COGNITIVE CARE ALLIANCE

August 31, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

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

Dear Administrator Verma:

On behalf of the Cognitive Care Alliance (Alliance), representing physicians from eight cognitive specialty societies, we appreciate the opportunity to provide comments on the CY2019 Physician Fee Schedule (PFS) proposed rule. Our members, representing the specialties of general internal medicine, endocrinology, infectious disease, gastroenterology, hematology, hepatology, and rheumatology, primarily provide evaluation & management (E/M) services to their patients. This Alliance is united in the belief that the existing E/M codes do not describe the cognitive work we deliver to patients and has strongly advocated for an evidence-based approach to improve the definitions and valuations of these services.

We commend the Centers for Medicare and Medicaid Services (CMS) for recognizing the documentation burden associated with the existing E/M codes and strongly support the "Patients Over Paperwork" initiative. E/M document and payment changes, if evidence-based, have the potential to improve patient access and satisfaction, as well as reduce physician burden and address cognitive workforce shortages. Furthermore, the development of new payment models demands the accurate pricing of all services. We appreciate that the agency's recognition that the existing outpatient E/M services and their documentation requirements do not accurately reflect current medial practice:

> "…it is clear to us that the burdens associated with documenting the selection of the level of E/M service arise from not only the documentation guidelines, but also from the coding structure itself…We believe that the most important distinctions between the kinds of visits furnished to Medicare beneficiaries are not well reflected by the current E/M visit coding. Most significantly, we have understood from stakeholders that the current E/M coding does not reflect important distinctions in services and differences in resources. At present, we believe the current payment

for E/M visit levels…are increasingly outdated in the context of changing models of care and information technologies."

It was upon this premise that the Alliance recommended that CMS develop an evidence-based understanding of the work "intensity" of the current outpatient E/M services based on representative research to better understand the resources required to deliver high quality, patient-centered cognitive care. The results of this study would then be used to develop new CPT codes, valuations, and documentation requirements that reflect the realities of contemporary medical practice.

The existing documentation requirements are over 20 years old and do pose real challenges for physicians. However, these challenges cannot be completely divorced from the payment inequities that we attribute to the under recognition of the cognitive intensity of the work of the Alliance's members and our colleagues in a range of specialties. The current outpatient E/M codes undervalue the purely cognitive physician work relative to that captured in the thousands of procedure codes. The failure of the current codes to capture the most complex E/M activities and the resultant relative undervaluation of these critical services must both addressed to ensure that Medicare beneficiaries have continued access to appropriate cognitive care.

Therefore, the Alliance opposes all of the proposed payment changes for E/M services that the agency states are "intrinsically linked" to the documentation changes. The agency proposed collapsing 99202-05 and 99212-15 and creating a single rate for these services, developing new G codes for primary and certain specialty care, a new G code for prolonged E/M service, and a multiple procedure payment reduction. These changes will do nothing to address the patient access problems and physician workforce shortages driven by the compensation gap for cognitive care driven by the outdated E/M codes. Instead, collapsing five levels of E/M codes into two will exacerbate the existing compensation disparities facing cognitive physicians who rely on reimbursement from these services.

Instead, we urge CMS to work with stakeholders to develop an alternative evidence-based approach to E/M payment and documentation that will reduce burden, be appropriate for inclusion in new models of health care delivery, address the compensation inequity of cognitive physicians, and support the delivery of high quality patient care that can be included in the proposed CY 2020 Physician Fee Schedule.

As an alternative payment scheme is being devised, we urge the agency to implement the following documentation changes that are not tied to E/M payment changes on January 1, 2019:

- Allow physicians to document visits based solely on the level of medical decision making or the face-to-face time of the visit as an alternative to the current 1995/1997 guidelines;
- If physicians choose to continue to document under the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients);
- Eliminate the requirement for physicians to re-document information that has already been included in the medical record by practice staff or by the patient; and
- Remove the need to justify providing a home visit rather than an office visit.

Finalizing these changes is a significant first step towards CMS' stated goal of reducing administrative burden. They can also easily be adopted by commercial payers who the agency correctly recognizes

tend to adopt Medicare payment policies. This will also eliminate the possibility that physicians will be forced to document E/M visits under two sets of requirements, one for Medicare and the other for private payers, representing an increase in physician burden, if only for the short term.

Single Payment Level Proposal

CMS proposed a single payment amount for codes 99202-25 and 99212-15 of $135 and $93 respectively. These values were determined by a weight average of the work RVUs based on specialty utilization for levels 2-5. To address the reimbursement shortfalls that some specialties would have experienced as a result of the code collapse, the agency proposed to create complexity add-ons for primary care of $5 and for certain specialty care of $13.70. These add-on codes were funded by a multiple procedure payment reduction for any E/M service billed with modifier 25 on the same day as a procedure to remain budget neutral.

In the proposal, CMS states that "E/M visits comprise approximately 40 percent of allowed charges for PFS services, and office/outpatient E/M visits comprise approximately 20 percent of allowed charges for PFS services." Given the significant amount of PFS spending represented these services, the Alliance since its formation, has recommended an evidence-based approach to changes that would reallocate such a large portion of PFS spending. The proposed payment changes were made to comply with the budget neutrality requirement and the program integrity concerns that resulted from the proposal to allow physicians to document medical necessity and either medical decision making, time, or the current 1995/1997 guidelines for a level 2 visit, not evidence. Furthermore, these proposed changes to E/M coding and payment are not resource based, which may be a violation of the Social Security Act.[1]

We are deeply concerned about unintended consequences for patients that may result from these payment proposals. These payment changes will result in provider behavioral changes that it is not clear from the rule that the agency has fully considered, although they are described by the CMS Office of the Actuary.[2,3] Our members treat patients with multiple complex and chronic conditions, many of whom are frail and elderly and require their physicians to spend significant amounts of time with them in the careful and deliberate assessment and planning for care. The reduced payment for level 4 and 5 visits may force them to spend less time during each clinical encounter or to limit each visit to 1 or 2 problems. Patients and their caregivers would then be forced to return for an additional visit at additional financial and time costs. Additionally, patients will either be overpaying or underpaying their co-payments for these services since their share will no longer vary with the service level.

In many cases, physician schedules are determined by institutional and enterprise financial need and though it would be ideal if physicians could determine how time is allocated for each patient, this is not the modern reality. There will be financial managers who will change booking patterns in order to optimize income and this will put physicians in the uncomfortable position of cutting time with patients or tangling with administrators. For some, this conflict will be unbearable.

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[1] Social Security Act - Sec. 1848. [42 U.S.C. 1395w–4]

[2] Song Z, Goodson J. The CMS Proposal to Reform Office-Visit Payments. N Engl J Med 2018; DOI: 10.1056/NEJMp1809742

[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PhysicianResponse.pdf

The reduced reimbursement may also drive some institutions and providers to cherry pick their patients because E/M reimbursement will no longer recognize the resources required to treat them. Academic medical centers and other large referral centers may end up being the only institutions that will treat the sickest and most complex Medicare beneficiaries. Besides the financial strain it may place on these institutions, it will likely create an additional burden on patients who may be forced to travel longer distances to find a physician who will treat them.

Alliance member specialties typically rely on level 4 and 5 visits and will be disproportionately impacted by this proposal. The agency provided their estimated impact in Table 22 of the rule, but this differed significantly from the analysis conducted by the American Medical Association (AMA) included in Appendix A. For instance, CMS estimated that hematology/oncology would have less than a 3% decrease in payment. The AMA estimated that hematology/oncology would see a 1% increase in payment, while hematology would see a 16% decrease in payment. CMS should delay implementation of this payment proposal until these discrepancies can be further studied and a policy with consistent impacts regardless of who conducts the analysis is developed.

CMS' model of the proposal's impact is very broad by specialty, but as the hematology and hematology/oncology example highlights, there may be differential impacts within a specialty that must be better understood. As the AMA analysis shows, benign hematologists who treat clinically unstable patients with sickle cell disease or hemophilia will see a practice altering reduction in payment.

Our own analysis, based on projections from the 2015 Medicare payment database show that there are some specialties that will have considerable intra-specialty variations. For example, for medical oncology, the physicians with the lowest usage of outpatient E/M codes will have a 3.84% loss of income while those with the highest usage will have a 11.18% loss of income. For rheumatology, the difference is even more striking. For the lowest users, there would be a 8.65% increase in income as compared to a 7.34% loss of income for the highest users. CMS must defer payment changes until the impact of such vast shifts of payment within a given specialty are fully understood and fully accounted, Appendix B.

The Alliance believes that the existing E/M code set does not accurately reflect the cognitive intensity required to care for the most complicated, challenging, and vulnerable patients our members treat. Preliminary analysis of this proposal confirms our belief. For specialties like hematology, primary care, endocrinology, and infectious disease that rely on level 4 and 5 visits, significant reimbursement decreases could be devastating to patients and providers. The Alliance believes the more demanding work load coupled with lower payments for this high intensity work will be another reason that medical students with growing student debt choose not to enter these cognitive specialties. We cannot support a proposal that has not been fully vetted and will exacerbate the workforce shortages facing our members and patient access challenges.

For all of these reasons, the Alliance does not support the single payment rate for both 99202-05 and 99212-15.

Add-on Proposals

The Alliance recognizes that the agency proposed the primary care and specialty complexity add-on codes (GPC1X and GCG0X) to address the cuts to reimbursement for certain services that would have resulted from collapsing the level 2 through 5 office visits. However, the Alliance cannot support the

add-on services as proposed because they do not capture the added work inherent in cognitive services and imply that the added work associated with some specialties is greater than others. We also believe the application of both these codes as defined by the agency is arbitrary. For GPC1X, 0.07 work RVUs vastly underestimate the time and complexity required to deliver primary care services, particularly to Medicare beneficiaries with multiple complex chronic conditions. Also, the agency does not provide a clear rationale for why GPC1X can only be applied to established patient visits, not new patient visits.

The Alliance also has significant concerns about GCG0X. CMS proposed that this add-on with a proposed value of 0.25 RVUs be billed with both new and established patient visits. The agency defines the proposed code's descriptor to be: Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management centered-care. In follow up discussions, the agency has stated GCG0X is not specialty specific, instead it applies to care related to these specialties.

Even if this proposed add-on does not violate the legal prohibition on creating specialty specific payment rates, it fails to recognize the complex care delivered by cognitive physicians. For instance, both nephrology and infectious disease are omitted from the code descriptor despite the fact that their patients have the first and second highest hierarchical condition category (HCC) scores respectively. Gastroenterology is omitted as well, meaning it will not apply to the services related to hepatology, a gastroenterological subspecialty that rarely bills procedures and relies on billing level 4 and 5 office visits. A complexity adjuster may be more appropriate if it were tied to the complexity of the patient rather than the work of certain specialties.

A better measure of complexity must be developed and must be captured by any new E/M coding and payment scheme. As the Alliance has advocated since its inception, the complex cognitive work our members deliver to patients is not reflected by the existing E/M codes. We welcome the opportunity to work with other stakeholders and the agency to explore how to code and appropriately value complex work.

The agency also proposed the creation of a new 30 minute prolonged service G code (GPRO1) that can be billed with longer visits. The Alliance appreciates the agency's intent to recognize there are circumstances where longer visits are necessary, as this add-on could be particularly relevant for our member societies. However, our members had difficulty determining when and how this code could be billed because of the lack of clarity around the time required for the single payment rate E/M services.

The agency requested feedback on the time required for the collapsed codes, either the weight averaged times of 38 and 31 minutes for the new and established level 2-5 services or the existing times for the individual codes. Evaluating how often a practice or specialty will utilize GPRO1 is dependent upon knowing how to account for the time of the base E/M code. We have significant concerns that some individuals might game the system and bill the add-on code for level 2 visits that last 26 minutes: the first 10 minutes would satisfy the time requirement for a level 2 visit and the additional 16 would meet the add-on code time requirement. The Alliance does not think this was the agency's intent and believes that the add-on code was intended to compensate the physicians for longer visits required to treat medically complex patients. We request that the agency clearly articulate the time requirements for any new E/M and add-on codes that may be considered in future rulemaking.

We have created our own modeling for the possible effect on overall Medicare spending if there is a modest 5% increase in outpatient E/M billing that develops as a consequence of higher payments for short, level 2 visit. Assuming a 5% growth only in established outpatient visits, the total added cost to Medicare would be $900 million, based on 2015 Medicare payment data, Appendix C.

Multiple Procedure Payment Reduction

As previously stated, CMS funded the flawed add-on codes through a multiple procedure payment reduction to be applied when a procedure and an E/M code is billed with modifier 25 on the same day. The agency provided no resource based justification for this reduction. The AMA Resource Based Relative Value Update Committee (RUC) has already eliminated the overlap in physician work, clinical staff time, supplies, and equipment. The current values of most procedures account for any overlap with an office visit, and this proposed reduction will only be an unjust decrease in value. Private payers have proposed similar proposals to reduce the value of an E/M services performed on the same day as a procedure and have not implemented them after understanding that the overlapping value has already been addressed by the RUC. If implemented, this policy will create an additional incentive for physicians to provide procedures separately from office visits at additional time and expense to patients.

Practice Expense Methodology

CMS proposed to create a single PE/HR value for E/M visits of approximately $136 based on an average of the PE/HR across all specialties billing the E/M code set and proposed add-ons weighted by the volume of those specialties' allowed E/M services. If the agency had not taken this approach, they recognized that "establishing a single PFS rate for new and established patient E/M levels 2 through 5 would have a large and unintended effect on many specialties." However, the proposal did have a significant impact on the Indirect Practice Cost Index (IPCI) for many specialties even though the agency was attempting to minimize any unintended consequences. Several cognitive specialties, including allergy, rheumatology, and hematology, have seen decreases in their IPCIs that have resulted in significant decreases in the procedures their members provide. For example, the chemotherapy administration codes have proposed reductions of over 10 percent because of this methodologic flaw. The Alliance recommends that any modeling of alternative E/M coding and payment methodologies should mitigate against unintended consequences such as these that cause significant, non-resource based decreases in the services upon which cognitive physicians rely.

A Path Forward

The Alliance cannot support coding and payment changes that reduce reimbursement for level 4 and 5 office visits that our members bill to see medically complex patients and would exacerbate physician workforce shortages and create new patient access challenges. We stand ready to work with CMS to develop a new coding and payment scheme for E/M services that both reduces administrative burden and equitably reimburses physicians for the services they provide to Medicare beneficiaries. We propose that CMS implement the documentation changes articulated in these comments on January 1, 2019.

Rather than implement the payment changes outlined in the rule that will have many unintended consequences, including limiting patient access to appropriate cognitive care, the Alliance urges CMS to collaborate with stakeholders to develop evidence-based alternative new and established outpatient E/M service codes that accurately reflect the breadth and depth of the clinical care provided by all specialties, including the cognitive specialties represented by this Alliance.

There are a range of coding and payment options that should be modeled and thoroughly evaluated. We will work with other stakeholder to present a new coding payment structure in time to be included in the CY 2020 Physician Fee Schedule proposed rule.

Thank you for the opportunity to provide these comments. If you require any further information or require additional information, please contact Erika Miller, Executive Director of the Cognitive Care Alliance, at emiller@dc-crd.com or (202) 484-1100.

Sincerely,

John Goodson, MD
Chair

Cognitive Care Alliance Member Organizations:

American Association of the Study of Liver Diseases
American College of Rheumatology
American Gastroenterological Association
American Society of Hematology
Coalition of State Rheumatology Organizations
Endocrine Society
Infectious Diseases Society of America
Society of General Internal Medicine