

September 4, 2018

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-1693-P

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) **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**, published in the *Federal Register*, vol. 83, no. 145, pages 35704 to 36368. 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:

- Determination of practice expense relative value units (RVUs)
- Modernizing Medicare physician payment by recognizing communication technology-based services
- Potentially misvalued services under the physician fee schedule (PFS)
- Payment rates under the Medicare PFS for nonexcepted items and services furnished by nonexcepted off-campus provider-based departments of a hospital
- Evaluation & Management (E&M visits)
- Chronic care management services in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Part B drugs: Application of an add-on percentage for certain wholesale acquisition cost (WAC)-based payments
- Clinical laboratory fee schedule (CLFS)
- Medicare Shared Savings Program (MSSP) quality measurement
- The Quality Payment Program: Year 3

Determination of practice expense relative value units (RVUs)

Practice expense RVUs are intended to cover the direct and indirect costs of operating a practice. Direct practice expenses include three components: medical equipment, medical supplies, and clinical staff. Indirect practice expenses include administrative labor, office expenses, and all other expenses. CMS collects information on the types and quantities of equipment, supplies, and clinical staff used for each service and the price of each of these inputs. CMS uses these data to determine the direct practice expense of each service. CMS has not systematically updated the prices of equipment and supplies since 2004–2005. For this proposed rule, CMS contracted with StrategyGen, a market research firm, to update these prices. StrategyGen used a variety of sources to estimate current prices for equipment and supplies, such as surveys of vendors, physician panel validation of market research results, the General Services Administration (GSA), and a database with discounted prices. StrategyGen recommended updated prices for about 1,300 supplies and 750 equipment items. If CMS adopts these recommendations, there would be large shifts in practice expense RVUs for individual codes with supplies or equipment that have major pricing changes.

CMS proposes to adopt these updated prices because the agency believes that using the most current pricing information instead of relying on prices that are more than a decade old will improve payment accuracy. To reduce the impact of new prices on Medicare payments for individual codes and specialties, CMS proposes to phase in the new prices over a four-year period. This phase in period would be consistent with the transition periods that CMS has previously used when making substantial changes to practice expense data and methods.

To maintain relativity between the clinical staff, equipment, and supplies components of practice expense RVUs, CMS believes that the wage rates for clinical staff should also be updated. CMS seeks comment on whether to update the wage rates during the four-year transition to new prices for equipment and supplies or to update the wage rates after the four-year transition period. The rationale for waiting until after the transition period is to avoid other potentially large changes in practice expense RVUs.

Comment

The Commission strongly supports CMS's proposal to adopt updated prices for equipment and supplies that are used to determine practice expense RVUs. In addition, CMS should update the wage rates for clinical staff without delay.

As we stated in our June 2006 report to the Congress, the Commission believes that CMS needs recurring and accurate sources of data to keep practice expense RVUs up to date.¹ Such data sources should capture the prices of equipment and supplies, wage rates for clinical staff, the types and quantities of direct practice expense inputs, and specialties' practice costs. Inaccurate prices

¹ Medicare Payment Advisory Commission. 2006. *Report to the Congress: Increasing the value of Medicare*. Washington, DC. MedPAC.

could lead to distortions in the practice expense RVUs. Therefore, we support CMS's proposal to update the prices for equipment and supplies using current, objective data from StrategyGen.

In addition, CMS should set a reasonable schedule for periodically updating the prices of all equipment and supply items in the future to ensure that they are accurate. It is also important to update the prices of expensive equipment and supplies more frequently than lower-cost items because they may account for a large share of a service's practice expense payment. In the Part B proposed rule for 2011, CMS proposed using the GSA medical supply schedule to update the prices of supplies with estimated prices of \$150 or more every two years.² Although CMS did not implement this proposal, the agency should consider adopting it in the future.

We urge CMS to phase in the new prices for equipment and supplies during a shorter transition period than the proposed four-year transition. Although a four-year transition is consistent with the previous transition periods that CMS has adopted when making substantial changes to practice expense data and methods, CMS's estimates of current prices for equipment and supplies are time sensitive. By the time a four-year transition is over, the updated prices may be out of date. In addition, a shorter transition period—such as two years—would be consistent with a biennial schedule for updating the prices of expensive equipment and supplies.

CMS last updated clinical staff wages in 2002. Because wages for different types of clinical staff increase at different rates, practice expense RVUs could become less accurate over time if wage data are not kept up to date. Therefore, we urge CMS to update the wage rates for all types of clinical staff as soon as practicable. CMS should not wait until the end of the transition period for new prices for equipment and supplies to update wage rates. We understand CMS's concern that updating wages could lead to potentially large changes in practice expense RVUs. However, this concern should be outweighed by the benefits of paying more accurately for physicians' clinical staff costs. In addition, CMS should set a reasonable schedule to periodically review and update wage data in the future to maintain payment accuracy.

Modernizing Medicare physician payment by recognizing communication technology-based services

CMS proposes to expand Medicare coverage for several communication technology-based services. CMS distinguishes these services from Medicare telehealth services, as defined by section 1834 (m) of the Social Security Act.

CMS asserts that communication technology-based services differ from Medicare telehealth services because they do not “ordinarily involve, and are defined, coded, and paid for as if they were furnished during an in-person encounter between a patient and a health care professional.” In other words, they are not telehealth services because they never contemplate a face-to-face in-person visit between the patient and the clinician, and therefore CMS asserts that they are not

² Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2010. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Proposed rule. *Federal Register* 75, no. 133 (July 13): 40039–40718.

subject to the statutory limitations governing telehealth (that services originate in pre-defined originating sites in rural areas, not from the patients' homes, and only for specific services).

CMS proposes to begin paying separately for several communication technology–based services beginning on January 1, 2019:

- Brief communication technology–based services, referred to as virtual check-ins, would be billable when a clinician has a brief non-face-to-face check-in with an established patient via communication technology (e.g., phone call or email) to assess whether the patient's condition necessitates an office visit. CMS will not pay separately for this service if the virtual check-in is related to an E&M service in the preceding 7 days or followed by a related face-to-face E&M visit in the subsequent 24 hours.
- Remote evaluation of pre-recorded patient information, referred to as store-and-forward services, would include the remote evaluation of recorded video and/or images submitted by the patient, including the interpretation with verbal follow-up with the patient within 24 hours. Similar to the above code, CMS will not pay separately for this service if the virtual check-in is related to an E&M service in the preceding 7 days or followed by a related face-to-face E&M visit in the subsequent 24 hours.
- CMS proposes six levels of codes for interprofessional internet consultations, which vary by the time involved in the consultation. These codes describe the assessment and management services conducted through telephone, internet, or electronic health record that are furnished when a patient's treating clinician requests the opinion and/or treatment of a consulting clinician without the need for a face-to-face visit with the consulting clinician. CMS also proposes requiring the treating clinician to obtain verbal beneficiary consent in advance of these services, which would be documented in the medical record.

Within this section of the Part B NPRM, CMS also proposes to add two new Medicare telehealth service codes related to prolonged E&M services that exceed the typical service time of a primary procedure. These two codes represent time spent by the clinician for the first 30 minutes beyond the typical service time and each additional 30-minute block of time, respectively.

Comment

The principles and conclusions included in the Congressionally-mandated chapter on telehealth in MedPAC's March 2018 report directly apply to CMS's proposed communication technology–based services.³ Although CMS defines communication technology–based services as non-telehealth services that are not subject to the limitations of Section 1834(m) of the Act, the Commission's principles and conclusions apply to both types of services because both are intended to leverage technology to create convenience for patients and providers and reduce spending.

In the report, the Commission suggested that policymakers adopt a measured approach to considering the incorporation of telehealth services into the fee schedule or other parts of the

³ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare program. The Commission found that telehealth services and other similar services are currently covered within several areas of the Medicare program. In some areas of the Medicare program, providers or payers bear some financial risk, but the fee schedule is largely a fee-for-service environment. The Commission also concluded that many of the differences between the coverage of telehealth services under Medicare and commercial plans are essentially derived from the different payment environments in which they operate. Under Medicare FFS, the taxpayers and beneficiaries that fund the program are not indemnified against the incentive of patients and providers to increase volume, whereas commercial plans operating in a managed care environment have policy tools to control these volume incentives.

Therefore, under FFS Medicare and the fee schedule, the Commission supports evaluating individual types of telehealth services for potential coverage using the principles of cost, access, and quality before new services are covered. If a given service demonstrates evidence of balancing these principles, policymakers should consider adopting that service. But if the service does not clearly balance these principles or if the evidence is unclear, policymakers should consider testing it first, as commercial plans tend to do.

The Commission's specific comments on CMS's proposals are summarized in three categories.

Medicare FFS should not make payments per click or per call

In unconstrained FFS, CMS should be extremely prejudicial toward proposals that would pay per click or per call, which provide an incentive for increased volume without improvements in quality. We do not believe that this payment method is the best way to manage patient care between visits.

Consequently, we do not agree with CMS's proposal to broadly pay for the virtual check-ins and remote evaluation services in unconstrained FFS. For example, direct-to-consumer (DTC) telehealth services, which allow the patient direct any-time access to clinicians for routine health care needs, appear to expand access, but at a potentially significant cost and without evidence of improved quality. Due to their greater convenience, these services are at risk of misuse by patients or providers. The Commission is specifically concerned that the proposed virtual check-ins and remote evaluation services are analogous to DTC services because they are patient-initiated, intended for routine care, have the potential for video and telephone use, and seek to expand convenience. Therefore, they have the same risk of excess utilization (and spending) without commensurate value to the program.

CMS could test these codes in a more limited fashion, including in a limited set of geographic areas or for patients with certain conditions that might be more likely to reduce their use of unnecessary office visits. With respect to remote evaluation services, CMS may wish to conduct a limited test of these services for conditions where evidence of clinical benefit exists (such as dermatological and ophthalmological services) similar to how these services are currently used under the Veterans Administration. In any case, the Commission agrees with CMS that it is important for patients who receive the virtual check-in to consent to receiving these services and

urge CMS to impose a frequency limit on virtual check-ins, because their convenience could lead to overuse.

When services that were previously bundled are paid separately, CMS should revalue the bundled code

Throughout the rule, CMS makes proposals to pay for services that were previously bundled into other codes or assumed in pre- and post-service time. CMS should also concurrently revalue these existing codes now that CMS proposes to pay separately for certain components.

In particular, the Commission is concerned about how the use of the new virtual check-in code will interact with existing services such as chronic care management (CCM) services and transitional care management (TCM) services. There appears to be a degree of redundancy in these codes, because these codes are among the few service codes within the fee schedule that potentially include telehealth services as a part of a larger bundled payment.

In addition, CMS proposes to pay for a new set of interprofessional consultation services, capturing interactions between clinicians. Prior to this year, CMS identified these services as bundled into the office/outpatient evaluation and management codes, and the vignette (describing a typical service) for office/outpatient E&M codes specifically describes care coordination, telephonic or electronic communication assistance, and other necessary management related to the office visit as well as coordination of care with other physicians in the code description. However, in separately paying for these codes, CMS is not proposing a concurrent revaluation for the existing E&M codes. We believe that CMS should revise the work and practice expense values for the codes in which the services were previously bundled.

CMS should consider the impact on beneficiaries' cost sharing

The virtual check-in code and remote evaluation codes would 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 patients were previously not charged separately for the virtual check-in.

In addition, the interprofessional virtual consultation codes, while they do entail discussion regarding a patient's care, may happen without the patient's explicit knowledge. Some of the proposed payments for these codes are akin to the payment for 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.

The potential that beneficiaries face significant financial exposure is another reason for constraining or limiting these services, given the likelihood for significant volume without improvements in beneficiary outcomes or reductions in program spending.

Potentially misvalued services under the physician fee schedule (PFS)

The payment rate for many surgical services includes the procedure itself and certain services that are provided immediately before and after the procedure (the global package). There are three categories of global codes based on the number of postoperative days included in the global period:

- 0-day global codes, which include the procedure and preoperative and postoperative physician services on the day of the procedure;
- 10-day global codes, which include the same services as the 0-day global codes plus physician visits related to the procedure during the 10 days after the procedure; and
- 90-day global codes, which include the same services as the 0-day global codes plus preoperative visits furnished one day before the procedure and postoperative visits during the 90 days after the procedure.

CMS has not previously collected data on how many postoperative visits are actually performed during the global period. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to collect data on the number and type of postoperative visits and use these data to assess the accuracy of global codes. From July 1, 2017, through December 31, 2017, CMS required clinicians in practices with at least 10 clinicians in 9 states to report postoperative visits that occurred after surgical procedures. Among 10-day global codes, clinicians reported one or more postoperative visits for only 4 percent of the procedures. Among 90-day global codes, clinicians reported one or more postoperative visits for 67 percent of the procedures.

CMS seeks comment on whether it might be reasonable to assume that many of the visits included in the 10-day global package are not actually provided or whether there is an alternative explanation for the small share of procedures that had at least one postoperative visit reported by the clinician. For example, it is possible that a clinician other than the one who performed the procedure provided a postoperative visit. It is also possible that some or all of the postoperative visits occurred after the global period ended. CMS also asks for comment on whether to change the global period and review the RVUs for 10-day global codes when the data suggest that postoperative visits are rarely provided by the clinician who performed the procedure.

Comment

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. Under this approach, CMS would remove the postoperative 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.

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.^{4,5,6} 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 payment for the global package. For example, OIG linked 202 cardiovascular procedures with 90-day global periods with their associated postoperative visits.⁷ For 132 of these procedures (65 percent), physicians provided fewer visits than were included in the global payment rates.

The analysis presented by CMS in the proposed rule is consistent with OIG's findings. CMS'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. CMS notes that one potential explanation for these results is that many clinicians who were required to report postoperative visits did not consistently report them. To test this hypothesis, CMS analyzed data for a subset of clinicians who provided at least 10 procedures with 90-day global periods. These clinicians reported at least one postoperative visit for 87 percent of their procedures with 90-day global periods. However, they reported a postoperative visit for only 16 percent of their procedures with 10-day global periods. This finding suggests that, among this subset of clinicians, the low frequency of postoperative visits associated with 10-day global codes reflects actual clinical practice rather than underreporting. If so, this result appears to conflict with the standard of practice in which patients generally have a postoperative visit within 10 days of a surgical procedure.

There are two potential explanations for CMS's 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 CMS's data. The global payment policy assumes that the same clinician who performs the procedure also provides all of the post-operative care. However, a 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.⁸ In these cases, there should be a formal transfer of care

⁴ 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.

⁵ 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.

⁶ 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.

⁷ 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.

⁸ Mehrotra, A., C. Gidengil, L. Hilborne, et al. 2016. *Developing codes to capture post-operative care*. Santa Monica, CA: RAND.

between the clinician who performed the surgical procedure and the clinician who provided the postoperative visits. Each physician would bill for the same code using a modifier, and CMS would split the payment between the two physicians. If there is no transfer of care agreement, however, CMS would pay the full global payment amount to the clinician who performed the procedure and also pay separately for each postoperative visit furnished by the second clinician. In other words, CMS would be paying twice for the same service.

In the Part B 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.⁹ 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 furnish.

We continue to agree with the concerns expressed by CMS about 10-day and 90-day global codes in the Part B proposed rule for 2015. 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 provided the procedure without a transfer agreement between the two clinicians. Because of the budget neutral nature of the fee schedule, revaluing 10-day and 90-day global codes would redistribute money from surgical procedures to services that are currently undervalued, such as E&M services.

We also urge CMS to regularly collect accurate data on the number and type of visits provided after common procedures. CMS should use this information to construct bundled payments that accurately reflect the typical frequency of postoperative visits. CMS should also develop a method to prevent duplicative payments for postoperative visits that are part of the bundled payment. For example, CMS could require that the clinician who performs the procedure include a modifier on the claim if the clinician does not intend to provide postoperative care. CMS could also require the clinician who provides the postoperative care to include a modifier on the claim for each visit even if there is no transfer agreement with the clinician who performed the procedure. CMS could use this information to adjust the payment for the bundled code to reflect that the postoperative visits were provided by another clinician.

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

⁹ 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.

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.

Payment rates under the Medicare PFS for nonexcepted items and services furnished by nonexcepted off-campus provider-based departments of a hospital

Section 603 of the Bipartisan Budget Act of 2015 prohibits certain provider-based departments (PBDs) that are located off a hospital campus (off-campus PBDs) from billing under the hospital outpatient prospective payment system (OPPS). This provision applies to off-campus PBDs that began providing OPPS services on or after November 2, 2015 (the date of passage of the Act). CMS calls these facilities “nonexcepted off-campus PBDs.” Instead of billing under the OPPS, nonexcepted off-campus PBDs must bill under “the applicable payment system,” which CMS established as the PFS.

The Congress passed this legislation in response to hospitals acquiring freestanding physician offices, establishing these offices as PBDs, and billing for their services under the OPPS. Medicare makes separate payments for the professional services of the practitioner under the PFS and for the facility services under the OPPS. In many cases, a physician’s practice that is purchased by a hospital stays in the same off-campus location and treats the same patients. The acquisition of freestanding offices has led to a shift of billing of ambulatory services from offices to PBDs.¹⁰ Because these services are paid under both the OPPS and PFS, they result in increased Medicare spending, which leads to higher costs for taxpayers and higher cost sharing for beneficiaries, without any changes in the services provided.

For 2018, CMS determined that the payment rate for services provided at nonexcepted off-campus PBDs would generally equal 40 percent of the OPPS rate (i.e., a 60 percent reduction to the OPPS rate). CMS applies this 60 percent reduction to all services except for drugs that are separately paid under the OPPS and services that are currently paid using PFS rates in hospital outpatient departments, such as physical therapy. CMS calculated the 60 percent reduction by comparing the OPPS rate with the PFS rate for the 25 most frequently billed codes in all off-campus PBDs in 2016.

For 2019, CMS proposes to continue applying a standard, across-the-board 60 percent reduction to the OPPS rate for all services provided at nonexcepted off-campus PBDs except for separately-paid drugs and services that are currently paid at PFS rates. CMS determined this adjustment by comparing the OPPS rate with the PFS rate for the 25 most frequently billed codes in nonexcepted off-campus PBDs in 2017. In addition, CMS proposes to maintain this standard adjustment factor in future years until updated data or other considerations indicate that a change is warranted. In other words, CMS would continue to apply the same 60 percent reduction to the OPPS rate to all services provided at nonexcepted off-campus PBDs even though the difference between the OPPS rate and the PFS rate varies for many services.

¹⁰ Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Comment

In 2012 and 2014, the Commission recommended a different approach to address the issue of the higher Medicare payments that result from hospitals converting freestanding offices to off-campus PBDs.^{11,12} Our approach would identify services that meet a certain set of criteria. For services that meet these criteria, the OPSS payment rates would be adjusted so that total Medicare payments are the same whether the service is provided in a freestanding office or a hospital outpatient department. The adjustments should apply at the level of ambulatory payment classifications (APCs), which are groups of services with clinical and cost similarity that are used in the OPSS. This policy would generally lead to reductions in OPSS rates. Because our recommended approach does not distinguish between on-campus and off-campus PBDs, it would be less complex to implement than the policy in Section 603. However, we recognize that the Congress took a different approach than ours based on whether an off-campus PBD began billing after a certain date (November 2, 2015).

To ensure that total Medicare payments for a service are the same regardless of setting, CMS should calculate separate adjustment factors for each APC instead of applying an across-the-board adjustment for all services furnished in nonexcepted off-campus PBDs. This method is consistent with Section 603 and consistent with the method we recommended in 2012 and 2014. Because differences in payment rates across settings often vary from service to service, applying a single adjustment factor leads to payment rates that are too high for certain services and too low for others. In addition, the adjustment factors for APCs should account for differences in payment policies between settings. For example, the OPSS is more likely to package ancillary services with the primary service than the PFS.

We recognize that it is not straightforward to compare payment rates between the OPSS and PFS for certain codes. However, there are methods that CMS could use to address these specific cases. For example, there is a single code in the OPSS for a hospital outpatient clinic visit for the assessment and management of a patient (G0463), which corresponds to ten codes in the PFS for different levels of office visits for new and established patients. To determine a site-neutral payment rate for G0463, CMS could calculate the average PFS rate for the ten office visit codes, weighted by the volume of each code when provided in an outpatient department. CMS would then compare this volume-weighted average PFS rate to the OPSS rate for G0463. There are also codes that are paid under the OPSS but not under the PFS. CMS could determine site-neutral rates for these codes by applying the standard adjustment factor that it proposes for 2019 (40 percent of the OPSS rate).

Evaluation and management visits

Office or 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 2016. There are

¹¹ Medicare Payment Advisory Commission. 2012. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

¹² Medicare Payment Advisory Commission. 2014. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

five levels of office/outpatient E&M services, representing the range of resources required to provide the service (with Level 1 requiring the lowest 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.

Presently, clinicians must document in the medical record the history, physical exam and medical decision making sufficient to justify the level of E&M code they bill (Table 1). In Medicare, they must use one of two sets of documentation guidelines (created in 1995 and 1997). These documentation guidelines outline the required history, exam and medical decision making needed to bill each level of E&M. The two sets of guidelines are similar, with minor variations in the description of the physical exam required.

Table 1. Elements of documentation requirements for E&M services

- History of present illness
 - Physical examination
 - Medical decision making, measured by
 - Problem—Number of diagnoses/treatment options
 - Data—Amount and/or complexity of data to be reviewed
 - Risk—Risk of complications and/or morbidity
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In the NPRM, CMS has proposed a number of changes to billing for office/outpatient E&M services, to take effect in 2019. These changes include:

- Adding two additional options for clinicians to document the level of E&M service they bill (time and medical decision making), making a total of four options for clinicians to document the level of E&M service billed;
- Combining the Level 2–5 codes into one composite code;
- Requiring that clinicians document only a Level 2 visit to receive the new composite code;
- Creating add-on codes for primary care;
- Creating add-on codes for certain specialty care;
- Creating a new prolonged E&M code (accounting for an additional 30 minutes of clinician time);
- Applying a multiple-procedure payment reduction for standalone E&M codes billed on the same day as a 0-day global procedure codes;
- Creating a new set of evaluation and management codes for podiatry services; and
- Proposing to pay separately for E&M services provided on the same day by the same clinician (or two clinicians with the same specialty in the same practice).

CMS's rationale for their changes is that the documentation guidelines have become outdated with changes in clinical practice, and that clinicians have stated that the guidelines are ambiguous, do not clearly differentiate between levels of E&M codes, and lead to repetitive and duplicative documentation of the history and examination.

In CMS’s proposal, clinicians would still bill one of the five E&M codes, but CMS would make one composite payment for the Levels 2–5 codes (Table 2). The documentation requirement for the composite payment would be equal to the current standard for a Level 2 visit.

Table 2. Evaluation and management payment amounts in the office or outpatient setting

New patient			Established patient		
<i>HCPCS code</i>	<i>2018 payment</i>	<i>Proposed composite rate</i>	<i>HCPCS code</i>	<i>2018 payment</i>	<i>Proposed composite rate</i>
99201	\$45	\$44	99211	\$22	\$24
99202	\$76	\$135	99212	\$45	\$93
99203	\$110		99213	\$74	
99204	\$167		99214	\$109	
99205	\$211		99215	\$148	

Note: HCPCS (Healthcare Common Procedure Coding System). This table reflects CMS’s proposed methodology for setting the composite rate, which averages the inputs for the individual codes, weighted by volume based on utilization data from the past five years.

Because this key change would have significant impacts on aggregate Medicare payments by clinician specialty (and significant changes in clinician revenue at the individual level), CMS is also proposing a series of add-on codes to be used with the revised E&M code set. These add-on codes include one to capture a prolonged E&M service, a visit complexity code for primary care services, and a visit complexity code for certain specialty care (Table 3).

Table 3. Proposed add-on codes for evaluation and management services

HCPCS code	Description	Total RVUs, office visit	Proposed payment rate for 2019, office visit
GPRO1	Prolonged E&M or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes	1.87	\$67.41
GPC1X	Visit complexity inherent to E&M associated with primary medical care services that serve as the continuing focal point for all needed health care services	0.15	\$5.41
GCG0X	Visit complexity inherent to E&M associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management–centered care	0.38	\$13.70

Note: RVU (relative value unit), E&M (evaluation and management).

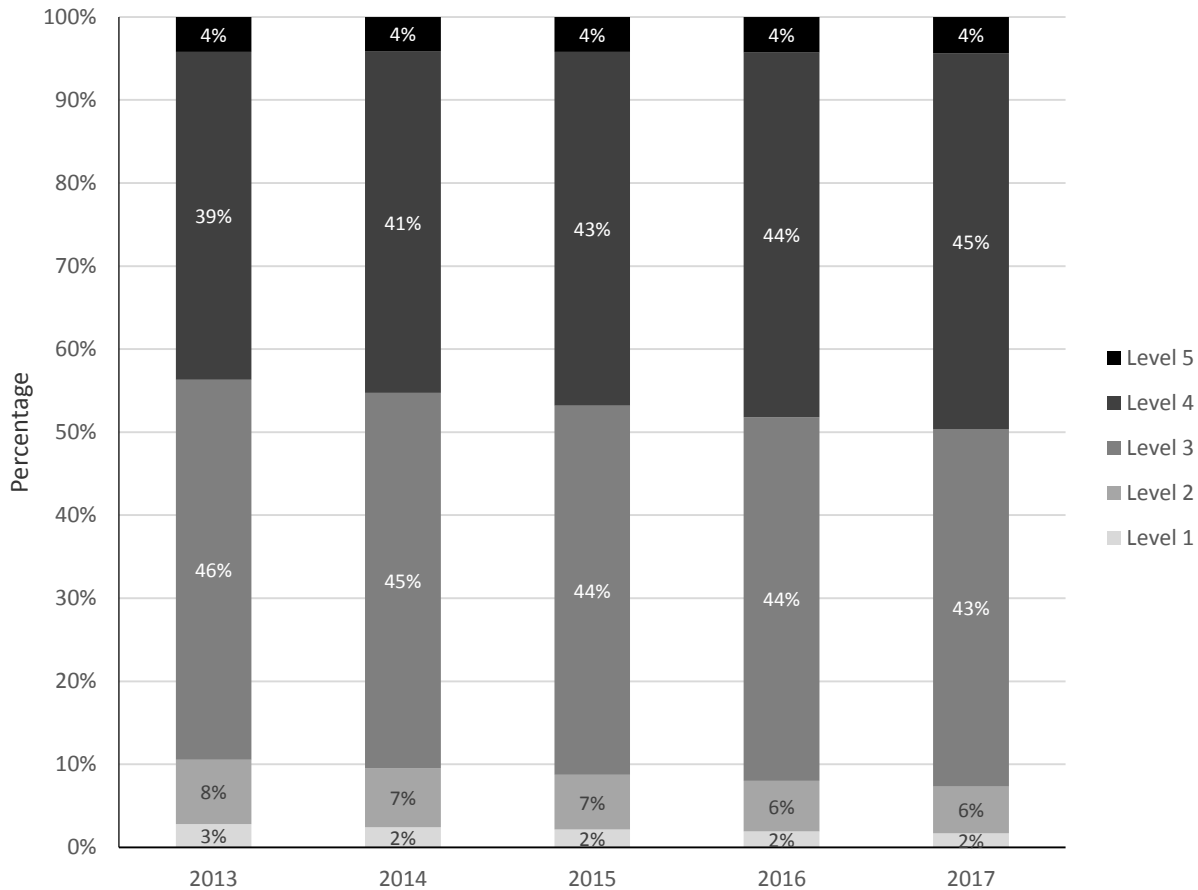
CMS seeks comment on defining the specific activities and specialties that would be included in GPC1X and GCG0X (the primary care and certain specialty add-on codes for visit complexity) and on the proposed valuation of these codes. CMS's proposed valuation for the add-on code for visit complexity for certain specialties is more than twice as high as the proposed valuation for the add-on code for primary care, and the primary care add-on code would only be paid when billed with a visit with an established patient, not a new patient. The add-on code for certain specialties could be billed with either new or established patients.

Comment

We support simplifying the documentation guidelines for E&M office/outpatient services. However, we strongly disagree with CMS's proposal to pay a composite rate for Level 2–5 office/outpatient E&M visits. Such an approach departs from the resource-based relativity underlying the fee schedule, while creating an incentive for clinicians to avoid more complex patients.

In general, MedPAC agrees 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). In addition, we (and others) have found that the average level of codes billed has increased over time. Just in the last five years, billing for Level 4 established-patient office visits has increased—as a percentage of all such visits—from 39 percent to 45 percent while billing for Levels 1 through 3 has decreased (Figure 1).

Figure 1. Distribution of service units among office visit levels



Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

While some increases in E&M coding are likely due to increases in patient complexity, some are also likely due to coding intensity. The variation in payment rates among the different levels of E&M services can be substantial. Within established-patient office visits, for example, the payment rate for a Level 4 visit is 47 percent higher than the payment rate for a Level 3 visit. Additional documentation included in the medical record, while providing a rationale for billing a higher-level code, may not correspond to a real increase in service complexity, a finding of the Office of the Inspector General.¹³

CMS’s policy would not address the issue of coding intensity. For example, the agency is not proposing to prospectively adjust the composite payment amounts to account for this coding intensity. Nonetheless, revisiting the guidelines may lead to documentation that better distinguishes the differences among levels of E&M services.

¹³ Office of Inspector General, Department of Health and Human Services. 2014. *Improper payments for evaluation and management services cost Medicare billions in 2010*. OEI-04-10-00181. Washington, DC: OIG.

We support in particular 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 and 80 percent of the variation in work RVUs in the fee schedule.¹⁴ Specific to E&M services, research has shown that time is predictive of physician perceptions of the work required to furnish the services.¹⁵ Further, some psychotherapy services are paid based on the amount of time involved in the service. Like E&M visits, psychotherapy visits involve a face-to-face encounter and management of the patient's condition.

If CMS finalizes the use of time as an option for documentation, we agree that CMS should monitor the results of clinicians' using time as the governing factor in selecting the appropriate E&M visit level. Indeed, we urge CMS to go further and consider requiring clinicians to report the time for each visit to CMS (for example, by using a modifier on the claim). CMS could use the information on time to differentiate the level of effort among E&M codes and revalue the E&M codes.

We do not support CMS's proposal to pay one composite rate for Levels 2–5 E&M codes. First, the proposed code would be overly broad, as is the composite E&M code in the OPSS.¹⁶ And while CMS has proposed a number of add-on codes so that most specialties would have aggregate payment changes of less than 3 percent, the effect for any given clinician could be substantial. In particular, clinicians may be less willing to see complex patients because they would be paid the same amount for less complex and more complex patients. Clinicians who treat less complex patients would receive a payment increase at the expense of clinicians who treat more complex patients.

Because we do not agree with CMS's core proposal to pay one composite rate (instead supporting differentiation in payment to account for differences in the required resources to provide the services), the add-on codes are thus unnecessary. Furthermore, we are concerned that the add-on codes are not well-specified in terms of who can bill each code and under what circumstances. For example, are only certain specialties allowed to bill the primary care code? Is the code appropriate for all services billed by a clinician, or only those services that require additional time or intensity? Only certain specialties would be eligible to bill for the add-on code for visit complexity (GCG0X). However, the specialties who treat complex patients may change in the future as medical practice evolves.

Finally, CMS's proposal does not fundamentally change the imbalance in the fee schedule between E&M services and other services. The Commission has been concerned for several years that

¹⁴ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

¹⁵ Berenson, R. A., P. Basch, A. Sussex. 2011. Revisiting E&M visit guidelines—a missing piece of payment reform. *New England Journal of Medicine* 364, no. 20 (May 19): 1892–1895.

¹⁶ Medicare Payment Advisory Commission. 2013. MedPAC comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Medicare Program: Hospital Outpatient Prospective Payment System; Ambulatory Surgical Center Payment System; Hospital Outpatient Quality Reporting Program; Quality Reporting for Ambulatory Surgical Centers; Inpatient Rehabilitation Facilities Quality Reporting Program; Revision to Quality Improvement Organization Regulations." Letter to the Administrator. http://www.medpac.gov/docs/default-source/comment-letters/08302013_medpac_opps_asc_comment.pdf?sfvrsn=0.

ambulatory E&M services are underpriced in the fee schedule relative to other services, such as procedures. 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. As a result, in MedPAC's June 2018 report to the Congress, we discussed a budget-neutral approach to rebalance the fee schedule that would increase payment rates for ambulatory E&M services while reducing payment rates for other services.¹⁷

On the specific issue of whether Medicare should pay for multiple E&M visits on the same day with the same clinician (or two clinicians in the same specialty and same group), CMS should apply a multiple procedure payment reduction to account for the economies in pre- and post-service time (as well as the history or exam portion of the face-to-face encounter) when the patient has two visits on the same day to the same clinician (or two clinicians in the same specialty in the same group practice).

The Commission supports CMS's proposal to apply an MPPR to standalone E&M services provided on the same day as a 0-day global procedure code. We agree that when a standalone E&M visit occurs on the same day as a procedure, there are efficiencies (e.g., in pre-service and post-service clinician work and practice expense) that are not accounted for in the current payment system. Applying an MPPR to the procedure or visit would account for these efficiencies.

CMS, in the NPRM, also requested feedback for considering E&M code changes in other settings (such as the inpatient hospital and emergency department). We plan, over the coming analytic cycle, to evaluate the relative valuation of services provided in hospital emergency departments, including the use of the ED setting for low-acuity cases. We hope this work will be helpful to CMS in developing future policy in this area.

Chronic care management services in FQHCs and RHCs

In the NPRM, CMS proposes to pay for a new code to account for direct clinician activity for chronic care management (CCM). This is in addition to three currently payable CCM codes, which account for clinician-directed staff time for standard CCM and complex CCM, and an extended time code for complex CCM (Table 4).

¹⁷ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Table 4. Chronic care management codes

<i>Code</i>	<i>Status</i>	<i>Description</i>	<i>RVU (non-facility)</i>	<i>2019 payment amount (non-facility)</i>
99490	Paid starting in 2015	20 minutes or more of chronic care management (CCM) services	1.21	\$43.62
99487	Paid starting in 2017	60 minutes or more of complex CCM services	2.71	\$97.69
99489	Paid starting in 2017	Add-on code to complex CCM for each additional 30 minutes of clinical staff time	1.35	\$48.66
G0506	Paid starting in 2017	Add-on code to E&M, AWV, or Welcome to Medicare visit initiating CCM	1.84	\$66.33
994X7	Proposed new for 2019	30 minutes or more of CCM furnished by physician or other qualified health professional	2.06	\$74.26

Note: RVU (relative value unit), CCM (chronic care management), E&M (evaluation and management), AWV (annual wellness visit).

CMS proposes to allow FQHCs and RHCs to provide the new Chronic Care Management Code and be paid through the FQHC and RHC payment systems in the way that the existing CCM codes are payable.

Comment

We continue to believe that the types of care coordination activities covered in the fee schedule through the suite of CCM codes are currently contemplated (and so implicitly paid for) in the FQHC per diem payment and the RHC all-inclusive rate. As we outlined in our 2015 comment letter, the FQHC bundle is designed to cover all activities related to a comprehensive primary care service, even if they did not occur on the same day.¹⁸ Therefore, we do not support making duplicative payments to FQHCs and RHCs for the same activities. The separate payment through the FQHC and RHC payment systems do not trigger a budget-neutrality adjustment, and so represent additional spending for the Medicare program and its beneficiaries.

Part B drugs: Application of an add-on percentage for certain wholesale acquisition cost (WAC)-based payments

CMS proposes to reduce the add-on percentage for certain Part B drugs that are paid based on WAC from 6 percent to 3 percent beginning January 1, 2019.

¹⁸ Medicare Payment Advisory Commission. 2015. MedPAC comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016." Letter to the Administrator. <http://www.medpac.gov/docs/default-source/comment-letters/medpac-comment-on-cms-s-proposed-rule-on-the-physician-fee-schedule-and-other-revisions-to-part-b.pdf?sfvrsn=0>

Comment

The Commission supports CMS’s proposal. As the Commission noted in its June 2017 report to the Congress, reducing the add-on for certain WAC-priced drugs is a modest, positive step toward lowering drug costs for beneficiaries and the Medicare program and helps equalize payment rates between the time periods when a drug is ASP-priced versus WAC-priced.¹⁹

Clinical laboratory fee schedule (CLFS)

Beginning on January 1, 2018, Medicare began paying for clinical diagnostic laboratory tests at median private payer rates based on information reported by applicable laboratories. One criterion to qualify as an applicable laboratory is for an entity to receive more than 50 percent of its Medicare revenues from the CLFS and/or the physician fee schedule, referred to as the “majority of Medicare revenues threshold.” To determine this percentage, laboratories divide their CLFS and physician fee schedule revenue by the sum of their total revenue from Medicare Parts A and B, Medicare Advantage, and Part D.

In this rule, CMS proposes to remove Medicare Advantage revenues from the denominator of this calculation. CMS believes this change would allow a greater number of laboratories to qualify as an applicable laboratory because laboratories that derive a significant share of their revenue from Medicare Advantage would be more likely to qualify.

In response to stakeholder comments, CMS also solicits comments regarding two alternative approaches to defining an applicable laboratory.

Comment

The Commission supports CMS’s proposal to exclude Medicare Advantage revenues from the denominator of the “majority of Medicare revenues threshold,” and agree that this change could result in more laboratories qualifying as applicable laboratories in the future. Also, we believe CMS’s current method for identifying applicable laboratories—using laboratories’ NPIs—is preferable to both stakeholder-suggested alternatives—using CMS-1450 bill type 14x or CLIA certificates. Both of the stakeholder suggested alternatives would increase the complexity of reporting without any clear benefits.

Medicare Shared Savings Program (MSSP) quality measurement

Accountable care organization (ACOs) participating in the Medicare Shared Savings Program (MSSP) are required to completely and accurately report quality data that are used to calculate and assess their quality performance. In order to be eligible to share in any savings generated, an ACO must meet the established quality performance standard that corresponds to its performance year.

¹⁹ Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

The MSSP quality measure set in 2018 included 32 process and outcome measures covering the following four quality domains: patient experience measures (e.g., getting timely care); care coordination and patient safety (e.g., readmissions, screening for risks of falls); preventive health (e.g., influenza immunization), and at-risk populations (e.g., depression remission at 12 months).

CMS is proposing to add two patient experience measures to the MSSP quality measure set for performance year 2019 and subsequent years. CMS explains that the two measures, *care coordination* and *courteous and helpful office staff*, align with the goals of the program and are important to beneficiaries. These measures are based on questions included in the Consumer Assessment of Healthcare Providers and System (CAHPS) for ACOs beneficiary survey.

In October 2017, CMS launched the Meaningful Measures Initiative aimed at improving patient outcomes and reducing burden by using a reduced set of measures for patients, clinicians, and providers in quality programs. As a part of the initiative, CMS identified 19 high-priority areas for quality measurement with a focus on improving patient outcomes (e.g., admissions and readmissions to hospitals, patient's experience of care, transfer of health information, preventive care).

As a part of the Meaningful Measures Initiative, CMS proposes to remove a total of ten measures from the MSSP quality measure set. Three of the measures are claims-calculated outcome measures that are repetitive of other measures in the measure set. For example, the *skilled nursing facility readmissions* measure is captured in the *all-condition readmission* measure. CMS also proposes to remove six ACO-reported, process measures (e.g., *body mass index screening*, *medication reconciliation post-discharge*). CMS also proposes to retire the *use of imaging for low-back pain* because of low denominator numbers issues because the measure is specified for beneficiaries age 18 to 50.

Comment

The Commission has recently formalized a set of principles for measuring quality in the Medicare program.²⁰ Overall, quality measurement should be patient-oriented, encourage coordination, and promote delivery system change. The Commission asserts that Medicare quality incentive programs should use a small set of outcomes, patient experience, and value measures that are not unduly burdensome to assess the quality of care across different populations, such as beneficiaries enrolled in Medicare Advantage (MA) plans, ACOs, and fee-for-service (FFS) in defined market areas, as well as those cared for by specified hospitals, groups of clinicians, and other providers. Process measures are burdensome on providers to report, while yielding limited information to support clinical improvement. The goals of CMS's Meaningful Measures Initiative—to improve patient outcomes and reduce burden—align with the Commission's principles for quality measurement. Therefore, the Commission supports CMS's proposal to remove the ten repetitive or process measures from the MSSP quality measure set. We also support the inclusion of the two new patient experience measures that capture beneficiary access and experience with care.

²⁰ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

The Commission has found substantial use of low-value care (e.g., service that has little or no clinical benefit or care in which the risk of harm from the service outweighs the potential benefit) in FFS Medicare. According to our analysis, imaging for patients with nonspecific low back pain affects between 3.1 to 8.9 percent of Medicare beneficiaries.²¹ We encourage CMS to consider re-specifying the *ACO imaging for low-back pain* measure to include beneficiaries over age 50 and continue to use the measure in the ACO quality measure set.

The Quality Payment Program: Year 3

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 (QPP). In the NPRM, CMS proposes policies for the third year of the QPP (the 2019 reporting year, which will result in payment adjustments in 2021).

Comment

We note that CMS, in its regulatory impact analysis and information collection request (ICR) material, has not made a total burden estimate available for the cost of reporting to CMS for the QPP. Instead, CMS has produced a narrative table describing changes in the burden estimate and a table showing the net effect from a prior-year baseline trended forward. In prior years' rulemaking, CMS provided a summary table in the section discussing annual recordkeeping and submission requirements. These total burden costs were significant—for example, CMS estimated compliance and reporting costs of \$694 million for the 2018 reporting year.²² These detailed burden estimates are important for policymakers to consider the total cost of pay-for-performance programs in light of the utility of the information collected. CMS should publish this information in the QPP final rule.

The Merit-based Incentive Payment System (MIPS)

Starting with the 2019 payment year, MIPS will make payment adjustments at the individual clinician- (or group-) level based on the quality and cost of care those clinicians (or groups of clinicians) provide. In the NPRM, CMS makes a number of changes to the policies for clinicians participating in the MIPS track in the third year of the program. The proposals apply to the 2019 reporting year, which affects clinician payment in 2021. Notable changes include additional flexibilities for clinicians to elect to participate in MIPS; removing some topped-out measures from the MIPS quality measure set; aligning some performance periods; and streamlining the new Promoting Interoperability (PI—formerly Advancing Care Information) category.

²¹ Medicare Payment Advisory Commission. 2018. *A data book: health care spending and the Medicare program*. Washington, DC: MedPAC.

²² Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2017. Medicare Program; CY 2018 Updates to the Quality Payment Program; and Quality Payment Program: Extreme and Uncontrollable Circumstance Policy for the Transition Year. Final rule with comment period. *Federal Register* 82, no. 220 (November 16): 53568–54229.

Comment

We appreciate that CMS recognizes the concerns that the Commission has outlined over the past three years with the MIPS program.²³ Our work has highlighted the complexity of the program and the resulting incentives (for providers and patients), the burden on providers and CMS, and the lack of comparability in performance scores across clinicians. CMS has made a significant effort to simplify the program, by, for example:

- Moving to eliminate topped-out and redundant quality measures;
- Simplifying scoring; and
- Focusing on deterring data-blocking of medical records.

As stated earlier, we also support CMS's efforts, through the Meaningful Measures Initiative, to focus on measures that are of high value to patients, clinicians and providers, and to use a set of factors to determine if measures are not meaningful. The goals of CMS's Meaningful Measures Initiative—to improve patient outcomes and reduce burden—align with the Commission's principles.

However, we believe that the MIPS program cannot succeed at its goals of identifying and rewarding or penalizing high- and low-value clinicians. As a result, after careful deliberation over the prior three years, in March 2018 the Commission recommended that Congress eliminate the current MIPS, and, in its place, suggested a general outline for a voluntary value program for clinician services.²⁴

Nevertheless, we still wish to provide CMS with actionable guidance as they implement the program as presently designed. To that end, we offer the following suggestions for CMS.

First, CMS should consider whether there is the possibility, within the current statute, to demonstrate or test our model of a program that assesses clinician performance at the voluntary group level, using a uniform set of claims- and survey-derived measures. For example, clinicians could opt in to this approach and receive a waiver from MIPS reporting. Such an approach could allow the agency to identify the minimum group sizes needed, consider attribution methods, and identify relevant outcomes, patient experience, and value (e.g., Medicare spending per beneficiary) measures.

Second, CMS should encourage both group reporting and virtual group creation and reporting, in order to allow for aggregation of clinicians to reach a sufficiently large size so that meaningful differences in population-based measures (as well as many of the individually-reported measures now used in MIPS) can be reliably determined.

²³ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. Medicare Payment Advisory Commission. 2017. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC. Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

²⁴ Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Third, CMS should consider, in its measure development work, pursuing the following priorities: measures that use claims only; measures assessing low-value care; and measures that assess potentially preventable emergency department visits. CMS could also consider the potential utility of patient-reported outcome measures.

Cost

In the NPRM, CMS has proposed eight cost measures in total for use in MIPS in year 3: total per-capita costs and MSPB, as well as use eight new episode measures. The eight new episode measures assess 5 procedural episodes and 3 inpatient hospitalizations for acute episodes.²⁵ CMS proposes that the cost category will account for 15 percent of the composite MIPS score in 2019 (up from 10 percent in 2018).

Comment

We appreciate CMS's attention to incorporating cost measures in the composite MIPS score, and support the inclusion of the MSPB and total per-capita cost measures, which have been used to assess clinician performance for years. However, we continue to have concerns about the manner in which the agency is developing new episode measures—releasing several stand-alone episode measures each year without first establishing a comprehensive underlying foundation for all episode measures.

As we stated in our comment letter in 2017, while we have no issue with retiring CMS's resource use episode measures that were used in the first year of MIPS, we are concerned that CMS's plans to develop new episode measures reveals a measure development process not materially different from previous multi-year processes that resulted in episode measures that have since been discarded.²⁶ While clinician input on the episode measures (as described in detail in the proposed rule) is important, it is not the sole key to success, as evidenced by the fact that all previous episode measures were also developed with clinician input.

Among other necessary characteristics, successful resource use episode measures must be constructed upon and consistent with an underlying foundation—a theoretical framework that forms the basis of all episode measures. This is because, unlike quality measures that can assess discrete events or conditions that may be unrelated to patients' other health services, cost-based episode measures are different. Episode measures are designed to work as part of an episode grouper that combines patients' health services into distinct treatment episodes and then attributes

²⁵ The five procedural episodes are 1) elective outpatient percutaneous coronary intervention (PCI), 2) knee arthroplasty, 3) revascularization for lower extremity chronic critical limb ischemia, 4) routine cataract removal with intraocular lens (IOL) implantation, and 5) screening/surveillance colonoscopy. The three acute inpatient medical condition episodes are 1) intracranial hemorrhage or cerebral infarction, 2) simple pneumonia with hospitalization, 3) ST-elevation myocardial infarction (STEMI) with percutaneous coronary intervention (PCI).

²⁶ Medicare Payment Advisory Commission. 2017. MedPAC comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule entitled "Medicare Program; CY 2018 Updates to the Quality Payment Program proposed rule." Letter to the Administrator. http://medpac.gov/docs/default-source/comment-letters/08182017_cms5522p_qualitypaymentprogram_comment_v3_sec.pdf?sfvrsn=0.

responsibility for these episodes to appropriate clinicians. Episode groupers tend to include hundreds of potential episodes that have been constructed following the pattern of the underlying foundation. This foundation addresses fundamental questions such as:

- If a patient undergoes a major procedure, are there separate episode types for the procedure and the condition it treats, and how is the episode or episodes attributed to the surgeon who performs the procedure and the clinician or clinicians managing the condition?
- For episodes involving acute conditions (e.g., pneumonia), are there separate episodes for stand-alone presentations of the condition versus those that are exacerbations of chronic conditions, or is a single episode type adjusted in some fashion to account for this difference?
- For long-term chronic conditions that tend to present with comorbidities (e.g., heart disease, diabetes, chronic kidney disease), are hybrid episode types created or are separate episode types for each of the discrete conditions used, and how do services that treat more than one of the discrete or comorbid conditions get grouped to episodes?

Considering the implications of potential answers to these types of questions, it is clear that proceeding with constructing a handful of episode measures before finalizing the underlying episode grouper foundation, risks yielding more episode measures that will prove to conceptually diverge from the foundation when it is later refined. As a result, these initial episode measures will conflict with future episode measures, as CMS continues to build out the episode measure set. We urge CMS to delay developing new cost-based episode measures, even for clinician feedback, until the underlying organizational foundation for a Medicare episode grouper is thoroughly developed, vetted, and refined. This tested foundation should then inform the development of a full or nearly full set of episode measures, which in turn should be subject to rigorous review, as feedback on the individual episodes may suggest refinements to the foundation and vice versa.

A-APMs

With respect to the A-APM track, CMS, for the third year of the program, has proposed extending the *revenue* standard of 8 percent for nominal risk for an additional 5 years (through 2024). For most model participants, this revenue threshold reflects a lower amount of risk than the general 3 percent of *benchmark* standard that CMS also applies to A-APMs.

Comment

In MedPAC's June 2016 report to the Congress, the Commission outlined a set of principles for guiding A-APMs.²⁷ They are:

²⁷ Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

- Clinicians should receive an incentive payment only if the eligible alternative payment entity in which they participate is successful in controlling cost, improving quality, or both.
- The eligible alternative payment entity should be at financial risk for total Part A and Part B spending.
- The eligible alternative payment entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The eligible alternative payment entity should have the ability to share savings with beneficiaries.
- CMS should give eligible alternative payment entities certain regulatory relief.
- Each eligible alternative payment entity should assume financial risk and enroll clinicians.

We reiterate these principles and highlight two additional considerations as CMS develops models and sets the parameters for model qualification as an A-APM.

In particular, we remain concerned about models qualifying as A-APMs where the increase in guaranteed payments outweighs the potential payments at risk: the Oncology Care Model and the Comprehensive Primary Care Plus model. Both models contain significant guaranteed payments on top of shared savings and losses. We believe that both models do not represent the same level of risk as other models such as two-sided ACOs, and therefore, should not be counted as A-APMs for the purposes of the Quality Payment Program.

Second, models qualifying as A-APMs should include a constraint or limit on total spending. However, CMS has determined that two bundling models—BPCI Advanced and the Comprehensive Care for Joint Replacement models—qualify. These models do not meet our criteria for A-APMs that the model entities bear risk for all Medicare Part A and Part B spending. In fact, under bundling models there is an incentive to reduce the cost per episode while increasing the number of episodes.

A-APMs and other payers

The NPRM also establishes policies for the all-payer threshold option, which will affect payments in 2021 (and will require reporting in 2019). Through the all-payer calculation, CMS will calculate whether clinicians that have some participation in a Medicare A-APM model have enough participation in other-payer A-APMs to meet the thresholds to qualify for an A-APM incentive payment (Table 4).

Table 4. Payment amount thresholds, Medicare FFS option and Medicare + All-payer option

	2019	2020	2021	2022	2023 and later
Medicare FFS option	25%	25%	50%	50%	75%
Medicare + All-payer option	N/A	N/A	50%	50%	75%
--Medicare FFS A-APM			25%	25%	25%
--Other payer A-APM			25%	25%	50%

Note: FFS (fee-for-service), A-APM (advanced alternative payment model). Clinicians cannot qualify through the Medicare + All-payer option in 2019 and 2020.

To carry out the all-payer calculations, CMS is required to obtain information, at the individual clinician or group level, on the number of patients seen by and payments made to each clinician (or group) by payer, and the nature of that clinician (or group's) contract with the payer.

Concurrent with the rule, CMS also proposes a new demonstration, the Medicare Advantage Qualifying Individual demonstration, to allow clinicians that participate substantially in MA plans to be exempt from MIPS reporting, even if the clinician does not meet the threshold for Medicare FFS A-APM participation.

Comment

The calculations and data collection required for CMS to administer the all-payer calculations in 2021 are significant and require CMS to obtain information about the specific contractual relationship between payers and clinicians. However, CMS is required by statute to administer the all-payer calculations. Therefore, over our next work cycle (2018–2019), MedPAC plans to develop an option for restructuring the A-APM incentive in statute so that it applies only to the FFS revenue coming through Medicare A-APMs.

Such an approach would eliminate the thresholds for qualifying for an A-APM incentive payment (using both the Medicare FFS and all-payer calculations) and would create a clear incentive for increasing participation in A-APMs. It would also eliminate the need for an all-payer calculation option (including the need for the MAQI demonstration). At that point, if so desired, policymakers could have a separate discussion of whether to provide a financial incentive for clinician participation in certain types of contracts with MA plans (or other payers).

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