



One Prince Street
Alexandria, VA 22314-3318
☎ 703.838.0033
✉ 703.548.1890

September 27, 2019

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. Verma:

On behalf of the AMGA, we appreciate the opportunity to comment on the “Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies” proposed rule (CMS-1715-P).

Founded in 1950, AMGA represents more than 450 multispecialty medical groups and integrated delivery systems representing approximately 177,000 physicians who care for one-in-three Americans. Our member medical groups work diligently to provide innovative, high-quality, cost-effective, patient-centered medical care. Our overarching legislative and regulatory goals revolve around advancing the shift from fee-for-service (FFS) payments to reimbursement based on the value of the care provided.

AMGA is pleased to offer these recommendations for your consideration.

Key Recommendations

Payment for Evaluation and Management (E/M) Services: The Centers for Medicare & Medicaid Services (CMS) should finalize its proposal for a separate payment rate for Levels 1 through 5 E/M services. CMS also should finalize its proposed documentation changes, which will provide additional options to providers.

Merit-based Incentive Payment System (MIPS) Low-Volume Threshold
CMS should remove the low-volume threshold from the MIPS program.

MIPS Value Pathways (MVP)

We applaud CMS’ efforts to reform the MIPS program; however, we believe that CMS should implement MIPS as Congress intended before moving forward with additional reforms.

MIPS Performance Thresholds

AMGA agrees with the increase to the composite performance threshold.

Aligning the Medicare Shared Saving Program (MSSP) with MIPS

Rather than seek to make significant shifts to the current MSSP quality scoring methodology, CMS should work with stakeholder groups to discuss the agency’s goals for the program and how any reforms can facilitate the continued transition to value.

Removing Accountable Care Organization’s (ACO’s) Pay-for-Reporting Year

AMGA opposes CMS’ suggestion to remove the initial pay-for-reporting period for new ACOs in their first agreement period.

Adding ACO-47 to the MSSP

CMS should not include ACO-47 in the in the MSSP quality measurement set, as Part B does not cover all of the vaccinations that are included in the measurement.

Chronic Care Management (CCM)

AMGA supports changes to CCM codes that will reduce provider burden and recommends that CMS work with Congress to waive cost-sharing requirements to encourage additional use of the code.

Principle Care Management (PCM)

AMGA is supportive of efforts to increase care coordination by ensuring providers are compensated for managing complex chronic conditions. Reimbursements for these services allow our members to reinvest in their practices.

Physician Supervision for Physician Assistant Services

AMGA supports changes to regulations that reduce provider burden and encourage team-based care, as these changes will remove impediments for providers to move to value. Team-based care is vital for any organization that seeks to focus on patient outcomes.

Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

AMGA supports policies that would broaden the access to treatment for opioid use disorder (OUD).

CMS Distribution of the 5% Incentive Payment for Advanced Alternative Payment Models (APMs)

AMGA encourages CMS to pay in a timely fashion the bonuses Advanced APM participants earned.

Payment for Evaluation and Management (E/M) Services

In response to last year's proposed Physician Fee Schedule rule (CMS-1693-P), AMGA wrote in opposition to CMS' proposal to consolidate E/M levels 2 through 5 into a single payment rate. Paying a single rate likely would have resulted in a number of negative consequences, such as requiring the most complex patients to have more visits, referring such patients to specialists, or shifting them to more acute care settings. AMGA was particularly concerned that collapsing E/M levels 2 through 5 would disrupt care coordination efforts and result in fragmentation, all of which would hinder the transition to value-based care. Therefore, AMGA is pleased that CMS continued to evaluate the proposal and in current rulemaking is proposing to assign a separate payment rate, rather than a blended rate, to each of the office and outpatient E/M visit codes. It also is important that CMS finalize its proposal to maintain the level 1 visit for established patients. The level 1 code helps facilitate a team-based approach to care delivery and allows various members of the care delivery team to develop a relationship with a patient.

While CMS should finalize its proposal, AMGA is concerned that a detailed estimate of what the effect of the changes will be is not yet available. CMS notes that it cannot "estimate with any degree of certainty what the impact" of the changes to E/M will be and that "potential coding changes and recommendations in overall valuation for new and existing codes between the CY 2020 proposed rule and the CY 2021 final rule could impact the actual change in overall RVUs for office/outpatient visits relative to the rest of the PFS." It is entirely possible that our members will not have an accurate estimate of the impact of this proposed rule until November 2020. This provides them with less than two months before the changes are implemented, which will make internal budgeting and compensation decisions more difficult. CMS should provide additional guidance on this issue as soon as possible to help group practices and integrated delivery systems conduct their internal planning and budgeting.

Regarding the proposed documentation changes, AMGA appreciates the efforts that CMS is taking to reduce the burden associated with documentation. Specifically, AMGA agrees with the proposal to allow a choice of time or medical decision-making (MDM) to select an appropriate code level. CMS rightly acknowledges that counting the number of body systems and/or areas under history or exam is "clinically outdated." As noted in previous comments, AMGA contends that documentation requirements should provide only the necessary information to allow the primary provider and all other cross-covering providers to treat the patient longitudinally. Using time or MDM will help them dedicate their efforts to patient care and reduce the time spent on an administrative task. For example, our members have reported that using time-based codes for Post Discharge Home Visits (G2001-G2015) have simplified the documentation process.

AMGA would note that using MDM to select an E/M code can be fairly subjective. While the American Medical Association updated its guidance on the elements and factors that inform MDM, MDM largely relies on physician interpretation. Any review of claims that are based on MDM needs to recognize that CMS has instituted a policy that defers to the clinician judgement on selecting an appropriate code.

Quality Payment Program

Low-Volume Threshold

For the MIPS 2020 performance period, CMS is not proposing any changes to the low-volume threshold criteria. As a result, those who bill \$90,000 or less in Part B-covered professional services, see 200 or fewer Part B patients, and provide 200 or fewer more covered professional services to Part B patients, will be excluded from the program. However, those who meet at least one, but not all three, of the low-volume threshold criteria, may voluntarily opt into MIPS. CMS estimates that for performance year 2020, slightly more than 31,000 clinicians will opt into MIPS. CMS estimates that an additional 380,000 clinicians would be eligible to opt into the program but will not elect to do so. Overall, about 666,000 clinicians will be excluded from MIPS, compared to the estimated 818,000 who will participate in the program.

AMGA opposes the continuation of the low-volume threshold because of concerns that the number of clinicians who are excused from MIPS remains high. Excluding such a large number of clinicians who would otherwise be required to participate in MIPS will continue to have adverse consequences for both those who participate in the program and those who do not. Due to the budget-neutral nature of MIPS, eliminating a substantial percentage of MIPS participants collapses the range of positive and negative Composite Performance Scores, which in turn causes a substantial decline in payment adjustments that providers will earn. For example, CMS estimates about 87% of clinicians will receive a neutral or positive payment adjustment for the 2020 performance period. Conversely, 12.7% will receive a negative payment adjustment. Such a lopsided distribution of scores creates an unsustainable reimbursement system and undermines congressional intent for the program. Rather than provide a realistic and meaningful opportunity to earn a payment adjustment of up to 9%, as authorized by Congress, CMS estimates the maximum payment adjustment will be 5.8% and the aggregate adjustment will be 1.4%. This estimate is misleading, however, as all payment adjustments of more than a positive 1% are possible only through the exceptional performance bonus. As illustrated in Figure 1 on page 40805 of the *Federal Register*, those who earn a score higher than the performance threshold but below the exceptional performance score can expect a nominal update. CMS also notes it is possible that even more clinicians will score more than the performance threshold, which will further reduce the payment adjustments.

AMGA must reiterate our concern that such negligible payment adjustments do not reflect the considerable investments our members have made in transitioning to a payment mechanism that is based on the quality and cost of care provided. The low volume threshold should be removed from the program. Not only would this improve the distribution of MIPS payment adjustments, it would provide meaningful incentives for all providers to move to value-based care. As AMGA has noted previously, the precursors to MIPS, the Physician Quality Reporting System program, the Meaningful Use incentive program, and the Value-Based Modifier program did not have an exemption for clinicians with a low volume of Medicare patients or allowed charges.

Performance Thresholds

CMS is proposing to raise the performance threshold from 30 to 45 points and the threshold for

exceptional performance from 75 to 80 points. AMGA agrees with the increase composite performance score threshold. However, we would like to reiterate previous comments regarding the level at which the performance threshold is set, as the thresholds and the low-volume exclusions results in an unsustainable distribution of performance scores.

MIPS Value Pathways (MVP) Request for Information

Beginning performance year 2021, CMS is proposing to implement a new conceptual framework for MIPS called the MIPS Value Pathways (MVP). CMS envisions that the MVP would do the following: unite and connect measures and activities across the four performance categories of MIPS; incorporate a set of administrative claims-based quality measures that focus on population health/public health priorities; and streamline MIPS reporting by limiting the number of required specialty or condition specific measures.

AMGA has specific concerns about the MVP concept as it relates to beneficiary assignment and measurement selection. CMS' focus appears to be on how a clinician or groups would be assigned to a specific or multiple MVPs. While this is an important aspect, CMS also must account for beneficiary assignment to a particular MVP. Current beneficiary assignment under MIPS is retrospective, which providers find disadvantageous to their ability to plan and create care processes. Under a retrospective arrangement, providers are not able to target coordination strategies to beneficiaries in the model. Under an MVP construct centered on a specific disease or condition, prospective assignment would allow providers to know which beneficiaries will be included in their cost and quality measurements. This creates a foundation on which providers can build a care delivery model. Having this information at the beginning of a performance period is vital to developing appropriate patient care and quality improvement strategies. For example, care managers or social workers may be added to a patient's provider team if appropriate.

Additionally, quality measurement should follow the care delivery processes that providers develop, not the other way around. CMS should select measures that are patient-centered, focused on outcomes, and largely supported by claims data. AMGA has shared with CMS our 14 value measures, which we believe capture the most relevant information that is important to clinicians, patients, and payers. These measures may help CMS form the basis of a number of MVPs that are based on a specific condition.

In working with AMGA and its members, CMS would be in a position to develop an MVP that considers how care actually is delivered. Rather than building an MVP around the four components of MIPS—quality, cost, improvement activities, and promoting interoperability—a structure that captures and evaluates those categories should be designed around how clinicians and interdisciplinary care teams actually work with their patients to provide them with the best possible treatment. Instead of viewing the MVP as tool to reduce administrative burdens, a properly constructed MVP would encapsulate the care management and delivery processes that are inherent in the group practice model.

AMGA supports efforts to streamline and simplify MIPS participation; however, the MVP model is premature. Instead, AMGA recommends that CMS resolve the underlying issues with the program, which would remain regardless of the implementation of this new framework, notably the clinician participation rates. AMGA believes the timeline for a 2021 start date will not allow

sufficient time to develop MVPs, educate the provider community, and enable clinicians to prepare for the new reporting and scoring mechanisms. AMGA would be pleased to work with CMS to develop an MVP framework.

Medicare Shared Savings Program

Alignment with MIPS

CMS is seeking comment on the possibility of aligning the MSSP quality performance scoring methodology to that of the MIPS program. Effectively, CMS is proposing to shift the MSSP quality scoring methodology to the mechanism that MIPS uses to score quality. AMGA has supported efforts to streamline and synchronize program rules when at all possible. However, AMGA cannot support yet another fundamental change to the MSSP so recently after the new “Pathways to Success” rules and requirements took effect. Similarly, CMS is seeking comment on a major revision to MIPS through the development and deployment of the MVPs. These concurrent efforts add uncertainty to both programs. In an abbreviated timespan, CMS overhauled the MSSP to accelerate ACOs’ transition to risk. Now, CMS is considering significant overhauls to the quality reporting and scoring in both MIPS and the MSSP. Rather than pursue these efforts through the current round of rulemaking, AMGA recommends that CMS meet with stakeholders to discuss the agency’s goals for the programs and how any reforms can further facilitate the transition to value-based care. Requiring ACOs to reconfigure their infrastructure, which was designed based on one reporting and scoring methodology, with a different method would be disruptive. AMGA also recommends that before moving forward with a proposal to align MSSP quality scoring with MIPS, the agency model the possible impact on ACOs. Providers would then have a more complete understanding of the proposal and be positioned to make more informed decisions on how to participate in the ACO program.

Removing Pay-for-Reporting Year

In the proposed rule, CMS discusses removing the pay-for-reporting year new ACOs are allotted in the first year of their first agreement period. AMGA strongly opposes this idea. Not only do ACOs need time to adjust to reporting new measures and benchmarks, the initial 12 months of experience under pay-for-reporting gives ACOs time to acclimate to the program and learn how to deliver care in the new model. ACOs use the experience gleaned from the pay-for-reporting year to implement care processes, workflow, and health information technology changes needed to succeed in the model.

Removing the pay-for-reporting period would have a negative impact on new ACOs. The amount of shared savings an ACO can receive is linked to its performance on quality measures. New ACOs could have their shared savings reduced in their initial year if they fail to meet quality targets. We believe this would unfairly penalize new ACOs. In addition, removing the pay-for-reporting period could discourage participation in the ACO program.

Addition of ACO Measure 47

CMS is proposing to add a Group Practice Reporting Option measure, ACO-47, Adult Immunization Status, to the MSSP. This measures the percentage of adults 19 years and older who are up-to-date on recommended routine vaccines for influenza, tetanus and diphtheria (Td)

or tetanus, Tdap, herpes zoster, and pneumococcal. However, Medicare Part B does not cover all of the vaccines in this bundle. For example, Medicare Part B does not cover the Tdap vaccine. This measure bundles a number of vaccinations and can create a burden for patients if they do not have coverage for a particular inoculation. Therefore, AMGA opposes inclusion of ACO-47 in the MSSP measure set.

Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

As part of Section 2005 of the SUPPORT Act, Congress established a new Medicare Part B benefit for opioid use disorder (OUD) treatment services, such as medication-assisted treatment. The proposed rule details CMS' proposals to implement the SUPPORT Act. AMGA understands the toll that opioid-related substance use disorder can inflict on patients, their families, and the larger community. As such, we support policies that would broaden the access to treatment for those suffering from OUD.

We would like to highlight the cost-sharing provisions that CMS proposes to implement for opioid treatment programs (OTP). In the proposed rule, CMS states that it will set the copayment amount to zero dollars for OTP for a time-limited duration. The agency cites flexibilities provided to them under the SUPPORT Act as the rationale for their ability to make this change. AMGA supports waiving the cost sharing for these services, as we believe they will increase beneficiary access to needed care. AMGA has long supported removing barriers to access for services that promote the well-being of the beneficiary.

Care Management Services

Chronic Care Management

Chronic care management (CCM) services are comprehensive care coordination services provided each calendar month to beneficiaries with two or more chronic conditions. CMS is proposing to replace a number of CCM codes with Medicare-specific codes to allow clinicians to bill incrementally to reflect additional time and resources required in certain cases and better distinguish the complexity of illness as measured by time. CMS is also proposing refinements to certain billing requirements and elements of care-planning services in order to reduce the burden associated with billing complex CCM codes. AMGA supports changes to CCM codes that will reduce provider burden.

In the rule, CMS states that while early analyses show the positive effects of CCM, there continues to be underutilization of these services. We agree with this statement, which is evidenced by the fact that the latest data show that only 684,000 out of 35 million beneficiaries benefited from these services in the first two years of the payment policy.¹ AMGA members have reported that the reason for this slow uptake of CCM is due in part to the 20% coinsurance that is required when a patient receives CCM. The 20% coinsurance may deter beneficiaries from consenting to receive CCM services. Additionally, these services are non-face-to-face, which could lead to some confusion when a beneficiary receives a bill for a visit they do not remember

¹ Schurrer, J., et. al. Evaluation of the Diffusion and Impact of the Chronic Care Management Services: Final Report. Mathematica. November 7, 2017.

occurring, leading to dissatisfaction with their provider. We have long advocated for the removal of the 20% coinsurance for these services and would encourage CMS to work with Congress to enact legislation that removes cost-sharing requirement for these services. We believe that removing the cost-sharing liability in conjunction with the streamlined documentation requirements CMS is proposing will have an impact on the uptake of these services, which are vital to care coordination needed by beneficiaries suffering from multiple chronic conditions.

Principle Care Management

CMS has identified an area of need for beneficiaries with one chronic condition. Because of the gap in payment and coding for those with one chronic condition, CMS is proposing separate coding and payment for Principle Care Management (PCM) services. The agency states that it envisions a majority of instances in which PCM services would be billed when a single condition reaches a complexity that can no longer be managed in a primary care setting and may require the care of a more specialized clinician. AMGA is supportive of efforts to increase care coordination and compensate providers for managing complex chronic conditions. Reimbursement for these services allows our members to reinvest in their practices and increase their ability to coordinate patient care by, for example, hiring more care managers.

Physician Supervision for Physician Assistant Services

CMS is proposing to modify current regulations regarding physician supervision requirements for physician assistants (PAs) to provide PAs greater flexibility in their practice of medicine. Specifically, the change would provide that the statutory supervision requirement for PA services would be met when a PA practices in accordance with state law and state scope-of-practice rules where the services are furnished, with medical direction and appropriate supervision as provided by state law. These changes will bring physician supervision requirements in line with the requirements for physician collaboration for nurse practitioners and clinical nurse specialists. AMGA supports changes to regulations that reduce provider burden and encourage team-based care, as we believe these changes will reduce the barriers for providers to move to value. Team-based care is vital for any organization that seeks to focus on patient outcomes and quality of care. Our member groups rely on a team-based approach to deliver care to their patients, and we believe this regulatory change will aid them in this process.

CMS Distribution of the 5% Incentive Payment for Advanced Alternative Payment Models

Under the Quality Payment Program, clinicians participating in an Advanced Alternative Payment Model (APM) are eligible to receive a 5% bonus to their Physician Fee Schedule revenue. Clinicians participating in Advanced APMs were set to receive their first incentive payments in 2019, based on performance in 2017. However, to our knowledge, there has been an unexpected delay to the distribution of these payments. On the other hand, clinicians participating in MIPS began receiving their MIPS payment adjustments from performance year 2017 on January 1, 2019. AMGA, along with other stakeholders, recently submitted a letter regarding this delay. We would like to again stress the impact of this delay on our member organizations' ability to plan and continue to make the investments needed to be successful in value-based models. Our member organizations seek to continue the move to value and need assurance and consistency as they continue to take on risk. Delays in paying this incentive payment hinder this progress. As such, we would like to again urge CMS to pay these bonuses to

Advanced APMs in a timely fashion.

We thank CMS for consideration of our comments. Should you have questions, please do not hesitate to contact AMGA's Darryl M. Drevna, senior director for regulatory affairs, at 703.838.0033 ext. 339 or at ddrevna@amga.org.

Sincerely,

A handwritten signature in cursive script that reads "Jerry Penso".

Jerry Penso, M.D., M.B.A.
President and Chief Executive Officer, AMGA