acofp AMERICAN COLLEGE OF OSTEOPATHIC FAMILY PHYSICIANS
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September 27, 2019

VIA ELECTRONIC SUBMISSION

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

Dear Administrator Verma:

On behalf of the American College of Osteopathic Family Physicians (ACOFP), we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) *Calendar Year (CY) 2020 Physician Fee Schedule (PFS) and Quality Payment* Program *(QPP)* proposed rule.

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.

As an organization with many osteopathic family physicians in solo, small and rural practices, we appreciate efforts to reduce physician administrative burden, and policies that recognize and support primary care services. Family physicians play a critical role in improving the overall health of Americans. We urge CMS to keep this critical role in mind when considering changes to the PFS and QPP that may result in reduced access to primary care services or shift care from family medicine physicians to other specialists.

Our full comments are detailed on the following pages. Thank you for the opportunity to share our feedback with you. Should you need any additional information or if you have any questions, please feel free to contact ACOFP at advocacy@acofp.org or (847) 952-5100.

Sincerely,

Robert C. DeLuca, DO, FACOFP *dist.*
ACOFP President

1. Comments to Proposed Changes to the Physician Fee Schedule

ACOFP appreciates CMS' Patients Over Paperwork Initiative and the Agency's goals to reduce physician burden. Physicians must be able to focus on treating their patients instead of spending countless hours filling out forms and struggling with electronic health record (EHR) systems. The health care delivery system must prioritize patient care and quality outcomes by supporting primary care physicians. CMS' proposed rule takes significant steps in supporting family physicians to deliver high-care quality care to patients across the country by reducing administrative burden. Although we have concerns that some proposals may shift traditional primary care services from family medicine physicians to other types of providers, we are generally supportive of the proposed rule and urge the Agency to consider additional avenues to support the delivery of physician-led primary care services.

Proposed Changes to Evaluation and Management Services

Last year, CMS proposed to collapse the evaluation and management (E/M) code levels 2 through 4 and set a single, blended payment rate. The blended payment rate would have been a reduction in total reimbursement for ACOFP members. In exchange for the reduced reimbursement, the proposal eliminated outdated documentation requirements. ACOFP had significant concerns with this proposal and we thank the Agency for its flexibility and openness to revise its approach in the CY 2020 PFS proposed rule.

In the CY 2020 PFS proposed rule, CMS proposes to incorporate the American Medical Association's (AMA) Relative Value Update Committee (RUC) recommendations for E/M coding and adjusting the value for such services. In general, the recommendations will: eliminate patient history and physical elements for the code section; allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or total time; modify the criteria for MDM; and create a shorter prolonged services code. These changes were driven by the Agency's objectives to decrease administrative burden associated with documentation. We believe the recommendations achieve their primary objectives, although there are areas for improvement. Overall, we are supportive of CMS' proposal to incorporate these recommendations.

Administrative burden is a significant issue for ACOFP members, especially solo, small and rural physicians that do not have the resources to manage excessive paperwork requirements in the Medicare program. According to the AMA, the recommendations could reduce administrative burden by 180 hours annually.[1] These additional hours will allow physicians to treat more patients every day. Family physicians provide critical preventive and acute care services. The value of primary care is well-known, and the time we spend with our patients directly results in a healthier population.

We appreciate the proposal to allow physicians to choose whether their documentation is based on MDM or total time. We believe it should be a choice for the physician, so the code can best reflect their practice. However, the proposals do not adequately capture the total time physicians spend on a patient visit. Many times, physicians review patient documentation or health records before a visit and spend significant time updating the documentation following a visit. The E/M codes should capture the time physicians spend on a patient visit beyond the face-to-face interaction. Additionally, osteopathic physicians practice and provide holistic treatment, which includes addressing the social factors that may impact or exacerbate the specific health condition. While not directly related to a

[1] See AMA CPT Evaluation and Management recommendations here: https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

condition or health issue, addressing social determinants of health and other non-clinical matters is a critical component of the care we provide. The existing code structure, and generally, using time as an element for coding, does not take these additional services into account and therefore does not accurately capture the time spent in fully treating our patients.

The proposals also still do not adequately account for the time it takes to document patient information in EHRs. Although CMS will adopt an RVU increase for all E/M service levels, which ACOFP supports, EHR burden outweighs the RVU increase. Physicians spend hours in EHR systems to adequately record patient severity to justify the appropriate code. Further, CMS suggests that prolonged visits are only associated with level 5 E/M codes. We disagree – prolonged visits may be necessary to address the full scope of issues associated with level 3 and 4 E/M visits to ensure patients do not deteriorate and to address the social factors that impact health status. We request CMS reassess its approach to appropriately value how osteopathic family physicians treat their patients. This could include streamlining E/M coding for levels 4 and 5 in a way that physicians can quickly log patient severity to efficiently use these codes and to support the additional time and effort associated with providing the highest quality care to our patients.

Telehealth Opioid Treatment and Opioid Substance Use Disorder Bundle

CMS is proposing to add three new telehealth codes to help providers respond to the opioid crisis. We applaud CMS' efforts and believe that the additional codes will be another avenue to improve opioid care. Many of our members utilize telehealth services and are hopeful the technology will curb the opioid crisis. However, there remain barriers for physicians to treat opioid use disorder (OUD), especially for physicians attempting to prescribe buprenorphine in rural areas. We hope CMS continues to facilitate family physician-led medication-assisted treatment (MAT) utilization. Our experience shows that MAT, when closely monitored by family physicians, can greatly reduce OUD. Specifically, we have deep connections with our patients built on years of trust and a strong patient-physician relationship, which enable sustained and tailored treatment based on each patient's unique needs.

While we appreciate CMS' efforts to find additional pathways to deliver OUD services, including establishing a new benefit category, we have concerns that this could result in OUD services, such as MAT, that are delivered without the necessary trust and relationships that are established between family physicians and their patients. Primary care physicians are on the front lines of the opioid epidemic and are in the best position to treat OUD patients. After all, OUD patients are members of the physicians' community and have a more personal connection with their family physician. This is a well-intentioned action authorized by Congress through the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act), but we are concerned this takes a very personal treatment that has been successfully delivered by primary care physicians and drives it to other clinicians, which could result in less successful outcomes. To ensure sustained high-quality care, we urge the Agency to closely monitor outcomes as a result of this effort.

As we previously commented, we have significant concerns with a bundled payment structure for OUD services. Each patient's treatment varies based on specific responses to therapy types and methods. Family physicians develop specific treatment plans based on the past experience with patients and their unique clinical needs, including the social factors that may impact substance use. Bundling payments assumes there is a "correct" way to treat OUD and other substance use disorders – this is not the case. Therefore, we strongly urge the Agency to reassess the value of bundling payment for these services. Specifically, we are concerned that this may create unwanted financial

incentives to limit treatment for an extremely vulnerable population. In addition, we have concerns that bundling payments, like the new benefit category, will drive patients to non-primary care for OUD services. While we fully support increased access to needed care, we urge CMS to consider whether existing primary care-focused codes could be leveraged in a way that supports family physicians' ability to treat OUDs. As described, we believe family physicians are in the best position to provide high quality, patient-focused OUD services.

Physician Assistant Supervision and Documentation Verification Proposals

CMS is proposing to revise its regulation (42 CFR § 410.74) establishing supervision requirements for physician assistants (PA). Specifically, CMS proposes to allow PAs to have greater ability to furnish appropriate medical services. This rule would only apply when it is not in conflict with state law and state scope of practice regarding physician supervision requirements.

We believe that states and state medical regulatory entities are in the best position to establish physician supervision requirements. It is also important to recognize that many rural areas are facing physician shortages, and in some large geographic areas, there may only be one physician. ACOFP supports physician-led care teams and expanding the availability of additional providers can support these efforts. We remind the Agency that physician-level care cannot be replaced by non-physician clinicians, but care can be appropriately expanded by better supporting physician-led teams.

We support CMS' proposal that would allow PAs and Advanced Practice Registered Nurses (APRNs) to verify and review information included in the medical record by physicians. As noted above, physicians are overly burdened by excessive paperwork and documentation requirements. Many of our members recognize that this change would alleviate some of the burdens associated with documentation requirements. This proposal will allow primary care physicians to treat more patients and spend less time on duplicative efforts of reviewing and verifying information and also will support the operation of physician-led care teams.

Chronic Care Remote Physiologic Monitoring Services

CMS is proposing to revalue CPT codes 99457 and 994X0 and change the physician supervision requirements under the codes in an effort to improve care for chronically ill patients. Specifically, the proposal would allow for remote physiologic monitoring treatment services for 20 minutes (CPT code 99457) and an additional 20 minutes (CPT code 994X0). We appreciate CMS' efforts to address the health issues for chronically ill patients and, as a general matter, we support enhanced access to care.

We are concerned, however, that this may push chronic care management to large systems and specialists rather than community-based primary care physicians. Family physicians are best-equipped and positioned to treat chronically ill patients, but this proposal to use remote monitoring technology will drive such services to specialists and larger practices that have the resources to invest in the technology needed to utilize the codes. This may push more patients to larger organizations and away from their primary care physician. We suggest CMS work with rural physicians to improve remote monitoring service utilization and to fully address chronic care needs. We are also concerned that the codes would allow general supervision. As noted above, we understand that some areas require general supervision to fill workforce shortages; however, physician-led teams deliver the highest quality outcomes, and this should be a prerequisite for addressing chronic illnesses.

Therapeutic Vaccinations

CMS is proposing to revalue certain vaccine administration codes that will impact access to vaccinations for adults and the elderly. CMS has analyzed certain procedures and found duplicative or unnecessary codes, and in doing so, unfortunately has created a potential access issue. By deleting and removing the practice expense and labor costs for therapeutic injection codes, which cross walks to the value for vaccine administration, the payment for vaccine administration will decrease. The decrease could be so great that reimbursement would be less than the cost for physicians to administer vaccines.

We urge CMS to abandon this proposal. Instead, we request that CMS reassess its coding for vaccinations such that they are fully supported and widely offered to patients. Our members have highlighted that many vaccines are reimbursed at increasingly lower rates. For some office visits, physicians are being reimbursed nominal amounts, which when compared against the costs for developing an EHR system, documenting the patient, administering the vaccine, verifying the procedure, and billing the procedure, creates a disincentive to provide any vaccinations. We offer our expertise related to office visit vaccinations, especially in rural areas, to assist CMS in achieving its goal of eliminating unnecessary duplication, while ensuring there is no adverse impact on vaccination rates.

Patient Harm and Revoking Medicare Privileges

CMS proposes to add a new reason for revocation of Medicare privileges that would apply if the physician or other eligible professional:

> Has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm.[2]

In determining whether revocation is appropriate, CMS would consider the nature of the patient harm, the nature of the physician/eligible professional's conduct, and the number and type(s) of sanctions or disciplinary actions imposed against that individual.

ACOFP is extremely concerned with the breadth and scope of this proposal. While we appreciate and support that patients, to the greatest extent possible, should be protected from improper conduct that leads to patient harm, the elements proposed are overly broad and may have unintended consequences that could result in other types of patient harm. For example, in rural and health professional shortage areas, revocation might result in significant patient risk as there may not be any other physician available to treat Medicare beneficiaries. While we are not suggesting that physicians should not be held accountable for improper conduct, we believe there should be limitations on this proposal or at least clearly delineated considerations and factors that CMS will adhere to when considering the revocation of Medicare privileges due to patient harm.

In addition, the various entities CMS identified often implement corrective action plans or some form of penalty for improper conduct. These entities are typically comprised of other physicians who understand the reality of practicing medicine as well as the circumstances under which care is

[2] 84 FR 157 at 40723.

delivered. If these oversight boards or review entities believe the physician or eligible professional's conduct warrants revocation, it would make such a determination by suspending or revoking that individual's state medical license. As CMS notes, this determination provides ample remedy for CMS to then revoke Medicare billing privileges. As proposed, this new reason for revocation would take this critical decision making out of the hands of the physician's peers, discounting the special expertise that state medical boards bring to these situations. For these reasons, we strongly urge CMS not finalize this problematic regulatory proposal.

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

Merit-based Incentive Payment System (MIPS)

ACOFP appreciates CMS' efforts to improve quality of care while driving health care costs down through the Quality Payment Program (QPP). However, we have increasing concerns with the implementation of MIPS. Overall, we are concerned that solo, small and rural practices are being left behind and overwhelmed by regulatory burdens. As the MIPS program 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 a result of increasing requirements and annual changes to the performance category weights 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 all beneficiaries have access to care. We are concerned that health care shortage areas will widen as more rural physicians retire in frustration of changing MIPS requirements or relocate to larger practices in urban areas that have greater administrative resources to handle MIPS' regulatory uncertainty. We also fear that many young physicians will avoid practicing in rural areas because of the burdensome regulations.

Proposed MIPS Value Pathways Request for Information

CMS has taken steps to improve the MIPS program through the Patients Over Paperwork and the Meaningful Measures initiatives. We appreciate these steps to help physicians participate in the program. CMS proposes to establish a new framework – the MIPS Value Pathways (MVPs) – to further improve the MIPS program. While this framework would not be implemented until CY 2021, we have concerns with the continually shifting nature of MIPS. The MIPS program has forced many practices to adjust their operations and make changes to adapt to new requirements. We are concerned that creating a new framework will only add to the burdens physicians currently face. Specifically, the MVP framework must still be built out and if adopted in 2021, would leave little time for our members to adjust. We urge CMS to not dramatically change the existing MIPS program as so many physicians are just now becoming familiar with it. Instead, we recommend the Agency revisit current MIPS requirements and phase-in adjustments over time to ensure MIPS participants, especially those in solo, small, and rural practices, have sufficient time and support to adapt as needed.

If the MVPs could be implemented in a way that would seamlessly align with current practices, they may be successful. Solo, small, and rural physicians have significantly invested in EHRs, training, and hiring staff to participate in MIPS. If CMS moves forward with MVPs, they must account for the changes many physicians have undertaken to participate in the current program. The MVPs should not force physicians to meet new EHR reporting standards, require further staff training, or add any additional administrative burdens. As it stands now, rural physicians are barely able to keep their practices open and see patients because they are spending too much time on documentation requirements. If the MVPs add new reporting standards, or require costly EHR updates, it would take

even more time and resources away from providing care for patients. MVPs must not add any new burdens for physicians.

CMS should also conduct research on the MVPs to understand whether the framework would improve care for patients. It is unclear whether a new framework for the MIPS program would improve patient outcomes. The general framework could be employed in a manner that simply shifts patient volume from one provider type to another without improving care. Before overhauling the MIPS program and creating undue burdens for physicians, we urge CMS to assess how the MVP framework would impact patient care and ensure it will not result in unintended consequences.