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September 11, 2017

Ms. Seema Verma  
Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

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

Dear Administrator Verma:

The Association of American Medical Colleges (AAMC) welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS') Proposed CY 2018 Physician Fee Schedule Rule. The AAMC is a not-for-profit association dedicated to transforming health care through innovative medical education, cutting-edge patient care, and groundbreaking medical research. Its members comprise all 147 accredited U.S. and 17 accredited Canadian medical schools; nearly 400 major teaching hospitals and health systems, including 51 Department of Veterans Affairs medical centers; and more than 80 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their nearly 167,000 full-time faculty members, 88,000 medical students, and 124,000 resident physicians.

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

The CY 2018 Physician Fee Schedule (PFS) rule proposes several policy change which impact AMCs. Among the areas addressed by this letter are the proposed payment rates for non-excepted off-campus hospital provider-based departments, appropriate use criteria for advanced diagnostic imaging services, evaluation and management documentation guidelines, coverage and payment for telehealth, patient relationship codes and modifiers, and recommendations for reducing regulatory burden.

The AAMC's key recommendations include the following:

- Do not reduce the PFS relativity adjuster from 50 percent to 25 percent of the OPPS rate for services provided in non-excepted off-campus hospital outpatient departments. This proposed reduction in payment is based on insufficient data. Reductions of this magnitude would set the rates well below the hospital's costs of providing care.
- Before determining future payments for non-excepted hospitals outpatient off-campus departments, CMS must undertake additional analysis that includes sufficient claims data with the "PN" modifier in order to best determine payment policies for non-excepted PBDs.
- CMS should amend its current policy that an off-campus provider-based HOPD that changes its location will become a non-excepted PBD.
- Finalize the proposal to delay the implementation of the Appropriate Use Criteria (AUC) consultation requirement until January 1, 2019 at the earliest. There is a need to engage providers and their staffs about the guidelines, introduce them to the CDSM software, modify their work flow patterns, update their EHRs, and pilot test the systems, including claims processing, to gradually build up the program.
- Finalize the proposal to delay the requirement that the patient relationship codes and modifiers be reported on the claim form. Ensure that there is minimal reporting burden for physicians and provide more information regarding how the patient relationship codes will be used in the future for attribution.
- With the advent of electronic health records, and the movement to team-based care, the evaluation and management guidelines have become an impediment to good patient care and impose a huge administrative burden. Therefore, CMS should focus efforts on revising these guidelines, particularly the history and physician examination requirements.
- Expand coverage for telehealth services by changing requirements regarding the originating site and rural location of services.
- Provide coverage and payment for consultations between primary care physicians and specialists.

**PROPOSED PAYMENT RULES UNDER THE PFS FOR NON-EXCEPTED ITEMS AND SERVICES FURNISHED BY NON-EXCEPTED OFF-CAMPUS PROVIDER-BASED DEPARTMENTS OF HOSPITAL**

***CMS Should Not Reduce the PFS relativity adjuster to 25 percent of the OPSS rate***

The Bipartisan Budget Act of 2015 included a provision (Section 603) that excluded from the definition of covered OPD services “applicable items and services furnished on or after January 1, 2017 by certain off-campus outpatient departments of a provider” (generally those that did not furnish OPD services before November 2, 2015). It also provides for payment for those services under a Part B payment system other than the Hospital Outpatient Prospective Payment System (OPSS). In the 2017 OPSS interim final rule with comment (81 FR 79729), CMS established initial payment policies under the PFS for non-exceptioned items and services furnished on or after January 1, 2017. In the current proposed rule, CMS proposes payment policies under the PFS for non-exceptioned items and services furnished during 2018.

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

For 2018, CMS proposes to maintain the 2017 payment mechanisms and establish new payment rates. In 2017, CMS adopted a set of payment rates that are based on a 50-percent reduction to the OPSS payment rates (inclusive of packaging) for non-exceptioned items and services furnished by non-exceptioned off-campus PBDs. CMS arrived at the 50-percent reduction by comparing (i) the payment differential between the OPSS and the ASC payment rates (where covered surgical procedures in ASCs are paid at 55 percent of the rate under the OPSS) and (ii) the weighted average payment differential for overall payment under the OPSS and the MPFS for 22 frequently billed HCPCS codes reported by outpatient hospital departments (45 percent). In the AAMC’s comments on the interim final OPSS CY 2017 rule, we stated that the PFS Relativity Adjuster should be higher than 50% because CMS needs to account for the fact that the OPSS incorporates far more packaging into its payments for services than the physician fee schedule. In addition, the AAMC also commented that CMS should use the full PFS payment for practice expenses in the non-facility setting when making comparisons of payment rates because a hospital incurs both indirect costs and direct costs when services are provided at off-campus

settings. Based on our analysis, done with Watson Policy Analysis, Inc. (WPA), when packaged costs are incorporated and the non-facility practice expense rates are used in the comparison, the ratio of PFS payments to OPFS payment amounts to 64%. Therefore, in 2017 we recommended a PFS Relativity Adjuster of 64%.

For 2018, CMS proposes to revise the PFS relativity adjuster to 25 percent of the OPFS payment rate. CMS believes that this change would ensure payment rates for these outpatient hospital departments better align with those that are frequently furnished by physicians. To determine this relativity adjuster, CMS made a code-level comparison for a clinician visit reported using HCPCS code G0462, the service most commonly billed in the off-campus PBD setting under the OPFS. The Agency compared the payment rate for this code to the difference between the non-facility and facility PFS payment under the PFS using 2017 rates for the weighted average of outpatient visits (CPT codes 99201-99205 and CPT codes 99211-99215) billed by physicians and other clinicians in an outpatient hospital place of service.

CMS states that until it is able to study 2017 claims data, it believes that the comparison between PFS and OPFS payment for the most common services furnished in off-campus PBDs is a better proxy than the 2017 approach that involved comparing the top HCPCS codes other than outpatient clinic visits. CMS requests comments on whether it should adopt a different PFS relativity adjuster. Specifically, CMS requests comments on whether it should adopt a 2018 PFS relativity adjuster such as 40 percent which would represent a middle ground between the 2017 and the proposed 2018 relativity adjuster.

The AAMC strongly opposes the 75% reduction in HOPD reimbursement to non-expected PBDs. We believe reductions of this magnitude would set the rates well below the hospital's costs of providing outpatient clinic visits and would be inadequate. As we recommended previously, CMS should improve the methodology to account for differences in packaging between the OPFS and physician fee schedule and to account for indirect and direct practice expenses. The AAMC performed an updated analysis of claims data (described in more detail below) and determined that accounting for these factors, would result in a payment relativity adjuster of 65% for non-expected services in CY 2018. If CMS does not consider this alternative methodology then it should maintain the CY 2017 methodology for determining the relativity adjuster, until there is an opportunity to collect more accurate data to use in setting payment rates

#### ***Updated Analysis Shows Relativity Adjuster for 2018 Should be 65 percent***

The AAMC opposes CMS' approach of determining the relativity adjuster by making a code-level comparison with only one code, G0462, due to CMS's assessment that this is the most commonly billed code in the off-campus PBD setting. Based on WPA's analysis, the 22 most commonly furnished services in off-campus PBDs constitute a larger share (over 50%) of the payment for OPFS services provided at off-campus PBDs. As discussed below, these results show it is inappropriate to set the relativity adjuster based on the payment comparison with one HCPCS code (G0462).

Working with WPA, the AAMC, repeated the analysis from CY 2017 using updated claims data to determine the appropriate rates for CY 2018. Specifically, WPA estimated the amount of

packaging included in the 22 most frequently billed services analyzed by CMS in the CY 2017 OPPS rule that are reported with the PO modifier. This analysis showed that the cost of packaged services account for approximately 22 percent of the total costs of performing these selected procedures at off-campus HOPDs. In addition, the analysis examined the impact of accounting for both the indirect practice expenses and direct practice expenses that the hospital incurred by using the full PFS payment for practice expenses when making comparisons. When the packaging adjustment is made and the non-facility practice expenses are used in the methodology, the ratio of PFS payment to OPPS payment for CY 2018 is 65%. (See following Table). This is a more accurate representation of payment relativity between the applicable MPFS rates and the OPPS payment rates.

Scenario	Ratio of MPFS to OPPS
Top 22 codes as listed in the 2017 OPPS rule	45%
Top 22 codes after adjusted for packaging costs	57.7%
Top 22 codes, using full MPFS non-facility rate instead of difference when applicable, adjusted for packaging costs	65%
Top 22 plus E&M codes, using full MPFS non-facility rate instead of difference when applicable, adjusted for packaging costs	93.6%

For determining future payments, we encourage CMS to undertake additional analysis that includes sufficient claims data with the “PN” modifier in order to best determine payment policies for non-excepted PBDs. It is important to ensure that hospitals are not disadvantaged by gross underpayment for services rendered to patients that seek care in non-excepted PBDs.

***CMS Should Amend its Policy Regarding Relocation of Off-Campus Hospital Outpatient Departments***

The AAMC strongly urges CMS to amend its current policy that requires an excepted off-campus provider-based HOPD that changes its location to lose its status and be subject to the site-neutral payment policy. CMS should allow a hospital to relocate its outpatient department without triggering the payment cuts. There are many important reasons that a HOPD would need to relocate, such as natural disasters, expiring leases, needing bigger space due to changing populations served, and increasing patient volume. Off-campus HOPDs must be able to expand the items and services that they offer to meet changes in clinical practice and the changing needs of their communities without losing their ability to be reimbursed under the OPPS.

- If hospitals are unable to relocate without losing their excepted status, patients may lose access to needed care.

- We recommend that CMS amend its policy to allow relocation without loss of the excepted status in the following circumstances:
  - Relocation to comply with federal/state requirements that focus on safety of the location;
  - Relocation of an HOPD that has been destroyed or substantially damaged in a disaster, such as a fire, flood, or hurricane;
  - Relocation due to losing a lease;
  - Relocation of an HOPD to provide access to care in an underserved area; or,
  - Relocation due to a growing patient population.

### **EXPAND COVERAGE OF TELEHEALTH**

Telehealth innovations directly improve care coordination between providers and patients, and providers who work to enhance access to care for populations that experience barriers to appropriate use of services should be enabled broadly through the reduction of regulatory barriers and the adoption of appropriate reimbursement incentives. Use of telehealth services that bring providers into more effective collaboration but do not generate a face-to-face billable encounter warrant expanded use. Hence, the AAMC encourages CMS to continue to expand the list of eligible telehealth services in future rulemaking. We acknowledge the limitations set forth in statute, but encourage CMS to work closely with Congress to expand the coverage of telehealth services.

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

#### ***Provider Coverage for Internet Consultation***

In this rule, CMS seeks comment for future rulemaking on other existing codes that describe use of communications technology. The AAMC encourages CMS to provide coverage and payment for consultations between primary care physicians and specialists. In 2014, the AAMC received a CMMI Health Care Innovation Award (HCIA), which allowed the AAMC to launch our Coordinating Optimal Referral Experiences (CORE) Project. Utilizing EMR-based tools (called eConsults and enhanced referrals), and a shift in physician workflow and incentives, CORE aims



to improve quality and efficiency in the ambulatory setting by reducing marginal referrals, improving access to specialty input, and enhancing the patient experience. Data from the project demonstrate a consistent high level of patient and provider satisfaction with eConsults, across all participating sites.

eConsults are an asynchronous exchange in the EMR that are initiated by the primary care provider (PCP) to a specialist for low acuity, condition-specific questions that can be answered without an in-person visit. An expectation of a 3-day response has been set within the CORE program, with an average turn-around time in practice of approximately 24 hours. eConsults enable the PCP to continue managing the patient's care, with the benefit of a specialist's advice, in lieu of a referral and subsequent in-person visit with the specialist. As such, it promotes comprehensiveness in primary care practice and supports better, more timely access for those patients who do require in-person care by specialists.

During the CMMI grant period, participating health systems agreed to provide both the PCP and the specialist with 0.5 wRVU (or an equivalent incentive) for each completed eConsult. This recognizes the time it takes for the specialist to review and complete the eConsult, and for the PCP to implement the specialist's recommendations. The theory for cost savings is that the eConsult averts an unnecessary referral to specialty care, and any associated downstream costs with tests, labs, follow-up visits, etc., saving money for both the payer and patient. Preliminary data from our program, as well as evidence published in the literature to date, confirm a decrease in primary care referral rates to participating specialties. While variable in applicability from one specialty to the next, eConsults now make up an average of approximately 10percent of all primary care providers' outreach to medical specialists, supplanting many referrals. We estimate an average of 400 referrals averted every month across our participating sites.

Through the HCIA award, the AAMC is working with CMS to articulate a sustainable payment model for eConsults. In a fee-for service model, savings to the payer may accrue that warrant consideration of a per episode eConsult payment to specialists, with appropriate guardrails to limit potential overuse of the tool. Within alternative payment models where the provider and/or health system shares accountability for the costs of care, eConsults are well-positioned as a tool to promote high-value care. For primary care physicians (PCPs) participating in demonstrations such as CPC+, ACOs, and the quality payment program (QP), eConsults could be positioned as a qualifying service in meeting expectations for care quality, promoting access, and supporting primary care comprehensiveness and effective communication between providers. It will be critical to set an appropriate RVU level in recognition of the clinical effort that goes into an eConsult response.

Under current Medicare payment policy, specialists that perform an eConsult would not receive reimbursement because they did not have a face-to-face encounter with the patient. While CPT codes approximating these services exist (Inter-professional phone/online consultation codes, 99446 series), no RVU values have been set. Additionally, these codes are listed as bundled services by CMS. Furthermore, the accompanying CPT description for this code series requires both written and verbal communication between the consulting physician and the consultant, and therefore is not aligned with eConsults conducted asynchronously in the EMR. Thus, we

anticipate that a modification in the current code's narrative description or a new code will be needed to establish payments to specialists for eConsults. The AAMC is in communication with CMMI, the CPT committee, and the RUC about these issues. While the code valuation process is ongoing, we support CMS allowing alternative payment models (APMs) to reimburse for these services, much in line with the flexibility some APMs have to provide other telehealth services. In the future, we believe that e-consults should be covered in alternative payment models and under the fee-for-service program.

### ***Reimburse for Remote Patient Monitoring***

The AAMC supports the use of remote patient monitoring, and the reimbursement of these services, though we acknowledge the challenge in the structure of CPT codes, which describe face-to-face interaction between the provider and the patient. We would support the unbundling of existing evaluation and management codes, and the creation of specific codes to describe remote patient monitoring activities in order to more accurately describe the services being provided. The AAMC notes that remote patient monitoring has been provided in numerous health systems, taking advantage of the increased flexibility that remote monitoring provides within the Medicare program. As we noted above, CMS has narrowly defined technologies that fit into the definition of telehealth, and those that do are subject to the statutory geographic and originating site restrictions. Technologies that fall outside of this definition, like remote monitoring, are not subject to this restrictions, and the AAMC supports CMS in expanding coverage of these services in order to allow patients the full availability of technologies for virtual care.

### **APPROPRIATE USE CRITERIA FOR ADVANCED DIAGNOSTIC IMAGING SERVICES**

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

In this rule, CMS focuses on the third component and proposes that ordering professionals must consult specified applicable AUC through qualified CDSMs for applicable imaging services furnished in an applicable setting and ordered on or after January 1, 2019. CMS establishes this date to allow sufficient time to prepare to meet all the requirements.



CMS also proposes that furnishing professionals report the following information on Medicare claims for applicable imaging service, furnished in an applicable setting, paid for under an applicable payment system, and ordered on or after January 1, 2019:

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

CMS proposes to establish a series of HCPCS level 3 codes to implement the reporting requirements. Initially, the Agency proposes using a generic G code but eventually would like to have one G-code for every qualified CDSM. CMS also proposes developing a series of modifiers to provide information as to whether the ordered service adheres to the AUC.

CMS expects voluntary reporting to be available beginning July 2018 and the mandatory start date would be January 1, 2019. CMS proposes to make the first year an educational and operations testing period rather than further delay the start of the program. The proposed rule indicates that the ordering professional would be required to consult AUC and the furnishing provider required to report the appropriate information on the claim without penalty for incorrect reporting.

The AAMC supports the use of clinician developed, evidence-based AUC to improve the quality of care. We commend CMS for recognizing the complexity of this program and delaying the date for the required consultation with CDSMs. The AAMC urges CMS to provide sufficient time for providers to learn and comply with this program. There is a need to engage providers and their staffs about the guidelines, introduce them to the CDSM software, modify their work flow patterns, update their EHRs, and pilot test the systems to gradually build up the program. Given these challenges, **the AAMC supports the CMS proposal to delay the implementation time frame. To provide sufficient time for education and operations testing, we urge CMS to finalize that CMS will pay claims for advanced diagnostic imaging services in 2019 regardless of whether or not the AUC consultation information is reported on the claim.**

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

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

- CDSMs need to be designed so that they are easy to use. Providers would prefer CDSMs that can be used quickly and efficiently and that are integrated with their electronic health record system. It is frustrating to providers if they are required to click out of their electronic health record system and go through an entirely new platform to order imaging services.
- This rule involves a complex system of tracking consultation of AUCs. CMS proposes new G codes and modifiers that must be included on the claim form in order for the furnishing provider to be paid. It can be difficult for the furnishing professional to supply the ordering physician's AUC-use information to CMS. For the most part, the ordering physician and furnishing professional will not share the same office space or EHR system. To share this information will require additional health IT interoperability between the ordering physician's EHR and the systems used by the furnishing physicians in their practices.
- It is also unclear as to whether the required information from the G codes and modifiers can be incorporated into the current claim form without some modification on how they may interact with the other codes and modifiers submitted. It is important to acknowledge that there are a number of MACRA-related provisions, such as the codes for physician-patient relationships, that also must be captured on the claims form in the near future. There could potentially be errors and disruption in claims processing and payment, which is another reason that a phase in of this policy is necessary.

## **EVALUATION AND MANAGEMENT (E/M) GUIDELINES**

The AAMC is pleased that CMS has requested information on how to make the current evaluation and management (E/M) guidelines less burdensome. Specifically, CMS is seeking comment on initial steps to take in the process of revising the E/M documentation guidelines, with a focus on whether CMS should remove documentation requirements for the history and physical exam for all E/M visits at all levels. The Agency writes that “[a]s long as a history and physical exam are documented and generally consistent with the complexity of medical decision-making, there may no longer be a need for us to maintain such detailed specifications for what must be performed and documented for the history and physical exam.” We applaud this rational step that the Agency is taking.

The original guidelines were developed at a time when medical records were maintained on paper and clinicians worked largely on their own. With the advent of electronic health records, and the movement to team-based care, the guidelines have become an impediment to good patient care and impose a huge administrative burden with little commensurate benefit. For AAMC-member institutions a unique consideration is that, because they are the places that teach the next generation of physicians and other health care professionals, it is essential their trainees learn to write notes that communicate the status of the patient, outline the planned medical care, and lead to optimal patient care. Our member institutions strive to ensure that trainees learn how

to synthesize and summarize information and turn that into a plan of care. With this in mind, the AAMC has the following comments related to changes to the E/M guidelines:

- A patient's history is already recorded in the EHR. During a visit, relevant changes should be noted but the history should not be restated unless it provides new information, such as a different practitioner's view of the patient. A specific count of the history and physical exam components should not be used to determine the level of service.
- For surgical specialties and subspecialties a comprehensive exam is not always relevant. Even when a focused exam is needed, generally the medical decision-making will be moderate to high. For example; the examination of an acute abdomen may be the key component of the examination of a patient who is suffering an acute appendicitis while examining the eyes, skin or cranial nerves or this patient may be less important, or even unnecessary.
- The determination of the level of service should be dependent on medical-decision making. Required documentation should include such factors as:
  - Changes, additions, or significant clinical updates to the existing record
  - Nature and intensity and acuity of presenting problem/number of problems
  - Management of medications, including a review of medications, and comorbidities
  - Review of allergies, but only if there is a change
  - Diagnosis and treatment options
  - Coordination with other providers
  - If applicable, notes as to patient's expressed wishes for care options
- Time alone should not be determinative of the level of service although time often is one indication of the complexity of the medical decision-making. However, CMS should avoid bright-line determinations that X amount of time alone indicates a certain level of service. CMS also should recognize that time spent face-to-face with the patient does not capture the medical decision-making which also concerns time spent reviewing labs, reviewing old medical records, calling or e-mailing the patient, or coordinating with other providers, for example. Time should be combined with the factors listed in the bullet above to determine level of service.

An illustrative example shows how important it is to avoid a "check the box" system to determine level of service. Assume two very different patient visits, both of whom went to a dermatologist because of a rash.

The first patient is an obese new patient with diabetes and heart failure who presents with a new onset rash. The patient needs 20 medications reconciled, is found to be short of breath, and requires the dermatologist to call the Primary Care Provider's (PCP) office to ensure the patient is given instructions on when to be seen for follow-up by the PCP after a medication adjustment. This is a complex patient, with multiple co-morbidities, and the visit involved a high level of medical decision-making.

The second patient is a healthy 35 year old who shows up with a rash and is on two medications. This patient also would get a medication and allergy check, a history and limited physical. This visit is relatively straightforward and requires a much lower level of medical decision-making.

### **PATIENT RELATIONSHIP REPORTING USING MODIFIERS**

The MACRA legislation included a provision specifying that claims for services include: 1) applicable codes for care episode groups; 2) applicable codes for patient condition groups; 3) applicable codes for patient relationship categories; and, 4) the NPI of the ordering physician or practitioner.

In the rule, CMS proposes to use the following patient relationship categories that would be reported with modifiers: Continuous/Broad Services; Continuous/Focused Services/Episodic/Broad Services; Episodic/Focused Services; and Only Ordered by Another Clinician.

CMS proposes that claims for services furnished beginning January 1, 2018 shall include the appropriate modifier and the NPI of the ordering practitioner. To support providers with their learning curve, CMS proposes that modifier reporting would be voluntary. It would not be a condition of payment or affect payment. CMS seeks comment on the proposed modifier list, the plan to resubmit the modifiers for CPT code and assignments, and initial voluntary reporting of the proposed modifiers.

As previously stated, faculty physicians at academic medical centers (AMCs) are usually organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of which require highly specialized care. Often care is multidisciplinary and team-based. Faculty physicians frequently are organized under a single tax identification number (TIN) with many specialties and subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. A large percentage of the services provided at AMCs are delivered as tertiary, quaternary, or specialty referral care. A patient may be transferred to, or seek care at, an AMC because the needed care is not available closer to a patient's home. As these patient relationship categories and codes are developed, it is important for CMS to recognize the unique characteristics of patients who are cared for by faculty physicians.

We appreciate CMS' effort to obtain input about the best description of clinician's relationships with the patient. The determination of who is ultimately responsible for a patient's health outcomes when multiple providers deliver care is a complex undertaking but is essential with the rapid movement to performance based payments. We recognize that attribution is necessary to link patient level health care quality and spending indicators to specific providers for accountability, but urge against CMS relying solely on one source of data for such attribution. **Even with the advent of new provider-reported codes, claims data and other information may still be important to an accurate methodology for attribution.**

Additionally, reporting a new code on every claim for every visit is burdensome. **The AAMC urges CMS to ensure that there is minimal reporting burden for physicians. We**

**recommend that CMS consider a different approach that would require proactive reporting of these patient codes only in situations where the patient relationship is not typical for the specialty and services provided.**

***Provide Context for Use of Codes***

It is difficult to provide feedback on these categories without further details regarding how this information would be used, particularly in the context of the episode groups and resource use category of MACRA. Patient relationships can be described in many different ways, so understanding how CMS intends to infer responsibility for cost and quality outcomes from these codes will be essential to offering meaningful comments. **AAMC recommends that CMS provide more information regarding their future plans about how the patient relationship categories and codes will be used to attribute cost and patient outcomes.**

While the AAMC welcomes the concept of further refining patient attribution, we are concerned about attributing patients to clinicians based solely on clinician reporting of their subjective interpretations of patient relationships. Clinicians may interpret these categories and patient codes differently for the same scenario. In addition, despite making progress towards truly coordinated care, clinicians may not be aware of the extent to which their patients are also seeking care from other providers. Clinicians may also be discouraged from taking on certain relationships that are high risk if they will be penalized under payment systems. To the extent that self-reported codes are ultimately used in value-based payments, we urge CMS to continue to work with stakeholders to ensure that the categories and codes are clear and that clinicians are trained to accurately interpret these categories.

Additionally, we anticipate that multiple providers involved in the patient's care may select the same category to describe their relationship with the patient. It is unclear how CMS will address attribution when multiple providers pick the same category, particularly for multiple providers who select themselves as the "lead" or primary care role. Therefore, the AAMC recommends that CMS also examine other data sources, such as medical claims and data from electronic health records to accurately determine the provider's relationship with the patient.

***Significant Education and Training is Needed***

Physicians will need significant education to understand and use these categories and codes. AAMC is concerned that CMS has not allowed adequate time to educate physicians, particularly in light of the time frame for other aspects of MACRA implementation. Physicians are currently focused on implementation of the many new requirements under the MACRA law. Faced with myriad new requirements, providers may not realize the implications of these codes on their future performance in value-based payment models or quality reporting scores. CMS should also broadly communicate the context and future consequences of these patient relationship codes.

***Operational Issues Must be Addressed***

It is important for CMS to address any operational issues related to reporting the patient relationship categories. Providers need an opportunity to test submission of claims with these new codes to make sure they understand the process. CMS also will need to provide sufficient

time for vendors to make changes to electronic health record systems to incorporate these new codes and test them to make sure that the claims submission process works.

Regarding the code categories, the AAMC recommends that CMS provide extensive provider education and outreach regarding these relationship categories prior to implementation and that this assistance be made available sufficiently early for physicians to learn how to meet the CMS requirements. Because these categories of codes are ambiguous, there is a need for additional information that would provide more clarity. CMS should develop many clinical examples for each of the patient relationship categories to assist the physicians in selecting the accurate category. In addition, CMS needs to provide guidance regarding documentation requirements related to the code selection. CMS also will need to provide sufficient time for vendors to make changes to electronic health record systems to incorporate these new codes and test them to make sure that the claims submission process works. We urge CMS to engage in discussions with electronic health record and billing vendors to ensure that they incorporate these new codes accurately in their systems.

### **REQUEST FOR INFORMATION ON CMS FLEXIBILITIES AND EFFICIENCIES**

CMS requests ideas for payment system redesign, elimination or streamlining of reporting, monitoring and documentation requirements, aligning Medicare requirements with those from other payers, operational flexibility, feedback mechanism and data sharing that would enhance patient care, support of the physician-patient relationship in care delivery, and other ways to reduce burdens for hospitals, physicians and patients.

The AAMC supports CMS's commitment to reduce burdens for hospitals, physicians, and patients. Identifying and revising or removing regulations that divert time and resources from patient care, care improvement, safety, and quality will benefit providers, patients, and the Medicare program. Many regulations were developed decades ago when reimbursement was strictly fee for service and delivery models did not rely on team-based care and other innovations. The AAMC supports initiatives to reduce, simplify, modernize, and harmonize regulations and recommends that any newly needed regulations be applied prospectively and have clear objectives and would be pleased to work with CMS.

Below are some actions that CMS or Congress could take to reduce the regulatory burden on hospitals, physicians, and the patients that they serve.

### **Take Additional Steps to Account for Sociodemographic Status (SDS) Factors in Quality Measurement**

The AAMC strongly supports the movement from volume to value. Academic medical centers are leaders in the area of providing quality health care, and in creating and implementing innovative care delivery models. There are numerous inpatient and outpatient quality programs under Medicare that link payment to quality. CMS has stated that outcome measures and cost measures are a priority in these programs. However, most



outcome measures, particularly readmission measures, are affected by Sociodemographic Factors (SDS), which are beyond the control of the physician or hospital. The nation's teaching hospitals and physicians, which provide superior patient care and disproportionately treat disadvantaged and vulnerable patient populations, are penalized by the performance and penalty programs in part due to the lack of adequate SDS adjustment. The AAMC recommends that the Administration uses its authority to implement sociodemographic (SDS) adjustments across all affected Medicare quality programs where appropriate.

### **Eliminate the SNF Three-Day Hospital Stay Requirements**

To better coordinate and improve care for patients, CMS should work with Congress to eliminate or modify the requirement that a patient must spend three days as a hospital inpatient before being eligible for SNF services. While we recognize that complete removal of the requirement would require legislative action, at a minimum we recommend CMS use its administrative flexibility to create additional waivers of the SNF three day stay for alternative payment models (APMs). Many patients who are not in APMs would benefit from an inpatient stay that is shorter than three days, followed by care in a SNF.

Eliminating the three-day stay would assist all physicians to ensure that their patients receive the most appropriate care in the most appropriate settings, without creating the possibility of an unforeseen financial burden on the patient.

### **Expand Medicare Coverage of Telehealth Services**

The general Medicare rules related to payment for telehealth services are that the services must be provided to a patient in a rural area and at an originating site specified in statute. The home is not included as the originating site. Patients in urban and other areas who do not have convenient access to a provider also could benefit from telehealth. Certain APMs, such as Next Generation ACOs, have telehealth waivers available, but such waivers should be provided to other APMs. In addition, CMS and its Innovation Center should undertake demonstrations, through its delivery reform models, to expand coverage of telehealth and evaluate if expanded telehealth services for specific patient populations is cost effective and improves care quality. As Medicare payments move toward having a strong quality component, there is little risk that these services will be used for other than the best quality, most cost efficient care. CMS should encourage the use of telemedicine beyond rural areas and outside of APMs, as many patients would benefit from the availability of telemedicine services.

### **Align Quality Measures Across Payers and Use Only Measures That Truly Matter**

The number of quality measures that providers must report to CMS and other payers is increasing rapidly in the inpatient and outpatient quality programs. CMS should align the measures used by both the Medicare and Medicaid programs as well as commercial payers to reduce burden and prevent confusion. A key step would be development of a national core

measure set, with measures that apply across health settings and across payers. CMS should focus on measures that are critical to driving the best possible outcomes for patients. We urge CMS to work with a variety of stakeholders, including the AAMC, to identify critical indicators of quality and safety that are meaningful to patients.

### **Reduce Clinician Burden and Complexity in the Quality Payment Programs (MACRA)**

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new physician payment system that took effect with physician reporting beginning January 1, 2017 that impacts 2019 payments. The program features two pathways for physicians: the Merit-Based Incentive Payment System and advanced APMs. This new payment program requires a significant learning curve for physicians and requires major operational changes for physician practices. The AAMC believes it is important for CMS to transition slowly to the new framework for physician payment and to reduce clinician burden and complexity of the program.

The AAMC is pleased that for 2017 and 2018 performance years, CMS is setting a weight of zero percent for the cost performance category under MACRA. Prior to implementing this category, it is important to address concerns with risk adjustment and attribution. Beginning with the 2021 MIPS payment year (2019 performance year), the MACRA legislation requires that CMS assign a weight of 30 percent of the MIPS final score to the cost performance category. The AAMC is concerned that there is not sufficient time to appropriately adjust the cost measures for clinical severity, sociodemographic factors, and ensure appropriate attribution by the 2019 performance year.

Starting in 2021, a clinician may achieve status as a qualified participant of an alternative payment model through the All-Payer Combination Option. Thresholds under this option can be met by combining payments or patients from Other Payer Advanced APMs with those from Medicare Advanced APMs. These processes involve either the payer or the eligible clinician submitting detailed information to CMS for a determination that would be made at the individual clinician level. The AAMC has significant concerns with the approach to the All Payer combination. It presents major operational challenges for eligible clinicians as compared to the Medicare option. Reporting the information to CMS would be extremely burdensome for the eligible clinicians, and is further compounded by the proposal to make the determination on an individual clinician level. For each individual clinician to submit this detailed information to CMS about the other alternative payment models would be very difficult, time consuming, and would require unnecessary duplicative effort on the part of each clinician. CMS needs to work with stakeholders to develop mechanisms to simplify determination of the threshold.

### **Prevent Inconsistent and Duplicative Audits**

Medicare subjects providers to claims review by multiple entities including Medicare Administrative Contractors (MACs), Recovery Audit Contractors (RACs), Zone Program Integrity Contractors (ZPICs), and Comprehensive Error Rate Testing Contractors (CERT). These redundant and overlapping audits place an enormous burden on providers and have

resulted in inappropriate denials. There is a need to streamline and eliminate these duplicative audits.

### **Loosen Stark and Anti-Kickback Laws and Regulations that are Barriers**

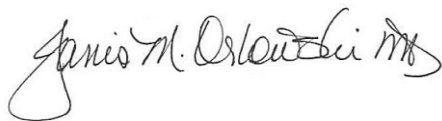
To achieve the goals of delivery system reform, there is a need for changes to federal laws and regulations affecting hospital-physician arrangements, including the Physician Self-Referral Laws (also known as “Stark”), the Anti-Kickback law, and the Civil Monetary Penalties (CMP) law. These laws were predicated on a fee-for-service reimbursement system. Since enactment of these laws, there have been major changes in health care delivery and payment, including many initiatives to align payment with quality and to improve coordination of care. Provisions in these laws present significant barriers to clinical and financial integration aimed at improving the quality of care, population health, and reducing costs. The AAMC encourages an approach that allows for maximum flexibility and supports innovation and changes that are needed to help move to a health care system that rewards providers for making the changes that are necessary to provide cost-efficient, patient-centered quality care. Physicians are barred from participating in innovative and cost-saving care models due to outdated regulations, including Anti-Kickback and complicated Stark prohibitions. While some safe harbors and exceptions exist in this area, they are limited in scope. CMS should create new exceptions or safe harbors for Stark and Anti-Kickback laws that facilitate coordinated care and promote cost reductions.

Recommendations include establishing an “alternative payment model” exception and safe harbor, and revising the definition of “fair market value” to account for new payment models.

### **CONCLUSION**

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

Sincerely,



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