other Payer" arrangements.

CMS has established the "Other Payer" process in a way in which the plan submits the required information prior to the performance year, but the providers can only submit the information after the performance year is completed (and only if the plan does not first submit any information). This leads to anxiety by the providers for the entire year regarding whether the arrangements met the criteria to qualify. For example, for MA arrangements, the plans can submit between April 2019 to June 2019 but the clinicians in those arrangements can only submit from September 2020 to November 2020. This means that they are submitting for approval of an arrangement after the performance year is completed.

In fact, in 2018 several APG members commented that their partner MA plans chose not to submit any data for the performance year 2019 either due to complexity, the burden of the application, or the fact that they were unaware of the application process at all. Having the clinician initiated process at the end of the performance year is leading to frustration for the clinicians that are committed to Advanced APMs. APG **recommends** that CMS allow a third tract – if the plan declines to submit prior to the start of the performance year, then the clinician has the option to submit in place of the plan.

APG does support the CMS proposal to allow multi-year determination of other payer applications to allow stability and reduce undue burden to both the payers and providers that are participating in the arrangements. A 5 year window would be typical of most contract terms.

Proposed changes to the Advanced Alternative Payment Model (Advanced APM) Track

The availability and proliferation of Advanced APMs is critical to the value movement. The proposed Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration is an important acknowledgment of the innovative value displayed by many MA plans and the risk arrangements providers engage in outside of traditional Medicare. While we certainly appreciate this recognition, APG believes that this proposed demonstration can and

[1] *Integrated Healthcare Association. (2018). California Regional Health Care Cost & Quality Atlas 2.0. Retrieved from https://costatlas.iha.org/*

should go further by affording full Advanced APM status to qualified participants and thus allowing the participants to receive the 5 percent advanced Alternative Payment Model Status bonus payment. The current MAQI demonstration that only grants a waiver from MIPS reporting is inadequate to support the movement of volume to value within the MA population.

Recommendations to Improve the Proposed MAQI Demonstration

- The limited number of models in Part B do not offer sufficiently attractive or numerous options for physician groups who want to qualify as advanced APMs. CMS clearly needs to swiftly adopt new Advanced APMs to remedy this problem. We believe that the fastest and most equitable way to do this is through the MAQI demonstration that would allow a 5 percent bonus opportunity for participants. The MAQI demonstration does allow participants to receive a waiver from MIPS, however, that incentive alone is simply not adequate to move additional physicians to value. Many of our members who participate in risk-based MA contracts scored high on MIPS in 2017 due to their level of experience in providing coordinated care. Receiving a waiver exempting them from MIPS when they received over a 90 score in 2017 appears to be a hollow reward.
- The MAQI RFI comments were due September 4, 2018 and the MAQI application portal was open from August 6, 2018 through September 6, 2018, a timeframe which indicates that industry feedback will not be incorporated into the application. We recommend that the application deadline remain open until November 6, 2018 so CMS may review the industry recommendations and possibly modify the application.
- We have noted that the MAQI applications are only accepted from individual clinicians rather than at the TIN or physician group level. Not only is this inconsistent with MIPS reporting options in which one can report at either the NPI, TIN, or APM entity level, but MA risk-based contracts are organized at the practice level. Thus, having individual physicians apply to participate in MAQI is causing undue burden and confusion. This requirement should be modified to include an opportunity for the participants to submit their data at the TIN (practice) level in addition to the NPI (individual) level.

Conclusion

APG applauds CMS and the Agency's work to put forth bold proposals aimed at responding to stakeholder requests on burden, red tape, flexibility, and advancing the value movement. We look forward to continuing to work with you to improve our nation's health care system. The challenges facing the Medicare program are widely recognized, and as our population continues to age, these challenges will only grow. It is essential that CMS continue to advance proposals that measure both the cost and quality of health care services rendered and provide for additional opportunities for participation in APMs that do so.

APMs, especially two-sided risk arrangements, have the potential to dramatically decrease the finical pressure on the Medicare system while simultaneously improving the quality of care

patients receive. It is also essential the CMS continue to work to strengthen the FFS chassis that most APM models are based on as we transition to a new model.

We appreciate the opportunity to submit these comments and offer ourselves and our members as a resource to you as you. Please do not hesitate to contact me or my Federal Affairs staff (Valinda Rutledge, VP of Federal Affairs vrutledge@apg.org; Margaret Peterson, Director of Federal Affairs mpeterson@apg.org) with any questions you may have.

Sincerely,

Donald H. Crane
President & CEO
America's Physician Groups