September 23, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1715-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

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

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:

On behalf of the Cognitive Care Alliance (CCA), representing physicians from eight cognitive specialty societies, we appreciate the opportunity to provide comments on the agency's proposals related to the payment for evaluation and management (E/M) services included in the CY2020 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. CCA members are united in the belief that the existing E/M codes do not describe the cognitive work delivered to patients and have strongly and consistently advocated for an evidence-based approach to improve the definitions and valuations of these services.

The CCA supports the agency's continued commitment to reduce administrative burden and improve the valuation of the outpatient evaluation and management (E/M) services that our members typically provide to patients. We are extremely pleased CMS has recognized the current E/M services do not accurately reflect the work of our members. If implemented on January 1, 2021, the proposals included in this year's PFS proposed rule will be the first major changes to these services since they were placed on the PFS. These proposals are an essential and important first step in accurately valuing the full range of cognitive work. The CCA encourages CMS to continue its work with stakeholders to ensure that the E/M service codes accurately describe cognitive medical practice and are appropriately valued.

The CCA continues to strongly recommend that the agency actively monitor the use patterns of the E/M service codes by physicians and qualified health professionals. This information can provide the basis for

the research needed to develop a representative, empirically-based understanding of the E/M services provided to Medicare beneficiaries by clinicians which is necessary to ensure that the E/M codes accurately represent the work delivered to patients. All future changes made to the E/M service code descriptions and valuations must be based on the best evidence-base possible if the E/M codes to accurately value cognitive work while protecting patient access, addressing workforce shortages and providing a foundation for value-based payment reforms. We urge CMS to formally propose in the CY 2021 rulemaking a process which incorporates evidence-based data into the valuation process of E/M service codes.

Outpatient Evaluation and Management Definitions and Valuations

The CCA has been urging CMS to address the definitions, valuations and documentation requirements for these services so they better reflect the complex work of our members. Therefore, we were extremely pleased that the agency recognized that the documentation requirements for these services were burdensome to our members and that the code structure was not meeting the needs of providers or Medicare beneficiaries.

Under the policy CMS finalized for January 1, 2021 in the CY2019 PFS final rule, physicians would no longer be required to document these services according to the 1995/1997 guidelines and instead would have the choice to document according to the level 2 requirements for medical decision making (MDM), time, or the 1995/1997 guidelines for any level 2 through 4 service. However, CMS also finalized a single payment level for all level 2 through 4 visits.

While the CCA supported CMS' goal to reduce administrative burden, we had significant concerns that the single payment level policy would significantly reduce reimbursement for our members and potentially threaten patients' access to care. The CCA represents specialties whose members provide care to the most complex patients. Reducing the values of the level 4 and 5 service codes would have further undervalued the care our members deliver to patients. Many of our member specialties are already experiencing significant workforce shortages and we strongly oppose any policy that might exacerbate these shortages by making these careers financially unsustainable.

Since the released of the CY2019 PFS final rule, the American Medical Association (AMA) CPT Editorial Panel and Resource Based Relative Value Update Committee (RUC) have revised the E/M code descriptors and associated documentation requirements and valuations respectively. The changes to the code family include eliminating CPT code 99201, revising the documentation requirements to allow providers to bill by MDM or time, and creating a new extended service add-on code, 99XXX, only to be billed with level 5 services when the time spent on the calendar date of service surpasses that of a level 5 visit. The RUC recommended values for the code family included significant increases, particularly for level 4 and 5 services. CMS has proposed to accept both the revisions to the code family and the RUC recommended values for implementation in 2021.

The CCA appreciates the work of the AMA's CPT Editorial Panel and RUC and urges the agency to implement these changes as proposed, with the understanding that we see this as the beginning of a long overdue CMS commitment to ensure that the E/M codes are accurately defined and appropriately valued.

Medical Decision Making Documentation Refinement and EHR Opportunities

The CCA is pleased that the revised documentation requirements will provide members with the option to document outpatient E/M services either by time or MDM according to the requirements approved by the CPT Editorial Panel. However, the CCA is concerned that the revised MDM requirements may not include key inputs and interactions that reflect the skills and expertise of our members. For example, the general internist must assess and manage many concurrent interacting medications and problems. The focus on data that is not clinically meaningful understates the importance of these interactions. Furthermore, the revised MDM criteria may not achieve the agency's goal to prevent upcoding or eliminate the opportunities to "cut-and-paste" data to fill out a note. MDM should be designed with gradations of complexity defined as clearly possible to allow the use of higher service codes levels where appropriate and prevent the accumulation of meaningless or repetitive data just for billing purposes.

The proposed level 5 MDM description provides an excellent example of the CCA's concerns. As written, the level 5 MDM requirements do not recognize encounters where the patient has several conditions, none of which is individually unstable, but when co-existing create a highly unstable situation. For example, a primary care physician might have a patient with several meta-stable problems such as diabetes, hypertension, elevated cholesterol, coronary artery disease, spinal stenosis, insomnia, and a difficult home situation. None is so unstable as to be considered "life threatening" but together are dire and highly tenuous. The current level 5 MDM defines High Risk as "Intensive" monitoring of drug therapy, a decision related to "elective major surgery with identified patient or procedure risk factors," a decision "regarding emergency major surgery," a decision "regarding hospitalization," or a decision "not to resuscitate or to de-escalate care." All of these definitions as revised by the CPT Editorial Panel focus on a single condition.

The CCA urges CMS to carefully review and analyze the implications of the MDM revisions to ensure that changes will sufficiently reduce administrative burden and optimize accurate code selection. Our members do not want to create a situation in 2021 where Medicare and private payors have different E/M documentation requirements. We believe that the commercial insurers will welcome the agency's leadership of a careful assessment of the proposed changes. CMS should work with the CPT Editorial Panel and other stakeholders to further refine the MDM documentation requirements to truly achieve CMS' goal of reducing administrative burden.

Furthermore, the CCA urges CMS to align MDM requirements and any future E/M documentation changes with the ongoing work of the Office of the National Coordinator for Health Information Technology (ONC) to ensure electronic health record (EHR) tracking capabilities support MDM documentation. The CCA believes that more work must be done to discourage physicians from cutting and pasting redundant and easily accessible data into their EHR notes. We believe the MDM refinement provides CMS with an invaluable opportunity to synergize with the ONC's role in developing EHR documentation and administrative certification requirements. Combining data review with electronic charting, based on refined MDM expectations, offers the genuine promise of behind-the-scenes documentation. Once the MDM expectations are optimized, then the EHR certification expectations can be developed in collaboration with stakeholders and the ONC.

Complexity Add-On Code

In the CY2019 PFS final rule, CMS finalized a policy to create two complexity add-on services, one for primary care and the other for certain types of specialty care. The specialty care add-on was linked to work performed by certain specialties identified by CMS. The CCA had significant concerns about this policy since it would not be available to all of our members, namely gastroenterologists and hepatologists, who treat patients with complex chronic conditions like hepatitis C. Therefore, we were extremely pleased CMS revised this policy and instead is proposing to create a single complexity add-on service, GPCX1. This add-on service is tied to the patient's condition rather than work related to certain specialties.

The CCA urges CMS to finalize its proposal to allow providers to bill add-on code GPCX1 with E/M visits. Our members feel this code is necessary to capture the complex work they provide to patients that is not recognized by the revised code family. We recognize that the revised level 4 and 5 services describe complex patients, but there are certain types of patient conditions that are more clinically intense, as described by the Resource Based Relative Value Scale (RBRVS), to which this add-on should be applied. For example, in primary care, geriatrics, infectious diseases, the vast majority of Medicare patients have many simultaneous interacting concurrent conditions. There are also interacting medications that may create a parallel challenge. Additionally, for specialists like endocrinologists, rheumatologists, gastroenterologists, and hepatologists, the visit complexity derives from the multiple organ systems that are impacted by disease.

The CCA recognizes that all of these clinical scenarios merit billing the complexity add-on code. We stand ready to work with CMS and other stakeholders to develop documentation requirements for this service to ensure this code is used appropriately in situations where the complexity of the patient care is such that it is not captured by the revised E/M code valuations and avoid its overuse by having it applied in less complex cases.

Global Surgical Packages

The CCA recognizes that CMS has been collecting data to inform potential changes to the 10 and 90-day global surgical packages and contracted with RAND to ensure future changes are data driven and reflect the work being performed as part of these packages. Our members do not typically perform any 10 or 90-day globals, but appreciate that CMS is planning to make any changes in an evidence-based manner. This is how we have urged CMS to approach changes to outpatient E/M visits.

CMS recognized that in its discussion of the complexity add-on code that "the typical visit described by the revised code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits", those typically delivered by our members. The agency states they proposed the add-on code "because the revised office/outpatient E/M code set does not recognize that there are additional resource costs inherent in furnishing some kinds of office/outpatient E/M visits." The CCA appreciates that CMS recognizes there is a fundamental difference between a cognitive office E/M visit and other visits, including post-operative follow up visits included in the global surgical packages.

The CCA urges CMS to ensure that any changes made to the global surgical packages reflect the actual physician work performed during these periods. We strongly support CMS' efforts to determine the appropriate number and type of E/M visits bundled into these packages.

Request for Comment on Revaluing Outpatient E/M Visits within Transitional Care Management (TCM), Cognitive Impairment Assessment/Care Planning and Similar Services

CMS identified a number of services that are closely tied to E/M values in addition to the other E/M code families and surgical global services for re-evaluation. Of the services listed, CCA members may utilize the Transitional Care Management Services (CPT codes 99495-6) and the other E/M code families, particularly the inpatient E/M codes. The agency requests comment on how to adjust the RVUs for these services and on systemic adjustments that may be needed to maintain relativity between these services and outpatient E/M services.

The CCA urges CMS to focus future efforts on the other E/M code families. Like the outpatient E/M codes, these services must reflect the complexity and expertise required to deliver cognitive care to Medicare beneficiaries. Specifically, the CCA recommends that CMS work with CPT and other stakeholders to refine the documentation expectations for all the E/M code families with the same expectation of reducing administrative burden. As noted, this work should be based on the best understanding possible of the actual services delivered, have clearly defined levels of service where appropriate, and foster increasing reliance on the capabilities of EHRs to capture MDM itself and documentation.

We strongly urge CMS to commit to the revaluation of other E/M codes and families in an evidence-based manner. As an interim step, we suggest that the agency apply the same documentation changes that were recommended for the outpatient E/M codes to the other code families. The agency should also consider modeling similar changes and applying a proportional work RVU increase across the other E/M code families as appropriate.

Conclusion

The CCA strongly supports the policy changes CMS has proposed for the outpatient E/M code families. The improvements made to the documentation requirements and the increased valuations will have a meaningful impact on our members and the patients they treat. We appreciate the profound implications of the agency's proposals and believe CMS has boldly initiated a new era of physician payment reform that will have a profound impact on the healthcare economy. The CCA believes the proposed payment policies are an important first step to ensuring that E/M services accurately represent cognitive medical practice and appropriately value this work and is encouraged that CMS understands the important fundamental distinction between cognitive and procedural work. The CCA contends that this distinction must be further explored and addressed to ensure Medicare beneficiaries receive comprehensive, coordinated cognitive care they require.

The CCA urges CMS to develop the comprehensive and representative evidence-base required to truly understand the work of cognitive physicians. The CCA believes that all future revisions to E/M services should be supported by an evidence-base that accurately represents current medical practice. The work of the CPT Editorial Panel and the RUC significantly advanced outpatient E/M coding and payment, but the CCA believes that more needs to be done to accurately capture the work of our members in all settings. We strongly recommend that CMS establish an advisory panel to help develop the necessary

evidence-base and assess the impact of the proposed changes to the outpatient E/M valuations to ensure this code family matures in a manner that fully captures the work of cognitive specialties. The CCA welcomes the opportunity to work with CMS to develop this process.

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