September 10, 2018

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via: https://www.regulations.gov

Re: 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 (CMS-1693-P)

Dear Administrator Verma:

As a national association representing primary care providers and specialists, the American Osteopathic Association (AOA), on behalf of nearly 138,000 osteopathic physicians and osteopathic medical students, appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule (PFS) proposed rule (CMS-1693-P) for calendar year (CY) 2019.

Standardization of Clinical Labor Tasks
In reviewing RUC-recommended direct practice expense (PE) inputs for CY 2019, CMS discovered an error in the clinical labor time. Specifically, the 3 minutes assigned for “Prepare room, equipment and supplies” (CA013) was inadvertently split and 1 minute of clinical labor time was assigned to “Confirm order, protocol exam” (CA014). While the total costs for clinical labor activities is unaffected, since the same 3 minutes of clinical labor time is still being used in the calculation of PE RVUs, the RUC points out that the refinement is inaccurate, as the clinical activity for CA014 is accounted for and divided across “Review patient clinical extant information and questionnaire” (CA007). If not corrected, the refinement will have long-term effects on the direct PE inputs across the PFS. We urge CMS to correct the refinement as requested by the RUC.

Equipment Recommendations for Scope Systems
CMS proposes to delay any further changes to scope equipment until CY 2020 to incorporate feedback from the workgroup, but would update the price of the scope video system (ES031) and change the name from “video system, endoscopy (processor, digital
capture, monitor, printer, cart)” to “scope video system (monitor, processor, digital capture, cart, printer, LED light)” since its use is not limited to endoscopy procedures. The AOA supports this decision to allow the workgroup to complete its review and to provide additional time for specialty societies to submit invoices to support appropriate pricing.

**Market-Based Supply and Equipment Pricing Update**

To update direct PE inputs for supply and equipment pricing for CY 2019, CMS hired a market research contractor (StrategyGen) to conduct an in-depth study. Given the potentially significant changes in payment that are expected to occur for approximately 1300 supplies and 750 equipment items based on the study results, the AOA supports CMS proposal to adopt and implement the recommended updates over a 4-year period. Gradually phasing in the direct PE inputs will provide a longer period for clinicians to address potential concerns about the payment changes and submit additional applicable data to support further refinement if needed.

**Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services**

The AOA commends CMS for acknowledging current technological advances that enable physicians and other clinicians to provide a broader range of health care services and for proposing to create new payment mechanisms for other technology-based modalities. Allowing a clinician to conduct a brief (5–10 minute) non-face-to-face virtual check-in (HCPCS code GVC11) to assess whether a patient’s condition requires an office visit could be useful in many ways. As CMS points out, a brief virtual check-in as part of a treatment regimen for patients with opioid and other substance use disorders would be particularly useful since there are several components of Medication Assisted Therapy (MAT) that could be done virtually.

Allowing a clinician to remotely review pre-recorded patient-transmitted information through “store and forward” or asynchronous technology in order to evaluate the patient’s condition (HCPCS code GRAS1) without being subjected to current Medicare telehealth restrictions that require real-time live-video communication will enable more clinicians to integrate telecommunication into their practices.

The AOA believes these types of technology-based services necessitate a prior physician-patient relationship, as the clinician should have basic knowledge of the patient’s conditions and medical needs, and therefore should be limited to established patients. However, in establishing timeframe and frequency limitations for these services, we urge CMS not to be overly restrictive in that the parameters impede upon furnishing health care services.

The AOA fully supports the creation of new interprofessional internet consultation (CPT codes 994X6, 994X0) telecommunication codes for treating physicians and other health care professionals seeking the opinion and/or treatment advice of a consulting provider. The creation of the new codes, in addition to the RUC re-affirmed Work RVUs for existing
CPT codes 99446, 99447, 99448, and 99449 will reward primary care physicians for the comprehensive patient-centered care management they provide for patients with chronic conditions. However, we disagree with the rationale to assign a Work RVU of 0.50 for 994X6 and urge CMS to finalize the RUC-recommended RVU of 0.70.

Expanding Access to Telehealth Services under the Bipartisan Budget Act of 2018

The AOA supports the addition of prolonged preventive codes (G0513 and G0514) to the list of covered Medicare telehealth services for beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries that have suffered an acute stroke. We also agree that current regulations must be revised to recognize a renal dialysis facility and the home of an individual as a telehealth originating site for monthly home dialysis ESRD-related clinical assessments. In addition, we support the creation of a new modifier for use by the practitioner and the originating site to identify acute stroke telehealth services, along with the addition of a mobile stroke unit as a permissible originating site for acute stroke telehealth services defined as a unit that furnishes services to diagnose, evaluate, and/or treat symptoms of an acute stroke.

Comment Solicitation on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders

The AOA commends CMS for seeking comment on potential non-opioid alternatives for pain treatment and management, and identification of barriers that may inhibit access, payment or coverage. From 1999 to 2016, more than 200,000 people died in the United States from overdoses related to prescription opioids. Overdose deaths involving prescription opioids were five times higher in 2016 than in 1999. To help curb the nation’s opioid epidemic, the AOA advocates for pain management protocols using non-pharmacological alternatives, such as osteopathic manipulative treatment (OMT). We believe treating pain osteopathically is a viable solution for non-opioid pain management and are working with legislatures in various states to promote such a solution.

The AOA also worked with the Federation of State Medical Boards (FSMB) to include OMT as a non-pharmacological therapy in the “Guidelines for the Chronic Use of Opioid Analgesics.” The guidelines were adopted as FSMB policy on April 30, 2017 and serve as a resource for state medical and osteopathic boards in assessing physicians’ management of pain in their patients and determining whether opioid analgesics are used in a medically appropriate manner.

However, policies such as the Evaluation and Management (E/M) multiple procedure payment adjustment proposed in this rule, that would reduce by 50 percent the least expensive procedure when billed with an office or other outpatient E/M visit appended with Modifier 25, would create a barrier to access OMT as a non-opioid alternative.

---

Therefore, we urge CMS to exclude OMT services from the proposed multiple procedure payment adjustment if confirmed in the final rule.

**Update on the Global Surgery Data Collection**
Due to low reporting of CPT code 99024 (Postoperative follow-up visit) as required by law for groups with 10 or more practitioners in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island, CMS’ is questioning whether the visits are typically being performed for services with a 10-day global period and what steps can be taken to increase awareness of the reporting requirement. The AOA discourages CMS from implementing any enforcement mechanisms, or further reporting requirements, such as Modifiers 54 (surgical care only) and 55 (postoperative management only), as these efforts would only increase administrative burden. Instead, we suggest that CMS allow more time to collect data to yield more representative information on post-operative visits.

**Chronic Care Management Services (CPT code 994X7)**
For the new Chronic Care Management Services (CPT code 994X7) code, CMS is proposing to establish a Work RVU of 1.22 for 30 minutes of physician time instead of the RUC-recommended Work RVU of 1.45. CMS arrived at this value of 1.22 by doubling the Work RVU of 0.61 for CPT code 99490, which has 15 minutes of physician time. We disagree with this rationale and urge CMS to adopt the RUC-recommended Work RVU of 1.45.

**Diabetes Management Training (HCPCS codes G0108 and G0109)**
The AOA supports CMS decision to adopt the HCPAC recommendations for Work RVU of 0.90 for code G0108 and the Work RVU of 0.25 for code G0109, and to maintain the current direct PE inputs. These recommendations will support expansion of the Medicare Diabetes Prevention Program (MDPP) and we urge CMS to finalize the proposal.

**Evaluation & Management (E&M) Visits**
The AOA commends CMS for its efforts to reduce regulatory requirements and excessive paperwork for physicians and other clinicians by proposing historic changes to reform office/other outpatient Evaluation and Management (E/M) visits (CPT codes 99201 through 99215). As many stakeholders have long maintained, and CMS has acknowledged, we agree that the current E/M documentation requirements are administratively burdensome and outdated with respect to the practice of medicine, and need to be revised. Overhauling E/M codes is a tremendous undertaking, and while we are encouraged by many of the proposals in the rule that would provide regulatory relief, we urge CMS to recognize that additional considerations must be taken into account to ensure successful implementation of this effort. We disagree with CMS that the proposed documentation changes and payment proposals for office/other outpatient E/M visits are intrinsically related, and that the following proposals can be implemented without altering PFS payment rates:
• Eliminating extra documentation requirements for the medical record to indicate medical necessity for furnishing the E/M visit in the home, rather than in the office.
• Eliminating the provision that prohibits payment for two E/M office visits billed on the same-day by practitioners of the same group and specialty.
• Allowing practitioners the option to exercise clinical judgment in choosing to use medical decision making (MDM) as the governing factor in selecting and documenting office/other outpatient E/M visits, or the option to continue using either the 1995 or 1997 versions of the E/M guidelines.
• Removing redundancy to allow E/M documentation to focus only on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history.
• No longer requiring practitioners to re-enter information in the record regarding the chief complaint and history for new and established patients that has already been entered by ancillary staff or the beneficiary.
• Amending documentation requirements for teaching physician E/M visits to allow for the physician, resident or nurse to document the presence and extent of the physician’s participation in the medical record. Current regulations require the teaching physician to “personally” document their participation in the medical record. However, the proposed rule does not reflect recent CMS guidance (transmittal 4068) regarding documentation requirements for students, which allows teaching physicians to use medical student documentation, including history, physical exam and/or medical student decision making provided that he/she personally performs or re-performs the physical exam and medical decision making of the E/M service and verifies the student’s documentation.

We believe that lifting the restrictions related to the above-mentioned documentation requirements align with CMS’ Patients Over Paperwork initiative and will provide immediate relief from regulatory burden.

Current PFS payment rates for office/other outpatient E/M visits increase with the level of service. Therefore, it is unclear how a “one size fits all” approach will improve payment accuracy for multiple E/M visits. As such, we are not convinced that simplifying payment amounts will minimize documentation requirements or improve payment accuracy for E/M visits.

CMS’ proposal to collapse payment for levels 2-5 of both new and established patient office visit codes, into two payment rates, and create new codes to offset complexity for primary care and certain specialties does not align with the current resource based relative value system (RBRVS) used for physician compensation models, and appears to violate statutory requirements that the PFS be based on the relative resources required to furnish a service.

The formula for payment rates for the PFS is based on the resource costs of physician work, PE and professional liability insurance. Current law requires that for each physician
service, the Secretary determine work RVUs based on the ‘relative resources incorporating physician time and intensity required in furnishing the service or group of services.”

Instead, CMS is attempting to create a payment rate based on the weighted averaged utilization of a code set, which eliminates the connection between the resources needed to provide E/M services relative to those needed to furnish other physician services. Because E/M services comprise such a significant share of physician services, severing the mandated connection to relative resource use for those services would undermine the integrity of the entire PFS.

The PE component of the formula is subdivided into practice overhead costs directly related to performing the physician service (e.g. clinical staff salaries/benefits, medical supplies and medical equipment) and costs that are indirectly related to performing services (i.e., rent, administrative staff salaries/benefits, utilities, etc.). PE accounts for nearly 45 percent of Medicare Allowed Charges. The portion of PE that is indirect is typically 65 to 85 percent for a large majority of services and is approximately 30 percent of the entire PFS (nearly $30 billion in Medicare Allowed Charges). A significant component of the PE formula to determine indirect practice expense payment is the Indirect Practice Cost Indices (or IPCIs). The proposal to alter PFS payments for office/other outpatient E/M visits included creating a new IPCI solely for office visits, overriding the current methodology for these services by treating office E/M as a separate Medicare Designated Specialty. This change would also create large shifts (approximately +/-10 percent) in the specialty-level IPCIs for several specialties and result in large swings in payment for many services predominantly performed by those specialties. CMS’ efforts to incorporate the E/M single payment rates into the current constraints of budget neutrality, along with a complex PE methodology, have led to an unacceptable payment proposal.

CMS’ proposals would also depart from the Patients Over Paperwork initiative, which aims to enable physicians to spend more time with patients by reducing paperwork and administrative burdens imposed through regulations. In reality, these proposals, if finalized, will increase administrative burden by creating two separate documentation and coding standards between office/other outpatient E/M visits, and all other E/M visits paid under the PFS, as well as between Medicare and private insurers.

Furthermore, many commercial payment rates are based on a percentage of Medicare Allowed Charges and payment contracts for the CY 2019 have already been negotiated. If the E/M payment changes are adopted in the final rule, physicians will not have enough time to re-negotiate contracts before the start of next year. We urge CMS not to disregard the negative impacts the E/M proposals will have on commercial contracts.

There is also widespread concern that payment policies may potentially discourage medical students from choosing careers in primary care. Sufficient payment is needed to

---

2 SSA §1848(c)(2)(C)(ii)
recruit and retain medical students after residency training is completed. Drastic cuts in payment for E/M visits will exacerbate an already inadequate supply of primary care physicians.

**Proposed HCPCS G-Code Add-On To Recognize Additional Relative Resources for Certain Kinds of Visits**

The definitions for the proposed primary care and specialty complexity adjuster codes appear arbitrary and unreasonable from a clinical perspective. The proposed payment amounts are far too low to be meaningful and they are not resource based because CMS has designed them to be budget neutral with respect to the savings generated from the proposed multiple procedure payment adjustment. It is unclear why the proposed code GPC1X (Visit Complexity Inherent to Primary Care Services) would only be applicable to established patients, instead of both established and new patients, particularly where the time and intensity of primary care visits are even higher. Application of specialty code GCC0X (Visit Complexity Inherent to Certain Specialist Visits) should not be determined by specialty designation, but rather based on the level of work performed to properly evaluate and treat the patient’s presenting complaints. It also is unclear if, and to what extent, documentation is required to support use of the complexity add-on codes. We are concerned that additional documentation requirements may undermine CMS’ efforts to simplify administrative burden.

**Proposed HCPCS G-Code for Prolonged Services**

In the proposed rule, CMS fails to clarify how the new prolonged service code (GPRO1) would be billed in conjunction with the single level payment E/M visits, and does not project utilization in the impact analysis. Yet, CMS assumes physicians will frequently bill the code to mitigate the financial impact of the single payment rates. Generally, prolonged visits occur unexpectedly, and because patients are seen based on an overall office schedule that does not include prolonged visits it is unlikely most physicians will be able to bill GPRO1 more than once or twice a day. While GPRO1 might allow practitioners to report occasional outliers with very long visits, we do not see how it could be reported frequently enough to address the distribution of usual patients.

In 2012-2014, the American Medical Association (AMA) CPT Editorial Panel established a CPT Workgroup to revise E/M documentation guidelines and code descriptors. The former Workgroup was charged with making MDM a required component for all codes that required at least two out of the three key components. To build upon previous Workgroup efforts and to support CMS’ current proposals to address ongoing concerns about E/M visits, the AMA’s CPT Editorial Panel and the Specialty Society RVS Update Committee (RUC) have joined together to convene a new Workgroup on E/M to develop a coding structure that will foster burden reduction while ensuring appropriate valuation of E/M visits. Implementation of a new coding structure requires substantial physician and office staff education, changes to EHR systems, as well as changes in procedures of Medicare Administrator Contractors (MACs), and private payers. CMS must allow ample time for these changes. The CPT/RUC Workgroup on E/M has provided a transparent process for
stakeholder engagement to build the new structure, and a clear and reasonable timeline for submission of a coding proposal by early November 2018 for consideration at the February 2019 CPT Editorial Panel meeting. For these reasons, we urge CMS to draw upon the expertise represented by the CPT/RUC Workgroup on E/M. The opportunity to join together with subject matter experts and stakeholder groups will prove to be a valuable resource for CMS, and we hope the agency takes a strong interest and actively participates in the efforts being pursued.

**E/M Multiple Procedure Payment Adjustment**

CMS proposes to apply a 50 percent reduction to the least expensive procedure or visit furnished on the same day as a separately identifiable E/M visit appended with Modifier -25 when performed by the same physician. CMS’ rationale for proposing to apply the multiple procedure payment adjustment is out of concern that there are significant overlapping resource costs when standalone E/M visits occur on the same day as a service with a 0-day global period. Because routine E/M is included in the valuation of codes with 0-, 10-, and 90-day global periods, Medicare only makes separate payment for E/M visits that are provided in excess of those considered included in the global procedure when billed with Modifier 25, which is defined as a significant, separately identifiable E/M service performed by the same physician on the day of a procedure above and beyond other services provided or beyond the usual pre-service and post-service care associated with the procedure that was performed. Modifier 25 allows physicians to be paid for E/M services that would otherwise be denied as bundled.

We are concerned that the multiple procedure payment adjustment will have unintended consequences that will penalize physicians and impede care for patients by jeopardizing timely access to care. Frail and elderly beneficiaries with complex medical conditions—such as those with diabetes mellitus, coronary artery disease, hypertension and hyperlipidemia—who may also report additional medical conditions, such as ear pain with difficulty hearing, stand to suffer the most, as they may have to seek care through multiple office visits resulting in additional out-of-pocket costs. CMS’ proposal runs the risk of disrupting physician’s ability to provide medical services in an efficient manner by limiting the number of clinical issues they are able to address per visit. Shorter E/M visits will direct care away from patients and stands to diminish the physician-patient relationship, which is counter to the Patients Over Paperwork initiative.

Furthermore, we believe CMS’ concerns about overlapping resources are unsound, as both CMS and the RUC have conducted multiple screens under the Potentially Misvalued Code Initiative to identify codes with potential overlap and made RVU adjustments accordingly. Thus, we urge CMS to abandon the proposed multiple procedure payment adjustment in its entirety.

Of particular concern about the multiple procedure payment adjustment is the impact it would have on OMT services (98925-98929), as they are usually billed with an E/M visit with Modifier 25. For the CY 2017 Identification and Review of Potentially Misvalued
Services, in the proposed rule CMS identified 83 codes for review and possible re-evaluation because they were billed with an E/M visit 50 percent of the time or more. As expected, the OMT codes 98925-98929 were flagged in this screen. In further review of the list of potentially misvalued services, CMS acknowledged that “when we established our valuation of the osteopathic manipulative treatment (OMT) services, described by CPT codes 98925-98929, we did so with the understanding that these codes are usually reported with E/M codes.” As such, CMS removed the OMT codes from the list of potentially misvalued services in the final rule.

On multiple occasions, the AOA has reached out to CMS about revising the assigned global designation for OMT codes from 000 to XXX. In May 2013, we met with CMS representatives to discuss the key issues summarized below:

In 1992, HCPCS M-codes for OMT were assigned an XXX global period. In 1993, the global period for OMT codes were re-assigned a 000 global period without an explanation in the final rule. Medicare Carriers were left to interpret payment policies for the global changes resulting in inconsistent guidance on how to correctly report OMT and E/M visits on the same day. In an attempt to clarify OMT payment policies, the Department of Health and Human Services (HHS) Office of Payment Policy issued a memo dated July 25, 1994, to all Associate Regional Administrators. This memo included a requirement that when OMT and a significant, separately identifiable E/M visit are performed on the same date, the E/M visit should be reported with a Modifier -25. Although the 1994 memo provided necessary guidance, CMS contractors and other payers continued to refer to the global designation without applying additional rules and regulations for exception. Over the past 20 years, the AOA has worked vigorously to educate members that they should appropriately code the E/M service billed with OMT, and that they should not omit the OMT service if they are providing such care.

CMS communicated with the AOA as recently as July 15, 2014 regarding OMT. According to CMS, rather than addressing individual codes in isolation, the agency preferred to look at the policies applicable to global codes as a package to assure that similar situations were treated alike. Given that the PFS is based on relativity, the agency believed it was critical. The agency noted its proposal to transform all 10- and 90-day global surgical codes to 0-day global codes.

In light of the CY 2019 proposed multiple procedure payment adjustment, we would like to reiterate our request that CMS reverse the assigned global designation for OMT codes from 000 back to XXX to accurately reflect that OMT provided to patients is often on the same day as E/M services. The current 0-day global period designation does not reflect the services provided, and therefore remains an ongoing source of confusion for MACs, as well as private payers. Audits resulting from the current designation also impose administrative

---

3 Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Final Rule, Vol. 81, No. 220, Federal Register, No. 220, November 15, 2016, pp.35.
burdens on physician practices and create additional expenses in response to medical
record requests, and denial of services. Until the global designation is changed, we ask that
CMS exclude OMT services from the multiple procedure payment adjustment should the
policy be confirmed in the final rule.

While we understand CMS’ need to seek new ways to improve payment within the PFS for
office and other outpatient E/M visits, time and expertise is required to adequately design
and appropriately value these services. An undertaking of this magnitude cannot be
accomplished within a mere 60-day comment period. Given past failed reform attempts,
and the significant impacts the changes will have on Medicare beneficiaries, primary care
practitioners and specialists alike, we respectfully urge CMS to proceed cautiously. Going
forward, we offer the following recommendations for consideration:

- Withdraw proposals to alter PFS payment for office/other outpatient E/M visits
  (CPT codes 99202-99205 and 99212-99215), the multiple procedure payment
  adjustment policy, HCPCS code GPC1X for primary care services, HCPCS code GCG0X
  for certain specialty visits, and HCPCS code GPRO1 for prolonged visits.
- Decouple the documentation proposals mentioned above on pages 4-5 from the
  payment methodology, and implement the documentation changes effective January
  1, 2019 to provide immediate relief from administrative burden.
- Maintain the current payment structure for CPT codes 99202-99205 and 99212-
  99215 until the CPT/RUC Workgroup on E/M has completed its work and made
  recommendations regarding changes in documentation guidelines and review of
  payments to ensure they are resource based.
- As CMS emphasizes increased reliance on MDM, we urge the agency to revisit the
  2012-2014 CPT Workgroup recommendations to revise documentation
  requirements.
- Consider innovative concepts, such as the Patient Centered Medical Home and other
  payment and service delivery models tested through the Center for Medicare and
  Medicaid Innovation (CMMI) to support primary care.
- Collaborate with physician stakeholder groups to collect data to support resource
  use.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
The AOA advocates for equity in reimbursement for rural physicians as part of the strategy
to increase the availability of quality health care in rural areas. To that point, we urge CMS
to finalize its proposal to create and implement a new CPT code (994X7) for General Care
Management effective January 1, 2019.

We also support the proposal to create a new virtual communications G-code to allow RHCs
and FQHCs to receive additional payment for the costs of communication technology-based
services and remote evaluations when there is no associated billable visit. Because RHC
and FQHC payments are all-inclusive, we believe separate payment for virtual
telecommunications would be helpful. However, the stipulation that the virtual service
must be unrelated to any services provided 7 days prior or 24 hours after a RHC or FQHC visit seems overly restrictive. We urge CMS to consider a shorter, more reasonable timeframe of 2-3 days.

**Appropriate Use Criteria for Advanced Diagnostic Imaging Services**

For the Medicare Appropriate Use Criteria (AUC) Program, CMS proposes use of a new G-code and modifiers to report use of AUC on claim forms, and to allow licensed clinical staff working incident to the ordering physician to perform consultation of AUC through a qualified clinical decision support mechanisms (CDSM). Prior AOA comments expressed numerous concerns about the AUC program and that it creates a looming burden for ordering physicians without any assurances of improved patient care. Therefore, we remain opposed to required participation in a stand-alone AUC reporting program, when AUC is inherent in the MIPS Improvement Activities performance category. This requirement is counterproductive to CMS' efforts to streamline and reduce administrative burden.

Aside from forced participation in the AUC program, the AOA does support CMS’ proposal to modify existing requirements and criteria to allow ordering professionals of advanced diagnostic imaging services to self-attest to significant hardship exceptions if they experience 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or 3) extreme and uncontrollable circumstances.

**Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs)**

For CY 2019, CMS is proposing to align Medicaid Promoting Interoperability Program electronic clinical quality measures (eCQMs) with MIPS eCQMs as part of the agency’s Meaningful Measures Initiative. Current AOA policies support reforms that aid in the reduction of regulatory burden and attempting to align the Medicaid Promoting Interoperability Program with other Medicare quality reporting programs would create much needed consistency across programs.

**Medicare Shared Savings Program**

To align the quality measure sets for ACOs in the Medicare Shared Savings Program (MSSP) with the Meaningful Measures Initiatives, CMS proposes to reduce the number of quality measures required for reporting from 31 to 24. The AOA supports streamlining the quality measures. Patient-centered care is at the core of our mission, and because most of the changes apply to the Patient Experience of Care Survey and the CMS Web Interface, the intention would focus quality reporting on outcomes and patient experience measures that align with MSSP goals for care coordination and patient engagement.

**Physician Self-Referral Law**

In light of statutory provisions in the Bipartisan Budget Act of 2018, CMS proposes to add a special rule that would essentially allow written agreements for compensation
arrangements to be satisfied by a collection of documents, including contemporaneous documents as evidence of the course of conduct between the parties, and allow the signature requirement for certain Stark Law exceptions to be met if the compensation agreement complies with the exception criteria, and is obtained within 90 consecutive calendar days following the date of a required signature. The AOA supports these proposals, as we believe many of the provisions in the physician self-referral law are outdated and prohibit physicians from entering into value-based financial arrangements such as alternative payment models (APMs).

**CY 2019 Updates to the Quality Payment Program**

**Low-Volume Threshold**
For the 2021 MIPS payment year and future years, CMS proposes to modify the criterion for the low-volume threshold. For Year 3 of MIPS, in addition to receiving $90,000 or less in Part B allowed charges or treating 200 or fewer Medicare beneficiaries, clinicians would qualify for the low-volume threshold if they provide 200 or less in covered professional services under the PFS. As part of this change, CMS proposes to implement their previously finalized policy to allow clinicians or groups that meet or exceed one, but not all, of the low-volume threshold criterion to opt-in to MIPS. While we realize that allowing fewer clinicians to participate in MIPS may reduce the pool of incentive money, we believe that flexibility to opt-in to MIPS will give eligible clinicians who would have previously been excluded from the program the choice to participate and possibly earn an incentive bonus.

**MIPS Performance Threshold**
CMS proposes to increase the performance threshold from 15 points to 30 points and raise the threshold to earn an additional bonus for exceptional performance from 70 points to 80 points. Although the Balance Budget Act of 2018 granted CMS flexibility to set the performance threshold for the initial 5 years of the MIPS program to ensure gradual and incremental transition, we believe that doubling the points from one year to the next is too steep of an increase and may disadvantage successful participation in the program for newly eligible clinicians and those still adjusting to program reporting requirements. We suggest setting the threshold at 20 points is a more reasonable increment.

**Quality Performance Category**
CMS also proposes to allow a 3-point bonus for small group practices (15 or fewer eligible clinicians) who submit data on at least one quality measure. The AOA supports the 3-point bonus, as we believe it will enable solo and small group practices to successfully participate in MIPS.

**Improvement Activities Performance Category**
The AOA supports CMS proposal to modify current regulations to more clearly and concisely capture previously established policies for Patient-Centered Medical Homes and comparable specialty practices.
Cost Performance Category
The Balanced Budget Act of 2018 granted CMS authority to reweight the Cost performance category to not less than 10 percent for the third year of the MIPS program. Therefore, CMS is proposing the Cost performance category will account for 15 percent of a MIPS eligible clinician’s final score for CY 2019. In addition to continuing to use the existing the Medicare Spending Per Beneficiary (MSPB) and Total Per Capita Cost measures for attribution, CMS proposes to add eight new episode-based measures to the Cost performance category. Since eligible clinicians are still learning about the Cost performance category and being introduced to the new episode-based measures, on top of trying to understand the existing Total Per Capita Cost and MSPB measures, we recommend that CMS maintain the current 10 percent performance weight for CY 2019 to allow more time to understand how the measures will be attributed before evaluating resource cost.

Promoting Interoperability (PI) (previously known as the Advancing Care Information Performance Category)
For the Promoting Interoperability performance category, CMS proposes a new individual level performance-based scoring methodology that would eliminate the base score and bonus points from the calculation, and focus on a smaller set of objectives and related measures. In addition, CMS also proposes to remove six measures from the Promoting Interoperability performance category and add three new measures beginning with the CY 2019 performance period. For the e-Prescribing objective, CMS proposes two new measures both of which support HHS initiatives related to the treatment of opioid and substance use disorders by helping health care providers avoid inappropriate prescriptions, improve coordination of prescribing amongst health care providers and focus on the advanced use of certified electronic health record technology (CEHRT). For the Health Information Exchange objective, CMS would add a new measure titled Support Electronic Referral Loops by Receiving and Incorporating Health Information, which builds upon and replaces the existing Request/Accept Summary of Care and Clinical Information Reconciliation measures, while furthering interoperability and the exchange of health information. In addition, CMS proposes to rename the Send a Summary of Care measure to Support Electronic Referral Loops by Sending Health Information.

The AOA supports the proposals for the Promoting Interoperability performance category for CY 2019, as we believe the new scoring methodology and the other proposed changes will provide a simpler, more flexible and less burdensome structure for EHR interoperability, and will allow MIPS eligible clinicians to put their focus back on patient care.

Small Practice Bonus
We agree that a bonus incentive for small group practices is appropriate due to the unique challenges they experience related to financial and other resources, as well as the performance gap (based on historical PQRS data) for small group practices in comparison to larger group practices. For these reasons, we support the proposal to maintain the 3-
point small group bonus by transferring it from the Promoting Interoperability performance category to the Quality performance category for CY 2019.

**Advanced APMs**

**Generally Applicable Nominal Amount Standard**
The AOA supports CMS’ proposal to amend current regulations to maintain the revenue-based nominal amount standard at eight percent (8%) of the average estimated total Medicare Parts A and B revenues of all providers and suppliers in participating Advanced APM through CY 2024. We believe maintaining the current nominal standard will provide a period of stability for physicians and allow them to better manage the costs and risks associated with being in an Advanced APM plan.

**Conclusion**
In closing, the AOA appreciates the opportunity to share our comments on the CY 2019 proposed rule for the PFS and Year 3 of the Quality Payment Program. The AOA strongly supports CMS’ Patients Over Paperwork initiative, and in that spirit, we stand ready to work with CMS to establish its goals as the regulations are finalized. If you have any questions or wish to discuss our comments, please contact Lisa Miller, Senior Director of Regulatory Affairs and Policy Engagement at lmiller@osteopathic.org or (202) 349-8744.

Sincerely,

William S. Mayo, DO
President, AOA