Association of
American Medical Colleges
655 K Street, N.W., Suite 100, Washington, D.C. 20001-2399
T 202 828 0400 F 202 828 1125
www.aamc.org

Via electronic submission (www.regulations.gov)

September 27, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201
Attention: CMS-1715-P

Re: Medicare Program: CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations (CMS-1715-P)

Dear Administrator Verma:

The Association of American Medical Colleges ("the AAMC" or "Association") welcomes this opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) 2020 Physician Fee Schedule and Quality Payment Program (QPP) proposed rule published August 14, 2019 (84 Fed. Reg. 40482). 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 are all 154 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 more than 173,000 full-time faculty members, 89,000 medical students, 129,000 resident physicians, and more than 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Together, these institutions and individuals are the American academic medicine community.

Teaching physicians who work at academic medical centers (AMCs) provide care in what are among the largest physician group practices in the country. They are typically organized into large multi-specialty group practices that deliver care to the most complex and vulnerable patient populations, many of whom require highly specialized care. Often care is multidisciplinary and team-based. These practices are frequently organized under a single tax identification number (TIN) that includes many specialties and subspecialties. Recent data shows that the practice plans

range in size from a low of 128 individual NPIs to a high of 4,319 NPIs, with a mean of 989 and a median of 816. AMCs provide primary care services for their local communities. In addition, 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 or region.

The AAMC commends CMS for its efforts to reduce burden, recognize clinicians for the time they spend with patients, and make the path toward value-based care easier. We are committed to working with CMS to ensure that Medicare payment policies ensure access to high quality care for patients, accurately reflect the resources involved in treating patients, and are not overly burdensome to clinicians.

The AAMC's key recommendations on the 2020 proposed rule include the following:

Physician Fee Schedule:

- ***E/M Payment:*** The AAMC strongly supports CMS' proposal to retain separate payment rates for the E/M code levels in 2021 instead of implementing a blended payment rate. We support CMS' proposal to increase the values for the E/M services.
- ***E/M Visit Level Selection and Documentation:*** We support finalizing the policy for 2021 that would allow physicians to select a level and document based on either medical decision-making or time, and the elimination of the requirement that physicians document in accordance with the 1995 or 1997 E/M guidelines**.**
- ***Add-On Code*****:** We recommend that CMS postpone implementation of the add-on code until there is further clarification provided on how it would be used and what the impact would be on payment and redistributions among specialties.
- ***Global Surgical Codes:*** We believe values for codes with global periods in which office visits are included in the service should be adjusted to reflect the new E/M values recommended for office visits.
- ***Future Updates to the Conversion Factor:*** While we recognize CMS does not have the authority to change the updates, we urge the Agency to work with the medical community to encourage Congress to replace these payment freezes with positive annual updates to not only offset the impact of the increases to the office visits but to recognize inflationary pressures.
- ***Medical Record Documentation/Verification:*** We strongly support the proposal to allow physicians, physician assistants, and Advanced Practice Registered Nurses (APRNs) who document and who are paid under the PFS for their professional services to review and verify (sign and date) rather than re-document notes made in the medical record by other physicians, residents, nurses, students, and other members of the medical team.
- ***Principal Care Management Code:*** We recommend that CMS finalize its proposal to establish a new code for principal care management services. Physicians spend a significant amount of time managing the care of patients with a single serious condition, just as they do for patients with multiple chronic conditions, and should be reimbursed for this work.

- ***Interprofessional Consult Code and Verbal Consent:*** To address the need for patient consent in a way that is practical for providers and practices, and to minimize inefficiencies and confusion for beneficiaries, we urge CMS to allow providers to obtain blanket consent at the practice level for this service on at least an annual basis.
- ***Medicare Shared Savings Program (MSSP):*** CMS should not change the quality scoring methodology for MSSP at a time when accountable care organizations (ACOs) are experiencing a major redesign of the MSSP program under the "Pathways to Success" program.
- ***Open Payments:*** The AAMC urges CMS to engage with stakeholders as new categories of covered recipients and payment categories are implemented to increase the accuracy of payment records in the system and facilitate care provider engagement. The AAMC strongly urges CMS to take active steps to decrease the burden for physicians in accessing and addressing payment records during the review and dispute period.

Quality Payment Program:

- ***MIPS Value Pathways (MVPs):*** Instead of assigning clinicians to MVPs, CMS should allow physicians to opt-in to CMS' suggested MVP, choose an alternative MVP, or continue to report measures through the traditional MIPS program.
- ***MVPs and Large Multi-Specialty Practices:*** With the large number of distinct specialties reporting under one TIN in academic medical centers, it would be very challenging to identify MVPs that would be meaningful for all specialties in the practice. A better solution would be to have subgroup identifiers that allow measurement of the performance at the subgroup level.
- ***Cost Category****:* Given the multiple undetermined factors under the cost category, including the need for risk adjustment, the need for better attribution methodologies, and further development of episode groups, the AAMC strongly urges CMS to maintain the weight of the cost category at 15% instead of increasing it to 20%. In future MIPS feedback reports, CMS should provide additional details in the cost category.
- ***Risk Adjustment***: As appropriate, CMS should risk-adjust outcome, population-based measures, and cost measures for clinical complexity and sociodemographic factors.
- ***Improvement Activities*****:** CMS should maintain the existing participating clinician threshold for improvement activities. CMS should not adopt a policy that would require 50% of the NPIs to perform the same improvement activity for 90 continuous days. Setting such a high threshold could force physicians to participate in an improvement activity that has no relevance in the field in which they are providing care and discourage participation in improvement activities that are meaningful.
- ***Advanced Alternative Payment Models:*** We recommend CMS support any Congressional efforts that would give the Agency the discretion to set the thresholds to be qualified participants in an advanced APM at an appropriate level to encourage AAPM participation. The AAMC also encourages CMS to support efforts by the medical community to urge Congress to extend the 5% bonus beyond 2024.

MEDICARE PHYSICIAN FEE SCHEDULE

The CY 2019 Physician Fee Schedule (PFS) rule proposes several policy changes which will specifically impact AMCs, as well as other providers**.** Among the areas addressed by this letter

are the significant changes to evaluation and management (E/M) coding, documentation, and payment, coverage, care management services, interprofessional consult payment policies, and changes to the Medicare Shared Savings Program.

Update to the Physician Fee Schedule for 2020 (Conversion Factor)

In the rule, CMS sets forth the dollar conversion factor that would be used to update the payment rates. For 2020, the conversion factor would be $36.0896, which is only a 5-cent increase over the 2019 conversion factor.

We are deeply concerned about the impact of the low positive payment updates in the fee schedule, and the upcoming six-year gap from 2020 through 2025 during which there are no updates set forth by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). By contrast, other Medicare providers will continue to receive regular, stable updates. The recent 2019 Medicare Trustees report found that scheduled physician payment amounts are not expected to keep pace with the average rate of physician cost increases which are forecast to average 2.2% per year[1]. Absent a change in delivery system or update in legislation, the Trustees expect access to participating physicians to become a major concern. While we recognize CMS does not have the authority to change the updates, we encourage CMS to support stakeholder efforts to urge Congress to replace these payment freezes with positive annual updates to enable practices to invest in improvement activities and transition to value-based care.

Evaluation and Management Documentation and Payment

In the 2020 Physician Fee Schedule proposed rule, CMS proposes significant modifications to several policies related to evaluation and management (E/M) office visits that were previously finalized for 2021. CMS also makes proposals that are new for implementation in 2021, primarily related to the CPT revisions that will become effective for 2021.

Specifically, CMS proposes to align its E/M office visit coding changes with the framework adopted by the CPT Editorial Panel for office/outpatient E/M visits. These coding changes would retain the five levels of coding for established patients, reduce the number of levels to four for office/outpatient E/M visits for new patients, and revise the code definitions. In addition, the times and medical decision-making process for all the codes would be revised. History and the exam would no longer be used as elements for code selection; however, a history and exam would be required if medically necessary. The changes would allow clinicians to choose the E/M visit level based on either medical decision-making or time.

CMS withdraws its proposal from the 2019 final rule of blended payments for levels 2 through 4 and instead would allow separate payments for established patients for levels 1 through 5 and

[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services. (April 22, 2019). *2019 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* Retrieved from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Trustees-Reports-Items/2016-2019.html

separate payments for new patients for levels 2 through 5. CMS proposes to adopt the Relative Value Update Committee (RUC) recommended values, times and practice costs for the E/M office visits.

While the AAMC supported the documentation changes that were included in the final 2019 Physician Fee Schedule rule, we opposed CMS' proposal to set the same payment rate for levels 2-5 outpatient office visits, which would have resulted in many negative unintended consequences. We commend CMS for listening to concerns and engaging with stakeholders over the past year to refine the payment and coding approach for outpatient/office visits. The AAMC strongly supports CMS' proposal to retain separate payment rates for the E/M code levels in 2021 instead of implementing a blended payment rate. Separate payment amounts are necessary to ensure that payment more accurately reflects the resources used to provide services and to protect patient access. Our comments on specific elements of the proposal follow.

Comments Related to Determination of Visit Level Selection and Documentation
We support finalizing the policy for 2021 that would allow physicians to select a visit level and document based on either medical decision-making or time, and the elimination of the requirement that physicians document in accordance with the 1995 or 1997 E/M guidelines. The original guidelines were developed at a time when medical records were maintained on paper and clinicians worked largely independently. With the advent of the EHR, team-based care, and other changes over the past two decades, the E/M guidelines are outdated and have led to much of the "note bloat" that is seen in EHRs. The current documentation requirements (such as noting negative review of systems) impose an onerous burden on physicians while providing little benefit to patients. In some cases, the requirements impede patient care by making it difficult to locate the physician's differential diagnosis or plan of care. The physician spends less time with the patient since so much time is spent on ensuring the information to support billing is included in the medical record.

Allowing physicians to document based on medical decision-making or time would help to alleviate these problems, lead to improved patient care and better align with current medical practice and the use of electronic medical records.

Comments Related to E/M Payment Proposals
Effective 2021, CMS proposes to adopt the RUC-recommended values, times and practice costs for the E/M office outpatient visits instead of the blended values and payment rates that were included in the final 2019 Physician Fee Schedule rule. The RUC recommendations for physician work, time, and direct practice expenses contribute to an approximate 5% redistribution between those physicians who routinely provide office visits and those physicians or other health care professionals who do not report office visits. CMS also proposes to adopt a prolonged services code and an add-on code.

We strongly support CMS' proposal to allow separate payments for E/M levels. We were deeply concerned with the impact that blended payment rates in the 2019 final Physician Fee Schedule rule would have had on patient access to care. Blended payment rates would have resulted in significant reductions in payment to non-procedural specialties that see patients with complex

conditions. These reductions would have been particularly problematic for teaching physicians in academic medical centers who work in large multi-specialty practices that include all the specialties that patients with complex needs may require, including primary care, oncology, neurology, endocrinology and many others. These faculty practices treat a disproportionate share of patients for whom social determinants of health, such as housing, nutrition, and transportation, contribute significantly to additional health challenges, adding additional complexity to their care.

We support CMS' proposal to increase the values for the E/M services. One of CMS' goals is to support primary care and patient-centered care management by improving accuracy to recognize the costs of primary care management, coordination and cognitive services. The values in the current proposal recognize the increasing complexity of these services and the resources required to provide them.

Systematic Adjustments to Other Stand-Alone Codes

CMS seeks comments on whether it is necessary to make systematic adjustments to other services to maintain relativity between these services and E/M office visits, and whether it is necessary to make corresponding adjustments to E/M codes describing visits in other settings. Identifying codes that were cross-walked or valued on the basis of E/M would be a major undertaking. Given the complexity of this undertaking, CMS should not make systematic adjustments to services without extensive review and additional surveys to determine appropriate values.

CMS Should Postpone Implementation of the Complexity Add-on Code (GPCIX) Until Further Information is Available on Impact and Use

In addition to the changes to E/M codes, CMS proposes a new add-on code (GPCIX) that could be used when an evaluation and management service is performed and the visit is considered to be a primary care visit, or when the medical services are part of ongoing care related to a patient's single, serious, or complex condition. The CMS impact tables show that more than $1.5 billion will be redistributed between specialties if this code is implemented. Although CMS indicates that all physicians may report this code, in the impact tables (111 and 115) only the following specialties are projected to receive payment for the service: allergy, cardiology, endocrinology, family medicine, general practice, geriatric medicine, hematology/oncology, internal medicine, interventional pain management, neurology, nurse practitioner, obstetrics/gynecology, otolaryngology, pediatric medicine, physician assistant, psychiatry, rheumatology, and urology.

We recommend that CMS postpone implementation of this add-on code until further clarification is provided on how it would be used and what the impact will be on payment and redistributions among specialties. While we agree with the importance of ensuring physicians are adequately reimbursed for more complex patients, it is our understanding that the E/M codes were revalued to account for the complexity and resources required to provide these services. Therefore, we question whether the need for this add-on code still exists. We also are concerned that this add-on code would result in an additional $1.5 billion or possibly more in

spending that would need to be redistributed across the fee schedule due to budget neutrality requirements.

In addition, even if there is adequate justification for the add-on code, we are concerned that it would add complexity to the system at a time when burden reduction is a key goal. We anticipate there would be significant confusion regarding when it would be appropriate to bill the add-on code. The addition of the code, which has a vague description, is likely to increase burden if there is a need to provide additional documentation to support the payment for the code. The documentation requirements could require extensive education for providers to comply and could potentially be as onerous as the current documentation requirements.

Global Surgical Codes

The RUC-recommended that values for codes with global periods in which office visits are included in the service should be adjusted to reflect the new values recommended for freestanding office visits by the RUC. However, CMS decided not to adjust the global surgical package values to reflect the updated office visit values. CMS indicates that the Agency is still gathering information on global surgery codes and therefore does not propose to modify the value of visits into the bundled payment until it is able to determine that the number and level of visits are accurate. **We recommend that CMS adjust the global period to reflect the new E/M values.**

Surgical specialties participated in the RUC survey on the revised E/M codes and their data were the same, and often greater, than primary care and other specialties. Office visits with patients should be valued consistently regardless of the specialty. It is important for CMS to ensure that relativity is fairly applied to all services described by the codes.

Historically, each time values of stand-alone office visits increased, CMS has also increased the value of these visits bundled into the surgical global period. Increasing the visits bundled into the surgical global payment would increase spending by approximately $440 million, which would require only a 0.4% reduction to the Medicare conversion factor. This impact on budget neutrality is small in comparison to the impacts of other changes proposed in the rule.

CMS encourages stakeholders to comment on the three RAND reports it released with the proposed rule regarding global surgery. There are a number of concerns with the analyses in the three RAND reports. For example, the RAND report on claims-based reporting of post-operative visit showed limited participation of eligible physicians and participation widely varied by both specialty and state. Because there are flaws in the RAND analyses, we believe that these reports should not be used to reject the RUC recommendation to apply the increases to E/M office visits to post-operative visits in the global period.

Further Information Needed on the Impact of E/M Office Visit Changes for 2021

CMS provides an impact analysis of the E/M value changes as if those changes were proposed for 2020 implementation. The tables (111 and 115) allow insights into potential payment shifts across specialties that would result from implementing the updated values for the office E/M codes and the revised, revalued visit complexity add-on code (GPCIX). We request that CMS

provide additional information on how the impacts presented in these tables were calculated so that stakeholders can perform their own impact analysis.

While we support the increase in payment for the E/M services, we are deeply concerned about the redistributive impacts on some specialties. Significant reductions in payment to some specialties could reduce access to medically necessary services. Because the Physician Fee Schedule is budget neutral, any changes to the codes that increase the payment amounts under the fee schedule need to be offset by decreases elsewhere within the fee schedule. As CMS shows in the rule, the E/M changes would benefit specialties that perform predominantly offices visits and will result in reductions in payment for specialties that do not perform office visits. It is projected that the changes to the E/M work values will result in an increase of $3 billion in spending that needs to be redistributed and the E/M physician time recommendations will result in an additional $2 billion to be redistributed. The RUC recommendations for physician work, time and direct practice expenses would result in a 5-6% redistribution between those physicians who routinely provide office visits and those physicians and other professionals who do not routinely report office visits. CMS indicates in the rule that the add-on code would result in another $1.5 billion that would need to be redistributed.

The reductions would be very difficult for some specialties to absorb in their practices, particularly given the fact that there are no payment updates in the fee schedule for six years from 2020-2025. The recent 2019 Medicare Trustees report found that scheduled physician payment amounts are not expected to keep pace with the average rate of physician cost increases which are forecast to average 2.2% per year.

In addition, at a time when there are growing physician shortages, the shortages may be exacerbated for specialties that face significant cuts in payment. According to the AAMC's recently updated projections, by 2025 the country could experience a shortfall of between 61,700 and 94,700 physicians[2]. Estimated shortages are predicted of 14,900 to 34,600 in primary care and between 37,400 and 60,300 in non-primary care specialties. While significant concerns have been raised about primary care shortages, there are also growing shortages in many specialties, especially surgical ones. Absent an update in legislation, access to participating physicians is likely to become a major concern. **While we recognize CMS does not have the authority to change the updates, we urge CMS to work with the medical community to encourage Congress to replace these payment freezes with positive annual updates.** Positive updates could help to offset the impact of the increases to the office visits.

Valuation of Specific Codes

In the proposed rule, CMS includes its recommendations for work values for codes reviewed by the RUC. CMS accepted approximately 70% of the RUC's work relative value recommendations submitted for 2020. The AAMC has concerns about the impact that significant reductions to the work values for certain codes could have on access to services.

[2] New England Journal of Medicine. *Physician Shortage Spikes Demand in Several Specialties.* (November 30, 2017) Retrieved from https://www.nejmcareercenter.org/article/physician-shortage-spikes-demand-in-several-specialties-/

As an example, major changes to the codes and reimbursement are proposed in this rule for reporting the professional service of reviewing, analyzing interpreting and reporting the results of the continuous recording of EEG or EEG with simultaneous video recording with recommendations based on the findings. For physicians who provide these services, CPT code 95951 would be reported in 2020 as 95X17 for the 24-hour VEEG service. The RUC recommendation for physician work of this code was 3.86 RVUs and CMS proposes 3.50 RVUs, which is a significant reduction from the current physician work RVU of 5.99 for 95951.

The typical patient requiring a VEEG service is a candidate for epilepsy surgery and the long-term EEG physician report is used by the neurosurgeon to determine whether epilepsy surgery is appropriate, which requires an EEG study with a particularly high level of intensity. This pre-surgical evaluation typically includes the withdrawal of anti-seizure medications to invoke seizures and identify the seizure focus. This involves detailed review to determine the site for surgical brain resection. Our analysis of CMS' 2017 utilization data of CPT code 95951 shows that over 90% of the utilization for these services occurs in a facility setting. Many of the patients receive this long-term EEG in academic medical centers, which are equipped with the necessary clinical staff, physician specialists, equipment, and other resources to safely provide this service. These academic medical centers see highly complex cases that require significant resources to evaluate, diagnose, and treat. The monitoring and interpretation of the study results and the development of the plan of care require high clinical expertise and significant physician time. The AAMC has deep concerns with the over 40% reduction in proposed payment for this VEEG service from 2019 to 2020 and the negative impact it could have on access to this important service.

In addition, we have concerns that the RUC survey may not have adequately reflected physicians doing this work in the inpatient academic medical center setting, and CMS' proposals to reduce the values further would exacerbate access issues. **We recommend that CMS delay implementation of these code changes and engage in dialogue with the impacted specialty groups to address concerns with the appropriateness of the values.** In the interim, CMS could establish a G-code to allow continued reporting of the long-term EEG until the concerns are resolved. If CMS chooses to go forward with these reductions, CMS should phase in the changes to the work RVUs rather than implementing them in their entirety in 2020.

Medical Record Documentation/Verification

The AAMC appreciates that CMS has continued to refine its policies for medical record documentation and verification to reduce burden. In this rule, CMS proposes to allow physicians, physician assistants, or Advanced Practice Registered Nurses (APRNs) who document and who are paid under the PFS for their professional services to review and verify (sign and date) rather than re-document notes made in the medical record by other physicians, residents, nurses, students and other members of the medical team. CMS also proposes that the presence of the teaching physician can be demonstrated by notes in the medical record made by the medical student. The AAMC strongly supports these proposals and appreciates that CMS took our comments on the CY 2019 proposed rule into consideration.

Along with these proposed changes, **the AAMC recommends that CMS clarify that the physician is ultimately responsible for reviewing and verifying the notes of the medical students or residents and remains responsible for the care provided.** Lastly, the AAMC would welcome the opportunity to work with CMS to ensure that the CMS documentation guidelines for teaching physicians, interns, and residents are appropriately updated to reflect these changes.

Care Management Services

In the 2020 rule, CMS proposes refinements to chronic care management (CCM) and transitional care management (TCM) codes and proposes new codes for principal care management (PCM) services. In past rules, CMS noted that utilization of CCM services is lower than anticipated, particularly for complex patient services. Stakeholders have noted the need for more discrete time increments for these codes. In response, CMS proposes two new G-codes (GCCC1 and GCCC2) to be used instead of CPT code 99490. Both G-codes note time in 20-minute increments over a calendar month. CMS also proposes two additional new G-codes to capture more complex CCM services, in 60 minute increments over a calendar month.

In the proposed rule, CMS discusses an interest in increasing the utilization of TCM services and expanded payment for care management. When the TCM codes were first finalized, CMS placed billing restrictions on the codes that did not permit the same practitioner reporting TCM services to bill 57 other HCPCS codes identified by CMS during the same 30-day period covered by those TCM services. To incentivize additional utilization of TCM codes, CMS proposes to modify billing requirements to allow TCM codes to be reported concurrently with other codes. CMS also proposes to increase payment for the two TCM codes as recommended by the RUC.

In order to better capture services for patients who have a single, serious, high-risk condition, CMS is also proposing two new codes for principal care management. The current CCM codes require that patient have two or more chronic conditions in order for the code to be billed, contrasting with these TCM codes, which would capture services for patients who have a single condition that is expected to last between three months a year, may have led to a recent hospitalization, and/or places the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

The AAMC supports these proposed changes and CMS' efforts to improve primary care and cognitive services and compensate physicians and other professionals for the work they perform managing care for Medicare beneficiaries. Care management services are essential for moving to a system that provides patients with higher quality care and ultimately saves the Medicare program money. Patients with complex chronic conditions, and single serious conditions require extensive care coordination that is non face-to-face. Yet the current payment system is not designed to reimburse for these activities that are required to furnish comprehensive coordinated care management for certain beneficiaries.

The AAMC recommends CMS finalize its proposal to establish a new code for principal care management services. Similar to patients with chronic conditions, physicians spend a significant amount of time managing the care of patients with a single serious condition and should be reimbursed for this work. Care management of these patients can reduce readmissions and emergency room visits.

The AAMC recommends that CMS work to further simplify the billing requirements for the codes to alleviate administrative burden. While we appreciate the refinement of the time increments for billing, collecting the small increments of time over the course of a month that a clinician spends furnishing care coordination and management services can be incredibly burdensome for both the clinician and their administrative staff. In the future, the AAMC recommends that CMS continue to evaluate the feasibility, utilization, and impact of the care management codes.

Comment on Solicitation on Consent for Communication Technology-Based Services (Including Interprofessional Internet Consultations)

CMS makes separate payment for services furnished via telecommunications technology, including: evaluation of recorded video and/or images (G2010), virtual check in (G2012), and interprofessional consult services (99446-99449, 99451 and 99452). CMS requires advance beneficiary consent for each of these services. CMS notes that stakeholders are concerned that requiring advance beneficiary consent for each of these services is burdensome, and specifically acknowledges that for interprofessional consultation services, stakeholders find it difficult for the consulting practitioner to obtain consent from a patient they have never seen.

Given CMS's longstanding goals to reduce burden and promote the use of communication technology-based services, the Agency is seeking comment on whether a single advance beneficiary consent could be obtained for a number of communication technology-based services. During the consent process, the practitioner would make the beneficiary aware that utilization of these services will result in a cost sharing obligation. CMS is also seeking comment on the appropriate interval of time or number of services for which consent could be obtained, for example, for all these services furnished within a 6 month or one-year period, or for a set number of services, after which a new consent would need to be obtained. The Agency also seeks comment on the potential program integrity concerns associated with allowing advance consent and how best to minimize those concerns.

The AAMC strongly recommends CMS reduce burden and promote the use of communication technology-based services by revising its requirements to allow greater flexibility around the process for obtaining beneficiary consent, including allowing a single advance beneficiary consent, on an annual basis. Our feedback on CMS' request for comments related to consent are enumerated in further detail below.

Background on Project CORE and the Use of Interprofessional Internet Consults

The AAMC and its member academic medical centers have significant experience with interprofessional consults, described by the CPT codes 99451 and 99452, and adopted by CMS in the 2019 Physician Fee Schedule final rule, that inform our comments.

In September 2014, the AAMC received a CMMI Round Two Health Care Innovation Award (HCIA2), which allowed the Association to launch Project CORE: Coordinating Optimal Referral Experiences. Utilizing EMR-based communication tools (including eConsults, the term used by the CORE program for an interprofessional internet consult), the CORE model aims to improve quality and efficiency in the ambulatory setting by reducing low-value referrals, improving timely access to specialty input, and enhancing the patient experience through more

effective communication and coordination between providers. In the CORE model, eConsults are an asynchronous exchange in the EMR that are initiated by a primary care provider (PCP) to a specialist for a low acuity, condition-specific question that can be answered without an in-person visit. Initially implemented in 5 AMCs through the HCIA award, the CORE model has now been implemented at more than 30 AMCs and children's hospitals across the country. There have been over 36,000 eConsults completed through the CORE model over the past five years, with more than 2,000 eConsults being completed each month.

Our analyses of eConsults from the HCIA CORE project demonstrate a positive impact on utilization of services, access to care, costs, and patient and provider experience. Analysis comparing participating CORE specialties to all other specialties from the 5 sites in our CMMI-funded program showed a savings of approximately $8.4 million to Medicare over the course of the three-year grant period from the net reduction of over 66,000 specialty visits for Medicare beneficiaries.

CMS Should Allow for a Single Advance Beneficiary Consent for the Interprofessional Consult Codes

The AAMC commends CMS for listening to our concerns and those of other stakeholders, and for seeking feedback on changes to the advance beneficiary consent requirements included in the 2019 final physician fee schedule rule. We urge CMS to allow providers greater flexibility in obtaining beneficiary consent for the interprofessional internet consult codes (99451 and 99452). Over the past year, the AAMC has advocated that requiring verbal patient consent for every interprofessional consult encounter is burdensome to the requesting provider and nearly impossible for the responding provider given that in most cases, the specialist consultant will not have a relationship with the patient. There are clinically appropriate scenarios where a treating provider might request an interprofessional consult after the patient has left the office (e.g. in response to an abnormal laboratory test or value). In these cases, requiring verbal consent creates inefficiencies and could further delay care if the treating provider is required to contact the patient and obtain consent before placing the consult. It could also cause undue stress for the patient, particularly if the specialist deems that the abnormal lab value is not of concern or does not need any additional follow-up at that time.

To address the need for patient consent in a way that is practical for providers and practices, and to minimize inefficiencies and confusion for beneficiaries, we urge CMS to allow physicians to obtain blanket consent at the practice level for this interprofessional consults on an annual basis. Operationally, this could be a one-time annual consent that is part of the practice's existing terms and conditions or general consent to care documents that patients sign each year. **Physicians should also be given flexibility around how the advance consent is obtained as many practices use a mix of approaches (e.g. through the patient portal or at sign-in at an annual visit).** Our CORE AMCs have indicated that having a separate global consent process for a single service, such as interprofessional consults, would be burdensome. Providing practices with the flexibility to fold consent for interprofessional consults and other technology-based services into existing terms and condition processes that patients are already familiar with would be more efficient for providers and beneficiaries.

In addition, having consent obtained on an annual basis is consistent with existing administrative processes for updating terms and conditions, something with which both beneficiaries and physician practices already are familiar. Having a separate process to obtain consent after a certain number of services (e.g. after five technology-based communications) would be very difficult for a practice to operationalize and track on an individual beneficiary basis.

Recommendations for Minimizing Potential Program Integrity Issues with Advance Beneficiary Consent

CMS raises the question about potential program integrity concerns associated with allowing advance consent and seeks comment on how best to minimize those concerns. One option to minimize program integrity concerns is for CMS to recommend that providers inform patients that an interprofessional consult is being placed, or has been placed, on their behalf. This can happen in the context of an in-person office visit or via the patient portal if the decision to place a consult is made when the patient is no longer in the office. In the CORE model, PCPs are trained to discuss eConsults with their patients and to close the loop with their patients as appropriate once they have received the specialist's recommendations. Allowing for advance consent and then encouraging providers to discuss the interprofessional consult as part of the visit, or to notify the patient through the portal, would be consistent with other types of services that a provider might order in the course of a visit or post-visit follow-up service.

Program Integrity: Require the Requesting Practitioner to Act on the Interprofessional Consultation to Bill

In our comments on the 2019 PFS proposed rule, and in subsequent discussions with CMS, we recommended that CMS clarify that the treating physician should not bill the patient merely for submitting their clinical question to the specialist, as there is a risk that the specialist will never respond. We strongly believe that the benefit of the eConsult to the patient can only occur when the treating physician receives a response from the specialist and then reviews the response and determines a course of action. Thus, we recommend that CMS clarify that 99452 should be reported for a treating physician (typically a primary care provider) who has sent a consultation to the specialist and received a response that they review and incorporate into the patient's care plan as appropriate. Often this will culminate in the requesting provider contacting the patient to inform him/her of the specialist's recommendations and subsequent course of action.

Patient Coinsurance Concerns with 99451 and 99452

CMS requires that providers collect coinsurance from their patients when billing for CPT codes 99451 and 99452. While the AAMC understands that CMS may not have the authority to waive coinsurance for CPT codes 99451 and 99452 under the Medicare fee-for-service program, we remain concerned that the coinsurance requirement is a barrier to providing these important services for several reasons. First, given the structure of two distinct codes, patients are responsible for two coinsurance payments for a single completed interprofessional consult - one for the treating provider (99452), and one for the consulting provider (99451). While we believe that it is appropriate to reimburse both providers for their work in conducting the internet interprofessional consultation, two coinsurance charges to the patient for what they perceive is a single service will predictably induce confusion. Interprofessional consults are often used for patients with new problems who are not established within the consulting specialty's practice

and therefore do not have an existing relationship with the consultant. A coinsurance bill for a service delivered from a provider that is unknown to the beneficiary could cause the patient to believe a billing error has occurred. This would place an undue burden on the practice's billing staff to address questions about billing. Additionally, if presented with the option of an interprofessional consult coinsurance payment versus a visit coinsurance payment, patients may elect to see the specialist in-person, which would be unnecessary and negatively impact the potential savings of these interprofessional consults.

While the AAMC recognizes there are typically limited scenarios where coinsurance is waived in the Medicare program, we continue to believe that the "two coinsurances" issue will stifle use of these value-promoting, physician-to-physician services that analyses of the CMMI-funded CORE model show to be cost-saving to CMS. Therefore, the Agency should explore a pathway to waiving the patient coinsurance for 99451 and 99452. In particular, CMS should explore whether there may be avenues available to waive the specialist coinsurance (99524) to minimize overall administrative complexity and confusion for beneficiaries who likely have no established relationship with the specialist consulting provider.

At a minimum, the coinsurance should be waived in circumstances where there is a straightforward mechanism to do so, such as CMMI's ability to do so for specific services in alternative payment model (APM) demonstrations.

Medicare Shared Savings Program (MSSP)

CMS seeks comments on how to align the MSSP quality performance scoring methodology with proposed changes to the Web Interface measure set under MIPS and align the Shared Savings Program quality score with the MIPS quality score. Specifically, CMS seeks comment on replacing the Shared Savings Program quality score with the MIPS quality performance category score for ACOs in Shared Savings Program tracks that do not qualify as Advanced APMs. CMS is also seeking feedback on how to determine whether the ACO has met the minimum attainment level and how to utilize the MIPS quality performance category score to adjust shared savings and shared losses under the Shared Savings Program.

While the AAMC understands CMS' desire to align programs, **the Association encourages CMS to maintain the current quality scoring methodology for the MSSP program and not adjust shared savings and losses based on the MIPS quality performance category.** At a time when ACOs are experiencing a major redesign of the MSSP program under the "Pathways to Success" program, CMS should not make major changes to the quality scoring methodology. A significant restructuring of the MSSP quality program will introduce more confusion for ACOs that are transitioning into the new pathway tracks. It is important to avoid setting policies that would potentially dissuade participation in these MSSP models in the future.

Physician Assistant Supervision Requirements

Currently, physician assistants are permitted to provide care under the general supervision of a physician, which is defined as being under the direction and control of the physician but does not require the physician to be present during the services. Physician assistants (PAs) are practicing more autonomously, consistent with state licensure, much like nurse practitioners (NPs) and clinical nurse specialists (CNSs), who furnish services "in collaboration" with a physician. CMS

proposes to adjust supervision requirements for PAs to state that the supervision requirements would be met when the PA furnishes services in accordance with state law and state scope of practice rules. In the absence of state law, CMS proposes that the supervision required by Medicare for PA services would be documented in the medical record.

The AAMC supports the proposal to defer to state law and state scope of practice rules regarding PA supervision. This proposal would align PA supervision requirements more closely with nurse practitioner and clinical nurse specialist requirements. States should be responsible for establishing and regulating scope of practice, including supervision requirements. If there is no applicable state law, **we recommend that there be documentation in the medical record that a collaborative agreement exists that details the supervisory requirements and arrangements between a physician and a PA.**

Changes to Rules for Revoking Medicare Billing Privileges

CMS proposes that Medicare billing privileges could be revoked for any physician or other provider who has been subject to "prior action from a state oversight board, federal or state health care program, Independent Review Organization determination, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of healthcare with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm."

The AAMC believes that it is essential to ensure that providers who treat Medicare beneficiaries are appropriately licensed and in good standing; however we have concerns about the overly broad expansion of authority for CMS were this proposal to be finalized. Additionally, we are concerned about the lack of definition and vague language proposed by CMS. State boards may take action for minor licensing issues, such as tardiness in license renewal, documentation requirements, or fee payment, that certainly do not raise concerns regarding quality of patient care. Under this expansive proposal, it is possible that group practices could lose valuable clinical staff should the staff have a minor licensing matter that CMS determines under the regulation puts the Medicare trust fund or its beneficiaries at risk of harm. We are also concerned about the burden this proposal would place on hospitals and practices, and the risk of diminishing access to physicians that could result from minor licensing issues. In addition, this action could have an unintended chilling effect that could lessen willingness to report minor licensing issues to state boards. State boards were created and are charged with protecting the public, including Medicare beneficiaries. Medicare should defer to the state boards decisions regarding adverse actions that should result in removal of licensing or enrollment.

Open Payments

The AAMC appreciates the opportunity to respond to the Centers for Medicare and Medicaid Services' (CMS) request for feedback on the changes to the "Open Payments" program and commends CMS' ongoing commitment to "stakeholder engagement in an effort to limit burden in the Open Payments program reporting processes and improve clarity for the public."

Expanding the Definition of a Covered Recipient

Matching and Validation Issues

Since the implementation of the Open Payments program, the reporting of payments or other transfers of value made to covered recipients by applicable manufacturers and GPOs has presented several challenges to academic institutions, including efforts to match and validate of Open Payment record data, which has the potential to affect the completeness and accuracy of the data reported.[3] As required by Section 6111 of the SUPPORT Act (Pub. L. 115-270), the definition of "covered recipient" is expanding to include five additional provider types (i.e., physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives), and may significantly increase the information submitted to CMS by applicable manufacturers and GPOs on or after January 1, 2022. **We suggest that CMS work with stakeholder groups that represent or employ the new categories of covered recipients to increase awareness of the records that will be made publicly available, to educate these individuals about the review and dispute process, and to improve the accuracy of collected and reported data through broad engagement.**

Designated Contacts in the Open Payments System

The AAMC in its letter to CMS in response to the CY 2017 Physician Fee Schedule (PFS) Proposed Rule,[4] supported the proposal to include additional non-public text fields in the Open Payments system to assist in the review and affirmation or dispute of payment records. The changes to the review and dispute process that now includes the required non-public text field for covered recipients, "Dispute Details and Contact Information" is a helpful communication facilitation mechanism. The AAMC continues to hear that covered recipients have no systematic mechanism through which they can contact an applicable manufacturer with questions about payment records other than by disputing an unrecognized record.

We propose that CMS require each applicable manufacturer and GPO to designate an internal contact to whom questions about records in Open Payments could be directed. Providing such information, including a name, email, and/or phone number on the company's summary page on the Open Payments website would provide an opportunity for better communication between covered recipients and applicable manufacturers during and outside of the 45-day review and dispute period. Improving this communication could improve the accuracy of the publicly reported data.

Decreasing Burden – Registration and 45 Day Review and Dispute Period

The AAMC strongly encourages CMS to continue to identify and implement ways to improve the Open Payments system through decreasing the burden associated with two-step registration process that many physicians see as a barrier preventing engagement during the brief review and dispute process. We appreciate the system enhancements CMS has made in direct response to public feedback and recommend continued engagement with key stakeholders to address the specific concerns that may arise from the broadened scope of individuals now covered under the Open Payments program. We also suggest CMS consult with

[3] *Open Payments Data: Review of Accuracy, Precision, and Consistency in Reporting*, Department of Health and Human Services, Office of Inspector General, OEI-01-15-00220 (August 2018).
[4] AAMC Comment Letter, *Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to* Part B for CY 2017, September 6, 2016, Available at: https://www.aamc.org/download/469304/data/aamccommentsoncy2017pfs.pdf.

stakeholders on potential system or registration enhancements *before* they are publicly released to ensure those updates are beneficial and user friendly.

The difficulty of registration in Open Payments is of notable concern for AAMC member institutions and is an issue that has persisted since implementation of Open Payments. Efforts to improve the registration process would significantly decrease frustration and increase provider participation, ultimately increasing Open Payments data accuracy. Potential solutions include: 1. extending the timeframe for which a registration and password remains valid because the review and dispute process is annual and registered users find that they have been removed from the system each time they return; 2. eliminating or streamlining the two-part registration in the CMS Enterprise Portal and the Open Payments system, and 3. increasing the variety and number of characters for acceptable user passwords.

As the AAMC recommended in our comments to CMS in response to the Proposed Rule[5] and reiterated in our comments on the CY 2017 PFS Proposed Rule, we believe expanding the 45-day review and dispute period would better ensure resolution of disputes and the accuracy of published information. The review and dispute period must *at least 45 days*, but there is no requirement that this period last *only* 45 days. We suggest that CMS consider extending the review period to more than 45 days to ensure covered recipients have ample opportunity to review the payments reported about them and resolve any disputes.

Nature of Payment Categories

In the 2020 PFS Proposed Rule Proposed Rule, CMS has recommended consolidation of two separate payment categories for continuing education programs and proposes adding three new categories: "Debt Forgiveness," "Long-Term Medical Supply or Device Loan," and "Acquisitions."

While the AAMC welcomes updates and revisions to the existing payment categories, CMS does not provide enough detail or context on how payments that fall within these categories should be characterized. The AAMC advised CMS in 2017 that "the lack of specificity in the nature of payment categories has led to apparent over-reporting or lack of critical contextual information" and has the same concerns with the proposed payment categories. We recommend that through FAQs, CMS provide specific examples of the types of payments that fall within each category as well as the types of relationships and payments that are not covered. We also suggest that CMS engage stakeholders to assist in the development of definitions and examples specific to these new categories and ensure this guidance is reflected in all relevant educational materials, written or published on the Open Payments website.

QUALITY PAYMENT PROGRAM

The AAMC appreciates that CMS recognizes the need to transition to the framework for physician payment required by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). We urge CMS to use the flexibility provided under the MACRA statute to create a longer transition period for the program and to reduce complexity and burden. While CMS has

[5] AAMC Comment Letter, *Medicare, Medicaid, Children's Health Insurance Programs; Transparency Reports and Reporting of Physician Ownership or Investment Interests*, February 17, 2012, Available at: https://www.aamc.org/download/274152/data/commentsonsunshineact.pdf

addressed many of the issues raised by stakeholders, the AAMC still has concerns with some of the components of the Quality Payment Program (QPP), which we discuss below.

We are committed to working with CMS to ensure that MACRA promotes improvements in delivery of care to patients and is not overly burdensome to clinicians and the organizations for which they work.

MIPS Value Pathways (MVPs)

In the proposed rule, CMS discusses a new MIPS participation framework, referred to as MIPS Value Pathways (MVPs), that would begin with the 2021 performance year. Key features of the MVPs include: 1) assigning MVPs to clinicians and groups based on factors such as specialty designation or place of service; 2) connecting measures and activities across the 4 MIPS performance categories and aligning them to specific clinical conditions and the practitioners who treat them; 3) establishing a base measure set of population health measures that would be included in all MVPs; 4) requiring completion of the promoting interoperability performance category; 5) providing actionable data and feedback to clinicians; and 6) enhancing information available to patients. CMS requests public input on all aspects of the MVP framework.

Participation in MVPs Should be Voluntary

While we appreciate CMS' efforts to develop a new pathway under the MIPS program, CMS should not completely restructure the program in a single year, especially when providers are experiencing numerous other pressures, such as increases in the thresholds to avoid the MIPS penalty, increases in the cost category weights and number of cost measures, increases in the thresholds to qualify as qualified participants in an advanced APM, and a new coding structure for evaluation and management services.

We urge CMS to make several refinements to the MVP framework proposed in the rule. **First, CMS must ensure that participation in the MVP is voluntary. Instead of assigning clinicians to MVPs, CMS should allow physicians to opt-in to CMS' suggested MVP, choose an alternative MVP, or continue to report measures through the traditional MIPS pathway**. Rather than mandating reporting of certain MVPs, CMS could create incentives for physicians to report. For example, CMS could provide more timely feedback and data analyses to eligible clinicians reporting MVPs about their performance under the program. CMS should use the first few years of MVP implementation as a pilot period during which there is an opportunity to refine and improve the program and allow physicians to gain experience with the MVP option.

Second, the MVP program should be refined to eliminate the requirement that physicians report in four separate performance categories. For example, instead of a physician attesting to improvement activities (IAs), the developer of each MVP should inform CMS of which IAs are inherent in a particular MVP and IA credit should be automatic. This is similar to the way MIPS APMs are currently scored in the improvement activity category. Rather than reporting on each individual promoting interoperability measure, a physician should be able to attest that they (or at least 75% of the eligible clinicians in their group) are using CEHRT.

CMS Should Address the Unique Challenges Posed for Large Multi-Specialty Practices Reporting MVPs

Of particular note, CMS indicates that stakeholders continue to request a group reporting option that would allow a portion of a group to report as a separate subgroup on measures and activities that are more applicable to the subgroup and be assessed and scored based on the subgroup's performance. CMS has not developed a MIPS subgroup option thus far due to operational challenges. CMS invites comments about whether the MVP approach could provide an alternative to subgroup reporting. CMS suggests that multispecialty groups potentially would report at the group level on multiple MVPs that would be assigned or selected. Subgroups of clinicians might choose to participate under one or more of the group's MVPs. Depending on how the MVPs are then combined and scored at the group level, the need for groups to create sub-TIN level identifiers and apply eligibility criteria the sub-TIN level might be eliminated.

We appreciate CMS' interest in exploring how the MVP approach would work for multispecialty practices and whether it provides an alternative to subgroup reporting. As CMS considers these refinements, it is important to understand the unique challenges posed by the QPP for large multi-specialty practices. AAMC members include academic medical centers in which faculty physicians are frequently organized under a single tax identification number (TIN). Recent data shows that the practice plans range in size from a low of 128 individual NPIs to a high of 4, 319 with a mean of 989 and a median of 816. These practices often have over 70 adult and pediatric specialties and numerous subspecialties, such as burn surgery, cardiac surgery, and general surgery, to name a few. In some cases, faculty practice plans are highly integrated and make decisions about quality and care coordination as a single entity. In other instances, such decision-making occurs at the specialty level.

With the large number of distinct specialties reporting under one TIN, it will be very challenging to identify MVPs that will be meaningful for all the different specialties in the practice. Even if multiple MVPs are selected for reporting, it will still be difficult to identify MVPs that describe the scope of conditions treated and vast number of specialties included in academic medical centers. If multiple MVPs are reported and scored at the group level, we question whether the information provided will be useful to consumers and whether it will drive improvements in performance.

The AAMC continues to believe that a better solution would be to have subgroup identifiers to allow reporting at subgroup level to measure the performance of the subgroup. Specifically, to allow participation in MIPS at a subgroup level, the AAMC recommends that CMS follow some of the policies set forth for virtual groups, which include:

- Establish a subgroup identifier.
- Require the subgroup to make an election prior to the start of the applicable performance period under MIPS to be a subgroup.
- Request that a list of participants who would be part of the subgroup identifier be provided to CMS. A subgroup would submit each TIN and NPI associated with the subgroup, the name and contact information for a subgroup representative and a confirmation that each member of the subgroup is aware of their participation.

- Identify each MIPS eligible clinician who is part of the subgroup by a unique subgroup participant identifier which would be a combination of 1) subgroup identifier (established by CMS); 2) TIN and 3) NPI.
- Assess performance by a method that combines performance of all MIPS eligible clinicians in the subgroup across all four performance categories.

Depending on the practice, there are advantages and disadvantages to reporting under a subgroup MIPS identifier, an NPI, a TIN, or a combination. Under the MIPS program, the practices should be given the opportunity to assess the advantages and disadvantages and select whichever option is most meaningful and least burdensome.

MIPS Performance Category: Quality

For the 2020 performance year, CMS proposes to set the quality performance weight at 45%. CMS still requires reporting of six quality measures, including one outcome or high priority measure. If providers choose to report via Web Interface, all Web Interface measures must be reported. CMS is proposing removal of 55 previously finalized quality measures, and substantive changes to 78 of the measures that have been finalized.

The AAMC has concerns with the removal of such a significant number of quality measures in the program. The removal of 55 measures represents a 21% decrease in the total number of quality measures available to report. Over the last two years, CMS has removed approximately 32% of MIPS traditional quality measures[6]. Removing measures creates a lack of consistency of available measures in the program, which does not allow CMS to measure practices on improvement or practices to focus on applying improvement strategies into practice. This continual reduction also reduces the number of measures available to form MIPS Value Pathways (MVPs). In addition, the AAMC is concerned with the increase in the data completeness standard to 70%.

Faculty practices invest time and resources to implement quality measures and update their systems. Removing measures forces a practice to pick new measures to satisfy MIPS requirements which would require additional changes to systems and more education to clinicians. It also affects the ability to document and track performance improvement.

Data Completeness Threshold

In the 2020 performance year, CMS proposes to increase the data completeness threshold when reporting on a quality measure from 60% of denominator eligible patients to 70% of denominator eligible patients. 2020 is the second year in a row that CMS is increasing this threshold.

The AAMC recommends that CMS maintain the data completeness threshold at 60% for all reporting mechanisms. The proposed increased threshold is inconsistent with the Administration's initiatives to reduce burden. It takes time to implement new measures or updates to measures into practice workflow or the registry or EHR and further discourages practices from reporting on new measures. Vendors often do not complete updating the measure

[6] Does not include the number of QCDR measures CMS has removed from the program or proposes to remove as part of the 2020 QCDR deeming process.

specification until after the beginning of the performance period. CMS also does not release measure specifications and educational materials in a timely manner and often does so in the middle of the performance period (after Jan. 1).

MIPS Performance Category: Cost

For the 2020 performance year, CMS proposes to weight the cost category at 20%, a substantial increase from the 2019 weight of 15%, and to gradually increase the weight of the category in 2021 to 25% and in 2022 to 30%. Given the multiple concerns under the cost category, including the need for risk adjustment, the need for better attribution methodologies, and further development of episode groups, the AAMC strongly urges CMS to continue the weight of the cost category at 15%. **Our concerns are enumerated in further detail below.**

Cost Category Measures

CMS plans to assess performance in the cost category by utilizing: 1) the Total Per Capita Cost of Care (TPCC) measure, 2) the Medicare Spending Per Beneficiary (MSPB) measure; and 3) 18 episode-based cost measures. CMS proposes eight new cost measures, listed below, in addition to the ten previously finalized episode-based measures:

- Acute Kidney Injury Requiring New Inpatient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Inpatient COPD Exacerbation
- Lower Gastrointestinal Hemorrhage*
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy, Partial Mastectomy, Simple Mastectomy
- Non-emergent Coronary Artery Bypass Graft (CABG)
- Renal or Ureteral Stone Surgical Treatment

**at group level only*

The AAMC is concerned about the rapidly increasing number of cost measures used to measure clinician's performance, particularly given the challenges with attribution and risk adjustment, which need further study.

All Cost Measures Must be Appropriately Adjusted to Account for Clinical Complexity and Sociodemographic Status

The 18-episode cost measures are risk-adjusted based on variables, such as age, and comorbidities by using Hierarchical Condition Categories (HCC) data and other clinical characteristics. While the Total Per Capita Cost (TPCC) measure and the Medicare Spending Per Beneficiary (MSPB) measure are risk adjusted to recognize demographic factors, such as age, or certain clinical conditions, these measures are not adjusted for other sociodemographic factors. Of special concern is that none of the cost measures are adjusted to account for sociodemographic status (SDS). In addition to differences in patient clinical complexity, sociodemographic status can drive differences in average episode costs. Recent reports from the National Academies of Science, Engineering and Medicine and Assistant Secretary for Planning and Evaluation (ASPE) have clearly acknowledged that sociodemographic status variables (such

as low income and education) may explain adverse outcomes and higher costs. Without accounting for these factors, the scores of physicians that treat vulnerable patients will be negatively and unfairly impacted and their performance will not be adequately represented to patients. Physicians at AMCs care for a vulnerable population of patients who are sicker, poorer, and more complex than many patients treated elsewhere.

The AAMC believes that there are ways to appropriately incorporate SDS factors in the risk adjustment methodology. **We request that these measures be adjusted to account for these risk factors.**

Attribution Method Should be Clear and Transparent and Accurately Determine Patient/Clinician Relationship

For cost measures it is critical that there be an accurate determination of the relationship between a patient and a clinician to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated given that most patients receive care from numerous clinicians across several facilities. The attribution method used should be clear and transparent to clinicians.

We suggest that better data sources and analytic techniques should be explored in the future to support more accurate attribution of these episodes. Attribution is a key component of these cost measures. There has been a focus on identifying how information from claims could be used to inform the attribution of services to clinicians or any other information that could clarify the relationship between patient and clinician. CMS indicated that there is a belief that in the future attribution will benefit from the development of patient relationship codes, which were finalized in the 2018 Physician Fee Schedule rule. CMS stated that the Agency plans to consider how to incorporate these patient relationship categories and codes into the cost measure methodology as clinicians gain experience with them. While use of these codes could have the potential to improve data and promote accurate assignment of accountability, concerns about their accuracy remain. Significant education and testing need to be completed before using this information for attribution.

Quality Payment Program Feedback Reports: Cost Category

Physicians have only received detailed feedback reports for one year (2018) and no information has been received about episode cost measures that went into effect in 2019. The feedback does not provide comparison information to help physicians determine the extent of unwarranted variation in spending and to understand their patterns of care.

In the past under the valued-based modifier program, our members found the feedback reports to have a significant amount of useful information. Information on the breakdown and utilization and cost by Medicare setting and service category can be actionable provided that the clinician is able to have some control over the referral or provision of services in a particular setting. Clinicians need to understand why a patient was attributed to him or her. Therefore, it is important for providers to have the opportunity to review feedback reports in advance and determine whether patients are accurately attributed to them.

It is essential that feedback contain actionable data related to the cost category. The reports should provide specific details about the patients, and the numerator and denominator

information. Reports should provide enough information to verify how the score was calculated, including the data that was used. The AAMC is concerned that without detailed information on the cost category, providers will be unable to determine how they are performing or how they compare to other providers, and ultimately will be unable to make improvements within the Quality Payment Program.

Medicare Spending Per Beneficiary (MSPB) Measure
The Medicare Spending Per Beneficiary (MSPB) measure has been problematic in the past because the attribution methodology does not incorporate the nature of team-based inpatient care, the methodology attributed episodes to specialties providing expensive services instead of those providing overall care management, and the measure captured costs for services that were unlikely to be influenced by the clinician's care decisions.

CMS proposes a revised MSPB measure that would improve the attribution by distinguishing medical episodes from potentially more expensive surgical episodes using the MS-DRG for the measure's index admission. Surgical episodes would be attributed to the surgeon who performed any surgical service during the inpatient stay and to the surgeon's TIN. Medical episodes would be attributed at the TIN level based on the volume of inpatient E/M services.

While we appreciate CMS efforts to refine this measure, significant concerns remain. For cost measures, an accurate determination of the relationship between a patient and a clinician is critical to ensure that the correct clinician is held responsible for the patient's outcomes and costs. This is complicated since most patients receive care from numerous clinicians across several facilities. The attribution method used should be clear and transparent to clinicians. Even with the revisions to the MSPB measure, the measure still may hold physicians accountable for medical conditions that are managed outside of their organization and for costs, such as drug prices, that they may be unable to influence. In addition, there is no risk-adjustment for SDS. Lastly, the MSPB measure captures the same costs as the episode-based measures, effectively "double counting" the costs.

Total Per Capita Cost of Care (TPCC) Measure
CMS proposes to retain and revise the Total Per Capita Cost of Care (TPCC) measure in an effort to address issues about the measure that have been raised. Providers are concerned that the TPCC measure assigns costs to clinicians over which they have no influence, inaccurately identifies primary care patient relationships, and has inaccurate risk adjustment because of the time frame used to capture risk factors.

The changes to the measure proposed by CMS would improve identification of the primary care clinician/patient relationship and categorize clinicians more accurately when determining attribution. In addition, they would determine the beneficiary's risk score on a rolling basis each month leading to a more accurate risk assessment and assess beneficiaries' costs on a monthly rather than annual basis.

While we appreciate CMS efforts to refine this measure, more work needs to be done. Similar to the MSPB measure, the TPCC measure holds physicians accountable for costs related to patients' medical conditions that are managed outside of their organization, and for costs they cannot control, such as drug prices. The measure also fails to risk-adjust for SDS. Lastly, the

TPCC measure captures the same costs as the episode-based measures, effectively "double counting" the costs, as is also true of the MSPB measure.

MIPS Performance Category: Improvement Activities

CMS proposes that the improvement activity category maintain the same weight of 15% for the 2020 performance year. CMS proposes to increase the group reporting threshold such that at least 50% of the group's clinicians (counted as NPIs) would be required to complete an improvement activity if the entire group (calculated at the TIN level) is to receive credit for it. This would be an increase from the current requirement that at least one clinician from the group must report for the group to receive credit. In addition, CMS proposes a new requirement that at least 50% of the NPIs within a group must perform the same improvement activity for the same continuous 90-day period within a performance year.

We urge CMS not to adopt a policy that would require 50% of the NPIs perform the same improvement activity. We recommend maintaining the existing participating clinician threshold to receive IA credit. Setting the 50% threshold could discourage participation in improvement activities by some physicians, particularly those in large, multi-specialty group practices. Physicians in faculty practice plans participate in numerous improvement activities with the goals such as expanding practice access, population management, care coordination, improving patient safety, and improving equity. These activities are very expensive in terms of cost and staff time; the investment in them should be recognized by providing credit under the MIPS program.

As mentioned previously in these comments, the mean number of NPIs in a faculty practice plan at an AAMC member institution that reports under one TIN is 989. Because this single TIN represents so many different specialties and practice locations, it would be burdensome, and maybe impossible, to ensure that 50% of the physicians under the TIN perform the same improvement activity for 90 days. Also, it is important to give specialties the opportunity to select improvement activities that are relevant for their specialty. For example, some specialists may be involved in improvement activities related to maintenance of certification while others, such as primary care providers, may be involved in population health activities.

MIPS Performance Category: Promoting Interoperability

For the 2020 performance year, the weight for the Promoting Interoperability (PI) category remains unchanged at 25%. CMS proposes changes to both the e-Prescribing Objective measures and Health Information Exchange Objective measures.

Specifically, CMS proposes that the Query of Prescription Drug Monitoring Program (PDMP) remain optional and eligible for 5 bonus points for 2020. This decision was made due to several challenges that have been identified with implementing this measure, including difficulties in implementing it in EHR clinical workflow and state variations in PDMP structure. CMS proposes to remove the Verify Opioid Treatment measure since as currently structured it is vague, burdensome, and provides limited clinical value to clinicians

The AAMC supports maintaining the Query of Prescription Drug Monitoring Program as voluntary and providing a 5-point bonus if reported. The AAMC recognizes the value of new tools to assist with the opioid addiction epidemic but has cautioned against making this

measure required until the measure is more clearly defined and there is better evidence of integration of these tools in CEHRT by vendors and into clinical workflows.

The AAMC also supports the removal of the Verify Opioid Treatment Measure. As CMS acknowledges, there are many problems with this measure, including the lack of defined data elements (e.g. definition of opioid agreement). The measure is burdensome, vague and subject to misinterpretation.

PI Reporting by Groups of Hospital-Based MIPS-eligible Clinicians
CMS currently requires that when clinicians elect to report PI data as a group, the data of all MIPS-eligible clinicians in the group must be aggregated, including those who qualify for PI reweighting to zero percent, unless all of the group's clinicians qualify for reweighting. Stakeholders informed CMS that the existing policy is too restrictive, particularly in the case of hospital- based groups. Inclusion of certain clinicians in a hospital-based group could preclude the group from the PI category reweighting. CMS agrees and proposes to revise the policy for 2020 to define a hospital-based MIPS eligible clinician as one who furnishes 75% or more of his or her covered professional services in the inpatient or outpatient hospital setting and that the definition would also include a group in which more than 75% of the NPI's billing under the group's TIN meet the definition of a hospital-based individual MIPS eligible clinician.

While we appreciate CMS' recognition that the existing policy is too restrictive, we believe that it will still not be feasible under the proposed change for facility-based physicians in large multi-specialty practices that bill under one TIN to select this scoring option. Facility-based physicians typically bill under the same TIN as the other physicians in large multi-specialty practices and therefore it would not be possible to meet the 75% threshold. We encourage CMS to develop other mechanisms for facility-based physicians in large practices to elect to be scored under the facility-based scoring approach. One option would be to allow a portion of the group under one TIN, such as the facility-based clinicians, to report as a separate subgroup on measures and activities.

Request for Information: Metric to Improve Efficiency of Providers within EHRs
CMS is interested in encouraging providers to adopt more efficient workflows and technologies to improve efficiency of providers within electronic health records. The Agency seeks comments on how implementing certain processes that improve efficiency can be measured and encouraged.

The AAMC believes it is premature to develop measures to assess provider efficiency using EHRs. We caution CMS against introducing any new provider requirements that will increase provider reporting burdens and costs. It is neither feasible nor practical to expect providers to measure and assess the efficiency of health IT. We recommend CMS work with ONC and NIST to focus greater effort and attention to improving the usability of certified EHRs and to identify best practices to ensure incorporation of EHRs within the clinical workflow. This joint work also should include strengthened oversight of certified EHRs and promoting increased provider satisfaction with EHRs.

Request for Information: Provider to Patient Exchange Objectives
CMS seeks comment in an RFI related to patients' electronic access to their health care information. The Agency requests comment on whether eligible clinicians should make patient health information available through an open standard based API no later than the business day after it is available to the clinician.

The Agency also wants feedback on the addition of a measure requiring clinicians to use technology certified to Electronic Health Information (EHI) criterion to provide a patient with their complete electronic health data within an EHR.

The AAMC opposes a requirement for providers to make patient health information available through the open, standards-based API no later than one business day after it is available. While we support patient access to information, we are concerned that a patient may not understand that their information obtained through these apps may be shared with third parties that are under no obligation to keep that information private. As proposed, the CMS and ONC rules require that health information be shared through apps; yet there are no patient privacy and security protections or any standards regarding how the information from the app may be used or by whom. Before finalizing these rules, patients, providers, and policymakers should have a comprehensive dialogue regarding the potential consequences of using apps and develop approaches that balance the need for information with the need for privacy and security. We support CMS' consideration of awarding bonus points under the PI programs for early adoption of a certified Fast Healthcare Interoperability Resources (FHIR) based API before the ONC's final rule compliance date.

The AAMC supports the requirement that HIT systems be able to export electronic health data, especially in the case of a provider seeking to transition to a new EHR system. The AAMC believes the EHI export should be limited to the U.S. Core Data for Interoperability (USCDI) data elements within the EHR. However, we believe it is premature to comment on specific questions about the export function until the ONC proposed rule is finalized.

APM Scoring Beyond 2020
CMS is seeking comment on potential policies for next year's rulemaking to address changing incentives for APM participation. As the QP threshold increases, CMS notes that more AAPM participants may be subject to MIPS under the APM scoring standard. CMS seeks comments/suggestions for ways it could modify the APM scoring standard to continue to encourage MIPS eligible clinicians to join APMs, with emphasis on encouraging movement towards participation in two-sided risk APMs.

The AAMC is concerned about the increasing thresholds that must be met to be considered qualified participants in an advanced APM. We recommend CMS support efforts by the provider community to convince Congress to make changes that would give CMS the discretion to set the thresholds at an appropriate level that encourages advanced APM participation. The AAMC also encourages CMS to support any efforts to extend the 5% bonus beyond 2024.

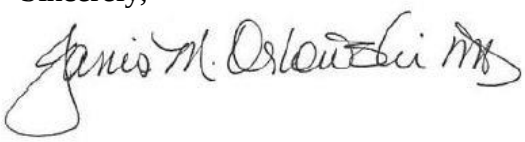
Make Timely Distributions of 5% Advanced Alternative Payment Model Bonus
To encourage participation in advanced Alternative Payment Models in the future, the AAMC urges CMS to make more timely payments to providers that qualify for the 5% bonus. Eligible

clinicians who qualified for the 5% bonus for performance year 2017 have not yet received any bonus payment. The reason for this delay is unclear. Many academic medical centers made significant investments to participate as advanced APMs, including hiring additional staff to improve care coordination and investing in new technologies to support advanced care processes and performance data submission. They took on financial risk with an expectation that some of these investments would be recouped in part by the 5% advanced APM bonus. If these payments are not made in a timely manner, we fear clinicians could be dissuaded from participating in advanced APMs in the future. We urge CMS to expeditiously pay the advanced APM bonuses in the future to support continued participation in these models.

CONCLUSION

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

Sincerely,



Janis M. Orlowski, MD, MACP
Chief Health Care Officer

Cc:
Ivy Baer, AAMC
Gayle Lee, AAMC
Kate Ogden, AAMC