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September 7, 2018

VIA ELECTRONIC SUBMISSION

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, Maryland 21244-8016

Dear Administrator Verma:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to respond to the Centers for Medicare & Medicaid Services (CMS) Calendar Year (CY) 2019 Physician Fee Schedule (PFS) and Quality Payment Program (QPP) proposed rule.

The ACOFP is the professional organization representing more than 20,000 practicing osteopathic family physicians, residents, and students throughout the United States who are deeply committed to advancing our nation's health care system by improving health care delivery and outcomes and ensuring that patients receive high-quality care. Generally, we appreciate the agency's efforts to relieve regulatory burdens for providers and promote flexibility and innovation.

Overall, as an organization with many osteopathic family medicine physicians in solo, small and rural practices, we support proposals designed to expand access in those areas, including providing additional telehealth service codes and payment for rural providers. While we have some concerns with elements of the proposed rule, we are hopeful that CMS will continue to keep in mind osteopathic family physicians and ensure that our members have the flexibility and opportunity to continue to deliver high quality and efficient care.

Our full comments are detailed on the following pages. Thank you for the opportunity to share these with you. Should you need any additional information or if you have any questions, please feel free to contact Debbie Sarason, Manager, Practice Enhancement and Quality Reporting at (847) 952-5523 or debbies@acofp.org.

Sincerely,

Duane G. Koehler, DO, FACOFP *dist.*
ACOFP President

1. Comments to Proposed Changes to the Physician Fee Schedule

ACOFP appreciates CMS's Patients Over Paperwork Initiative and the agency's goals to reduce physician burden. The health care delivery system must be improved so that physicians are able to focus on patient care instead of navigating barriers and confronting administrative burdens of questionable use for high quality patient care. We do, however, have significant concerns about CMS' proposal to change the reimbursement methodology for evaluation and management (E/M) services in addition to its proposed changes to documentation requirements. We offer the following comments on this proposal and others in the proposed rule.

Proposed Changes to E/M Services

In exchange for the anticipated burden reduction from changes to outdated documentation requirements for E/M services, CMS proposes to reimburse E/M services at a blended amount. While ACOFP appreciates CMS' effort to reform these documentation requirements, we are concerned that this proposal would not help achieve the goal of reducing physician burden and actually could adversely impact patient outcomes and increase health care costs. The significantly reduced reimbursement for E/M services disproportionately impacts physicians in rural and underserved areas and will adversely impact how care is delivered to the most complex beneficiaries.

Further, many of the documentation requirements and practices are entrenched deeply in how health care is currently delivered. Specifically, stringent documentation practices are needed to protect physicians in the event of legal action, permeate across multiple payers, and support team-based and collaborative care. In addition, the agency has pushed physicians to adopt electronic health record (EHR) systems and the associated documentation requirements are built into these systems. The proposed changes would require EHR vendors to update systems, likely at a significant cost to physicians, and would create separate documentation requirements across multiple payers.

For the reasons detailed below, **we strongly urge CMS not to finalize its proposed changes to E/M services.** ACOFP offers its support in continuing to work with CMS on the shared goal of simplifying documentation requirements in a way that does not result in unintended consequences or adverse patient outcomes.

E/M Visit Blended Reimbursement Rate

ACOFP strongly opposes the proposal to collapse E/M codes such that there is one blended reimbursement rate for established patients and one blended reimbursement rate for new patients. As CMS notes, the estimated proposed payment would be $93 for established patients and $135 for new patients. These amounts are more than the current level 3 reimbursement, but less than the current level 4 and level 5 reimbursement for each type of patient. Effectively, this proposal disincentivizes physicians from treating sicker, more complex patients who would normally receive a level 4 or level 5 E/M service. Physicians would instead be rewarded for treating less complex patients, subsequently rewarding lower levels of work based on current relative value units (RVUs). This directly impacts our members, many of whom provide comprehensive primary care for complex patients who have multiple chronic conditions (i.e., level 4 or level 5 E/M service).

ACOFP also is deeply concerned that this proposal will significantly disadvantage physicians in rural areas. A significant portion of our membership provides primary care services to Medicare beneficiaries in rural areas. The patients they serve are often more complex and more likely to require level 4 or level 5 E/M services. Reducing reimbursement for the care provided to these

patients will have significant impact on the ability of physicians to continue to serve already underserved communities.

This proposed reimbursement structure effectively will force our members to offer single service visits, addressing one of a patient's many conditions over a series of visits, instead of offering timely, comprehensive primary care. Further, this proposed policy change creates incentives for volume-based treatment, which is the opposite direction of value-based care. To make up for the reimbursement reduction, physicians will have to spend less time with patients, but see more patients per day. This increases physician burden and is a disservice to our patients. As a result, this proposal creates several negative financial outcomes, including increased beneficiary out-of-pocket liability and potentially increased costs to Medicare. Most importantly, this structure will result in adverse patient care outcomes, including delayed treatment and forcing patients to make multiple trips to obtain treatment for multiple chronic conditions, which instead could be managed in one visit. This impact is compounded by CMS' proposed multiple procedure payment reduction (MPPR) described below.

Proposed Additional Payment Codes and Multiple Procedure Payment Reduction

ACOFP appreciates that CMS has recognized additional resources are needed to address the inherent complexity in E/M primary care visits and that family physicians often spend extended time with patients to address care management and coordination issues not directly related to treating a patient's condition. However, even with the two proposed add-on codes, physicians treating new, level 5 patients would be reimbursed at a lower rate than the current reimbursement amount. In practice, this disincentivizes physicians from taking on new patients who are complex or who have multiple chronic conditions. This will significantly impact patient access to primary care services. Further, the add-on payment for prolonged E/M services requires physicians to spend additional time (i.e., an additional 30 minutes) beyond what would be expected, effectively requiring physicians to perform more work for the same or less reimbursement. This proposal does not support physicians or reduce burdens. Instead, it creates inappropriate incentives and emphasizes quantity over quality.

ACOFP also strongly opposes the proposed multiple procedure payment reduction (MPPR), which would reduce the payment for the lower cost service when an E/M visit is furnished in combination with another procedure on the same day. The issue of multiple services provided on the same day is factored into the valuation of codes, meaning that this proposal to reduce payment for the code with lesser value by 50 percent is an additional, unjustified reduction. As described previously, this reimbursement structure will incentivize an excess amount of service delivery and fragmented patient care, instead of comprehensive care provided in the most cost and time efficient manner.

Our members typically provide E/M services in conjunction with osteopathic manipulative treatment (OMT). Overall, OMT has successfully been used to treat and manage a variety of chronic pain, especially low back pain.[1] OMT also has been proven to ease other pain, promote healing, and increase overall mobility. While often used to treat muscle pain, OMT can also assist patients with asthma, carpal tunnel syndrome, and migraines. Thus, the provision of E/M services and OMT has avoided unnecessary utilization of prescription drugs and pain medications, including opioids. The proposed MPPR would drive physicians to provide E/M services and OMT separately, meaning

[1] *See,* Licciardone JC, Brimhall AK, King LN. Osteopathic manipulative treatment for low back pain: a systematic review and meta-analysis of randomized controlled trials. BMC Musculoskeletal Disorders. 2005;6:43. doi:10.1186/1471-2474-6-43.

patients will have to suffer from treatable pain in between those services or receive over-the-counter or prescription drugs. Again, we do not believe this is the agency's intent, but we note that this is a potential adverse outcome of this proposal.

E/M Documentation Requirements

ACOFP appreciates the agency's efforts to address redundant and overly burdensome E/M documentation requirements. We strongly support proposals that would eliminate unnecessary duplicative documentation. Several of the existing documentation requirements pose significant challenges to physicians, especially to those in solo, small, or rural practices. While we believe eliminating these unnecessary requirements could improve patient care and support physician practices, additional changes are needed to support fully efforts to reduce these burdens and to ensure these proposals are truly meaningful.

Physicians must adhere to strict documentation practices for reasons beyond reimbursement, including for legal purposes. Further, other payers are unlikely to revise their current documentation requirements and practices in a similar manner to reduce burdens. In addition, as the health care system moves toward team-based and coordinated care, physicians need to ensure the medical record contains sufficient information, so all members of the care team provide consistent care without duplicating services or creating additional documentation burdens for other physicians. Finally, ACOFP is concerned that finalizing these proposals will result in a significant burden and cost to physicians. Many physicians contract with EHR vendors and will likely incur a significant cost to update those systems to reflect the proposed changes. Further, physician and staff time will have to be devoted to implement these changes, and we therefore do not believe it is feasible for these changes to be implemented by January 1, 2019. This burden would be disproportionately felt by solo, small, and rural practice physicians who typically have less financial resources to adopt such changes.

Though well-intentioned and with legitimate merit, the proposed documentation changes therefore are not likely to benefit physicians or patients. This proposal does not support physicians or improve care for patients. Instead, this proposal could result in fractured patient care resulting from incomplete or insufficient documentation and may inadvertently create additional burdens for physicians.

Technology-Based Services

ACOFP generally supports proposals that would expand access to telehealth and technology-based services. Specifically, we support CMS's proposals to create new codes for communication technology-based services and for remote evaluation of recorded video and/or images submitted by the patient. We also support expanding telehealth services to include chronic care remote physiologic monitoring and an inter-professional internet consultation. Because many of our physicians fill a critical need in rural and underserved areas, we believe it is imperative to leverage existing and new technology to continue to improve access for patients. Therefore, we support and urge CMS to continue to identify and develop appropriate codes for technology-based services.

We are concerned, however, with how CMS proposes to value technology-based services. When family physicians provide telehealth services, they involve the same level of cognitive skill, time, and documentation. Physicians should be reimbursed at equivalent rates regardless of whether a service is furnished using technology or in-person. Specifically, for the proposed HCPCS code GRAS1 code, we question the crosswalk to the value of CPT code 93793. If a family physician receives a prerecorded video or image, the physician will have to assess and evaluate several factors, including

the patient's history and whether the patient's chief complaint is in fact the main issue or a product of another condition. In many instances, this will likely require the patient to come to the office for an in-person visit, meaning a physician will have performed additional work without being reimbursed for the remote evaluation.

ACOFP also is concerned with cybersecurity risks associated with the transfer of recorded videos or images. The increased transmittal rate of attachments and files may lead to malicious attempts to compromise physician systems, steal data, or lock physicians out of their network until they pay a "ransom" to unlock the system. We also are concerned with the potential program integrity issues of technology-based services. We ask the agency to consider these potential threats and ways to mitigate them so that physicians can safely and appropriately increase access to patients. Further, we ask the agency to better define approved telehealth and technology-based systems as well as what functions they should include.

We share CMS' goal of improving access to care, especially in rural and underserved areas; however, these applicable codes need to be refined to accurately reflect how they will be utilized. Moving forward, we offer our support in developing and appropriately valuing technology-based services so that they can be effectively used by all physicians for the benefit of patients.

Bundled Episode of Care for Substance Use Disorders (SUDs)

ACOFP continues to be concerned with the high rates of SUDs, especially considering the ongoing opioid epidemic. We support efforts to improve access to SUD treatment, including medication-assisted treatment for opioid addiction and enhanced access to behavioral health and counseling services. We do not believe a bundled episode of care is appropriate to treat SUDs. A SUD is a complex, chronic disease that involves mental health and physical components. Further, each patient with a SUD is unique and must be treated differently. Factors outside of medical treatment can increase the rate of relapses or complications, and many of these factors are outside of the physician's control, cannot be measured, and do not have well-defined quality measures. Therefore, we are concerned that limiting SUD treatment to some type of bundled payment will result in a lack of providers who would be willing to take on the risk associated with such a bundled payment.

Instead, we believe SUDs are most effectively treated by sustained and appropriately reimbursed counseling services. Because of the primary care physician's unique position of identifying and treating SUDs, we believe family physicians are best situated to direct the provision of this care. Based on our firsthand experience combating the opioid crisis, we believe these patients would be best served by a recognition that addiction is a chronic condition and that it can be treated accordingly.

2. Comments to the Proposed Changes to the Quality Payment Program

Merit-based Incentive Payment System (MIPS)

ACOFP has increasing concerns with the continued implementation of MIPS. Overall, we are concerned that solo, small, and rural practice physicians are being left behind. As the MIPS progresses, our members have expressed significant concerns that they will not be able to keep up with the stringent requirements imposed on their practices. As solo, small, and rural physicians face increased MIPS requirements, including increasing performance thresholds and payment adjustments, our members face increasing difficulties and burdens when providing primary care services to Medicare beneficiaries. As the population ages and more Americans become eligible for

Medicare, it is critical that the primary care physicians treating these patients are not unnecessarily burdened or disincentivized from providing care.

While we appreciate that CMS proposes to continue to offer certain protections for solo, small, and rural practice physicians, we believe a widening of MIPS to include additional clinician types will only serve to water down the performance pool. Increasing the number of participants will create increased competition for a limited bonus pool, making it more difficult for disadvantaged physicians to meaningfully participate in MIPS.

We also appreciate CMS using its new flexibility to increase the weight of the cost performance category to 15 percent, as opposed to 30 percent. However, we believe the small practice bonus should remain an addition to the final score and not be incorporated in the Quality performance category. The weight of the Quality performance category decreased, meaning the utility of this small practice bonus is lessened. To ensure small practices can perform at comparable rates to larger groups, it is critical that this bonus be added to the final score.

ACOFP especially is concerned with the requirement that MIPS-eligible clinicians use the 2015 Edition of Certified EHR Technology (CEHRT). This proposal fails to recognize that many solo, small, and rural practice physicians do not have the capacity or financial flexibility to transition to the 2015 Edition of CEHRT. Further, some EHR vendors do not yet offer the 2015 Edition of CEHRT, meaning physicians engaged with these companies will have to break contracts or hire a different vendor. We urge the agency to consider protections for physicians who may be disadvantaged based on their size or geographic location when participating in MIPS. Further, while we support efforts to improve interoperability among health care providers, we urge CMS to recognize the varying capabilities and abilities to implement needed changes. More detailed comments are included as a response to the Promoting Interoperability and Electronic Health Care Information Exchange Request for Information (RFI) (below).

Advanced Alternative Payment Models (APMs)

ACOFP continues to be concerned that there are limited APM opportunities for solo, small, and rural practice physicians. These physicians are essentially precluded from participating in an Advanced APM. As these physicians continue to be squeezed by MIPS, there must be a meaningful outlet or pathway for them to participate in an Advanced APM. We ask CMS to work with ACOFP and other stakeholders to develop such opportunities to ensure all physicians, not just those in large institutions or urban areas, can participate in models that promote value-based care.

3. Response to the Agency's RFI on Promoting Interoperability

ACOFP supports promoting interoperability and advancing the electronic exchange of information in a safe, effective manner. While CMS has taken steps to address administrative burdens to support rural practices, more assistance is needed to support rural physicians and their patients. Specifically, rural physicians face a stark financial reality with deploying health information technology because they serve a disproportionate share of Medicaid and dually-eligible individuals. Further, interoperability requires certain health information technology capabilities and broadband connections that are unavailable in many parts of the country. Many of our rural family physicians do not have the capacity to update their systems to achieve interoperability, let alone improve it.

Imposing any additional requirements or burdens will result in an impossible situation for these physicians. As the agency proceeds with its efforts, we ask that you consider these issues and ways

to ensure that disadvantaged practices have the sufficient technical and financial assistance to promote interoperability. Further, we ask CMS to first consider how best to improve capabilities in rural areas consistent with the agency's Rural Health Strategy.