



425 I Street, NW • Suite 701
Washington, DC 20001
202-220-3700 • Fax: 202-220-3759
www.medpac.gov

Francis J. Crosson, M.D., Chairman
Paul B. Ginsburg, Ph.D., Vice Chairman
James E. Mathews, Ph.D., Executive Director

September 13, 2019

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

RE: File code CMS-1715-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) proposed rule entitled: “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,” published in the *Federal Register*, vol. 84, no. 157, pages 40482 to 41289. We appreciate your staff’s ongoing efforts to administer and improve payment systems for physician and other health professional services (including implementing the Quality Payment Program and Medicare Shared Savings Program), particularly considering the competing demands on the agency. We hope that our comments are helpful in those endeavors.

Our comments address the following provisions in the proposed rule:

- Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs
- Medicare enrollment of opioid treatment programs and enhancements to existing general enrollment policies related to improper prescribing and patient harm
- Bundled payments under the physician fee schedule for substance use disorders
- Telehealth services
- Care management services
- Payment for evaluation and management services
- Ambulance fee schedule–Medicare ground ambulance services data collection system
- Open Payments
- Updates to the Quality Payment Program

Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs

CMS proposes in detail the new Part B benefit category for opioid use disorder (OUD) treatment services furnished by an opioid treatment program (OTP) beginning January 1, 2020, that is required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) of 2018. Under the proposed rule, OTPs would be required to enroll as Medicare participating providers, be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), maintain accreditation by an accreditation body approved by SAMHSA, and meet additional conditions as determined by the Secretary (e.g., requiring site visits and fingerprinting of owners).

CMS proposes to create a bundled payment for OTPs under Part B that is separate from the physician fee schedule (PFS). The payment bundle would cover a one-week episode of care that can recur an unlimited number of times. The payment bundle would assume one substance use counseling session, one individual therapy session, and one group therapy session per typical week. The proposal would allow for reduced payment amounts when less than half of assumed services are provided, and add-on codes to account for instances in which effective treatment requires additional counseling or therapy. CMS specifically requests comments on including higher bundled payment amounts or additional codes to address the costs associated with the beginning of an episode of care (i.e., intake and initiation services, assessment, and care planning).

The proposed rule would allow Medicare to pay for methadone for medication-assisted treatment (MAT) of OUD by allowing OTPs, the only providers permitted by statute to administer methadone for MAT, to bill the program. Methadone is one of only three FDA-approved drugs for MAT and is not currently covered by Medicare for this use. As CMS noted, about three-fourths of patients receiving services from OTPs rely on methadone for MAT, and methadone is significantly less costly than the other two FDA-approved drugs for MAT.

Comment

The Commission supports CMS's comprehensive proposal to implement the requirements of the SUPPORT Act. Allowing OTPs the opportunity to become Medicare participating providers would increase beneficiary access to the full range of services essential for OUD treatment. Paying OTPs for administering methadone as part of the existing arsenal of MAT services would ensure that Medicare beneficiaries are not excluded from this important treatment option. As we would with the introduction of any new benefit and type of provider, the Commission encourages CMS to monitor the rollout of OUD services provided by OTPs and their effect on Medicare beneficiaries.

Medicare enrollment of opioid treatment programs and enhancements to existing general enrollment policies related to improper prescribing and patient harm

As noted above, CMS proposes to require that OTPs enroll as Medicare participating providers, be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), maintain accreditation by an accreditation body approved by SAMHSA, and meet additional

conditions as determined by the Secretary (e.g., requiring site visits and fingerprinting of owners). The agency proposes that these “additional conditions” include meeting specific requirements as part of the enrollment (including maintenance of enrollment) process. CMS relies on the enrollment process “to help ensure that providers and suppliers that seek to bill the Medicare program for services or items furnished to Medicare beneficiaries are qualified to do so under federal and state laws.” As part of the enrollment process, CMS assigns prospective providers to categories—high, moderate, and limited—based on the “CMS-assessed level of risk of fraud, waste, and abuse posed by a particular category of provider or supplier.”

CMS proposes that OTPs meet additional enrollment requirements based on their assessed risk level. Newly enrolling OTP providers would be screened at the high-risk level, which requires a site visit and the submission of “fingerprints for a national background check from all individuals who maintain a 5 percent or greater direct or indirect ownership interest in the provider or supplier.” The only other provider types assessed at the high-risk level when newly enrolling are home health agencies (HHAs); suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and Medicare Diabetes Prevention Program (MDPP) suppliers. When OTPs later revalidate their Medicare enrollment, they would be screened at the moderate-risk level, which requires a site visit but not the fingerprint submission. This would also be consistent with the revalidation requirements for HHAs, DMEPOS suppliers, and MDPPs.

Comment

The Commission supports CMS’s detailed proposal to require OTPs to meet additional enrollment requirements based on their assessed risk level. CMS raises a pertinent concern that there is “no historical information on OTPs (either from an enrollment, billing, or claims payment perspective) upon which [the agency] can fairly estimate the degree of risk they may pose.” Once OTPs have gained sufficient experience as Medicare providers, CMS might consider reviewing their assessed risk level and resulting requirements. However, for the first several years of OTPs newly serving as Medicare providers, the proposed requirements are reasonably prudent.

Bundled payments under the physician fee schedule for substance use disorders

CMS also proposes under the Secretary’s discretionary authority to create a similar bundled payment under the PFS for physicians and other health care providers who choose to provide OUD treatment outside of an OTP. As CMS notes, although there are about 1,700 OTPs nationwide, they are not distributed evenly throughout the country and tend to be located in more urban areas. The PFS bundle would differ from the OTP bundle in multiple ways. The proposed bundle would be for an episode of care that is one month in duration, while the OTP bundle would be for one week in duration. CMS intends these bundle durations to mirror the different timeframes that the two places of service tend to bill other payers (in the cases of OTPs) and Medicare (in the case of PFS providers). The PFS bundle would assume two individual psychotherapy sessions and four group psychotherapy sessions per month, compared with the OTP bundle, which would assume four substance use counseling sessions, four individual therapy sessions, and four group therapy sessions per month. Unlike the proposal for OTPs, there would be no partial bundle available under the PFS, but there would be an add-on code for additional services rendered. Lastly,

physicians would be able to bill separately for services associated with the beginning of an episode of care.

Comment

The Commission also supports the proposal to create a similar bundle for physicians and other health care providers within the PFS. The PFS bundle would provide an opportunity to increase access to OUD treatment for beneficiaries who live in areas without an OTP. To the extent that physicians and other health care providers opt to begin providing OUD treatment, these services could become better integrated with primary care and, eventually, less stigmatized.

However, in light of our preference for site-neutral payment, the Commission questions the necessity of the numerous differences between the bundles proposed for OUD treatment at an OTP versus in a physician office or hospital outpatient department. Some, such as the length of time of the bundle (i.e., weekly versus monthly), may be worth preserving if they best suit the needs of different types of providers without unduly putting one type at an advantage over others. However, other differences between OTPs and PFS providers, such as the number of psychotherapy sessions included in the bundle and the provision (or lack) of additional payments for services necessary for initiating an episode, may create financial incentives to choose a particular setting for OUD treatment. The Commission encourages CMS to seek opportunities to more closely align the benefit across OTP and PFS settings before it is introduced and to subsequently monitor for any unintended responses to payment incentives.

Telehealth services

Relying on the Secretary's discretionary authority, CMS proposes to allow the use of telehealth for face-to-face (i.e., counseling) services in OUD treatment bundles billed by OTPs and physicians and other health care providers. The agency notes that these face-to-face services included in the OUD bundles are similar to existing psychotherapy codes in the PFS that have already been approved for telehealth.

Comment

Similarly, the Commission supports CMS's proposal to allow for the use of telehealth services to furnish substance use counseling, individual therapy, and group therapy in the OTP and PFS bundles. This may further improve access to care for beneficiaries, especially those in rural and other underserved areas. As with the other parts of the proposal that expand services, CMS should monitor these telehealth services to ensure that the benefit is used appropriately.

Care management services

Transitional Care Management (TCM) billing codes have been included in the PFS since 2013. These codes cover the cost of a clinician following up with a patient within 2 business days of a discharge from an inpatient hospital setting, having a face-to-face visit with the patient within 1 or 2 weeks of the discharge, and engaging in certain non-face-to-face services in the 30 days

following the discharge (e.g., obtaining and reviewing a discharge summary, following up on pending tests, and interacting with other health care professionals).

In this proposed rule, CMS proposes slight increases to the work RVUs associated with TCM codes for moderate- and high-complexity patients, based on a re-survey of clinicians in 2018 by the American Medical Association’s Relative Value Scale Update Committee (RUC) (Table 1).

Table 1. Proposed changes to work RVUs for Transitional Care Management codes

Code	Description	Current (2019) payment amount	Current (2019) work RVUs	Proposed (2020) work RVUs
99495	Follow-up communication post-discharge, face-to-face visit, and <i>moderate</i> complexity decision-making	\$166.50	2.11	2.36
99496	Follow-up communication post-discharge, face-to-face visit, and <i>high</i> complexity decision-making	\$234.97	3.05	3.10

Note: RVU (relative value unit). Payment amounts are nonfacility national payment amounts.

Another set of Medicare billing codes have allowed practitioners to receive payment for Chronic Care Management (CCM) services since 2015. CCM codes are available to practitioners caring for beneficiaries with two or more chronic conditions and cover the cost of engaging in certain non–face-to-face services over a one-month period (e.g., assessing a beneficiary’s medical, functional, and psychosocial needs; maintaining a comprehensive care plan; coordinating care with other practitioners; and reconciling medications prescribed by different practitioners).

CMS proposes replacing one CCM code (99490) with two temporary G codes that would allow practitioners to receive an add-on payment for each additional 20 minutes of staff time spent per month on non-complex (as opposed to complex) CCM services (Table 2). (A billing code for each additional 20 minutes spent on *complex* CCM services is already available.)

Table 2. Proposed changes to non-complex Chronic Care Management codes

Code	Status	Description	Current (2019) payment amount	Current (2019) work RVUs	Proposed (2020) work RVUs
99490	Existing code, proposed for discontinuation in 2020	First 20 min. of clinical staff time per month, directed by a physician or other qualified professional	\$42.17	0.61	--
GCCC1	Proposed replacement for 99490, to be paid starting in 2020		--	--	0.61
GCCC2	Proposed new code for 2020	Each additional 20 min.	--	--	0.54

Note: RVU (relative value unit). The payment amount is the nonfacility national payment amount.

CMS proposes creating new billing codes for Principal Care Management (PCM) services, which would allow practitioners to bill for managing only one of a beneficiary's chronic conditions—either because the beneficiary only has one condition or because the practitioner chooses to only treat one of the beneficiary's conditions. In contrast, existing CCM billing codes are only available for practitioners managing the care of beneficiaries with two or more conditions. For reference, 81 percent of U.S. adults aged 65 and older have multiple chronic conditions.¹ CMS expects that most physicians billing for PCM services would be specialists; in contrast, most clinicians billing for CCM services have been primary care practitioners (and some specialists, such as cardiologists and nephrologists). CMS would allow multiple practitioners to use the new PCM codes in a given month for the same patient, if each practitioner manages a different condition that the patient has. In addition, another practitioner could use the CCM code for that same patient in that same month.

CMS also asks for input on existing billing codes available for communication technology-enabled check-ins with patients and consultations between practitioners, which were added to the fee schedule starting in 2019. (These codes include virtual check-ins with an established patient involving 5–10 minutes of medical discussion, and inter-professional telephone/internet/electronic health record assessment and management provided by a consulting physician including a verbal and written report to the requesting physician, for example.) Currently, clinicians must obtain verbal consent from beneficiaries before engaging in these activities because they trigger beneficiary cost sharing. In response to clinician feedback about the burden of obtaining this consent, CMS proposes allowing clinicians to obtain blanket consent from beneficiaries for a defined period of time (such as every 6 or 12 months) or for a defined number of these services.

Comment

The Commission supports CMS's proposal to slightly increase RVUs for TCM codes and add a billing code for additional time spent providing non-complex CCM services. These changes reflect the resources involved in providing care management services and should increase the accuracy of CCM and TCM payments.

The Commission does not support CMS's proposal to create new PCM codes because it would provide incentives for clinicians to manage only one of a beneficiary's chronic conditions and could encourage situations where multiple clinicians separately manage each of a beneficiary's multiple conditions, with little consultation or coordination among them. This is inconsistent with the goals of care coordination. CMS acknowledges in the proposed rule that creating PCM codes could lead to care fragmentation and duplicative services. Encouraging multiple practitioners to act as a beneficiary's care manager at the same time would mean that multiple practitioners would assess the beneficiary's medical and psychosocial needs, develop care plans, reconcile medications, deliver preventive services, and try to coordinate with the beneficiary's other practitioners, yet each clinician would only focus on a single condition. This situation could lead to

¹ Buttorff, C., T. Ruder, and M. Bauman. 2017. *Multiple chronic conditions in the United States*. Santa Monica, CA: RAND Corporation.

confusion, overlapping or duplicative services, and higher cost-sharing liability for beneficiaries—while increasing Medicare spending.

The Commission supports continuing to require beneficiary consent each time a communication technology–based service code is used because beneficiaries must pay cost sharing for these services. Requiring less-frequent consent could lead to beneficiaries receiving “surprise” medical bills for non–face-to-face services.

Consent is particularly important for the inter-professional virtual consultation codes, which may happen without the patient’s explicit knowledge. Some of these codes are paid about as much as an office visit, with similar cost-sharing liability for the beneficiary. Therefore, we urge CMS to require beneficiary consent to treatment (including understanding the cost-sharing liability) prior to the service being delivered.

Other codes, such as the virtual check-in code, involve beneficiary involvement with the billing clinician, so there is some degree of beneficiary awareness that the service is provided. However, we still believe that beneficiaries should separately consent to receive these services (and understand their financial liability). This discussion should be explicit, particularly if a patient was previously not charged separately for phone calls with practitioners.

Payment for evaluation and management services

Office/outpatient evaluation and management (E&M) services are the most common set of services billed in the fee schedule, accounting for 27 percent of allowed charges in 2017.² There are currently five levels of office/outpatient E&M visits, representing the range of resources required to provide the service (with level 1 requiring the fewest resources and level 5 requiring the most). There are two sets of office/outpatient E&M codes—one for new patients and one for established patients.

Currently, clinicians must document in the medical record the patient’s history and information about the physical exam performed and medical decision making to justify the level of E&M code they bill. In Medicare, they must use one of two sets of documentation guidelines (created in 1995 and 1997), which outline the required history, exam, and medical decision making needed to bill each E&M code.

In the physician fee schedule final rule for 2019, CMS finalized several significant coding, payment, and documentation changes to the E&M office/outpatient visits, which are scheduled to take effect in 2021.³ The goal of these changes was to reduce clinicians’ administrative burden,

² Medicare Payment Advisory Commission. 2019. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

³ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2018. 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. Final rules and interim final rule. *Federal Register* 83, no. 226 (November 23): 59452–60303.

improve payment accuracy, and ensure that the codes better reflect the current practice of medicine. The key changes will be to:

- pay a single, blended rate for E&M visit levels 2 through 4 (CMS created separate rates for new patients and established patients);
- allow clinicians to document E&M visits using medical decision making, time, or the current 1995 or 1997 documentation guidelines;
- adopt new add-on codes for primary care visits and specialized medical care visits that use additional resources (GPC1X and GCG0X, respectively);
- adopt a new extended visit add-on code that clinicians will be able to bill when they spend extended time with the patient.

After CMS published the physician fee schedule final rule for 2019, the Current Procedural Terminology (CPT) Editorial Panel reviewed the 10 existing E&M office/outpatient visit codes and approved simpler documentation and coding guidelines based on the time spent by the clinician on the day of the visit or medical decision making; the history and physical exam would no longer be used to document the visit code.⁴ In addition, the CPT Editorial Panel:

- maintained the current 5 levels of E&M visits for established patients but deleted the level 1 code for new patient visits (99201) because it is similar to the level 2 code for new patient visits (99202);
- developed new time ranges for the total time spent by the clinician on the day of the visit for each E&M visit code; and
- approved a new add-on code for a prolonged E&M service to be reported when the time for a level 5 E&M visit (new or established patient) is exceeded by at least 15 minutes.

Based on an extensive survey of over 50 clinician specialties, the RUC revalued the 9 E&M office/outpatient visit codes revised by the CPT Editorial Panel and the new prolonged E&M visit add-on code. The RUC recommended higher work RVUs for 8 of the 9 visit codes and changes to the direct practice expense inputs. For example, the RUC recommended that the work RVUs for a level 3 E&M visit for an established patient (99213) increase from 0.97 to 1.3.

CMS proposes to adopt the CPT Editorial Panel's changes to the E&M office/outpatient visit codes and the new documentation guidelines because the agency believes that these changes would accomplish greater reduction in documentation burden than the changes that CMS adopted in the final rule for 2019. CMS also asserts that these changes are more intuitive and consistent with the current practice of medicine. CMS also proposes to adopt the RUC's recommended work RVUs and direct practice expense inputs (with one minor change) for the E&M visit codes. In other words, CMS no longer plans to pay a single, blended rate for E&M visit levels 2 through 4. As a result of the RUC-recommended changes to work RVUs, we estimate that payment rates for E&M visits for established patients would increase by 15 percent, on average (we weighted each service

⁴ American Medical Association. 2019. CPT® evaluation and management (E/M) office or other outpatient (99202-99215) and prolonged services (99354, 99355, 99356, 99XXX) code and guideline changes. <https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf>.

by its volume in 2018 to calculate the average). We estimate that payment rates for E&M visits for new patients would increase by 5 percent, on average. CMS proposes that these changes to the E&M codes, documentation guidelines, and RVUs would take effect in 2021 to allow time for provider education and changes in clinical workflows and electronic health records.

In addition, CMS proposes several changes to add-on codes to the E&M office/outpatient visit codes. CMS proposes to adopt the new add-on code created by the CPT Editorial Panel for a prolonged E&M service for a level 5 E&M visit. CMS proposes to delete the extended visit add-on code that the agency created in the final rule for 2019 because this code would no longer be needed since the time it describes would instead be described by a level 3, 4, or 5 visit code and, if applicable, by the new add-on code for a prolonged E&M service. In addition, CMS proposes to combine the two add-on codes for primary care visits (GPC1X) and specialized medical care visits (GCG0X) that use additional resources (which it created in the final rule for 2019) into a single add-on code (GPC1X) that describes the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. CMS would set the work RVUs for this single add-on code at 0.33; by comparison, the work RVUs for each of the two add-on codes that it would replace are 0.25. Clinicians could bill this single add-on code with all levels of E&M office/outpatient visits for new or established patients.

In addition to recommending new work RVUs for the 9 E&M office/outpatient visit codes, the RUC also recommended adjusting the work RVUs for postoperative E&M visits that are part of surgical codes with 10-day and 90-day global periods. This change would increase the work RVUs for codes with 10-day and 90-day global periods because they all include postoperative visits. However, CMS does not propose to adopt this recommendation.

In the final rule for 2015, CMS discussed the challenges of accurately accounting for the number of visits included in 10-day and 90-day global periods and adopted a policy to convert all global surgical codes to 0-day global codes and allow clinicians to bill separately for each postoperative E&M visit.⁵ The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) prohibited CMS from implementing this policy and required CMS to collect data on the number and type of postoperative visits and use these data to improve the accuracy of the valuation of global surgical codes. To fulfill MACRA's requirement, CMS required clinicians in practices with at least 10 clinicians in 9 states to submit claims for postoperative visits that occurred after select surgical procedures provided on or after July 1, 2017. CMS released three reports by its contractor, RAND, with this proposed rule: (1) an analysis of the data on postoperative visits collected through claims-based reporting from clinicians in nine states, (2) an analysis of physician time and work for postoperative visits associated with three high-volume procedures (these data were collected through a clinician survey), and (3) a report that models alternative changes to RVUs for global surgical codes based on the difference between the number of postoperative visits observed via

⁵ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. Medicare program; revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, access to identifiable data for the Center for Medicare and Medicaid Innovation models & other revisions to Part B for CY 2015. Final rule. *Federal Register* 79, no. 219 (November 13): 67548–68010.

claims and the number used to value the codes. CMS does not propose any changes to the 10-day and 90-day global surgical codes in this proposed rule. The agency states that it wants to give the public and stakeholders time to study the RAND reports and consider an appropriate approach to revaluing global surgical codes.

Comment

The Commission strongly supports CMS's proposed changes to the E&M office/outpatient visit codes, the new documentation guidelines for these codes, and the revised RVUs for these codes, with one exception (noted below). We agree that the documentation guidelines for E&M services have become outdated and may cause clinicians undue burden (e.g., by requiring them to record unnecessary information in the medical record). Therefore, we agree with simplifying these guidelines. In particular, we support CMS's proposal to allow clinicians to use time to document the complexity of an E&M office/outpatient service. We have found that time accounts for between 75 percent and 80 percent of the variation in work RVUs in the fee schedule.⁶

The Commission has long been concerned that E&M office/outpatient visits are undervalued relative to other services in the fee schedule. This mispricing may lead to problems with beneficiary access to these services and, over the longer term, may even influence the pipeline of physicians in specialties that tend to provide a large share of E&M services. The fee schedule's work RVUs, which account for the amount of work required to provide a service, are based on an assessment of how much time and intensity services require relative to one another. If estimates of time and intensity are not kept up to date, especially for services that experience efficiency improvements, the work RVUs become inaccurate.

Because of advances in technology, technique, and clinical practice, efficiency improvements are more easily attained for procedures, imaging, and tests than for E&M office/outpatient visits, which are composed largely of activities that require the clinician's time and so do not lend themselves to efficiency gains. When efficiency gains reduce the amount of work needed for a service, the work RVUs for the affected services should decline accordingly. Under the budget-neutral fee schedule, a reduction in the RVUs of these services would raise the RVUs for all other services, such as E&M office/outpatient visits. But because of problems with the process of reviewing overpriced services and the data used to set prices, this two-step sequence tends not to occur.⁷ Therefore, E&M office/outpatient visits have become passively devalued over time.

By substantially increasing the work RVUs for E&M office/outpatient visits, CMS's proposal would start to address several years of passive devaluation of these services. Even if this proposal is adopted, however, we urge CMS to accelerate its efforts to improve the overall accuracy of the fee schedule by developing a better mechanism to identify overpriced services and adjust their

⁶ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

⁷ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

payment rates. CMS's review of potentially mispriced services is hampered by the lack of current, accurate, and objective data on clinician work time and practice expenses. To address this problem, the Commission has recommended that CMS use a streamlined method to regularly collect data from a cohort of efficient practices—including service volume and work time—to establish more accurate work and practice expense RVUs.⁸ These data should be used in a “top-down” approach to calculate the amount of time that a physician worked over the course of a week or month and compare it with the time estimates in the fee schedule for all of the services that the physician billed over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates are too high.

We do not support CMS's proposal to combine the two new add-on codes for primary care visits (GPC1X) and specialized medical care visits (GCG0X) that use additional resources into a single add-on code (GPC1X) that describes the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. Even though CMS proposes to revise the standard codes for E&M office/outpatient visits, the agency states that this new add-on code is needed to account for the additional resource costs inherent in furnishing some kinds of E&M visits. However, CMS does not specify these additional resources or the types of visits that require additional resources. CMS's proposed definition for this code appears to cover a very wide range of visits. Does CMS intend for this code to be billed along with all or the majority of E&M office/outpatient visits? How will clinicians document the necessity of billing this code? Assuming that CMS increases the work RVUs for the standard codes for E&M office/outpatient visits, what is the rationale for creating this add-on code?

We support CMS's decision to not adopt the RUC's recommendation that CMS adjust the work RVUs for postoperative E&M visits that are part of surgical codes with 10-day and 90-day global periods. Although the Commission generally supports bundled payment rates that include services furnished during an episode of care, there is evidence that 10-day and 90-day global surgical codes are overpriced. Therefore, the Commission supports converting all 10-day and 90-day global codes to 0-day global codes and revaluing these codes as 0-day codes.^{9,10} Under this approach, CMS would remove the postoperative E&M visits from the payment rates for these codes and clinicians would bill separately for all postoperative visits that occur after the day of the procedure. If these

⁸ Medicare Payment Advisory Commission. 2011. *Moving forward from the sustainable growth rate system*. Letter to the Congress. October 14.

⁹ Medicare Payment Advisory Commission. 2018. MedPAC comment on the Centers for Medicare & Medicaid Services' proposed rule entitled “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.” Letter to the Administrator. http://medpac.gov/docs/default-source/comment-letters/09042018_macra_feeschedule_1693p_medpac_comment_v2_sec.pdf?sfvrsn=0.

¹⁰ Medicare Payment Advisory Commission. 2014. MedPAC comment on the Centers for Medicare & Medicaid Services' proposed rule entitled “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015.” Letter to the Administrator. http://medpac.gov/docs/default-source/comment-letters/08282014_comment_letter_2015_pt_b_rule_final.pdf?sfvrsn=0.

postoperative visits are office/outpatient visits, clinicians would receive higher rates for these services if CMS adopts its proposal to increase the work RVUs for these codes for 2021.

The RVUs for 10-day and 90-day global codes assume that a certain number of postoperative visits are provided by the clinician who performed the procedure (the number of visits varies by code). However, the Office of Inspector General (OIG) conducted three studies which found that the number of visits actually provided during the global period is often lower than the number assumed in the global payment.^{11,12,13} OIG reviewed a sample of medical records for several types of global surgical codes (e.g., cardiovascular procedures) and counted the number of postoperative visits provided by the performing physician. In many cases, OIG found that the physician provided fewer postoperative visits than were included in the global payment rates. For example, physicians provided fewer visits than were included in the global payment rates for 65 percent of cardiovascular procedures with 90-day global periods.¹⁴

RAND's study of postoperative visits reported by clinicians in nine states, which was released with this proposed rule, is generally consistent with OIG's findings. RAND's analysis indicates that postoperative visits are furnished by the performing clinician for only 4 percent of procedures with a 10-day global period and 67 percent of procedures with a 90-day global period. There are two potential explanations for the finding that postoperative visits are rarely furnished by the performing clinician during the 10-day global period. The first is that the visits occur after the 10-day window. The second is that the postoperative visits were provided by a clinician other than the clinician who performed the procedure, which would not have been captured by the data.

The global payment policy assumes that the same clinician who performs the procedure also provides all of the postoperative care. However, another study performed by RAND for CMS observed that postoperative care is shifting from the clinician who performed the procedure to other clinicians, such as hospitalists and nonphysician practitioners, who bill separately for each postoperative visit.¹⁵ In these cases, the clinician who performs the surgical procedure should formally agree to transfer postoperative care to the clinician who provides the postoperative visits. This agreement may be in the form of a letter or an annotation in the discharge summary or

¹¹ Office of Inspector General, Department of Health and Human Services. 2012. *Cardiovascular global surgery fees often did not reflect the number of evaluation and management services provided*. No. A-05-09-00054. Washington, DC: OIG.

¹² Office of Inspector General, Department of Health and Human Services. 2012. *Musculoskeletal global surgery fees often did not reflect the number of evaluation and management services provided*. No. A-05-09-00053. Washington, DC: OIG.

¹³ Office of Inspector General, Department of Health and Human Services. 2009. *Nationwide review of evaluation and management services included in eye and ocular adnexa global surgery fees for calendar year 2005*. No. A-05-07-00077. Washington, DC: OIG.

¹⁴ Office of Inspector General, Department of Health and Human Services. 2012. *Cardiovascular global surgery fees often did not reflect the number of evaluation and management services provided*. No. A-05-09-00054. Washington, DC: OIG.

¹⁵ Mehrotra, A., C. Gidengil, L. Hilborne, et al. 2016. *Developing codes to capture post-operative care*. Santa Monica, CA: RAND.

hospital record.¹⁶ Each clinician would bill for the same global surgical code using special modifiers, and CMS would split the payment for the procedure and the postoperative care between the two clinicians.¹⁷ If there is no formal agreement to transfer care, however, the clinicians are not required to bill using these special modifiers. In this case, CMS would pay the full global payment amount to the clinician who performed the procedure and pay separately for each postoperative visit furnished by the second clinician. In other words, CMS would pay twice for the same services.

In the physician fee schedule proposed rule for 2015, CMS raised several concerns about the 10-day and 90-day global codes and proposed converting these codes to 0-day global codes.¹⁸ For example, it is difficult to accurately value global packages that include postoperative visits because the number and type of visits in the package for a given code are likely to change over time as medical practice and the patient population changes. In addition, global codes contribute to payment disparities between specialties. Physicians who bill for global codes are paid for E&M visits that are included in the global package even if they do not furnish them, while physicians who do not bill for global codes are only paid for visits that they actually provide.

We continue to agree with the concerns expressed by CMS about 10-day and 90-day global codes. We support CMS's prior proposal to convert these codes to 0-day global codes because it is difficult to accurately estimate the typical number, type, and location of postoperative visits within the global period. In addition, Medicare makes duplicative payments when a beneficiary receives postoperative care from a different clinician than the one who performed the procedure and there is no formal agreement to transfer care from one clinician to another. In this case, beneficiaries also pay higher cost sharing.

We reiterate our support for creating larger units of payment that include multiple services provided on the same day as well as bundled payments that include services furnished during an episode of care. However, the individual services that are part of a bundled payment need to have accurate values and there needs to be a mechanism to prevent unbundling. CMS should move forward with improving payment accuracy for global surgical codes while also developing bundled payments that incorporate services furnished by multiple providers during an episode of care.

¹⁶ The clinician who performs the surgery and the clinician who furnishes the postoperative care must each keep a copy of the transfer agreement in the beneficiary's medical record.

¹⁷ Modifier "54" indicates that the clinician provided only the surgical care, and modifier "55" indicates that the clinician provided only the postoperative care.

¹⁸ Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2014. Medicare program; revisions to payment policies under the physician fee schedule, clinical laboratory fee schedule, access to identifiable data for the Center for Medicare and Medicaid Innovation models & other revisions to Part B for CY 2015. Proposed rule. *Federal Register* 79, no. 133 (July 11): 40318–40540.

Ambulance fee schedule—Medicare ground ambulance services data collection system

The proposed rule describes CMS’s plan for collecting cost, revenue, utilization, and other information from ground ambulance providers and suppliers, as mandated by the Bipartisan Budget Act of 2018. That law requires MedPAC to use these data to produce a report in 2023 that:

- assesses the adequacy of ground ambulance payments,
- assesses geographic variation in costs,
- analyzes the burden associated with collecting the data, and
- recommends whether CMS’s ambulance data collection system should be revised.

CMS proposes to collect its first round of data in 2021, covering a one-year period beginning in 2020. Three subsequent rounds of data would be collected annually thereafter, as required by law. After 2024, data must be collected at least every three years.

In the proposed rule, CMS seeks feedback on its proposal to survey 25 percent of ambulance organizations in each of four years, yielding data from all ambulance organizations by the end of this period. CMS assumes that 100 percent of respondents will complete the survey in order to avoid the one-year 10 percent payment cut that they will be subject to if they are asked to submit data but fail to do so.

In the proposed rule, CMS describes the lengthy survey it has developed to collect data from ambulance organizations, which was informed by a report by researchers at RAND. CMS estimates that it will take each responding organization 23 hours to collect the required data and submit it using their proposed web-based data collection system.

Comment

Medicare’s ambulance payment policy has been a work in progress over the past few decades. For most of Medicare’s history, Medicare paid ambulance providers based on their reasonable costs and paid ambulance suppliers based on their reasonable charges—meaning ambulance organizations were paid different amounts for the same ambulance services. In 1997, Congress directed the Secretary to develop a single national fee schedule for Medicare ambulance services, which was phased in starting in 2002 and fully implemented by 2010. In 2003, Congress introduced several add-on payments for Medicare ground transports, which MedPAC found to be ill-targeted and in need of reform in our June 2013 report.¹⁹

CMS’s proposal to collect consistent data from ambulance suppliers and providers should facilitate setting more accurate payment rates. We currently lack good data on ambulance organizations’ costs because non-institutional ambulance suppliers (the primary type of organization that bills Medicare for ground transports) do not submit cost report data to Medicare, and institutional

¹⁹ Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the Health Care Delivery System*. Washington, DC: MedPAC.

ambulance providers submit cost data that is comingled with non-ambulance costs and impossible to separate from air transport costs.²⁰

The Commission is impressed with the thoroughness of the survey proposed by CMS, but we are concerned that the survey will suffer from a low response rate because of its complexity. There is a risk that ambulance organizations that would have difficulty completing the survey and/or have low Medicare volume will decline to complete the survey and instead opt for the one-year 10 percent payment cut. As CMS notes in the proposed rule, 50 percent of ambulance organizations provide only 3 percent of transports; for these organizations, the payment cut may amount to a relatively small amount of revenue. To increase the likelihood of getting at least some data from these organizations, the Secretary should ask low-volume ambulance organizations (e.g., those providing 600 or fewer all-payer ground transports per year²¹) to complete a much shorter version of CMS's proposed survey. The short-form survey for these organizations should ask for the bare minimum information needed to calculate an organization's cost per transport (e.g., the organization's total annual budget, total number and type of transports regardless of payer, average number of miles per transport, type of organization, non-profit vs. for-profit status, use of shared space, percent of labor hours donated by volunteers, et cetera).

CMS should select a sample of respondents that is representative of the organizations that bill Medicare for ambulance services. For example, if 94 percent of Medicare claims are submitted by independent ambulance suppliers, then ideally 94 percent of each year's survey sample would consist of independent ambulance suppliers. Similarly, the 50 percent of organizations that make up only 3 percent of Medicare claims would make up only 3 percent of the sample.

To allow MedPAC to produce the most accurate analysis possible by the March 15, 2023, statutory deadline for our report to the Congress, we will need to receive data from a robust sample of ambulance organizations by March 2022. Therefore, the first year's survey sample should be large enough to produce statistically reliable results using that year's data alone. In addition, all high-volume ambulance organizations (e.g., the 10 percent of organizations that provide 70 percent of Medicare ground transports) should be surveyed within the first two years of data collection—with 50 percent of these organizations surveyed in the first year and the other 50 percent surveyed in the second year.

On a more technical note, MedPAC requests that in the full-length version of the survey, respondents be asked to estimate the fair market value of any ambulances, other vehicles, and

²⁰ Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

²¹ The GAO has found that costs per transport are higher for ambulance organizations that provide 600 or fewer ground transports per year, compared to ambulance organizations that provide more than 600 transports per year. (See: Government Accountability Office. 2007. *Ambulance providers: Costs and expected Medicare margins vary greatly*. GAO-07-383. Washington, DC: GAO.) MedPAC has recommended increasing payments for ground transports that originate in geographically isolated, low-volume zip codes (e.g., those that do not have sufficient population to generate at least 600 transports per year across all payers) instead of the current rural short-mileage add-on payment. (Medicare Payment Advisory Commission. 2013. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.)

buildings that have been donated, rather than relying on CMS or MedPAC to impute these values. Respondents could be given the option of identifying the estimated value as of the year the item was donated (and the year it was donated), if that is less burdensome than estimating the current value. Respondents will be in a much better position to accurately estimate these values than CMS or MedPAC.

Open Payments

Open Payments is a program mandated by statute that requires manufacturers of drugs, devices, biologics, or medical supplies to annually report to the Secretary certain payments or transfers of value provided to covered recipients. Covered recipients include physicians and teaching hospitals. In addition, Open Payments requires manufacturers and group purchasing organizations (GPOs) to report on physician ownership or investment interests. CMS publishes the information submitted by manufacturers and GPOs on a public website.

Section 6111 of the SUPPORT Act expanded the definition of covered recipient to include physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialists (CNSs), certified registered nurse anesthetists (CRNAs), and certified nurse midwives (CNMs). CMS proposes to implement this provision for data collected beginning in 2021 and reported to CMS in 2022.

Manufacturers and GPOs are required to characterize the types of payments or transfers of value made to covered recipients by selecting the “nature of payment” category that most closely describes the payment. CMS proposes several changes to the nature of payment categories to enhance their clarity and simplify reporting by manufacturers and GPOs. Currently, Open Payments distinguishes between compensation to physicians for serving as faculty for “accredited medical education programs” and “unaccredited medical education programs.” To streamline the reporting requirements, CMS proposes to consolidate these two categories into a single category: “medical education programs.” CMS also proposes to add three new categories:

- debt forgiveness, which would include transfers of value related to forgiving the debt of a covered recipient or physician owner;
- long-term medical supply or device loan, which would apply to loans of medical supplies and devices for longer than 90 days; and
- acquisitions, which would include buyout payments made to a covered recipient that were related to the acquisition of a company in which the recipient had an ownership interest.

When manufacturers and GPOs report payments or transfers of value related to a specific drug or biologic, CMS requires them to report the name and national drug code of the product. However, there is currently no requirement to report a unique identifier for a medical device. The Office of Inspector General has recommended that CMS require the reporting of more specific information about devices.²² The Food and Drug Administration requires that most devices include a unique device identifier (UDI), and the device identifier is a portion of the UDI. CMS proposes to require

²² Office of the Inspector General, Department of Health and Human Services. 2018. *Open Payments data: Review of accuracy, precision, and consistency in reporting*. No. OEI-03-15-00220. Washington, DC: OIG.

that manufacturers and GPOs report the device identifier component of the UDI when they report payments related to a device. CMS believes that requiring reporting of the device identifier would enable the agency to validate information submitted about devices and enhance the usefulness of the Open Payments data to the public.

Comment

We strongly support CMS's proposal to implement the SUPPORT Act's requirement to expand covered recipients to include additional types of clinicians, such as NPs and PAs. In 2009, the Commission recommended that manufacturers be required to report financial ties with many types of health professionals, including NPs and PAs.²³ The number of NPs and PAs has been growing rapidly, and they play an increasingly important role in the health care system, such as coordinating care and managing medications. A literature review found that nonphysician health professionals (such as NPs and PAs) report frequent interactions with manufacturers of drugs and other products.²⁴ For example, almost half of NPs reported regular attendance (one to five times during the prior six months) at industry-sponsored lunch events, and 64 percent reported regular attendance at industry-sponsored dinner events.²⁵

We also support CMS's proposed changes to the nature of payment categories and to require that manufacturers and GPOs report the device identifier component of the UDI when they report payments related to a device. These changes will streamline reporting and significantly increase the usefulness of the information for researchers, government oversight agencies, and the public.

We also reiterate the suggestions for enhancing the utility of Open Payments data from our June 2017 report to the Congress.²⁶ Although the Open Payments records list the name of each manufacturer or GPO that made the payment or transfer of value, they do not indicate whether the company was a GPO or a manufacturer, nor do they indicate whether the manufacturer produces drugs, biologics, devices, or supplies. Although some manufacturers are well-known and the general public may recognize whether they produce drugs, devices, or another product, some manufacturers are less well-known. In addition, some manufacturers report payments in the name of their subsidiaries.

Moreover, GPOs do not report whether they are physician-owned distributors (PODs). PODs are entities that derive revenue from selling, or arranging for the sale of, devices ordered by their

²³ Medicare Payment Advisory Commission. 2009. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

²⁴ Grundy, Q., L. Bero, R. Malone. 2013. Interactions between non-physician clinicians and industry: A systematic review. *PLOS Medicine* 10, no.11: e1001561.

²⁵ Ladd, E.C., D.F. Mahoney, S. Emani. 2010. "Under the radar": Nurse practitioner prescribers and pharmaceutical industry promotions. *The American Journal of Managed Care* 16, no. 12 (December 21): e358–e362.

²⁶ Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

physician-owners for use in procedures the physician-owners perform on their own patients.²⁷ PODs allow physicians to profit from the sale of medical devices they use. PODs have been the subject of reports and investigations by OIG and the Senate Finance Committee.^{28,29} According to CMS, PODs that purchase devices and other items for resale or distribution to groups of individuals or entities are a type of GPO and therefore subject to Open Payments requirements. Nevertheless, the Senate Finance Committee report found evidence that many PODs do not report their physician ownership interests to Open Payments, and some PODs have changed how they compensate physicians to circumvent the reporting requirements. Very few PODs appear in Open Payments data. For example, using data from 2015, the Commission found that only 16 PODs reported physician ownership.³⁰ The Commission supports requiring all PODs to report under the Open Payments program.³¹

CMS should require each manufacturer or GPO that reports data under Open Payments to indicate:

- whether it is a manufacturer or GPO;
- whether, if a manufacturer, it produces drugs, biologics, devices, supplies, or a combination of products; and
- whether, if a GPO, it is a POD.

In addition, CMS should assess penalties on PODs that do not comply with the statute. Including more information on the types of companies that have financial relationships with clinicians and teaching hospitals would enable researchers, oversight agencies, and the public to better understand these relationships.

Updates to the Quality Payment Program

MACRA created two new policies: an incentive payment for qualifying participants in advanced alternative payment models (A-APMs) and the Merit-Based Incentive Payment System (MIPS). CMS refers to these two programs collectively as the Quality Payment Program. Most clinicians are in the MIPS track, which means they receive increases or decreases to their Medicare PFS payments based on their performance on measures of quality, cost, improvement activities, and promoting interoperability.³² Clinicians are exempt from MIPS's reporting requirements and

²⁷ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

²⁸ Office of Inspector General, Department of Health and Human Services. 2013. *Spinal devices supplied by physician-owned distributors: Overview of prevalence and use*. Washington, DC: OIG.

²⁹ U.S. Senate Committee on Finance. 2016. *Physician owned distributorships: An update on key issues and areas of congressional concern*. A Senate Finance Committee majority staff report. Washington, DC: Government Printing Office.

³⁰ Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

³¹ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

³² Clinicians can also meet their MIPS reporting obligations by participating in various CMS APMs. A clinician participating in an A-APM but not treating enough Medicare beneficiaries to be considered a "qualifying APM

performance-based payment adjustments if they achieve threshold levels of payments or patients in an A-APM (e.g., Comprehensive Primary Care Plus, the Next Generation ACO Model). These clinicians in A-APMs receive an incentive payment worth 5 percent of their prior year's Medicare revenues.³³

In the proposed rule, CMS states that it “believe[s] there is room to improve upon the [MIPS] program.” The agency goes on to say that it believes that CMS’s approach of trying to make MIPS a flexible program “has inadvertently resulted in a complex MIPS program that is not producing the level of robust clinician performance information we envision providing to meet patient needs and spur clinician care improvements.” CMS mentions concerns raised by stakeholders about the MIPS program; for example, the agency has “heard concerns from some stakeholders that MIPS presents clinicians with too much complexity and choice (for example, of several hundred MIPS and QCDR quality measures), causing unnecessary burden.” It has also “received feedback that some clinicians find the performance requirements confusing, and that it is difficult for them to choose measures that are meaningful to their practice and have a direct benefit to beneficiaries.” CMS has also “heard concerns from stakeholders that MIPS does not allow for sufficient differentiation of performance across practices due to clinician quality measure selection bias.” CMS states that this last concern “detracts from the program’s ability to effectively measure and compare performance, provide meaningful feedback, and incentivize quality.”

CMS is proposing significant changes to MIPS in order to collect information that is “less burdensome and more meaningful to clinicians and patients,” through the creation of MIPS Value Pathways (MVPs). MVPs are specialty- or condition-specific measure sets that will include the same types of measures and activities as the current MIPS program, plus administrative claims-based outcome measures. For example, CMS is contemplating including outcome measures that assess rates of unplanned admissions, preventable admissions, acute hospital utilization, and emergency department utilization. CMS believes that MVP measure sets could facilitate clinician movement into A-APMs because some of the outcome measures it is contemplating adding are currently used in A-APMs. CMS envisions starting to use some MVP measure sets to adjust payments in 2023, using 2021 performance information. Eventually, all clinicians not participating in an A-APM would be assessed using MVP measure sets.

CMS also plans to provide more data and feedback to clinicians, to help clinicians identify opportunities for improvement.

CMS asks for feedback on many MVP implementation issues, including:

- How to ensure different specialty-specific measure sets are equitably constructed, so one measure set is not easier to do well on than another.

participant” or a “partial qualifying APM participant” can meet their MIPS reporting obligations by participating in that A-APM. In addition, clinicians in non-advanced APMs (including one-sided risk models) can meet their MIPS reporting obligations by participating in that APM.

³³ Clinicians with low Medicare volumes are also exempt from MIPS.

- How to operationalize MVP measure sets for multi-specialty group practices. Although clinicians in such practices would prefer to divide themselves up by specialty and only require clinicians to report on the measure set applicable to their specialty, CMS advises that there are numerous operational challenges to such an approach. One option CMS is considering would ask multi-specialty practices to report on multiple MVP measure sets.
- How to operationalize MVP measure sets for clinicians in small practices with limited infrastructure to support quality reporting and/or with small Medicare patient panels that cannot produce reliable measure results. CMS contemplates allowing such practices to report on fewer measures or alternative measure sets.
- How to enhance the performance feedback CMS gives clinicians.

Comment

The Commission appreciates CMS's acknowledgment of the problems with the MIPS program, such as its burden and complexity, its inability to generate meaningful information that differentiates performance, and the difficulty of producing reliable measure data for clinicians with small panels of Medicare patients.

MedPAC has heard much of the same feedback in our annual physician focus groups: More physicians know that they are participating in MIPS compared to three years ago, but physicians continue to express confusion with requirements and many cannot identify the measures they are reporting for MIPS because office staff or their parent health system manage meeting the MIPS requirements. Physicians report that MIPS is not changing their behavior other than by increasing their documentation requirements.

Problems with MIPS led MedPAC to recommend that the Congress eliminate the program in our March 2018 report.³⁴ In MIPS's place, we recommended a Voluntary Value Program (VVP), through which groups of clinicians would receive increases or decreases to their PFS payment rates based on their performance on a uniform set of measures assessing outcomes, patient experience, and value. These measures would be calculated by CMS from claims and surveys—eliminating clinician reporting requirements.

While we still believe MIPS should be eliminated and replaced with something like our VVP, we recognize that the MIPS statute constrains CMS's ability to shift to a model that reflects all of our recommended VVP program features. We therefore offer suggestions to CMS that are meant to minimize aspects of MIPS that the Commission believes are problematic. In general, MedPAC applauds CMS's effort to move away from the current program toward one that could reduce MIPS's complexity and burden, incorporate more meaningful population-based outcome measures, and facilitate providers' movement into A-APMs, but MedPAC has concerns with certain aspects

³⁴ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare Payment Policy*. Washington, DC: MedPAC.

of the proposed MVP framework, such as the use of specialty- or condition-specific clinical process and intermediate outcome measures. More specific comments follow.

MedPAC strongly supports CMS's plan to assess clinicians using "a population health administrative claims-based measure set." These measures align with some of the measures we contemplated for the Commission's VVP.³⁵ Examples of CMS-administered measures that we envisioned in our illustrative VVP include measures of readmissions; avoidable hospitalizations; ED visits; mortality; Medicare spending per beneficiary (e.g., Parts A and B costs prior to, during, and 30 days following an inpatient hospital stay); total cost of care per beneficiary (e.g., total Medicare Parts A and B costs for a beneficiary during a performance period); and performance on the Consumer Assessment of Healthcare Providers and Systems[®] patient experience surveys.³⁶ CMS should consider using more of these uniform population-based measures of outcomes, patient experience, and value in MIPS because they are comparable with measures used to assess A-APM performance, can be used by the Medicare program to assess quality across time and the delivery system, and do not require additional clinician reporting.

MedPAC disagrees with CMS's assertion that claims-based outcome measures are "applicable" to primary care clinicians but have "less relevance" for some specialists, and that specialty-specific measure sets containing process measures and intermediate outcome measures are therefore needed. We believe that holding all providers accountable for the same set of outcome measures will align their incentives, encourage coordination between providers, and promote meaningful change in the delivery system. For example, holding all clinicians accountable for avoidable hospitalizations of their patients would give specialists an incentive to collaborate with primary care practitioners to provide appropriate, high-quality, and timely care to keep patients out of the hospital. The Secretary should therefore drop specialty- and condition-specific measure sets from MIPS and instead use a small set of claims-based outcome measures, patient experience measures, and value measures like the ones mentioned above in order to send a stronger signal to clinicians about where to focus their quality improvement efforts. Using a consistent set of measures for all providers will also eliminate inequities between clinicians, since different specialty-specific measure sets would inevitably be easier or harder to perform well on than others. It will also minimize clinician reporting burden, including for multi-specialty group practices whose clinicians could otherwise be required to report on multiple MVP measure sets.

If CMS believes the MIPS statute prevents the agency from relying entirely on measures of outcomes, patient experience, and value, CMS should at least minimize the scoring weight assigned to other types of measures. For example, if CMS chooses to use measures of clinical processes and intermediate outcomes, it should give these measures much less scoring weight than outcome measures. We note that this would be consistent with the MIPS statute's requirement that

³⁵ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

³⁶ CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.

“the Secretary shall, as feasible, emphasize the application of outcome measures” in the quality category.³⁷

Many measures cannot be reliably calculated for individual clinicians or for small practices with small Medicare patient panels. Rather than exempting these clinicians from measurement or requiring them to report on fewer measures or alternative measures, CMS should encourage clinicians to elect to be measured as a virtual group that is sufficiently large for performance assessment. Clinicians already have the ability to be measured as part of a virtual group under MIPS; this policy should be continued, but CMS should facilitate clinicians’ ability to participate as part of *larger* groups. CMS could provide technical assistance to clinicians by identifying virtual referral networks consisting of other clinicians that their patients see. CMS could also encourage clinicians to form reporting groups based on groups they are already a member of, such as accountable care organizations, independent practice associations, local medical societies, or networks of clinicians affiliated with a hospital or health system. This would allow for aggregation of clinicians to reach a sufficiently large size so that differences in performance can be reliably measured.

Finally, MedPAC supports CMS’s proposal to give enhanced data and performance feedback to clinicians. Such data should be as timely as possible, clinician-specific, include comparative benchmarks, and allow clinicians to identify specific outlier patients who are in need of closer management.

Conclusion

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship. If you have any questions, or require clarification of our comments, please feel free to contact James E. Mathews, the Commission’s Executive Director, at 202-220-3700.

Sincerely,



Francis J. Crosson, M.D.
Chairman

³⁷ See Social Security Act Section 1848(q)(2)(C)(i).