February 10, 2020

Carol Blackford
Director, Hospital and Ambulatory Policy Group
Gift Tee
Director, Division of Practitioner Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Ms. Blackford and Mr. Tee:

The Cognitive Care Alliance (CCA), representing physicians from eight cognitive specialty societies including general internal medicine, endocrinology, infectious diseases, gastroenterology, hematology, hepatology, and rheumatology, unequivocally support the revisions and subsequent RVU changes to the evaluation and management (E/M) CPT codes as finalized in the Centers for Medicare & Medicaid Services (CMS) CY 2020 Medicare Physician Fee Schedule Final Rule (CMS-1715-F). We appreciate the opportunity to provide comments regarding the utilization of GPC1X.

BACKGROUND

The CCA was founded on the shared concern about E/M services, namely the low relative value units for these services has exacerbated workforce shortages in primary care and internal medicine subspecialties, and consequently, adversely and unequally affect the health of Medicare beneficiaries. This is especially true for Medicare patients in rural and urban underserved areas as well as patients with single or multiple chronic conditions. The current national concern arising from the potential novel coronavirus pandemic points to the need to have a well-distributed, robust workforce with cognitive skills and clinical expertise.

When the Resource-based Relative Value Scale (RBRVS) was first developed, the preexisting specialty specific service codes were collapsed into families with essentially four levels of physician service identified for each. Some specialties, such as rheumatology, had as many as 27 service vignettes prior to the RBRVS' implementation. This allowed customization of billing to match a whole range of individual clinical encounter types. The Medicare Physician Fee Schedule (PFS), the national pricing system for physician services, eliminated this granularity in 1992. All physicians in all specialties were ultimately confined to two outpatient E/M service code families, one for new patients and one for established patients. There was a separate set of E/M codes for outpatient consultative care, however beginning in 2010, Medicare has not paid for services reported by the CPT consultation codes.

The elimination of specialty specific E/M codes might have been a reasonable compromise if the code definitions and valuations had been continuously updated to reflect the evolving complexity of the knowledge-base required to provide comprehensive cognitive E/M services. However, this never happened. In addition, the gradations within the outpatient E/M code families never reflected a logical progression of work "intensity." Though the outpatient codes came to account for 27 percent of Part B expenditures, CMS did not meaningfully address them until the CY 2019 PFS.

The Agency's work over the last two rulemaking cycles reflects an insightful and meaningful response to longstanding issues with the outpatient E/M codes and their effects on the health of Medicare

beneficiaries. The PFS itself, the mandate for a single payment scale with all physician services valued relatively to one another, was based on the Congressional directive in the Budget Reconciliation Act of 1989. Any fundamental change, such as specialty specific codes or the elimination of the RBRVS, would require Congressional intervention. Working within these constraints, CMS staff, under your administrative leadership, has begun the necessary process of reforming the out-of-date and biased PFS pricing structure.

THE ROLE OF THE GPC1X ADD-ON CODE

CMS finalized the revised outpatient E/M code definitions, values, and documentation requirements. However, the Agency stated in the final rule, "Although we believe that the RUC-recommended values for the revised office/outpatient E/M visit codes will more accurately reflect the resources involved in furnishing a typical office/outpatient E/M visit, we believe that the revalued office/outpatient E/M visit code set itself still does not appropriately reflect differences in resource costs between certain types of office/outpatient E/M visits." The CCA agrees and believes that despite the improvements made to the outpatient E/M codes, the revised values for these codes still do not reflect the complexity and intensity of certain types of cognitive care.

In finalizing GPC1X, CMS states that physicians may submit the add-on code in addition to all levels of outpatient E/M services under conditions that reflect the nature of the patient-physician relationship. This code aims to capture "*visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition."*

In the CY 2020 PFS final rule, CMS lists several specialties whose patients might qualify to use this code as follows: family practice, general practice, internal medicine, pediatrics, geriatrics, nurse practitioner, physician's assistant, endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious diseases, psychiatry, and pulmonary disease.

CMS requested comments on the utilization of GPC1X, but before the CCA or any stakeholder can estimate utilization, the Agency must work with stakeholders to define its appropriate use.

THE ADDED WORK CAPTURED BY GPC1X

The CCA believes the GPC1X add-on code captures the additional patient-based work "intensity" arising from three input categories not included in the existing outpatient E/M service codes: (1) the clinical complexity of care provided by our members in the context of patient characteristics; (2) the nature of the physician-patient relationship developed and maintained, in many cases indefinitely; and (3) the responsibility assumed by physicians to continually update and maintain the knowledge-base required to deliver cognitively intense services.

The GPC1X add-on code captures the work associated with a primary care relationship that is continuous and comprehensive. In the case of the non-primary care specialties, it captures the work associated with the continuous and comprehensive care of a single condition or a cluster of conditions. In addition, for all specialties represented by the CCA, the GPC1X add-on code captures the work required to maintain cognitive expertise, an input that outpatient E/M codes have never captured.

Cognitive outpatient E/M visits have an added dimension that does not exist with other types of E/M visits – an element of medical decision making that is based on the development and maintenance of an ongoing patient-physician relationship and the constantly evolving science of medicine.

As noted, the existing outpatient E/M service code CPT definitions do not identify any inputs related to the work "intensity" of patient relationship development and maintenance nor do they capture the work and investment associated with attaining and maintaining cognitive capabilities. This remains a deficiency that cannot be captured by coding at a higher level or billing for an extended time. When Dr. William Hsiao developed the RBRVS, he recognized extended training in his original construction of the RBRVS, but this concept was not finalized. In his final report, Hsiao noted that more work was needed to accurately define and relatively value the E/M service codes.

The GPC1X add-on code captures these added dimensions omitted from E/M services: expertise and responsibility. Expertise enables a provider to comprehensively understand the patient's concurrent problems, the clinical contribution of other members of the care team, the implications of all therapeutics and interventions, and the impact of illness on the patient and their family. Responsibility implies an enduring commitment to the best resolution of all health problems. In some cases, this will be short term, especially when the experience and talent of the clinician and the ability to assess and formulate an effective plan based on a comprehensive understanding, allow quick and effective intervention. More commonly, the members of our societies take responsibility for longitudinal care over months and years.

GPC1X RECOGNIZES WORK NOT CAPTURED BY OTHER EXISTING E/M CODES
A number of services have been added to the PFS to recognize the additional work required to deliver high quality, cognitive care, but none capture the expertise and responsibility represented by GPC1X. The CPT codes 99358 (Prolonged evaluation and management service before and/or after direct patient care; first hour) and 99359 (each additional 30 minutes) allow providers to bill for time spent reviewing records and for interprofessional consultation. Though these services may provide essential background information in addition to the clinical history, they only offer the opportunity to base a relationship on the information derived.

The Transitional Care Management (TCM) codes have a very specific purpose, namely, to ensure that care is as seamless as possible once the patient has left a facility. These codes were implemented to support the updating of the primary care physician's understanding of clinical care provided at a facility, to connect the patient to needed office-based or community care, and to ensure medication reconciliation. The TCMs are for rebooting care and reflect the discontinuity of inpatient and outpatient care. TCM payment does not overlap with payment for outpatient E/M care so there would not be any duplication with the add-on code, GPC1X.

The Chronic Care Management (CCM) codes support the care coordination provided by professional staff or physicians by paying for the care required to manage specific chronic illnesses, such as chronic heart failure or diabetes. CCMs provide content-focused payments. In many ways, the CCMs reiterate and support the core relationships that are developed by those members the CCA represents who provide first contact comprehensive care. They were never designed to recognize the value of relationship building and maintenance or support the inputs derived from cognitive expertise.

The Principle Care Management *(*PCM) codes are analogous to the CCMs. These codes capture the work of care management around a single condition and are not designed to recognize the value of relationship building and maintenance or support the inputs derived from cognitive expertise.

APPROPRIATE USE OF GPC1X

CMS recognized stakeholders' concern about the impact of the add-on code's utilization on their specialty. To mitigate these concerns, the CCA believes the conditions for the add-on code's use requires further refinement prior to its implementation. We agree this code should be utilized for all outpatient E/M codes where the physician assumes the responsibility for providing the "*continuing focal point for all needed health care services and/or with medical* care *services that are part of ongoing care related to a patient's single, serious, or complex condition."* In practice, this expectation will require stipulations based on the nature of the physician-patient relationship and the medical decision making of the cognitive services provided.

The GPC1X add-on code should be billable with any E/M service for any physician providing continuous primary or specialty care around a single condition or cluster of conditions. Billing for GPC1X should be sufficient attestation of the billing physician's commitment to continuous care and becomes a statement of assumed responsibility. Anything more complicated would result in unnecessary administrative burden.

For the physician providing consultative care, the use of the GPC1X add-on should reflect an assumption of responsibility for access and continuity in support of direct care or care provided by the referring physician. For example, the infectious diseases physician providing consultation for a patient with HIV assumes the responsibility for future access as needed and, in many cases, becomes that patient's primary care physician at least in terms of the care needed for their HIV and its multiple associated conditions.

The establishment and maintenance of cognitive competency is an added work requirement for certain physicians. As noted, prior to 1992, specialists had the option of fine-tuning their fees to match a broad range of clinical vignettes reflecting different cognitive demands.

Currently, the PFS provides no recognition of the inputs required to acquire or maintain an updated professional knowledge-base. This need is both qualitatively and quantitatively different from the need of our procedurally oriented colleague who must maintain technical skills and assimilate new procedural techniques. In the case of procedurally oriented service delivery, improved skills and techniques allow for shorter procedural times and the opportunity for increasing service volume. By contrast, the expanding complexity of the cognitively oriented services increases intra-service time and reduces service volume, hence the need for GPC1X.

For example, the biomodulators now available for the treatment of osteoporosis are powerful but the long-term experience remains limited. Rheumatologists, endocrinologists, and internists must be continually aware of the evolving medical literature. A newly observed side effect can change practice within 24 hours. For the oncologist, the advent of immunologically based interventions has profoundly changed the algorithms for clinical care. The need for all our members to maintain the continuity and content of their clinical knowledge-base as a component of the work "intensity" has never been recognized or valued by the PFS. The GPC1X add-on code begins to correct this deficiency.

SUMMARY

In summary, the GPC1X refinements developed by CMS should allow the GPC1X add-on code to be used with all the new and established outpatient E/M visits by (1) all first contact primary care physicians and specialty physicians assuming responsibility for continuous care and (2) those primary care and consultative specialty physicians where the focus of the specialty requires a continually updated knowledge-base. With these parameters in place, CMS can begin to estimate the GPC1X's utilization.

The CCA appreciates your consideration of these comments and welcomes the opportunity to work with you to refine the GPC1X add-on code to capture the previously unreimbursed work delivered by our members. 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 D. Goodson, MD
Chair

cc: Marge Watchorn
Michael Soracoe

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