MSMS
MICHIGAN STATE MEDICAL SOCIETY

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September 10, 2018

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; CY 2019 Updates to the Physician Fee Schedule and Quality Payment Program (CMS-1693-P)

Dear Administrator Verma:

On behalf of the Michigan State Medical Society (MSMS), I am writing to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed rule impacting the 2019 Medicare physician fee schedule, as well as the Quality Payment Program (QPP). MSMS represents approximately 15,000 Michigan physicians of all specialties and practice settings.

We appreciate CMS's efforts to ease administrative burdens for physicians and other health care professionals. Additionally, we are supportive of the ongoing strategy to incrementally evolve the QPP's reimbursement structure and refine expectations and requirements to reflect broader care delivery goals. As shared in previous comments, Michigan physicians have been leaders in innovative quality improvement activities and are supportive of rewarding and cultivating local efforts to improve care delivery and population health that are consistent with the QPPs overall mission.

MSMS offers the following positions and comments regarding the proposed 2019 Medicare PFS and QPP updates:

<u>Support</u>

- Changing the required documentation of the patient's history to focus only on the interval history since the previous visit.

- Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient.

- Removing the need to justify providing a home visit instead of an office visit.

- Expanding coverage of telehealth services and identifying reasonable reimbursement for such services and other telecommunications technology.

- Removing the prohibition on same-day E/M visits billed by physicians in the same group or medical specialty.

- Adding a third element, number of covered professional services, to the low-volume threshold determination under the Merit-Based Incentive Payment System (MIPS).

- Provision of the MIPS participation opt-in option for those individuals or groups that meet two out of three exclusion criteria. MSMS believes eligible clinicians (ECs) should be given the opportunity to earn an uplift that recognizes their efforts and would propose that this option be extended even if the EC meets or exceeds all the exclusion elements.

- Promoting Interoperability changes that emphasize interoperability and the electronic exchange of health information and simplify the process for users. MSMS believes that the streamlined and refocused measures and continuation of a 90-day reporting period will help to increase successful reporting by ECs.

- Increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.

- Continuation of bonus points for small practices and practices whose patient panels include complex patients.

- The implementation of facility-based scoring options for facility based eligible clinicians. Many of these clinicians are involved in quality improvement efforts within their facilities. As noted previously, the Michigan Health & Hospital Association's Keystone Center has been very active in implementing and sharing evidence-based, best practices through several patient safety and quality improvement initiatives; thereby, benefitting patient care and health care cost trends.

- Allowance for a combination of data collection types for the reporting of quality measures. This should increase the number of quality options from which individuals can select. In the past, some ECs were precluded from reporting on quality measures that were important to their practice simply because they did not utilize an eligible data collection mechanism.

<u>Oppose</u>

- Wholesale evaluation and management (E/M) coding changes prior to a comprehensive review of the issues pertaining to coding and document requirements for varying levels of E/M services. Although CMS' proposals may be well-intentioned, MSMS believes there will be unintentional consequences that will negatively impact the financial stability and sustainability of certain physician practices, access to care in already underserved areas, and access to care for patients with complex medical needs.

  In medically underserved communities, there may only be one or relatively few primary care and other specialty physicians. Patient panels for these physicians often include an above average mix of complex patients, including complex elderly patients. And, in general, the treatment and management of complex medical problems requires significant time commitments often involving comprehensive consultations, complicated medical decision-making, scheduling and following up on tests and laboratory procedures, and making appropriate referrals.

  MSMS believes collapsing the payment rates for eight office visit services for new and established patients down to two each will have the following effect:

  - More frequent office visits to properly manage patients with multiple chronic conditions which will lead to higher costs. There is a reason that there are higher level codes to appropriately reimburse physicians and other health care professionals for the added time and

services necessary to treat and manage patients with complex and challenging health conditions.

- Reluctance to accept new patients with complex medical needs.

- Inaccurate reflection of the health status of Medicare patients. If physicians and other health professionals adjust their documentation and coding to the lowest level required to receive the new standard payment, the complexity and risk level of that patient is no longer readily identified. With the movement to more outcomes-based reimbursement, physicians should be strongly encouraged to continue to code appropriately, not simply default to the lower level codes and document proportionally.

- A down-grading of the average payment in future years. It should also be noted that the collapsed payment rates are based on a five-year time period that may not reflect improved documentation in electronic health records of work performed or greater responsibilities assumed by certain specialties such as those represented by primary care physicians.

MSMS is one of 170 organizations representing physicians and other health professionals that signed the August 27th letter submitted by the American Medical Association. We support the AMA's suggestion to set aside the proposed office visit and multiple services proposals in order to allow the AMA's workgroup to further analyze the issue and develop actionable recommendations for submission to CMS for consideration in the 2020 Medicare Physician Fee Schedule proposal.

- Payment reductions for multiple services provided on the same date of service as those scenarios are already factored into prior valuations of the affected codes.

- Mandatory use of 2015 Edition of Certified Electronic Health Record Technology (CEHRT). We appreciated CMS' decision last year to delay this requirement and request that CMS continue that delay for calendar year 2019. MSMS is concerned that the proposal requires users, beginning with the CY 2019 reporting period, to use 2015 Edition CEHRT. While we support the continued progress in technology, this may pose a large barrier for many practices. Although most EHR vendors may have this version ready, there are some who may not, or may not be able to support the need for updates as practices work through the changes. We encourage the continuation of the flexibility for providers who may not have the ability to use a 2015 CEHRT EHR. This would provide the vendors time to roll out updates to all users, while also allowing those who may need to make changes the time to continue. EHR vendors may elect to not offer any other version, which would support the migration of all users.

- The option of claims-based reporting being limited to only individuals in small practices. MSMS believes this option should remain for individuals regardless of the size of the group in which they practice. Physicians may not have any control over decisions made by their groups pertaining to chosen reporting options.

<u>Suggestions for consideration</u>

- Give credit for all learning and continuing medical education activities under the Improvement Activities component. Physicians are required to keep current with best practices involving health care trends that are affecting their patients and the communities they serve. For example, in Michigan, physicians are required to obtain 150 hours of CME credit per license cycle including

mandatory courses on ethics, opioid utilization and human trafficking to obtain and/or maintain licensure. This education is timely and directly correlates to improved care.

- If CMS pursues the implementation of a bundled episode-based payment for substance use disorder (SUD) treatment, it should be implemented first as a pilot initiative and not subject to budget neutrality requirements.

Thank you for the opportunity to comment. Your thoughtful consideration is appreciated.

Sincerely,

Betty S. Chu, MD, MBA
President

c: Julie L. Novak, MSMS Chief Executive Officer