



September 18, 2019

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

Dear Administrator Verma:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies as published by the Centers for Medicare & Medicaid Services (CMS) in the August 14, 2019 *Federal Register*.

The AAFP continues to commend CMS' leadership and commitment to improving the Medicare program for all beneficiaries—and in improving access to high-quality, comprehensive, and coordinated care, especially your efforts to support family medicine and primary care. We look forward to working with CMS on designing and implementing policies that support these shared goals through both the Medicare Physician Fee Schedule (MPFS) and the Quality Payment Program (QPP).

Our members are on the frontline of caring for patients with diverse needs—and they practice in all settings. More than 90% of family physicians accept Medicare—making them the foundation of care delivery for our health system. In addition, family physicians practice in 90% of U.S. counties, many of which include rural and underserved areas. The recommendations we offer in this letter reflect our members' experiences caring for patients across the country and our goal to build a health system founded in family medicine and primary care that improves health and reduces system costs.

The AAFP respectfully offers comments on the following high-level issues for your consideration, in addition to more detailed responses that follow on the proposed rule.

- **Office/Outpatient Evaluation and Management (E/M) Coding.** The AAFP supports the adoption of the work relative value units (RVUs) recommended by the RVU Update Committee (RUC) for all the office/outpatient E/M codes, the new prolonged services add-on code, and CMS' proposal to maintain separate values for levels two through four visits rather than implement its plan for a blended payment rate for those services. However, since most family medicine practices already operate on extremely thin margins and these services have been undervalued for decades, we implore CMS to implement these changes in 2020 rather than 2021 as proposed.

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- **Global Surgical Packages.** Based upon analysis available from RAND and the Medicare Payment Advisory Commission, we believe the proposed recommendations put forth by CMS are the appropriate policy. Therefore, we strongly support CMS' proposal to not adjust the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits.
- **Chronic Care Management.** The AAFP is concerned the addition of new principal care management (PCM) codes would move away from the continuous, comprehensive, and coordinated value-based care and primary care CMS has otherwise been encouraging as a cost-effective way to care for Medicare patients. We offer alternative recommendations in the body of the letter to strengthen care for beneficiaries with chronic conditions and urge CMS to use the existing Current Procedural Terminology (CPT) coding process to make changes to these codes.
- **Merit-based Incentive Payment System (MIPS) Value Pathways.** We share CMS' goals of reducing administrative complexity in the MIPS program, structuring the program to help providers move to Alternative Payment Models (APMs), and strengthening the ability of providers and practices to engage in continual quality improvement through the sharing of performance data and feedback. The AAFP offers a number of recommendations to accomplish these objectives and looks forward to working with CMS on these proposals.
- **MIPS Cost Measures.** Many of our members are small practices, including those who practice in rural areas. We remain concerned about the impact of outlier, high-cost cases on these practices and their performance on cost measures—and we offer recommendations to mitigate these potential impacts. We are also concerned about the potential for overlap between the total cost of care and episode-based measures as primary care physicians will be measured on total costs that also include episodes. This discrepancy would hold primary care physicians doubly accountable for costs, particularly on episodes where they are unable to control costs.
- **MIPS APMs.** The AAFP continues to be concerned about the impact of MIPS APMs—and their preferential scoring—on the MIPS program and providers in smaller practice settings. The differential treatment between MIPS and MIPS APMs disadvantages small and rural practice MIPS providers and creates an incentive for larger practices and organizations to remain in MIPS APMs and not move to the Advanced APM track.
- **Advanced APMs.** The AAFP is cautiously optimistic about CMS' recent announcement of the Primary Care First (PCF) initiative and its potential to strengthen access to comprehensive and coordinated primary care. However, we continue to believe more Advanced APM options must be available to primary care physicians to move the Medicare program towards value—especially for small and rural practices. The AAFP was one of the first organizations to successfully submit a model through the Physician-Focused Payment Model Technical Advisory Committee (PTAC). The AAFP's Advanced Primary Care Alternative Payment Model was approved by the PTAC in December 2017, receiving one of the strongest recommendations by the PTAC to date. Following approval of the APC-APM, the AAFP worked with CMS and the Innovation Center to inform the design of the Primary Care First (PCF) model—but as currently designed it likely does not represent an increased investment in primary care. We continue to advocate for improvements to the model and encourage CMS to implement the AAFP's APC-APM proposal.

The AAFP appreciates the opportunity to offer our comments to the proposed rule, and we look forward to serving as a resource and partner to CMS in refining and implementing policies that improve the health of Medicare beneficiaries and reduce program costs.

II. D. Geographic Practice Cost Indices

Summary

As required by statute, CMS has completed a review of the geographic practice cost indices (GPCIs) and proposes new GPCIs, which will be phased in during 2020 and 2021. These GPCIs include the permanent 1.5 work GPCI floor for Alaska and the permanent 1.0 practice expense (PE) GPCI floor for frontier states (MT, WY, NV, ND, and SD). The proposed GPCIs do not include the current 1.0 work GPCI for localities outside Alaska, since that statutory provision is set to expire at the end of 2019. CMS proposes to use updated data for this GPCI update and make two technical refinements applicable to the work GPCI and the employee wage index and purchased services index components of the PE GPCI. One of those proposed technical refinements is to weight by total employment when computing county median wages for each occupation code, which addresses the fact that the occupation wage can vary by industry within a county. The other proposed technical refinement is to use a weighted average when calculating the final county-level wage index. This removes the possibility that a county index would imply a wage of zero for any occupation group not present in the county's data. Otherwise, CMS is using the same methodology and data sources for this GPCI update as it has used in previous updates.

AAFP Response

The AAFP understands the GPCIs are a statutory part of the payment formula under the Medicare Physician Fee Schedule (MPFS), as is the requirement to review and, if necessary, adjust them at least every three years. We appreciate CMS' diligent efforts to fulfill this part of the statute and support its proposal to use the most current data available in the proposed GPCI update.

That said, as a matter of policy, the AAFP supports the elimination of all geographic adjustment factors from the MPFS except for those designed to achieve a specific public policy goal (e.g., to encourage physicians to practice in underserved areas). A cursory examination of the proposed geographic adjustment factors (GAFs) shows that the GPCIs tend to favor urban and suburban localities over their rural counterparts, even though the latter tend to be underserved. Among the 20 lowest GAFs when the proposed GPCI's are fully implemented in 2021, all represent states or portions of states that are predominantly rural, while among the 20 highest GAFs, all but one (Alaska) represent urban or suburban localities. Thus, the GPCI structure works at cross purposes to the health professional shortage area (HPSA) bonus and other incentives intended to encourage and support rural physicians. We believe rural Medicare beneficiaries would be better served if GPCIs were eliminated from the MPFS, so the HPSA bonus and other incentives are not undermined in their efforts to sustain the rural physician workforce needed to care for those beneficiaries. The AAFP continues to work with Congress to accomplish this goal.

II. E. Potentially Misvalued Services

Summary

CMS proposes to consider the following codes as potentially misvalued:

- 10005 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion)
- 10021 (Fine needle aspiration biopsy, without imaging guidance; first lesion)
- G0166 (External counterpulsation, per treatment session)
- 76377 (3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image

postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation)

CMS notes that a commenter (i.e., the AAFP) provided information to CMS arguing the work involved in furnishing services represented by the office/outpatient E/M code set (CPT codes 99201-99215) has changed sufficiently to warrant reevaluation. CMS thanks the commenter and reiterates “we agree in principle that the existing set of office/outpatient E/M CPT codes may not be correctly valued, and therefore, we will continue to consider opportunities to revalue these codes, in light of their significance to payment for services billed under Medicare.”

AAFP Response

The AAFP appreciates CMS’ diligent, ongoing efforts to identify, review, and, where appropriate, revalue potentially misvalued services. We especially appreciate CMS’ acknowledgement that the existing set of office/outpatient E/M CPT codes may not be correctly valued, and therefore, CMS will continue to consider opportunities to revalue these codes. We note CMS proposes just that elsewhere in the rule, and we will comment further on those efforts in response to that section.

As CMS continues to identify potentially misvalued services, we strongly urge CMS to explore the potential development of additional data sources, such as hospitals’ EHR time stamp data to, better assess the time and effort physicians dedicate to their services. Such an inquiry would be consistent with CMS’ observation in the proposed rule that supporting documentation for codes nominated for the annual review of potentially misvalued codes may include analysis of other data on time. The availability of additional data sources, such as hospital EHR time stamp data, may be a useful tool to help value physician services. The AAFP strongly believes it is time for CMS to explore the use of these additional data in addressing what may be the historical overvaluation of many services.

II.F. Payment for Medicare Telehealth Services under Section 1834(m) of the Act

Summary

CMS maintains a process that provides the public with an ongoing opportunity to submit requests for adding and deleting services from the list of Medicare telehealth services. These requests are categorized as either services similar to services already on the list (Category 1), or services that are not similar (Category 2). Services determined to be Category 1 are added to the telehealth list. CMS proposes three new G-codes the agency believes are sufficiently similar to services currently on the telehealth list and would be added based on being Category 1. The three codes are:

- HCPCS code GYYY1: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.
- HCPCS code GYYY2: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- HCPCS code GYYY3: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).

AAFP Response

The AAFP supports efforts to address the opioid crisis. We understand high levels of misuse and addiction persist with devastating consequences despite annual decreases in the number of opioids prescribed in the U.S. since 2010. We believe telehealth can play an important role in treating and coordinating care for beneficiaries with opioid use disorders (OUDs). The AAFP agrees that these fall into Category 1 and should be added to the Medicare Telehealth Services list.

II.G. Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

Summary

Currently, Medicare covers medications for medication-assisted treatment (MAT), including buprenorphine, buprenorphine-naloxone combination products, and extended-release injectable naltrexone under Part B or Part D, but does not cover methadone. Methadone for MAT can only be dispensed and administered by an opioid treatment program (OTP). OTPs are health care entities that focus on providing MAT for people diagnosed with OUD and are not currently able to bill and receive payment from Medicare for the services they furnish.

The *Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)* established a new Part B benefit category for OUD treatment services furnished by an OTP beginning on or after January 1, 2020. To implement this, CMS proposes:

- Definitions of OTP and OUD treatment services;
- Enrollment policies for OTPs;
- Methodology and estimated bundled payment rates for OTPs that vary by the medication used to treat OUD and service intensity, and by full and partial weeks;
- Adjustments to the bundled payments rates for geography and annual updates;
- Flexibility to deliver the counseling and therapy services described in the bundled payments via two-way interactive audio-video communication technology as clinically appropriate; and
- Zero beneficiary copayment for a time limited duration.

AAFP Response

Stemming the opioid crisis will be a long-term and complex effort for years to come, but we support the agency's initial implementation of the *SUPPORT Act* as needed progress for prevention efforts, improved treatment access, and support for the needs of vulnerable populations. The AAFP supports the proposed OTPs.

II.H. Bundled Payments Under the PFS for Substance Use Disorders

Summary

CMS proposes to create new coding and payment for a bundled episode of care for management and counseling for OUD. The new proposed codes describe a monthly bundle of services for the treatment of OUD that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling.

One code describes the initial month of treatment, which would include administering assessments and developing a treatment plan. Another code describes subsequent months of treatment; and an add-on code describes additional counseling. CMS proposes that the individual psychotherapy, group psychotherapy, and substance use counseling included in

these codes could be furnished as Medicare telehealth services using communication technology as clinically appropriate.

AAFP Response

The AAFP supports these proposals as needed efforts to address the opioid crisis. We also support these codes being furnished as a Medicare telehealth service as clinically appropriate.

However, the AAFP opposes bundled payments for primary care in a fee-for-service (FFS) context. Instead, the AAFP supports efforts, such as those already underway through the Innovation Center, to move primary care away from FFS and into alternative payment models (APMs) that are more consistent with the continuous, comprehensive, and longitudinal nature of primary care.

II.J. Review and Verification of Medical Record Documentation

Summary

Building on medical record documentation relief it implemented in 2019, CMS proposes to establish a general principle to allow the physician, the physician assistant (PA), or the advanced practice registered nurse (APRN) who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team. This principle would apply across the spectrum of all Medicare-covered services paid under the physician fee schedule. Because this proposal is intended to apply broadly, CMS proposes to amend regulations for teaching physicians, physicians, PAs, and APRNs to add this new flexibility for medical record documentation requirements for professional services furnished by teaching physicians, physicians, PAs, and APRNs in all settings.

Specifically, CMS proposes to amend relevant sections of its regulations to add a new paragraph entitled, "Medical record documentation." This paragraph would specify that, when furnishing their professional services, the clinician may review and verify (sign/date) notes in a patient's medical record made by other physicians, residents, nurses, students, or other members of the medical team, including notes documenting the practitioner's presence and participation in the services, rather than fully re-documenting the information. CMS notes that, while the proposed change addresses who may document services in the medical record, subject to review and verification by the furnishing and billing clinician, it does not modify the scope of, or standards for, the documentation that is needed in the medical record to demonstrate medical necessity of services, or otherwise for purposes of appropriate medical recordkeeping.

CMS also proposes to make conforming amendments to its regulations to also allow physicians, residents, nurses, students, or other members of the medical team to enter information in the medical record that can then be reviewed and verified by a teaching physician without the need for re-documentation.

AAFP Response

The AAFP strongly supports CMS' proposals in this regard as it is long overdue. The proposed principle and related regulatory changes are consistent with prior CMS efforts to reduce the administrative burden associated with medical record documentation. They are also consistent with the team-based model of care used in family medicine practices and residencies. However, we urge CMS to clarify that multiple students and residents can enter patient information into the medical record even on the same day and during the same office visit. We encourage CMS to finalize this proposal as clarified per AAFP's recommendation in the final rule this fall.

II. K. Care Management Services

Summary - Transitional Care Management (TCM) Services

CMS proposes to revise billing requirements for transitional care management (TCM) by allowing TCM codes to be billed concurrently with any of the following codes:

TABLE 17: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS

Code Family	HCPCS Code	Descriptor
Prolonged Services without Direct Patient Contact	99358	Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
	99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792	Patient/caregiver training for initiation of home INR monitoring
	93793	Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s)
End Stage Renal Disease Services (patients who are 20+ years)	90960	ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older
	90961	ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older
	90962	ESRD related services with 1 face-to-face visit per month; for patients 20 years and older
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older
Interpretation of Physiological Data	99091	Collection & interpretation of physiologic data, requiring a minimum of 30 minutes each 30 days
Complex Chronic Care Management Services	99487	Complex Chronic Care with 60 minutes of clinical staff time per calendar month
	99489	Complex Chronic Care; additional 30 minutes of clinical staff time per month
Care Plan Oversight Services	G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes
	G0182	Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

CMS seeks comment on whether overlap of these services and TCM services exists, and if so, which services should be restricted from being billed concurrently with TCM. CMS also seeks comment on whether any overlap would depend upon whether the same or a different practitioner reports the services. CMS notes that CPT reporting rules generally apply at the practitioner level, and CMS seeks input from stakeholders as to whether its policy should differ based on whether it is the same or a different practitioner reporting the services. CMS seeks comment on whether the newest CPT code in the chronic care management (CCM) services family (CPT code 99491 for CCM by a physician or other qualified health professional, established in 2019) overlaps with TCM or should be reportable and separately payable in the same service period.

For 2020, CMS proposes to increase the work (RVUs) for TCM code 99495 from 2.11 to 2.36 and to increase the work RVUs for TCM code 99496 from 3.05 to 3.10 based on RUC recommendations. CMS also proposes to accept the RUC's PE input recommendations for these codes.

AAFP Response - TCM Services

As noted in our [policy on "Coding and Payment."](#) the AAFP supports Current Procedural Terminology (CPT) and the coding principles it contains. Thus, the AAFP believes it is important for both physicians and health plans to abide by the principles of CPT. This means when a single code accurately describes multiple services provided by the physician, the physician should report that code rather than codes for each of the individual services provided. It also means the AAFP expects health plans to abide by CPT rules.

Per CPT, a physician or other qualified health care professional who reports code 99495 or 99496 may not report any of the services for which CMS otherwise proposes to allow separate payment during the 30-day time period covered by the TCM codes. **Given that guidance and our policy, we encourage CMS not to unilaterally revise its billing requirements as proposed, whether the services are reported by the same or a different practitioner within the practice. Instead, we would encourage CMS to approach the CPT Editorial Panel, on which CMS has representation, with a proposal to revise the CPT guidelines, so the codes in question may be separately reported during the same time period covered by the TCM codes.**

Part of the administrative complexity and burden that hampers our members' ability to care for their patients is variability in payment policy among payers and payment policy at odds with guidance otherwise included in CPT. **CMS' proposal would add to physician's administrative complexity and burden. As a result, we encourage CMS to work through the CPT process, so the change applies to more than just Medicare—and not finalize the provision as proposed until these changes in CPT are considered and adopted.**

Regarding code 99491, CPT guidelines do not prohibit physicians from reporting it during the same time period covered by the TCM codes. We agree with CPT coding that this service does not overlap with TCM and should be reportable and separately payable in the same service period.

We appreciate and support CMS' proposal to increase the work RVUs for both TCM codes as recommended by the RUC and to accept the RUC's recommendations regarding the direct PE inputs. The AAFP participated in the survey of these codes at the RUC and supports the RUC's recommendations in this regard.

Summary - CCM Services

CMS proposes to adopt two new G-codes with new increments of clinical staff time instead of the existing single CPT code (CPT code 99490). The first G-code would describe the initial 20 minutes of clinical staff time, and the second G-code would describe each additional 20 minutes thereafter. CMS intends these would be temporary G-codes, to be used for MPFS payment instead of CPT code 99490 until the CPT Editorial Panel can consider revisions to the current CPT code set. CMS seeks comment on whether the benefit of proceeding with the proposed G-codes outweighs the burden of transitioning to their use in the intervening year(s) before a decision by the CPT Editorial Panel.

Specifically, CMS proposes that the base code would be code GCCC1 (Chronic care management services, initial 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; and comprehensive care plan established,

implemented, revised, or monitored. [Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately]). CMS proposes a work RVU of 0.61 for code GCCC1, which is crosswalked from CPT code 99490.

CMS proposes an add-on code GCCC2 (Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month [List separately in addition to code for primary procedure]. [Use GCCC2 in conjunction with GCCC1]. [Do not report GCCC1, GCCC2 in the same calendar month as GCCC3, GCCC4, 99491]). CMS proposes a work RVU of 0.54 for code GCCC2 based on a crosswalk to CPT code 11107 (Incisional biopsy of skin [e.g., wedge] [including simple closure, when performed]; each separate/additional lesion [List separately in addition to code for primary procedure]), which has a work RVU of 0.54, with the understanding that add-on codes often have lower intensity than the base codes, because they describe the continuation of an already initiated service.

CMS solicits public comment on whether it should limit the number of times this add-on code (code GCCC2) can be reported in a given service period for a given beneficiary. CMS believes a limit (such as allowing the add-on code to be reported only once per service period, per beneficiary) may be appropriate to maintain distinctions between complex and non-complex CCM, as well as appropriately limit beneficiary cost sharing and program spending to medically necessary services. CMS seeks comment on whether and how often beneficiaries who do not require complex CCM (e.g., do not require the complex medical decision making that is part of complex CCM) would need 60 or more minutes of non-complex CCM clinical staff time and thereby warrant more than one use of code GCCC2 within a service period.

CMS further proposes to adopt two new G-codes that would be used for billing under the fee schedule instead of CPT codes 99487 and 99489, and that would not include the service component of substantial care plan revision. CMS believes patients needing complex CCM implicitly need and receive substantial care plan revision, which makes the service component of substantial care plan revision potentially duplicative with the medical decision-making service component and, therefore, unnecessary as a means of distinguishing eligible patients.

Instead of CPT code 99487, CMS proposes to adopt code GCCC3 (Complex chronic care management services, with the following required elements: multiple [two or more] chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. [Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately]). CMS proposes a work RVU of 1.00 for code GCCC3, which is a crosswalk to CPT code 99487.

Instead of CPT code 99489, CMS proposes to adopt code GCCC4 (each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month [List separately in addition to code for primary procedure]. [Report GCCC4 in conjunction with GCCC3]. [Do not report GCCC4 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month]). CMS proposes a work RVU of 0.50 for HCPCS code GCCC4, which is a crosswalk to CPT code 99489.

Like GCCC1 and GCCC2, CMS intends these would be temporary G-codes to remain in place until the CPT Editorial Panel can consider revising the current code descriptors for complex CCM services. CMS seeks comment on whether the benefit of proceeding with the proposed G-codes outweighs the burden of transitioning to their use in the intervening year(s) before a decision by the CPT Editorial Panel.

Beyond the proposed G-codes, CMS also proposes to modify its description of what a care plan typically includes. Specifically, CMS proposes to eliminate the phrase “community/social services ordered, how the services of agencies and specialists unconnected to the practice will be directed/coordinated, identify the individuals responsible for each intervention” and insert the phrase “interaction and coordination with outside resources and practitioners and providers,” such that the new description would read as follows:

The comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals
- Cognitive and functional assessment
- Symptom management
- Planned interventions
- Medical management
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers
- Requirements for periodic review
- When applicable, revision of the care plan

CMS notes that because these are “typical” care plan elements, they do not comprise a set of strict requirements that must be included in a care plan for purposes of billing for CCM services. CMS welcomes feedback on its proposal, including language that would best guide physicians as they decide what to include in their comprehensive care plan for CCM recipients.

AAFP Response - CCM Services

The AAFP fully agrees with CMS that the CCM code set within CPT needs ample refinement to improve payment accuracy, reduce unnecessary burden, and help ensure that beneficiaries who need CCM services have access to them. **The AAFP opposes the proposed addition of four temporary codes as doing so is not only confusing, but creates needless additional administrative burden. CMS’ approach would lower application of these services for patients and physicians. CMS should not implement a policy that potentially prevents beneficiaries from receiving these services.** The AAFP has made proposals to the CPT Editorial Panel in this regard.

Instead, as with the TCM codes, we urge CMS to pursue changes through a proposal to CPT rather than the creation of separate G-codes, even if those G-codes are only temporary. As noted in the proposed rule, creating a transitional period during which temporary G-codes would be used under the fee schedule in lieu of the CPT codes is extremely disruptive and confusing to our members. **The benefit of proceeding with the proposed G-codes does not outweigh the burden of transitioning to their use in the intervening year(s) before a**

decision by the CPT Editorial Panel. G-codes that duplicate existing CPT codes, which other payers will likely continue to require, only adds to administrative complexity and burden.

If CMS finalizes its proposed G-codes despite our objections, then we concur with the proposed descriptors for GCCC1, GCCC2, GCCC3, and GCCC4. We also support the proposed work RVUs for GCCC1, GCCC3, and GCCC4 based on the crosswalks specified in the proposed rule.

Regarding the proposed work RVU for GCCC2, we believe CMS has erred in proposing to set it at 0.54 on the assumption that the add-on code is less intense over the same intra-service time as GCCC1. We note that CMS currently assigns 1.00 work RVUs to code 99487 for 26 minutes of physician intra-service time and 0.50 to its add-on code 99489 for 13 minutes of physician intra-service time, thus clearly assuming the same intensity for the add-on as the base code, both of which cover complex CCM. We further note that CMS proposes to crosswalk those values to its proposed codes GCCC3 and GCCC4, respectively. Given how CMS has already valued 99487 and 99489 and how it proposes to value the proposed GCCC3 and GCCC4, we believe CMS should assign 0.61 work RVUs to GCCC2 just as it proposes to do to GCCC1, since both codes will have the same physician intra-service time of 15 minutes.

If CMS finalizes its proposed G-codes despite our objections, then we agree a limit to the number of times GCCC2 may be reported (such as allowing the add-on code to be reported only twice per service period, per beneficiary) may be appropriate to maintain distinctions between complex and non-complex CCM, as well as appropriately limit beneficiary cost sharing and program spending to medically necessary services. We think it would be rare that a beneficiary who does not require complex CCM would need more than 60 minutes of non-complex CCM clinical staff time and thereby warrant more than two uses of code GCCC2 within a service period.

Lastly, with respect to CCM, we support the proposed revision to the description of a comprehensive care plan. The proposed change to the bullet in question is a simplification, which we appreciate. The description as revised provides a clear guide for physicians on what to include in their comprehensive care plan for CCM recipients. We support the use of a list of “typical” care plan elements that are not a set of strict requirements that must be included in a care plan for purposes of billing for CCM services.

Summary - Principal Care Management (PCM) Services

CMS proposes separate coding and payment for principal care management (PCM) services, which describe care management services for one serious chronic condition. CMS expects most of these services would be billed by specialists who are focused on managing patients with a single complex chronic condition requiring substantial care management and that most instances, PCM services would be billed when a single condition is of such complexity that it could not be managed as effectively in the primary care setting. Per CMS, the primary care practitioner would still oversee the overall care for the patient while the practitioner billing for PCM services would provide care management services for the specific complex chronic condition. In fact, CMS notes many patients will have more than one complex chronic condition, and that if a clinician is providing PCM services for one complex chronic condition, management of the patient’s other conditions would continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition. CMS acknowledges it’s also possible the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously.

The expected outcome of PCM is for the patient's condition to be stabilized by the treating clinician, so overall care management for the patient's condition can be returned to the patient's primary care practitioner. If the beneficiary only has one complex chronic condition that is overseen by the primary care practitioner, then the primary care practitioner would also be able to bill for PCM services. CMS proposes that PCM services include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified health care professional.

Specifically, for 2020, CMS proposes to make separate payment for PCM services via two new G-codes:

- GPPP1 (Comprehensive care management services for a single high-risk disease, e.g., principal care management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: One complex chronic condition lasting at least three months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities)
- GPPP2 (Comprehensive care management for a single high-risk disease services, e.g., principal care management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least three months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities)

For GPPP1, CMS proposes a work RVU of 1.28, based on a crosswalk to 99217 (Observation care discharge day management [This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status."]) For code GPPP2, CMS proposes a crosswalk to the work (0.61 RVUs) and PE inputs for 99490.

CMS seeks comments on whether both codes are necessary and whether it would be appropriate to create an add-on code for additional time spent each month (like proposed code GCCC2) when PCM services are furnished by clinical staff under the direction of the billing practitioner.

CMS also seeks comments on whether additional requirements to report PCM services are necessary or appropriate. For instance, to prevent potential care fragmentation or service duplication. CMS is concerned that a possible unintended consequence of making separate payment for care management for a single chronic condition is that a patient with multiple chronic conditions could have their care managed by multiple practitioners, each only billing for PCM, which could potentially result in fragmented patient care, an overlap in services, and/or duplicative services. Additional requirements considered, but not proposed, include requiring the practitioner billing PCM to document ongoing communication with the patient's primary care

practitioner to demonstrate that there is continuity of care between the specialist and primary care settings, or requiring the patient to have had a face-to-face visit with the practitioner billing PCM within the prior 30 days to demonstrate that they have an ongoing relationship.

CMS proposes that the full CCM scope of service requirements apply to PCM, including an initiating visit and documenting the patient's verbal consent in the medical record. CMS seeks comment on whether there are required elements of CCM services that the public and stakeholders believe should not be applicable to PCM and should be removed or altered. CMS seeks comments on how best to educate practitioners and beneficiaries on the benefits of PCM services.

CMS proposes to add GPPP2 to the list of designated care management services for which it allows general supervision. Due to the potential for duplicative payment, CMS proposes that PCM could not be billed by the same practitioner for the same patient concurrent with certain other care management services, such as CCM, behavioral health integration services, and monthly capitated end-stage renal disease (ESRD) payments. CMS also proposes that PCM would not be billable by the same practitioner for the same patient during a surgical global period, as CMS believes those resource costs would already be included in the valuation of the global surgical code.

Lastly, CMS seeks comment on any potential duplicative payment between the proposed PCM services and other services such as:

- Interprofessional consultation services (CPT codes 99446-99449 and 99451-99452)
- Remote patient monitoring (CPT code 99091)
- Remote monitoring of physiologic parameter(s) (CPT code 99453)
- Remote physiologic monitoring treatment management services (CPT code 99457)

AAFP Response - PCM Services

In this section of the proposed rule, CMS initially states, "A gap we identified in coding and payment for care management services is care management for patients with only one chronic condition." (*emphasis added*) **However, the AAFP believes there are more effective ways to fill this gap rather than finalizing the PCM proposal as written.**

Like CMS, we are very concerned that the proposed PCM codes will lead to the unintended, but not unanticipated consequence that a patient with multiple chronic conditions could have their care managed by multiple practitioners, each only billing for PCM, which could result in fragmented patient care, and overlapping and duplicative services. **The AAFP therefore opposes the proposed PCM codes.** As CMS notes in the proposed rule, many patients have more than one complex chronic condition. In 2017, [Medicare data](#) indicate that approximately two-thirds of beneficiaries have two or more chronic conditions. **Allowing PCM to be reported for such patients either in addition to, or instead of, complex chronic care management is an invitation to linger in FFS and move away from the continuous, comprehensive, and coordinated value-based and primary care that CMS has otherwise been encouraging as a cost-effective way to care for Medicare patients.**

As CMS notes, some chronic care conditions that are otherwise managed effectively in the primary care setting will sometimes be of such complexity that the services of a specialist are needed. In such instances, patients and their primary care physicians can access that specialist care through face-to-face visits (which are separately reportable by the specialist using existing E/M codes) or via interprofessional telephone/internet/EHR assessment and management

services (which are also separately reportable by specialists using existing E/M codes). As CMS alludes toward the end of this section of the proposed rule, many of these existing services duplicate the proposed PCM services. Carving out PCM services for patients with multiple chronic conditions and creating new G-codes for them could fragment patient care, undermine efforts to coordinate care across providers and settings, and move away from increasing access to comprehensive, coordinated primary care.

Like CMS, we are aware there is a potential gap in coding and payment for care management services for patients with only one chronic condition. We are also aware there are efforts to address that gap through the CPT process. We would encourage CMS to work through the CPT process to address the gap rather than create its own codes for this purpose.

If CMS proceeds down the proposed path despite the concerns both it and we have noted, then we support CMS' stated intent that a primary care physician would also be able to bill for PCM services if the beneficiary only has one complex chronic condition overseen by the primary care physician. If CMS proceeds as proposed, we would also encourage the agency to ensure reporting of GPPP1 or GPPP2 by one physician (e.g., a non-primary care physician) does not prohibit reporting of 99490, 99491, or 99487 by the patient's primary care physician. We also encourage CMS to prohibit GPP1 and GPP2 from being billed in the same month as 99490, 99491, or 99487 by the same physician.

If implemented by CMS, we would strongly encourage the agency to attach additional requirements to the PCM codes to help mitigate the potential fragmentation of care. CMS should require ongoing communication and sharing of initial and revised care plans with the patient's primary care physician to demonstrate that there is continuity of care between the specialist and primary care settings. If CMS requires the patient to have had a face-to-face visit with the physician billing PCM before receiving PCM services, that visit should occur within the prior 60 or 90 days to demonstrate that they have an ongoing relationship.

Lastly, we agree that an initiating visit and verbal consent should be required, just as they are for CCM. From our perspective, PCM services are no different than CCM services except in the total number of chronic conditions the patient has. Thus, we agree GPPP2, however it is described, should be subject to general supervision as CMS proposes, and we also agree PCM should not be billed by the same practitioner for the same patient concurrent with certain other care management services nor by the same practitioner for the same patient during a surgical global period.

Summary - Chronic Care Remote Physiologic Monitoring (RPM) Services

For 2020, CPT is dividing existing code 99457 into a base code and add-on code as follows:

- 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes)
- 994X0 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes).

Given the value of the base code (99457) at 0.61 work RVUs, CMS proposes a work RVU of 0.50 for the add-on code (994X0), supported by CPT code 88381 (Microdissection [i.e., sample preparation of microscopically identified target]; manual), which has the same intra-service and

total times of 20 minutes with an XXX global period and work RVU of 0.53, as well as the RUC survey value at the 25th percentile. The RUC had recommended 0.61 work RVUs for 994X0. CMS does propose the RUC-recommended direct PE inputs for CPT code 994X0. Finally, CMS proposes that remote physiologic monitoring (RPM) services reported with codes 99457 and 994X0 may be furnished under general supervision rather than the currently required direct supervision.

AAFP Response - RPM Services

Regarding the proposed value of new code 994X0, we again point out that CMS has already set the precedent of paying add-on codes at the same rate as their corresponding base code, as evidenced by the current values for 99487 and 99489 and the proposed values for GCCC3 and GCCC4. **Accordingly, we encourage CMS to accept the RUC-recommended value of 0.61 work RVUs for 994X0.** We appreciate CMS' proposal to accept the RUC-recommended direct PE inputs for this code, and we support CMS' proposal to change the level of supervision required for 99457 and 994X0 from direct to general.

Summary - Consent for Communication Technology-based Services

CMS currently stipulates that verbal consent must be documented in the medical record for each service furnished (so the beneficiary is aware of any applicable cost sharing) whenever any of the following services are provided:

- G2010 (Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment)
- G2012 (Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)
- 99446-99449 (Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional)
- 99451 (Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, five minutes or more of medical consultative time)
- 99452 (Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes).

CMS seeks comment on whether a single advance beneficiary consent could be obtained for a number of communication technology-based services. During the consent process, the practitioner would make sure the beneficiary is aware that use of these services will result in a cost-sharing obligation. CMS seeks comment on the appropriate interval of time or number of services for which consent could be obtained, after which a new consent would need to be obtained. CMS also seeks comment on the potential program integrity concerns associated with allowing advance consent and how best to minimize those concerns.

AAFP Response - Consent for Communication Technology-Based Services

The AAFP supports CMS' consideration of moving to a single advance beneficiary consent for communication technology-based services. Such a move would represent a move toward administrative simplification and burden reduction, which CMS is otherwise pursuing through its Patients Over Paperwork initiative. We think a consent that covers a specified period rather than a specified number of services would be easier for both physicians and their Medicare patients to understand and administratively track. For instance, knowing a consent was good for one year, the practice would only need to remember or set a reminder to have another consent signed one year hence, rather than keep track of the number of applicable services over time. An annual consent makes the most sense, since some Medicare beneficiaries may be seen no more frequently than that and since many other aspects of Medicare Part B run on an annual cycle (e.g., applicability of deductible, eligibility for Annual Wellness Visit).

Summary - Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

Rural health clinics (RHCs) and federally-qualified health centers (FQHCs) are paid for general care management services using code G0511, which is an RHC and FQHC-specific G-code for 20 minutes or more of CCM services, complex CCM services, or general behavioral health services. Payment for this service is set at the average of the national, non-facility payment rates for CPT codes 99490, 99487, and 99484.

CMS proposes to use the non-facility payment rates for codes GCCC1 and GCCC3 instead of the non-facility payment rates for CPT codes 99490 and 99487, respectively, if these changes are finalized for practitioners billing under the MPFS. Upon finalization, the payment for code G0511 would be set at the average of the national, non-facility payment rates for codes GCCC1, GCCC3, and 99484.

AAFP Response - Rural Health Clinics (RHCs) and Federally-Qualified Health Centers (FQHCs)

The AAFP supports CMS' intent to set the payment for code G0511 at the average of the national, non-facility payment rates for codes GCCC1, GCCC3, and 99484, if CMS otherwise finalizes its proposals related to GCCC1 and GCCC3.

II.L. Coinsurance for Colorectal Cancer Screening Tests

Summary

Colorectal cancer screening tests fall within the scope of Medicare Part B benefits and under the definition of "preventive services." The *Affordable Care Act* provides for payment for U.S. Preventive Services Task Force (USPSTF) grade A or B preventive services at 100% of the lesser of the actual charge or the fee schedule amount, thus no beneficiary coinsurance is required. When a flexible sigmoidoscopy or colonoscopy is performed as a diagnostic test, the beneficiary is responsible for Part B coinsurance (normally 20%) associated with the service.

CMS has excluded from the definition of "screening test" any flex sigmoidoscopy or colonoscopy that started as a screening test and ended with the need to remove a polyp.

AAFP Response

We strongly encourage CMS to work with Congress to assure that a polypectomy resulting from a screening colonoscopy be included in the colorectal cancer screening benefit.

While the AAFP appreciates that CMS has recognized and defined the problem with coinsurance for Medicare beneficiaries regarding screening versus diagnostic flexible sigmoidoscopy and colonoscopy, in most cases, physician practices account for the collection of coinsurance via patient intake forms that acknowledge the patient's responsibility to pay for additional and non-covered services. Given that, we believe the solution suggested by CMS increases administrative burden to physician offices screening their patients for colon cancer. Requiring these offices to check one more box in the EHR and track documentation of conversations that are necessary only because of inadequate payment policy for clinically recommended tests undermines patient-centered care. Requiring these offices to check one more meaningless box in the EHR and track documentation of conversations that are necessary only because of poor payment policy for these needed screening tests is non-productive and insulting to those practicing good medicine. **The true problem to be solved is the financial burden facing the Medicare beneficiaries whose screenings result in a diagnostic procedure through no fault of their own.**

II.N. Valuation of Specific Codes

These sections describe, in general terms, the process and methodology that CMS uses to value the physician work and direct PE inputs for new, revised, and potentially misvalued codes. The AAFP offers the following response for codes that are most relevant to family medicine.

X-Ray Exam – Sinuses (CPT Codes 70210 and 70220)

Summary

CMS proposes to accept the RUC-recommended direct PE inputs for both codes and the RUC-recommended work RVU of 0.22 for code 70220. CMS proposes to maintain the current work RVU (0.17) for code 70210 rather than increase it to 0.20, which is what the RUC recommended. CMS notes that the total time (five minutes) for this code has not changed from the current total time and without a corresponding explanation for an increase in valuation despite maintaining the same total time, CMS is not convinced that the work RVU for this code should increase. In addition, CMS notes that based on a general comparison of CPT codes with identical intra-service time and total time (approximately 23 comparison codes, excluding those currently under review), a work RVU of 0.20 would establish a new upper threshold among this cohort.

AAFP Response

The AAFP appreciates CMS' acceptance of the RUC's recommendations regarding the physician work for 70220 and the direct PE inputs for both codes. However, we have concerns with the proposed valuation of CPT code 70210. We participated in the survey and presentation of these codes to the RUC.

According to Medicare claims data, family physicians are the most common providers of code 70210. CPT code 70210 was identified by the "*CMS/Other Source – Medicare Utilization Over 30,000*" screen, thus the current source of time for the code is CMS/Other. The crosswalk or methodology used in the original valuation of this service is unknown and not resource based. Therefore, it is invalid to compare the current time and work to the surveyed time and work. This code's source of time is CMS/Other, implying that the time was merely crosswalked or selected by a single CMS staffer some time ago.

CMS disagrees with the RUC's recommendation to increase the work RVU for CPT code 70210 from the current value of 0.17 to 0.20. Its reasons for disagreement discount the value of the valid physician survey. The RUC recommended the following time components based on the survey and the CMS agreed: one minute of pre-service time, three minutes of intra-service time,

and one minute of immediate post-service time. The survey verified that the current total time happened to be correct for this service, and the survey also determined that the value was incorrect. The RUC adjusted the physician work value based on the survey 25th percentile.

The best corresponding explanation for an increase in valuation despite maintaining the same total time is that the current time and value have no validity for comparison since they are CMS/Other, and were assigned using an unknown methodology. Therefore, the value recommendation is based on the survey, which is supported by the survey times and the comparison with other axial X-ray codes.

The AAFP recognizes there are many other radiology codes that have the same physician work and times as CPT code 70210. However, these other codes apply to the extremities unlike CPT code 70210, which is an axillary skeletal radiograph. Similarly, the two codes that CMS references, CPT code 73501 - *Radiologic examination, hip, unilateral, with pelvis when performed; one view* (work RVU = 0.18, one minute pre-service time, three minutes intra-service time, one minute post-service time) and CPT code 73560 *Radiologic examination, knee; one or two views* (work RVU = 0.16, one minute pre-service time, three minutes intra-service time, one minute post-service time) are also studies of extremities. CPT code 70210 is an X-ray procedure to evaluate the degree and pattern of sinus opacification, which is more complex than these other studies. The sinus exams include axial views that contain overlapping structures (head, neck, spine) which are more difficult images to interpret and have historically been considered more complex.

The AAFP encourages CMS to independently review the surveyed time and work and not compare it to the invalidated CMS/Other source of the current time and work. The AAFP further urges CMS to accept a work RVU of 0.20 for CPT code 70210.

X-Ray Exam – Neck (CPT Code 70360)

Summary

CMS proposes to accept the RUC-recommended direct PE inputs for this code, but disagrees with the RUC recommendation to increase the work RVUs from 0.17 to 0.20 despite no change in the existing total time. Instead, CMS proposes a work RVU of 0.18 based on a crosswalk to code 73552 (Radiologic examination, femur; minimum two views).

AAFP Response

The AAFP participated in the survey and presentation of this code to the RUC, and we appreciate CMS' acceptance of the RUC's recommendations regarding the direct PE inputs. However, we recommend that CMS accept the RUC's recommendation to increase the RVU for CPT code 70360 to 0.20.

CPT code 70360 was originally identified by the “*CMS/Other Source – Medicare Utilization Over 30,000*” screen, thus the current time source for the code is CMS/Other. The crosswalk or methodology used in the original valuation of this service is unknown and not resource-based, therefore it is invalid to compare the current time and work to the surveyed time and work. This code's source of time is CMS/Other, implying that the time was merely crosswalked or selected by a single CMS staffer some time ago.

CMS disagrees with the RUC's recommendation to increase the work RVU for CPT code 70360 from the current value of 0.17 to 0.20 as supported by the survey 25th percentile and questions the reduction in total time for this code from six minutes to five minutes in the RUC recommendation. The adjustment of one minute of *pre-service* time is proforma and typical for

recently-reviewed X-ray procedures. Moreover, a reduction of one minute of pre-service time does not necessarily justify a reduction in physician work value as intra-service work has a higher intensity than pre-service and post-service work.

The RUC recommended the following time components and the CMS made no refinements: one minute of pre-service time, three minutes of intra-service time, and one minute of immediate post-service time. The total time for the code, as recommended by the RUC, is unchanged from the existing total time. However, CMS should not compare the valid survey time to the initial CMS/Other time, because, as noted, the initial CMS/Other source data is flawed and maintains zero validity for comparison. Rather, CMS should adhere to the robust survey results which recommend an increase in value for this service to the 25th percentile of the survey.

The RUC precedent, which has been supported by CMS, is not to consider either the times or values of a CMS/Other code as valid unless supported by survey, which is why CMS/Other valuation is considered sufficient to meet compelling evidence for changes in code valuation when the survey and relativity comparisons support an increase in value, as in this case. To the point of why the current work RVU is insufficient, we point to the unknown valuation process by which it was originally assigned a value. Since the method is unknown (i.e., CMS/Other), the current value has no bearing on the consideration of the modern survey-supported recommendation.

CMS is proposing a crosswalk to CPT code 73552 *Radiologic examination, femur; minimum two views* (work RVU = 0.18, one minute of pre-service time, four minutes of intra-service time, one minute of post-service time) as a more appropriate valuation for CPT code 70360. CMS states that they “looked at CPT codes with identical times to the survey code for a crosswalk” and identified 73552. However, the times for the two codes are not, in fact, identical. The intra-service time differs by a full minute, which is a key component of a valid crosswalk. Moreover, CMS rejected the RUC crosswalk methodology for radiology codes in the proposed rule for calendar year 2019, so it is ironic that a crosswalk is now being suggested to value CPT code 70360.

The crosswalk code proposed by CMS is a study of an appendicular structure. Appendicular structures tend to not have as many overlapping structures on single plane images. CPT code 70360 is an X-ray procedure used to assess the airway and soft tissues of the neck, a part of the axial skeleton, with potential evaluation of foreign bodies. Interpretation includes evaluation of all soft tissues of the neck, including the prevertebral soft tissues and epiglottis. When interpreting X-rays of axial body parts, there are numerous overlapping structures, multiple organ systems, and generally higher risk of consequential injury, especially in the spine. From this standpoint, axial X-ray exams are considered in general to be more difficult to interpret than appendicular X-ray exams, and so should be valued higher for equivalent views or times.

Likewise, the RUC compared CPT code 70360 to CPT code 73562 *Radiologic examination, knee; three views* (work RVU = 0.18, one minute of pre-service time, four minutes of intra-service time, one minute of post-service time) and noted that the anatomic region of the knee (appendicular skeleton) is less complex than the neck (axial), where subtle soft tissue findings may be a clue to underlying pathology such as airway compromise. Therefore, the survey code involves a slightly greater intensity of physician work, supporting a higher valuation.

The AAFP continues to support the RUC recommendation that CPT code 70360 should be valued at the 25th percentile work RVU as supported by the survey. The AAFP urges CMS to accept a work RVU of 0.20 for CPT code 70360.

Open Wound Debridement (CPT Codes 97597 and 97598)

Summary

CMS proposes to accept the RUC-recommended work RVU of 0.50 for code 97598 and the RUC-recommended direct PE inputs for both codes. CMS disagrees with the RUC's recommendation to increase the work RVUs for 94597 from 0.51 to 0.88 and instead proposes an increase in work RVUs for that code to 0.77 based on a crosswalk to code 27369 (Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography). CMS notes code 27369 is a recently-reviewed code with the same intra-service time of 15 minutes and a total time of 28 minutes, one minute less than code 97597.

In reviewing code 97597, CMS noted the recommended intra-service time is increasing from 14 minutes to 15 minutes (7%), and the recommended total time is increasing from 24 minutes to 29 minutes (21%). However, the RUC-recommended work RVU is increasing from 0.51 to 0.88, which is an increase of 73%. CMS believes that since the two components of work are time and intensity, modest increases in time should be appropriately reflected with a commensurate increase in the work RVUs.

AAFP Response

The AAFP participated in the survey and presentation of these codes to the RUC because family physicians are among the most common providers of code 97598. We appreciate CMS' acceptance of the RUC-recommended work RVU for that code and the RUC-recommended direct PE inputs for both codes.

Family physicians provide only a small fraction (approximately 7%) of the Medicare volume of code 97597. Another specialty, podiatry, is the dominant provider of that service, and we defer to them and CMS on the appropriate increase in work RVUs to reflect the increase in intra-service and total time demonstrated by the RUC surveys.

Online Digital Evaluation Service (e-Visit) (CPT Codes 9X0X1, 9X0X2, and 9X0X3)

Summary

For CY 2020, CMS is proposing the RUC-recommended work RVUs of 0.25 for code 9X0X1, 0.50 for code 9X0X2, and 0.80 for code 9X0X3. CMS is proposing the RUC-recommended direct PE inputs for all codes in the family.

AAFP Response

The AAFP participated in the survey and presentation of these codes to the RUC. We appreciate CMS' acceptance of the RUC-recommended work RVUs and direct PE inputs for all three codes.

Immunization Administration Services (90460, 90471, and 90470)

Summary

In Addendum B of the proposed rule, CMS proposes to reduce the practice expense RVUs for each of these codes from 0.29 to 0.22, due to the continued crosswalk from 96372 (Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular) to 90460, 90471, and 90473. Code 96372 was reviewed by the RUC in January 2017, at which time its practice expense inputs were significantly reduced to remove overlap with E/M codes. CMS further refined the RUC-recommended direct practice expense inputs for code 96372 in the 2018 proposed rule, resulting in nine minutes of clinical staff time rather than 12 as the RUC recommended. CMS also made reductions in the RUC-recommended medical

supplies and equipment. That reduction, which CMS is phasing in for 96372, is also being applied to the vaccine administration codes noted, since their values are crosswalked to 96372.

AAFP Response

The AAFP respectfully requests that CMS utilize the RUC-recommended direct PE inputs to publish practice expense RVUs for CPT immunization administration codes 90460, 90471, and 90473, each of which has been reviewed by the RUC. For instance, CPT code 90460 was reviewed by the RUC in October 2009. Rather than accepting the RUC recommendations, CMS crosswalked 90460 from CPT code 90471, which, in turn, is crosswalked from CPT code 96372.

The recent measles crisis spotlights the importance of immunization administration being appropriately valued. Appropriate payment for immunization administration is essential to ensure access to vaccines provided in the medical home, where studies have shown immunization rates are higher.

The crosswalk from CPT code 96372 to these codes has brought about a 60% reduction in practice expense RVUs, resulting in substantially lower payments under Medicare and other payers that use the Medicare physician fee schedule in setting their own fees. The impact to bottom line of a family medicine practice can cause some practices to stop offering vaccines.

Historically, CMS typically only uses a crosswalk for work values, not practice expense values. Additionally, when the RUC makes crosswalks, it disconnects the codes after the initial crosswalk, so changes to the source code no longer affect the crosswalked code. CMS also has this option.

Finally, it should be noted that CMS has already validated the RUC-recommended values for CPT code 90460. CMS used the RUC-recommended values for CPT code 90460 to value the fast-tracked H1N1 immunization administration code (90470) for 2010—as both codes were reviewed during the same RUC meeting (October 2009).

II. O. Comment Solicitation on Opportunities for Bundled Payments under the PFS

Summary

CMS is interested in exploring new options for establishing MPFS payment rates or adjustments for services that are furnished together. For purposes of this discussion, CMS refers to the circumstances where a set of services is grouped together for purposes of rate setting and payment as “bundled payment.” CMS references the work the Innovation Center is doing around physician payment, both on a per-beneficiary basis and episode basis. CMS is actively exploring the extent to which these basic principles of bundled payment, such as establishing per-beneficiary payments for multiple services or condition-specific episodes of care, can be applied within the statutory framework of the MPFS.

CMS seeks public comments on opportunities to expand the concept of bundling to recognize efficiencies among physicians’ services paid under the MPFS and better aligning Medicare payment policies with the Triple Aim. CMS believes the statute, while requiring CMS to pay for physicians’ services based on the relative resources involved in furnishing the service, allows considerable flexibility for developing payments under the MPFS.

AAFP Response

The AAFP appreciates CMS’ interest in bundled payments within the context of the MPFS. **However, the AAFP strongly opposes bundled payments for primary care in a FFS**

context. Instead, the AAFP supports efforts, such as those already underway through the Innovation Center, to move primary care away from FFS and into APMs that are more consistent with the continuous, comprehensive, and longitudinal nature of primary care. We believe the best thing for primary care is to get out of FFS and into APMs, not mimic APMs within FFS. As such, we continue to call on CMS to make improvements to the Primary Care First model and also to test the AAFP's APC-APM proposal.

II. P. Payment for Evaluation and Management (E/M) Visits

Summary - Office/Outpatient E/M Visit Coding and Documentation

For calendar year 2021, for office/outpatient E/M visits (CPT codes 99201-99215), CMS proposes to adopt the new coding, prefatory language, and interpretive guidance framework adopted by the CPT Editorial Panel for CPT 2021. This includes deletion of code 99201 and acceptance of a new, single add-on CPT code for prolonged office/outpatient E/M visits (code 99XXX) that would only be reported when time is used for code-level selection and the time for a level five office/outpatient visit (the floor of the level five time range) is exceeded by 15 minutes or more on the date of service. This new add-on code would obviate the need for code GPRO1 (extended office/outpatient E/M time), which CMS had planned to implement in 2021, but now proposes to delete instead.

The one variance from CPT in this regard is that, for Medicare, CPT codes 99358 and 99359 (Prolonged E/M without direct patient contact) would no longer be reportable in association or "conjunction" with office/outpatient E/M visits. New CPT prefatory language specifies 99358 and 99359 may be reported for prolonged services on a date other than the date of a face-to-face encounter. CMS believes its proposed policy regarding 99358 and 99359 would be consistent with the way the office/outpatient E/M visit codes were resurveyed, where the RUC instructed those surveyed to consider all time spent three days prior to, or seven days after, the office/outpatient E/M visit. CMS finds the CPT language and reporting instructions related to 99358 and 99359 to be unclear and circular and believes CPT codes 99358 and 99359 may need to be redefined, resurveyed, and revalued. In the meantime, CMS seeks public input on its proposal and whether it would be appropriate to interpret the CPT reporting instructions for CPT codes 99358 and 99359 as proposed, as well as how this interpretation may impact valuation.

AAFP Response - Office/Outpatient E/M Visit Coding and Documentation

The AAFP appreciates and strongly supports CMS' proposal to adopt the new coding, prefatory language, and interpretive guidance framework adopted by the CPT Editorial Panel for CPT 2021. This includes deletion of code 99201 and acceptance of a new, single add-on CPT code for prolonged office/outpatient E/M visits (code 99XXX) in lieu of the code (GPRO1) CMS previously planned to use.

Changes of this magnitude may have an impact on EHRs, since most are built around the current CPT structure and 1995/1997 E/M documentation guidelines. If CMS finalizes this proposal, it must provide this updated framework to EHR vendors as soon as possible and work with the American Medical Association (AMA) and specialty societies on the physician communications and educational efforts that will be needed between now and 2021.

Regarding codes 99358 and 99359 (Prolonged E/M without direct patient contact), we acknowledge the points of confusion in the CPT guidance for use of these codes in conjunction with office/outpatient visit codes vis-à-vis the parameters in which the latter codes were surveyed for the RUC. However, we would encourage CMS to work with the CPT Editorial Panel to resolve these points of confusion between now and 2021 rather than unilaterally

making 99358 and 99359 no longer reportable in conjunction with office/outpatient E/M visits for Medicare.

As noted elsewhere in our comments on this proposed rule, part of the administrative complexity and burden that hampers our members' ability to care for their patients is variability in payment policy among payers and payment policy at odds with guidance otherwise included in CPT. CMS' proposal to unilaterally change its payment policy in this regard, and in conflict with CPT would add to our members' administrative complexity and burden. This is why we oppose CMS' proposal and instead urge CMS to work through the CPT process so any changes apply to more than just Medicare. As noted in our [policy on "Coding and Payment,"](#) the AAFP supports CPT and the coding principles it contains. Thus, the AAFP believes it is important for both physicians and health plans to abide by the principles of CPT.

Summary - Office/Outpatient E/M Visit Revaluation (CPT codes 99201 through 99215)

CMS proposes to adopt the RUC-recommended work RVUs for all the office/outpatient E/M codes and the new prolonged services add-on code, effective for dates of service on or after January 1, 2021. CMS proposes to maintain separate values for levels two through four visits rather than implement its plan for a blended rate for those services.

Regarding the RUC recommendations for PE inputs for these codes, CMS proposes to remove equipment item ED021 (computer, desktop with monitor), as CMS does not believe that this item would be allocated to the use of an individual patient for an individual service. Instead, CMS believes this item is better characterized as part of indirect costs like office rent or administrative expenses.

The one point of confusion or concern for CMS in valuing these codes concerns the total physician time to be assigned to each code. As CMS notes, the RUC separately averaged the survey results for pre-service, day of service, and post-service times, and the survey results for total time, with the result that, for some of the codes, the sum of the average times associated with the three service periods does not match the RUC-recommended total time, which was the average of the respondents' total time. A simple example illustrates how this might occur:

	Pre-Service Time	Intra-Service Time	Post-Service Time	Total Time
Respondent A	1	2	1	4
Respondent B	2	2	0	4
Respondent C	3	2	1	6
Median	2	2	1	4

CMS is concerned by the fact that if one adds up the medians of the individual time components (which is 5 [2+2+1] in the illustration above), the total does not equal the median of total time among all respondents (which is 4 in this illustration).

CMS proposes to adopt the RUC-recommended times, in which total time reflects the median of total time among all respondents rather than the sum of the medians for the three components of total time. However, CMS seeks comment on how it should address the discrepancies in median total times versus sum of the median component times. CMS believes this has implications both for valuation of individual codes and for MPFS rate setting in general, as the intra-service times and total times are used as references for valuing many other services under the MPFS and the programming used for MPFS rate setting requires that the component times

sum to the total time. Specifically, CMS requests comment on which times it should use, and how it should resolve differences between the sum of the components and median total times when they conflict.

AAFP Response - Office/Outpatient E/M Visit Revaluation (CPT codes 99201 through 99215)

The AAFP appreciates and strongly supports CMS' proposal to adopt the RUC-recommended work RVUs for all the office/outpatient E/M codes and the new prolonged services add-on code, effective for dates of service on or after January 1, 2021. However, since most family medicine practices already operate on extremely thin margins and these services have been undervalued for decades, we implore CMS to implement these changes in 2020. We also appreciate and support the CMS proposal to maintain separate values and payment for levels two through four visits rather than implement its plan for a blended rate for those services.

However, we respectfully disagree with the CMS proposal to remove equipment item ED021 (computer, desktop with monitor) from the direct PE inputs for these codes. According to the Centers for Disease Control and Prevention (CDC), [85.9%](#) of office-based physicians are using an EHR. Medication and problem lists must be accurately maintained by physicians during a visit using their EHRs. Furthermore, with the multiple medications now required by many patients, monitoring for drug-drug interactions becomes an essential component for patient safety and quality care. All of this makes a computer a typical, indispensable part of the medical equipment used during an office visit. Whether it's a desktop computer with monitor or a laptop, some computer is typically being used during an office visit, and contrary to CMS' belief, is allocated to the use of an individual patient for an individual service, just like the exam table in the room.

There is precedent for including a computer as a direct PE. There are 52 CPT codes that include equipment item ED021. For office visits, the work being performed using the computer is not administrative in nature. Rather, it is used to record, analyze, and communicate to the physician about every element of data that the clinical staff collects from the individual patient for the individual service.

In sum, the computer is dedicated solely to each patient throughout the visit to collect history, share and discuss lab and test results, and document the visit. It is an essential tool in conducting today's office visits, and CMS should recognize it as a direct medical equipment cost. We encourage CMS to accept the RUC's recommendation to include item ED021 (computer, desktop with monitor) among the direct PE inputs for these codes.

We appreciate and support that CMS proposes to adopt the RUC-recommended times in which total time reflects the median of total time among all respondents, rather than the sum of the medians for the three components of total time. As the RUC noted in its rationale, "total time is the appropriate measurement of time and each individual survey respondent's total time response should be used in determining the median total time." Like the RUC, we think that approach makes the most sense and best honors the robust survey data that CMS acknowledges in the proposed rule.

We understand this approach differs from the way in which CMS usually approaches total time. That said, for these codes, we believe it's important to use, as the RUC did and as CMS proposes to do, the median total time among all respondents. We are happy to work with the RUC and CMS to sort out any implications both for valuation of individual codes and for MPFS

rate setting in general, as well as how CMS should resolve differences between the sum of the components and median total times when they conflict.

Summary - Simplification, Consolidation, and Revaluation of HCPCS codes GCG0X and GPC1X

In the final rule on the 2019 fee schedule, CMS stated its intent in 2021 to implement two G-codes, GCG0X (Visit complexity inherent to E/M associated with non-procedural specialty care) and GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services). CMS said it would value both codes via a crosswalk to 75% of the work and time value of code 90785 (Interactive complexity [List separately in addition to the code for primary procedure]).

In the current proposed rule, CMS states the typical visit described by the revised office/outpatient E/M visit code set still does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits. Thus, CMS proposes to simplify the coding by consolidating the two add-on codes into a single add-on code and revising the single code descriptor to better describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

Specifically, CMS proposes to revise the descriptor for code GPC1X and delete code GCG0X. The proposed descriptor for GPC1X would read: Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established).

Lastly, CMS proposes to value code GPC1X at 100% of the work and time values for code 90785, which would yield a proposed work RVU of 0.33 and a physician time of 11 minutes. CMS also proposes that this add-on G-code could be billed as applicable with every level of office and outpatient E/M visit.

AAFP Response - Simplification, Consolidation and Revaluation of HCPCS codes GCG0X and GPC1X

The AAFP appreciates and supports CMS' intent to simplify the potential add-on codes associated with the revised office/outpatient visit E/M codes. Like CMS, we believe the typical visit described by the revised code set still does not adequately describe or reflect the resources associated with primary care visits. Accordingly, we support CMS' proposal to maintain an add-on G-code (GPC1X) that could be reported in conjunction with a primary care office visit.

The AAFP [defines "primary care"](#) as:

Primary care is that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis.

Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician

often collaborating with other health professionals and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care.

Given this definition, we would encourage CMS to consider revising its description of GPC1X as follows (language to be added is underlined):

Visit complexity inherent to evaluation and management associated with medical care services that serve as the first contact and continuing focal point for all needed health care services in coordination with others as needed and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition(s). (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new, or established).

The proposed definition includes the continuing and comprehensive ("all needed health care services") elements of primary care. However, it lacks the "first contact" and "coordination" elements that are otherwise essential in distinguishing primary care visits from other types of office/outpatient E/M visits.

There is inherent administrative burden associated with use of an add-on code, and regardless of how CMS defines the new add-on code, we recognize CMS will need to issue documentation guidance to support its appropriate use. That said, we urge CMS to ensure its documentation guidance is clear and minimizes the burden of using the new code.

If revised as we suggest, we support CMS' proposal to value code GPC1X at 100% of the work and time values for code 90785, which would yield a proposed work RVU of 0.33 and a physician time of 11 minutes.

Summary - Valuation of CPT Code 99XXX (Prolonged Office/Outpatient E/M)

CMS proposes to delete the planned add-on code for extended visits (GPRO1) it finalized last year for calendar year 2021 and instead adopt the new CPT code 99XXX. Further, CMS proposes to accept the RUC recommended values for CPT code 99XXX without refinement.

AAFP Response - Valuation of CPT Code 99XXX (Prolonged Office/Outpatient E/M)

The AAFP appreciates and strongly supports CMS' proposal to adopt the RUC-recommended work RVUs for the new prolonged services add-on code, effective for dates of service on or after January 1, [2021](#). **However, since most family medicine practices already operate on extremely thin margins, we implore CMS to implement these changes in 2020.**

Summary - Global Surgical Packages

Considering three RAND reports on the subject and CMS' understanding that work RVUs for procedures with a global period are generally valued using magnitude estimation, CMS does not state its intent to accept the RUC recommendation to adjust the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits. Instead, CMS states it will give the public and stakeholders time to study the RAND reports (which CMS makes available), along with this rule and consider an appropriate approach to revaluing global surgical procedures. CMS will continue to study and consider alternative ways to address the values for these services.

AAFP Response - Global Surgical Packages

Based upon analysis available from RAND and the Medicare Payment Advisory Commission, we believe the proposed recommendations put forth by CMS are the appropriate policy. Until such time that verifiable, third-party data provides a clearer justification for the inclusion of E/M codes in the global period we strongly support CMS' decisions as outlined in the proposed rule. As CMS notes in the proposed rule and as the RUC and the surgical specialties have frequently maintained, work RVUs for procedures with a global period are generally valued using magnitude estimation rather than building blocks.

As noted in the proposed rule and as required by law, CMS is collecting data to validate the number and level of E/M services assumed to be included in global surgical services. The RAND study analyzing data collected through claims supports CMS' intent not to accept the RUC recommendation to adjust the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits. For instance, during the first 12 months of reporting post-operative visits via claims, RAND found most procedures with 10-day global periods did not have an associated post-operative visit. Further, among procedures with 90-day global periods, the ratio of observed-to-expected post-operative visits provided was only 0.39. Further, in its study of the levels of post-procedure visits, RAND found the reported physician time and work for the post-operative visits in the two 90-day global codes studied (i.e., cataract surgery and hip replacement) were generally similar—but slightly less—than the levels expected based on the E/M visits assumed to typically occur by CMS when valuing these procedures

The Office of Inspector General and others have questioned the accuracy of current assumptions underlying 10- and 90-day global codes. **Until CMS can adequately address those questions, we believe it would be imprudent to adjust the E/M component because of any changes to the values of stand-alone office/outpatient visit codes 99201-99215 and we strongly support CMS' decision in this regard.** We continue to believe the best approach to this issue is to convert all codes with a 10- or 90-day global period to zero-day global periods and revalue the codes accordingly and thereby allow physicians to appropriately code and document necessary pre- and post-operative services using the E/M codes inclusive of their new values and payment amounts. For decades, physicians using these global codes have not been required to follow the E/M documentation guidelines for charting in the medical record for such visits which has been blatantly unfair to the rest of the physician community and especially primary care—it is time for the global service codes to be eliminated and level the playing field for all physicians and other clinicians.

Summary - Revaluing the Office/Outpatient E/M Visit within TCM, Cognitive Impairment Assessment/Care Planning and Similar Services

CMS notes there are services other than the global surgical codes for which the values are closely tied to the values of the office/outpatient E/M visit codes, such as TCM services (CPT codes 99495, 99496); cognitive impairment assessment and care planning (CPT code 99483); certain end-stage renal disease (ESRD) monthly services (CPT codes 90951 through 90961); the Initial Preventive Physical Exam (G0438) and the Annual Wellness Visit (G0439). CMS notes that, unlike the global surgical codes, these services always include an office/outpatient E/M visit(s) furnished by the reporting practitioner as part of the service, and it may therefore be appropriate to adjust their valuation commensurate with any changes to the values for the revised codes for office/outpatient E/M visits. Further, some services do not involve an E/M visit. CMS has valued them using a direct crosswalk to the RVUs assigned to an office/outpatient E/M visit(s), and for this reason they are closely tied to values for office/outpatient E/M visits. In

future rulemaking, CMS may consider adjusting the RVUs for these services and seeks public input on such a policy.

CMS also seeks comment on whether the public believes it would be necessary or beneficial to make systematic adjustments to other related MPFS services to maintain relativity between these services and office/outpatient E/M visits. These other services include:

- E/M codes describing visits in other settings (e.g., home visits)
- Codes describing more specific kinds of visits (e.g., counseling visits)
- Ophthalmology visit services
- Psychotherapy and psychiatric diagnostic evaluations

CMS seeks public comment on whether it should make similar adjustments to E/M codes in different settings, and other types of visits.

AAFP Response - Revaluing the Office/Outpatient E/M Visit within TCM, Cognitive Impairment Assessment/Care Planning, and Similar Services

We appreciate that CMS is cognizant of the potential effects its revaluation of the office/outpatient E/M visit codes might have on the relative value of other services in the MPFS. However, we do not believe it's necessary or beneficial to make systematic adjustments to other related services to maintain relativity between these services and office/outpatient E/M visits.

As noted elsewhere in the proposed rule, there is an established process for stakeholders to ask for review of potentially misvalued services under the fee schedule. If stakeholders believe the revaluation of the office/outpatient office visit E/M codes results in a misvaluation of other codes (e.g., by creating a rank-order anomaly), then it is incumbent on those stakeholders to nominate those other codes as potentially misvalued using the process set forth by CMS. We encourage CMS to follow its own process in this regard, including additional review by the CPT Editorial Panel and the RUC.

As CMS notes in the proposed rule, more than 50 specialty societies engaged in a robust survey of the office/outpatient visit E/M codes to demonstrate their values needed to be adjusted by CMS as the RUC recommended. Making systematic adjustments to other services without subjecting them to similar rigors will risk potentially unwarranted changes in their relative values. Thus, we do not think CMS should make such systematic adjustments.

To enable successful transitions from FFS, we recommend CMS systematically adjust RVUs to incorporate the proposed increases in E/M values and the proposed primary care add-on code into APMs where payment for office/outpatient visits is based on current E/M values. An example is the flat-visit fee to be paid under Primary Care First. Failure to adjust APM payments consistent with these proposals will disadvantage relevant APMs, vis-à-vis FFS and discourage physicians from moving to the former, contrary to CMS' goals.

D. Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs)

Summary

CMS' intent is to align electronic clinical quality measures (eCQMs) across MIPS and Medicaid promoting interoperability to reduce physician reporting burden and to promote participation in the Medicaid promoting interoperability program. For 2020, CMS proposes to require (as in 2019) that Medicaid eligible professionals (EPs) report on any six eCQMs, regardless of whether they report via attestation or electronically. This policy would generally align with the MIPS data submission requirement for eligible clinicians (ECs) using the eCQM collection type

for the quality performance category. CMS again (as in 2019) proposes to require EPs in the Medicaid promoting interoperability program to report on at least one outcome measure (if an outcome measure is available and relevant). CMS proposes to use the same methods to identify high-priority measures as 2019.

CMS proposes that the Medicaid EPs reporting period be any continuous 274-day (9-month) period within CY 2020. Medicaid EPs can opt for a longer period up to a full calendar year.

To not create additional burdens on EPs, CMS is “proposing to allow Medicaid EPs to conduct a security risk analysis at any time during CY 2021, even if the EP conducts the analysis after the EP attests to meaningful use of CEHRT to the state.” EPs would be required to attest that they will complete a security-risk analysis by December 31, 2021, if they have not completed one by meaningful use attestation.

AAFP Response

Reducing quality measurement reporting burden is a critical goal for the AAFP. We are pleased to see CMS’ concern about quality reporting burdens. We believe that alignment and harmonization among all payers, as well as programs within CMS can significantly reduce quality measurement reporting burdens. We are supportive of the proposal to align eCQMs across MIPS and Medicaid promoting interoperability.

The AAFP is supportive of the flexibility proposed around the timing for EPs to conduct security risk assessments for Meaningful Use.

III.E. Medicare Shared Savings Program

Summary

CMS proposes to redesignate ACO-43 Ambulatory Sensitive Condition Acute Composite as pay-for-reporting for 2020 and 2021 due to a substantial change. Since the measure is claims-based, CMS also considered recalculating historical performance using the new specifications and keeping it as pay-for-performance. CMS seeks comment on these two alternatives.

CMS is seeking comment on their proposal to align the shared savings quality score with the MIPS quality score. Currently the same web interface measures are used for both programs, but the scoring methodology differs. Accountable care organizations (ACOs) must completely report all quality measures (or they will receive zero points and fail the quality performance standard) and meet minimum attainment threshold defined as the 30th percentile (equivalent to the 4th decile benchmark under MIPS APM scoring standard) on at least one measure in each of four domains to be eligible for any shared savings. ACOs earn up to two points per measure and can earn up to four additional points for improvement in each domain. ACOs measures include three claims-based measures.

In contrast, under MIPS web interface, each measure is assessed against its benchmark and earns between 3-10 points (plus bonus points) if it meets completeness and case minimum. Under MIPS, a group can receive no points for one measure, but still receive a score for other measures. The all-cause hospital readmission measure is also calculated via claims for groups of 16 or more. CMS is proposing to add the All-cause Unplanned Admission for Patients with Multiple Chronic Conditions to the MIPS quality category in 2021 and may add more claims-based measures in the future.

CMS is proposing to use a single scoring methodology (the MIPS web interface methodology) and the MIPS claims-based measures under both the shared savings program and MIPS in

order to reduce burden, align the programs, reduce complexity, and reduce confusion. This would also provide a single quality score for ACOs that do not meet the criteria for an Advanced APM and for ACO participants that do not meet qualifying participant (QP) status. Under this methodology, the first year of ACO reporting would no longer be pay-for-reporting, but would immediately be under pay-for-performance.

AAFP Response

The AAFP appreciates the effort to align and simplify scoring under quality scoring between MIPS and the shared savings program. Using the MIPS scoring methodology for ACOs would result in a somewhat higher standard than is currently used because ACOs would need to meet a minimum overall threshold rather than a threshold for one measure in each domain. However, ACOs would benefit by being able to earn a quality score even if they fail one measure. We also believe ACOs should be able to proceed directly to pay-for-performance, particularly since failure on one measure would no longer result in overall failure in quality performance, but instead would lead to earning a score on a sliding scale, as is currently earned under MIPS. We believe the benefits outweigh the drawbacks and agree with CMS' proposal to align scoring methodologies based on current methodology used for MIPS web interface reporting.

We agree with CMS' proposal to redesignate ACO-43 Ambulatory Sensitive Condition Acute Composite as pay-for-reporting for 2020 and 2021 due to a substantial change, rather than recalculating historical performance and placing the measure as pay-for-performance in 2020 and 2021. As CMS stated, this will give ACOs time to refine care processes and educate clinicians, while also gaining experience with the refined composite measure and understanding of performance under revised benchmarks prior to the start of a pay-for-performance year.

III.K. CY 2020 Updates to the Quality Payment Program

Summary

CMS proposes a new pathway named the MIPS value pathways (MVP) and requests feedback on this proposal. The agency believes it will provide a more streamlined and cohesive reporting experience for MIPS ECs. MVPs would begin in the 2021 MIPS performance year. CMS believes that MVP participation will remove barriers to APM participation. CMS would organize MVPs around clinician specialty or health condition and encompass a set of related measures and activities. MVPs are proposed to be assigned to specialty-specific physicians.

CMS is proposing that beginning with the 2020 call for measures, MIPS quality measure stewards must link their quality measure to existing and related cost measures and improvement activities (IAs) as applicable and feasible.

CMS seeks comments on how the promoting interoperability performance category could evolve in the future to meet the shared goal of greater cohesion between the MIPS performance categories.

CMS believes interoperability is a foundational element and would generally apply to all clinicians, regardless of the specific MVP. CMS developed four guiding principles they would use to define MVPs:

1. MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data.

2. MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care.
3. MVPs should include measures that encourage performance improvements in high-priority areas.
4. MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement.

AAFP Response

The AAFP appreciates CMS' acknowledgement of the complexity within MIPS and their willingness to improve the program by providing ECs with more timely and meaningful performance feedback that can be used for continual quality improvement and care management. In general, we support CMS' four guiding principles for MVPs. **However, we note that while the MVP structure may reduce burden related to selection of measures, it does not necessarily reduce the overall burden of the program.** As currently structured, MIPS ECs will still need to report each category separately. **We believe CMS could further reduce reporting burden by incorporating multi-category credit into the MIPS and/or MVP structure.** For instance, an EC could report the quality measure, Comprehensive Diabetes Care: HbA1C Poor Control (>9%), and the improvement activity, Glycemic Screening Services (IA_PM_19) and receive credit for both a core measure and improvement activity. CMS' goal should be to reduce overall program burden—not only burden associated with selecting measures and activities.

Additionally, the AAFP believes MIPS complexity and the complexity of quality measure choice is not the biggest barrier to APM participation. One of the major barriers continues to be there are not enough APMs in which a physician can participate. In addition, many small practices are not equipped to handle the financial risk of an Advanced APM. However, a restructured MIPS program could better prepare these practices for the transition to an APM.

We strongly urge CMS to carefully consider the impact of MVPs on practices. We offer our comments below should CMS move forward with this proposal.

Engaging Stakeholders - The AAFP strongly encourages CMS to collaborate with stakeholders, including practicing ECs, as they develop MVPs. We provide some suggested MVP groupings below. CMS could develop a "call for MVPs" to solicit recommendations. Stakeholders are familiar with such a process as it is currently used for quality measures. CMS could also utilize technical expert panels (TEPs) to vet proposed MVPs. TEPs are an established avenue that allows practicing physicians the opportunity to provide meaningful input. We strongly encourage CMS to include MVPs in the MFPS proposed rule prior to finalizing and implementing them. All proposed and final MVPs should be publicly available. The AAFP stands ready to engage and collaborate with CMS to create a program that promotes quality improvement rather than increasing burden through quality measurement.

Structure of MVPs - The AAFP encourages CMS to reduce the number of quality measures, improvement activities, and promoting interoperability measures. We remain a strong advocate of measure harmonization and including the use of the core measure sets developed by the Core Quality Measure Collaborative (CQMC). By doing so, CMS would reduce the number of measures in each specialty sub-category, making choice of measures more meaningful and less burdensome. We understand the ACO/Patient-centered Medical Home (PCMH) Primary Care Core Measures Set is already included in MIPS inventory, but we ask CMS to take it a step further and reduce the measures available to only those included in the existing

ACO/PCMH Primary Care Core Measure Set. A smaller set of quality measures will also reduce variability. We support the continued work of the CQMC to update the specialty sets more frequently to better align with the MIPS program. To the extent that administrative claims-based measures are reliable and valid at the individual level, we would support their inclusion to replace some of the existing quality category reporting requirements.

The AAFP suggests the scope of family medicine is far too wide and comprehensive for it to be condensed into a single MVP. As such, we caution CMS against creating a single MVP per specialty. CMS needs to carefully consider the differences in practice types and specialties and create a sufficient number of MVPs to meet the diverse needs of practices.

We strongly urge CMS to maintain equitable reporting requirements across all specialties; such fairness is essential in furthering the agency's support of family medicine and primary care. All specialties should still be required to report the same number of measures (but no more than six), including at least one outcome measure. CMS can utilize cross-cutting measures in instances where a specialty or sub-specialists has fewer than the required number of measures within their specialty set to create MVPs with enough measures. All other scoring policies should remain unchanged. As we state in our comments on the cost category, we ask CMS to develop adjustments for small/rural practices to mitigate the impact of outliers.

We also ask CMS to crosswalk the measures with relevant improvement activities and promoting interoperability measures and provide multi-category credit where there is sufficient overlap. We envision a program that allows physicians to select their measures and identify which measures and activities include multi-category credit when they align. Physicians would, in effect, build their own MVP from a smaller set of available measures and improvement activities. We believe this accomplishes CMS' goal of reducing burden related to measure selection, while retaining physician autonomy in selecting measures meaningful to their unique patient panel.

Requiring qualified registries, qualified clinical data registries (QCDRs), and health IT vendors to be able to report on three categories (quality, improvement activities, and promoting interoperability) would assist in implementing a multi-category credit policy. We believe multi-category credit reduces the complexity and burden of the program.

We reiterate our eagerness to work with CMS to identify areas of overlap to help reduce reporting burden for program participants.

Regardless of MVP, practices that attest to PCMH recognition or accreditation should receive full credit in the improvement activities. We believe a specialty medical home designation alone, in the absence of a primary care medical home, is not sufficient to earn automatic improvement activities credit. Specialty practices support and complement a primary care medical home, but do not replicate all aspects of the medical home, and do not replace the need for a primary care medical home. Small and rural practices should also receive the same flexibilities in the improvement activities category provided to them in the current MIPS structure.

Regarding the promoting interoperability category, we believe practices that attest to using 2015 Edition Certified EHR Technology (CEHRT) or having PCMH recognition or accreditation should automatically receive full credit in the promoting interoperability category. We remain steadfastly opposed to health IT utilization measures. Removing the

significant burden associated with these measures and this category would be an encouraging step CMS could take in improving the MIPS program. The AAFP will continue to call on Congress to repeal the Meaningful Use requirements. However, we believe CMS can still make significant changes to the category to ease burden until this is accomplished.

Assignment/Selection - To accommodate multi-specialty practices, the AAFP believes CMS could allow subgroup reporting. We believe this would be a simpler solution to multi-specialty reporting than CMS trying to score groups by MVP.

CMS should be able to operationalize subgroup reporting as it already has a similar infrastructure created for virtual group (VG) reporting. Those wishing to form a subgroup could make an election through the CMS Portal. CMS could assign an identifier to the subgroup and assess the subgroup's performance, scoring, and payment adjustment. ECs within a subgroup would be identified by tax identification number (TIN)/national provider identifier (NPI)/subgroup identifier. MIPS final scores should be calculated at the subgroup level and any corresponding payment adjustments applied to NPIs associated with the subgroup. When splitting into a subgroup, the practice would need to account for all eligible NPIs within the TIN (i.e., each NPI would need to be associated with either the primary group or a subgroup). All ECs within a TIN should still be required to report if a TIN has been determined to be above the low-volume threshold (LVT) and the TIN has decided to a group. For example, a TIN should not be able to "carve out" high-performing individuals to form a subgroup and choose not to report on the remaining ECs. This would ensure consistency with the policies established for group reporting. We urge CMS to apply its group policies to subgroups, as it has done with VGs, and not create a separate set of policies.

Implementation - The AAFP asks CMS to acknowledge that any significant change, even changes intended to improve a program, require time and preparation by a practice. CMS will need to provide widespread educational efforts for physicians. Education should be provided in multiple modalities to allow physicians the flexibility to access information in a manner that best suits their preferences. Practices will need adequate time to understand any changes and update their workflows accordingly. Additionally, CMS needs to ensure there are sufficient MVPs for all specialties before implementing them. We do not believe there is enough time for CMS to work with stakeholders to develop MVPs and provide adequate education before the 2021 performance period. **Therefore, we strongly urge CMS not to implement MVPs in the 2021 performance period.**

Feedback - Timely and actionable data is critical to physicians as they strive to improve quality and outcomes for their patients. To make impactful changes, data that are no more than three to four months old are needed. For example, knowing how many patients with diabetes currently have an A1C less than 9.0 is useful. However, comparing that to performance 6 and 12 months prior allows the physician to examine historical trends. Instead of waiting to learn this at the end of the performance year, a dashboard of where the physician stands on a monthly or quarterly basis would allow them to make necessary changes in real time. Trended data and data on outliers are also helpful. Quality and cost data at both the group and individual level for the specialists seen by attributed beneficiaries could help primary care physicians better assess their referral options. Since not all practices will use a qualified registry, QCDR, or will be able to afford data analytics services, we encourage CMS to explore ways it can provide tools for practices to analyze their data. Data should be in a format that is easily understood and assists practices in identifying areas for improvement. We note that simply providing more data is not always the solution. CMS historically provided detailed information through the Quality and Resource Use Reports (QRURs). However, much of this information was contained in an excel

file that was difficult to manage and manipulate so physicians could actually make use of the data. We would welcome the opportunity to work with CMS to identify data that are easily understood and actionable for family medicine.

III.c. MIPS Performance Category Measures and Activities

Summary

CMS proposes an incremental approach to reducing the weight of the quality category (40% in 2022; 35% in 2023; 30% in 2024) while increasing the weight of the cost category to the level required by statute. CMS proposes no changes to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) measure for 2020, but proposes to add measures to cover seven domains of care in the future (satisfaction, trust, quality, ease/simplicity, efficiency/speed, equity/transparency, employee helpfulness). They also propose collecting CAHPS data at the individual clinician level, and adding open-ended questions to allow patients to tell a story about a clinician and to publicly report these reviews.

CMS proposes to increase the level of completeness criteria to 70% in the 2020 performance period, regardless of payer.

CMS proposes that beginning in 2020, MIPS quality measure stewards would be required to link their MIPS quality measures to existing and related cost measures and improvement activities, as applicable and feasible. CMS also proposes to realign the MIPS quality measure update cycle with that of the eCQM annual update process, which means measures would be gathered earlier.

CMS has proposed additions, removals, and substantive changes to individual quality measures. CMS has proposed the addition of a global population measure, the All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions measure, beginning with the 2021 MIPS performance period.

CMS finalized its ability to remove “extremely topped-out measures” in the next rulemaking cycle rather than following the four-year removal timeline. CMS is seeking comment on whether they should increase the data completeness threshold for extremely topped-out measures because a) clinicians select measures to report and topped-out performance rates are not representative of how clinicians perform across the country; and b) removing all topped-out measures causes a shortage of measures for some specialties.

CMS proposes the removal of quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive performance periods. CMS proposes to allow removal of a MIPS quality measure if it is not available for MIPS reporting by or on behalf of all MIPS ECs.

AAFP Response

The AAFP agrees with the incremental approach proposed by CMS for increasing the weight of the cost category while decreasing the weight of the quality category to the level required by statute.

Regarding the CAHPS measure for 2020, we agree that the CAHPS survey could be strengthened by focusing on patient experience instead of satisfaction. However, the length, timeliness, small sample size, and cost of the survey are major concerns. CMS may wish to draw questions from existing patient-reported surveys that have already been validated (e.g., the Patient-Reported Outcomes Measurement Information System [PROMIS]) or replace

CAHPS completely with another instrument (e.g., the person-centered primary care measure). The [Person-Centered Primary Care](#) measure, developed by Virginia Commonwealth University, is patient reported, addresses eleven primary care domains, and is more relevant than the current CAHPS measure for primary care. The measure has been thoroughly tested, is currently approved as a QCDR measure, and will be submitted to the National Quality Forum (NQF) for endorsement consideration in 2020.

The length of patient survey should be short (no more than 10-15 questions) to avoid patient survey fatigue and a larger sample should be drawn to improve reliability. Finally, CMS should seek a means to administer a patient survey immediately following an encounter to strengthen the reliability of the patient response. Timely physician feedback would add actionability and meaningfulness. The survey should be available to a practice at no cost for administration.

Clinicians appreciate hearing the patient voice so they can make changes to improve their care. We encourage CMS to seek a method of gathering patient-reported outcomes that is valid, timely, short, meaningful to the clinician, covers a larger sample of patients, and free.

The AAFP opposes adding open-ended questions to patient satisfaction surveys. We urge CMS to not collect narrative data using open-ended questions and publicly report these comments. There are existing websites for patients to share their comments regarding their physicians and such comments are not scientifically validated and are not representative of the overall care provided by a clinician. Since comments would be very extensive, CMS would need to establish a process for determining which comments to post and in what format as to not overwhelm patients reading the comments.

The AAFP is concerned regarding the proposal to add measures to cover seven domains of care. Specifically, the domain of efficiency/speed can be difficult to interpret correctly. Some patients want to be seen quickly and efficiently, and a fast appointment meets their needs. Others would interpret this as the physician rushing and not paying attention to all their needs. Also, the patient looking for an efficient appointment may be thrown off if several patients scheduled ahead of them had emergencies and the physician was running late.

CMS asks for comments on balancing the need for information at the individual clinician level with the burden of reporting. We disagree that CMS should publish data at the individual clinician level. Individual scores and personal comments could be very disheartening for a physician workforce that is already struggling with burnout resulting from excessive oversight and intrusion on professionalism.

The AAFP disagrees with CMS proposal to increase the level of completeness to 70% unless real-time (or near real-time) feedback is provided to physicians to alert them when a patient is eligible for a quality measure. While "cherry picking" may occur in some instances, we have heard that a major challenge for clinicians is identifying all the patients that are eligible for a quality measure and that lack of data completeness is unintentional. We encourage CMS and other payers to establish a process that will allow practices to verify which patients should be in the denominator of a selected measure at the time the patient is being seen, or at minimum, at least monthly. Increasing the level of data completeness in the absences of a timely verification process will disadvantage small practices, which were able to achieve only 74.76% completeness in 2017, according to CMS.

Regarding the proposal that MIPS quality measure stewards be required to link their MIPS quality measures to existing and related cost measures and improvement activities, we agree

that when possible, measure stewards should link their quality measures to cost and improvement activities. While it should be possible to link all quality measures with improvement activities, there may not be existing cost measures that are relevant. The AAFP welcomes the opportunity to work with CMS to identify appropriate and linkable cost measures.

We also agree that realigning the MIPS quality measure update cycle with that of the eCQM annual update process is desirable and would give EHR vendors more time to update their systems and clinicians more time to familiarize themselves with new measures.

The AAFP does not agree that increasing the data completeness threshold will solve the problem that extremely topped-out measures are not representative of the country's performance as a whole. The only way to address representativeness is to require reporting of the measure by all physicians, but this is not the route CMS has chosen for MIPS at this time. CMS should shrink the list of measures in general, leave data completeness at 60% unless a measure is extremely topped out. If it is, then data completeness could increase to 80%.

The AAFP disagrees with the removal of quality measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for two consecutive years, particularly in light of CMS proposal to move toward MVPs. CMS states the reason these measures aren't reported is because the measure is not a meaningful metric. However, some of the measures may be high-quality outcome measures, but may not be used simply because clinicians have established a habit of reporting certain measures (especially process measures) or because other measures are easier to report. As MIPS measures moves toward more meaningful measures and as topped-out measures are removed, the use of these low-volume measures may increase. It's also possible that physicians do not report certain measures because of the data collection method, especially measures that are only available as e-measures or through QCDRs. As technology enhances the ability to collect data electronically, use of the low-volume measures may increase. The AAFP encourages CMS to monitor the reasons measures are consistently not meeting the case minimum and reporting volumes for benchmarking. CMS should assess each measure on a case-by-case basis rather than creating a blanket policy to remove them.

We agree with CMS that if a measure steward does not make their measure available for use by all MIPS ECs it should be considered for removal.

Comments on Individual Quality Measure Changes:

- Web interface measure: Tobacco Use: Screening and Cessation Intervention:
 - The AAFP agrees with updating the guidance and including the corrected version for 2019 and 2020 MIPS performance period.
- (2022 payment year) Adult Immunization Status: Percentage of members 19 years of age and older who are up-to-date on recommended routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap); zoster; and pneumococcal.
 - The AAFP opposes inclusion of this measure in MIPS and in the web interface. The look-back period for some of these immunizations of 10 years is not captured in the EHRs for patients that are new to a practice or where the EHR has changed. In addition, state immunization registries vary in their robustness and functionality, and would not have the data available for look up and interstate communication regarding vaccines is rare. This means data capture would need to be manual and/or rely on the memory of patients. There are other barriers to Medicare beneficiaries receiving

- recommended immunizations. For instance, most vaccines (other than influenza or pneumonia) that are recommended by the Advisory Committee on Immunization Practices (ACIP) are covered under Medicare Part D—and can be accompanied by high-cost sharing (e.g., the zoster vaccine). Most vaccines are given at pharmacies or hospitals, so communication with the primary care physician is sporadic, and payers do not consistently share data with practices when payment is made for an immunization. Not all immunizations given at ancillary sites include a Medicare claim or payment, further complicating the ability of the primary care practice to determine whether the patient was immunized. Though important, until the problem with data integration is solved, the measure carries too high of a burden to the primary care physician. In addition, the measure has only been tested at the health plan level and not at the individual physician level. Health plans have a distinct advantage in data availability from all sources through billing, an advantage that is not available to clinicians. Finally, the AAFP opposes all-or-none composite measures because of the loss of actionability and the performance impact (i.e., missing all vaccines is seen as equivalent performance to missing only one vaccine).
- (2023 payment year) All-Cause Unplanned Admission for Patients with Multiple Chronic Conditions: Risk-adjusted outcome measure that uses the outcome of acute, unplanned admissions (per 100 person-years at risk of admission) to assess care quality. Includes Medicare fee-for-service beneficiaries aged 65 years or older who have two or more of the following nine chronic conditions: (1) acute myocardial infarction, (2) Alzheimer's disease and related disorders or senile dementia, (3) atrial fibrillation, (4) chronic kidney disease, (5) chronic obstructive pulmonary disease or asthma, (6) depression, (7) diabetes, (8) heart failure, and (9) stroke or transient ischemic attack.
 - The AAFP appreciates the attention to monitoring care coordination and clinical outcomes for patients with multiple chronic conditions who are some of the most clinically complex patients. Practices have not had the opportunity to review their own data which would be generated from this measure, making it very difficult to critically comment on the accuracy, reliability, and meaningfulness of the measure's specifications, attribution, and risk adjustment. We suggest implementing the measure on an informational basis for at least two years to provide clinicians a period of time to educate and familiarize themselves with the measure and provide practical feedback. More frequent feedback (at least quarterly, working up to real-time) is needed to improve actionability and measure analysis. In addition, the AAFP has concerns with the stated reliability of the measure (0.5), but the AAFP has repeatedly advocated that CMS set a consistent minimum reliability threshold of 0.7 for all MIPS measures which is considered the minimum by statisticians.

In summary, we recommend CMS make the above changes to the measure and implement the measure on an informational basis for two years.

Comments on Changes to Specialty Measure Sets: Family Medicine—Measures proposed for addition

- Measure #182 Functional Outcome Assessment - Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.

- The AAFP opposes the addition of this measure because of the frequency requirement of every visit or every 30 days for all patients over age 18. Doing a functional assessment at this frequency for all patients seen by family physicians, particularly healthy patients, is burdensome, wasteful, and detracts from meaningful care needed by patients during a visit. The measure requires a more targeted denominator that will benefit from functional assessment. At the most recent meeting of the CQMC, stakeholders opposed this measure for the reasons stated above.
- Adult immunization status
 - The AAFP opposes addition of this measure to the family medicine specialty set for the reasons outlined previously.

Comments on Measures Proposed for Removal:

- Measure #046 Medication Reconciliation Post-Discharge
 - Measure #046 is in the current CQMC core set for ACO/Primary Care. CMS states the measure is duplicative of Measure #130 Documentation of Current Medications in the medical record. At the most recent meeting of the CQMC, the stakeholders determined that measure #130 was a check-box measure with no guarantee that accurate reconciliation takes place and also stated Measure #130 is topped out for 2019. The CQMC prefer measure #046 over measure #130. Both measures are check box and may not show evidence of improved patient outcome.
- Measure #109 Osteoarthritis Functional and Pain Assessment: Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain.
 - The AAFP prefers this existing measure over the proposed replacement measure #182 (see above) because it is more targeted to a population that will benefit from functional assessment. There is no evidence that doing a functional assessment on healthy patients will improve patient outcomes.
- Measure #110, #111, and #474 (Influenza, Pneumococcal, and Zoster Vaccination Status)
 - The AAFP prefers retention of the individual measures for vaccination status over the proposed replacement composite measure of Adult Vaccination status for the reasons cited above.

Comments on Measures with Substantive Change:

- Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
 - At the most recent CQMC meeting, stakeholders indicated the need to update this measure to reflect current recommendations of 150/90. The AAFP supports the optional use of this measure, but would oppose CMS making it a mandatory measure in the MIPS program.

The AAFP agrees with all other additions, removals, and revisions as proposed by CMS.

(v) Request for Information on Potential Opioid Overuse Measure

Summary

To address concerns associated with long-term, high-dose opioids, CMS developed an eCQM titled: Potential Opioid Overuse. The Potential Opioid Overuse measure captures the proportion of patients aged 18 years or older who receive opioid therapy for 90 days or more with no more than a 7-day gap between prescriptions with a daily dosage of 90 morphine milligram equivalents (MME) or higher. CMS seeks to mitigate the usability and feasibility issues

for the measure by gathering information from a wider audience of technical implementers to strengthen the potential for measure adoption.

AAFP Response

The AAFP offers the following feedback to questions asked in the proposed rule.

- *Would you select this measure to support your quality measure initiatives? Why?*

The AAFP does not support use of this performance measure. We oppose measures that address specific milliequivalents among patients currently on opioids. There is a lack of agreement and evidence in the scientific community on measures that cite specific dosages. The AAFP anticipates unintended consequences (i.e., patients being stopped abruptly, refusal to accept patients with an opioid use disorder [OUD], refusal to prescribe opioids completely even in situations in which benefits might outweigh risks). Considering recent feedback from the CDC, AMA, and speakers at the CMS Quality Conference, experts have suggested that use of morphine milligram equivalents (MME) in quality measures is too prescriptive, difficult to locate in the EHR, and inadvisable for use in performance measures.

A >90 MME/d cut off must be applied cautiously to a provider of pain services in the context of a rural setting without ready access to adjunctive therapies and pain consultants to help treat those patients. A small, but certain number of chronic pain patients are receiving >90 MME/d of opioids and are in the process of tapering to the lowest effective dosage needed to control pain according to protocol. There are other “legacy” patients who have been through multiple procedures and are stable on a high dose—these are not the ones who seek medications unless forced to because of a forced taper. We do not believe we are yet ready for dosage-based opioid measures to be used for accountability without additional evidence and testing, and without availability of complete prescription information to the physician at the time of prescribing.

It would be more impactful to push real-time, complete prescribing data to providers using all-payer claims and prescription/pharmacy databases at point of care so physicians can accurately identify unsafe levels and can use this information to make patient-centered decisions, and thereby prevent unintentional over-prescribing in the first place. A primary care physician (or other clinician) might be careful in opioid prescribing practices, but have limited control over patients getting large quantities of opioids from other clinicians. The physician may not know about other prescriptions and should not be held accountable for that. Aggregation of such data would allow identification of outliers, but should not be used to assess provider performance without confirmation that the outlier status is unjustified. For example, there are a limited number of rural physicians that provide pain management therapy whose numbers may be high due to referral patterns.

- *Would you implement this measure in its current state? Why?*

We do not recommend implementation of this measure in its current state. Lack of insurance and availability (particularly in rural areas) for alternative pain management therapies is a problem. As previously stated, some legacy patients that are stable must be excepted.

The AAFP would prefer a measure that looks at compliance with the use of adjunctive treatments and/or compliance with pain management and opioid prescribing protocols

(reinforced by National Academy of Medicine [\[NAM\] tapering paper](#) and the recent New England Journal of Medicine [\[NEJM\] editorial](#) from the authors of the 2016 CDC guideline on the misapplication of the 90 MME recommendation). We also agree with authors of the NEJM editorial that efforts should focus on “starting fewer patients on opioid treatment and not escalating to high dosages in the first place to reduce the numbers of patients prescribed high dosages in the long term particularly for new patients.”

- *How can we improve the usability of this measure?*
Again, we do not recommend implementation of this measure in its current state.
- *This measure performs medication calculations, to calculate MME, which helps compare different opioids and opioid dosages. Are there any workflow, mapping, or other implementation factors to consider related to the required medication-related data elements needed to perform the MME calculations in this measure? Specifically related to: Use of the opioid data library, which clearly lists the required medication information directly in the measure specification; Use of medication end dates, to calculate medication durations; Use of coded medication frequencies, such as “three times daily” or “every six hours,” required to calculate daily medication dosages.*

Daily medication dosages: At least one EHR forces an end date and tries to force a number even if the physician is trying to add PRN to the sig line. The prescription drug monitoring program (PDMP) does NOT calculate the MME correctly and is sometimes way off, so the physician has to look closely each time and NOT assume it is correct.

Inaccuracies have been reported when combination medications are used so the MME may not be properly captured. This has been seen on a state-controlled substance database which automatically calculates MMEs and does not include buprenorphine products in the MME calculation (e.g., there are two FDA-approved products for pain) and these are often prescribed with an opioid full agonist and only the MME of the full agonist is reported given a falsely lower MME.

There are different conversion factors used than what is listed in the measure for methadone and hydromorphone. Non standardization of sig (TID versus every four hours, etc.) is a problem.

- *Are there any other foreseeable challenges to implementing this measure?*
Measuring for multiple providers may be problematic for practices operating as part of a medical home or patients who are managed in team-based context. Also, patients who are hospitalized during the intake period may receive prescriptions from inpatient physicians at discharge, increasing the number of prescribers.

The measure implies the CDC guideline is the definitive guideline for opioid prescribing. However, the AAFP had concerns about the CDC guideline used in the development of this measure and it did not meet our criteria for full endorsement. The primary reasons the AAFP did not endorse this guideline include:

- Strong (category A) recommendations were made based on limited or insufficient evidence. None of the recommendations are based on high-quality evidence.
- Due to the poor evidence base, the recommendations are generally consensus and therefore are “good practice points” rather than category A recommendations.
- The methodology included inconsistent inclusion and exclusion support.

III.K.3.c(2)(a) Cost Performance Category – Weight in the Final Score

Summary

CMS is proposing a steady increase in the weight of the cost category. For the 2020 performance year, cost will make up 20% of the final score. CMS intends to increase the weight in increments of 5% until the 2024 payment year. CMS proposes to weigh the cost category at 25% for the 2021 performance year and 30% for the 2022 performance year and all subsequent performance years. CMS invites comments on whether they should consider an alternative weight for the 2022 and/or 2023 MIPS payment years.

AAFP Response

The AAFP is supportive of CMS' proposal to continue to gradually increase the cost category as this prevents a drastic increase in the 2022 performance year, when CMS is required to increase the weight to 30%.

K.3.c(2)(b)(v)(B) Total Per Capita Cost Measure

Summary

CMS continues to believe the existing measure is appropriate to use in MIPS. CMS is proposing to change the attribution methodology to more accurately identify a beneficiary's primary care relationships. A primary care relationship is identified by a candidate event, defined as the occurrence of an E/M service, paired with one or more additional services indicative of general primary care (e.g., routine chest x-ray, electrocardiogram, or a second E/M service provided at a later date). The candidate event initiates a year-long risk window from the E/M primary care service. The risk window is the period during which a clinician or group could reasonably be held responsible for a beneficiary's treatment costs. Only the portion of the risk window that overlaps with the performance period, which is divided into 13 four-week blocks, is attributable to a clinician for a given performance period. Beneficiary months that overlap between the two risk windows are collapsed to ensure that costs are only accounted for once. If two different clinician groups initiated two risk windows for the same beneficiary, the risk windows would occur concurrently and would be attributed to their respective TINs. Within a TIN, only the clinician with the TIN/NPI performing the highest number of candidate events is attributed the beneficiary months. Multiple TINs and TIN/NPIs billing under different TINs may be attributed beneficiary months for the same beneficiary during the performance period.

CMS is also proposing to change the attribution methodology to more accurately identify clinicians who provide primary care services by adding service category and specialty exclusions. Candidate events are excluded if they are performed by clinicians who: 1) frequently perform non-primary care services, or 2) are in specialties unlikely to be responsible for providing primary care to a beneficiary. CMS does not propose to change the adjustment for specialty.

CMS is proposing to change the risk-adjustment methodology to determine a beneficiary's risk score for each beneficiary-month using diagnostic data from the year prior to that month rather than calculating one risk score for the entire performance year.

CMS is proposing to change the measure to evaluate beneficiaries' costs on a monthly basis rather than an annual basis.

CMS is proposing to include this revised total per capita cost measure beginning with the CY 2020 performance period.

AAFP Response

The AAFP appreciates CMS recognizing the need to revise this measure. While the revised measure addresses some of our previous concerns, we are still concerned with the appropriateness of this measure for small and rural practices. Small and rural practices may have less influence on total costs for their patients. Small referral networks exacerbate this issue, particularly for rural practices, as physicians may not have the option of referring to a lower-cost specialist. Additionally, it is difficult for physicians to be held accountable for total costs when they are not provided detailed information on the quality and cost of other physicians.

CMS should provide additional protections for small and rural practices to mitigate the impact of outliers. CMS should also explore the appropriateness of comparing all physicians to all physicians for this measure. While CMS does make geographic adjustments when calculating the measure, it is unclear whether these are adequate. The AAFP notes that these adjustments are based, in part, on GPCIs. The AAFP opposes the use of GPCIs as they tend to favor urban and suburban localities over their rural counterparts. We encourage CMS to winsorize costs for small and rural practices at the 95th percentile, as opposed to the 99th percentile, to better protect against the random variation that will occur with smaller numbers of attributed beneficiaries. Smaller referral networks and the increased impact of outliers will always be concerns for small and rural practices and need to be accounted for in the measure design and implementation.

The AAFP is also very concerned with the potential for measure overlap as it pertains to total cost of care and episode-based measures. Some MIPS ECs may only be measured on episode-based cost measures, while primary care physicians will be measured on total costs that include these episodes. **This discrepancy holds primary care physicians doubly accountable for costs, particularly on episodes where they did not and could not control costs. The AAFP strongly urges CMS and its measure development team to address this disparity before any implementation.**

III.K.3.c(2)(b)(v)(C) Medicare Spending Per Beneficiary Clinician Measure

Summary

CMS continues to believe the existing measure is appropriate to use in MIPS.

CMS is proposing to change the attribution methodology to distinguish between medical episodes and surgical episodes. A medical episode is first attributed to the TIN billing at least 30% of the inpatient E/M services on Part B claims during the inpatient stay. The episode is then attributed to any clinician in the TIN who billed at least one inpatient E/M services that was used to determine the episode's attribution to the TIN.

A surgical episode is attributed to the surgeon(s) who performed any related surgical procedure during the inpatient stay, as determined by clinical input, as well as to the TIN under which the surgeon(s) billed for the procedure.

CMS is proposing to add service exclusions to remove costs that are unlikely to be influenced by the clinician's care decisions. CMS is proposing to exclude unrelated services specific to groups of Medicare severity-diagnosis related groups (MS-DRGs) aggregated by major diagnostic categories (MDCs).

CMS is proposing to include the revised Medicare spending per beneficiary (MSPB) clinician measure beginning with the CY 2020 performance period.

AAFP Response

The AAFP appreciates CMS' willingness to improve this measure. As we are recommending for the total per capita cost measure, we ask CMS to extend protections for small and rural practices. We suggest CMS to exclude outliers below the fifth percentile and above the 95th percentile for small and rural practices.

(3) Improvement Activities Performance Category

(c) Patient-Centered Medical Home and Comparable Specialty Practice Accreditation

Summary

CMS has listed the Accreditation Association for Ambulatory Health Care (AAAHC), National Committee for Quality Assurance (NCQA), The Joint Commission, and URAC, along with programs that are national in scope and have evidence of being used by a large number of medical organizations as the eligible organizations for PCMH designation. However, they do not want to exclude others who might have PCMH programs. Therefore, they are proposing to remove the entity names from the list.

AAFP Response

The AAFP strongly supports this proposal.

(iii) Group Reporting

Summary

CMS proposes to increase the group reporting threshold from one clinician performing an improvement activity to at least 50% of the group performing the improvement activity. In addition, at least 50% of the NPIs must perform the same improvement activity for the same continuous 90 days.

AAFP Response

The AAFP supports this proposal.

(e) Improvement Activities Inventory Proposed Factors for Consideration in Removing Improvement Activities

Summary

CMS proposes to adopt the following factors for consideration when proposing to remove an improvement activity: activity is duplicative of another activity; there is an alternative activity with a stronger relationship to quality care or improvements in clinical practice; does not align with current clinical guidelines or practice; does not align with at least one meaningful measures area; does not align with the quality, cost, or promoting interoperability performance categories; there have been no attestations of the activity for three consecutive years; or the activity is obsolete.

AAFP Response

The AAFP appreciates CMS' efforts to align criteria for improvement activity removal with quality measure removal criteria. We would ask for clarification of CMS' interpretation of the final criteria and the use of the word "obsolete."

(ii) New Improvement Activities and Modifications to and Removal of Existing Improvement Activities

Summary

CMS proposes to remove 15 improvement activities, modify seven existing improvement activities, and add two new improvement activities.

AAFP Response

The AAFP supports these proposals.

III.K.3.c(4)(c) Promoting Interoperability Performance Category Performance Period

Summary

CMS is proposing to establish a promoting interoperability performance period of a minimum of a continuous 90-day period within the calendar year that occurs two years prior to the applicable MIPS payment year, up to and including the full calendar year (CY 2021). CMS is seeking comment on this proposal.

AAFP Response

The AAFP is supportive of this proposal and encourages CMS to continue assessing the need for a truncated performance period for the promoting interoperability category prior to requiring a full calendar year.

III.K.3.c(4)(d)(i)(B)(aa) Query of Prescription Drug Monitoring Program (PDMP) Measure

Summary

CMS is proposing to make the query of PDMP measure optional and eligible for five bonus points for the electronic prescribing objective in CY 2020. Should CMS finalize this proposal for the query of PDMP measure, the e-prescribing measure would be worth up to 10 points in CY 2020.

CMS is also proposing to remove the numerator and denominator for the query of PDMP measure and instead require a “yes/no” response. A “yes” would indicate that for at least one Schedule II opioid electronically prescribed using CEHRT during the performance period, the MIPS EC used data from CEHRT to conduct a query of a PDMP for prescription drug history, except where prohibited and in accordance with applicable law.

CMS welcomes comments on future timing for requiring a measure that includes EHR-PDMP integration and on the value of the measure for advancing the effective prevention and treatment of OUD especially in relation to the requirements of the *SUPPORT Act*.

AAFP Response

We strongly encourage CMS to not have requirements for prescribers to query stand-alone PDMPs. Not all states yet have PDMPs, thus providing bonus points is premature. We support integration of opioid treatment history into the standard EHR electronic prescribing process. Current CEHRT and PDMPs do not support the level of interoperability needed for this seamless integration. **Therefore, the AAFP is supportive of making query a completely optional component of promoting interoperability. CMS should work with the Office of the National Coordinator for Health Information Technology (ONC) and other federal entities to drive integration of PDMP data into CEHRT.**

III.K.3.c(4)(d)(i)(C) Verify Opioid Treatment Agreement Measure

Summary

Stakeholders have expressed concerns regarding the lack of definition and standards around this measure. CMS is proposing to remove the verify opioid treatment agreement measure from the promoting interoperability performance category beginning with the CY 2020 performance period. CMS believes there may be other opioid measures that would be more effective in combatting the opioid epidemic. CMS invites comments on this proposal.

AAFP Response

The AAFP supports this proposal.

III.K.3.c(4)(g)(i) Request for Information on Potential Opioid Measures for Future Inclusion in the Promoting Interoperability Performance Category

Summary

CMS is seeking comment on potential new measures for OUD prevention and treatment. CMS is seeking comment specifically on possible OUD prevention and treatment measures that include the following characteristics:

- Include evidence of positive impact on outcome-focused improvement activities, and the opioid crisis overall;
- Leverage the capabilities of CEHRT where possible, including: near-automatic calculation and reporting of numerator, denominator, exclusions, and exceptions to minimize manual documentation required of the provider; and timing elements to reduce quality measurement and reporting burdens to the greatest extent possible;
- Based on well-defined clinical concepts, measure logic and timing elements that can be captured by CHERT in standard clinical workflow and/or routine business operations. Well-defined clinical concepts include those that can be discretely represented by available clinical and/or claims vocabularies such as SNOMED CT, LOINC, RxNorm, ICD-10, or CPT;
- Align with clinical workflows in such a way that data used in the calculation of the measure is collected as part of a standard workflow and does not require any additional steps or actions by the health care provider;
- Applicable to all clinicians (e.g., clinicians participating as individuals or as a group, or clinicians located in a rural, designated HPSA or medically underserved areas [MUA], or urban area);
- Could potentially align with other MIPS performance categories; and
- Are represented by a measure description, numerator/denominator or yes/no attestation statement, and possible exclusions.

CMS is seeking comment on the following three NQF measures for possible inclusion in the promoting interoperability category and any modifications that may be necessary to maximize their use in the promoting interoperability category.

- Use of Opioids at High Dosage in Patients without Cancer (NQF #2940)
- Use of Opioids from Multiple Providers in Persons without Cancer (NQF #2950)
- Use of Opioids from Multiple Providers and at High Dosage in Persons without Cancer (NQF #2951)

CMS is seeking comment on how the promoting interoperability category can incorporate the description of the use of technology into measure guidance if these measures were considered for use by MIPS ECs.

CMS is seeking comment on which of the 15 CDC quality improvement opioid measures have value for potential consideration for the promoting interoperability category. CMS is seeking comment on whether they should consider a different type of measurement concept for OUD prevention and treatment, such as reporting on a set of cross-cutting activities and measures to earn credit in the promoting interoperability category (e.g., a set of one clinical decision support, the related CDC quality improvement opioid measure, and a potentially relevant clinical quality measure).

AAFP Response

The AAFP does not believe adding OUD quality measures to the promoting interoperability category is appropriate. It does not address nor promote interoperability. OUD interoperability is already addressed in the PDMP and eRx requirements. **The AAFP reiterates its opposition to the use of health IT utilization measures and believes these measures would only add unnecessary utilization measures and administrative burden. ECs should be provided automatic credit in the promoting interoperability category if they report any OUD measure that leverages the use of CEHRT.** Creating the same or similar measures in two performance categories only increases administrative burden for ECs and directly contradicts the intent of the proposed MVPs, which is to connect measures and activities across the four MIPS categories. While the measures may be “connected” in topic, requiring ECs to report them separately does nothing to improve the program.

III.K.3.c(4)(g)(iii) Request for Information on a Metric to Improve Efficiency of Providers with EHRs

Summary

CMS is seeking feedback on a potential metric to evaluate health care provider efficiency using EHRs. Specifically, CMS is requesting information on the following questions:

- What do stakeholders believe would be most useful ways to measure the efficiency of health care processes due to the use of health information technology (HIT)? What are the measurable outcomes demonstrating greater efficiency in costs or resource use that can be linked to the use of HIT-enabled processes?
- What do stakeholders believe may be hindering their ability to achieve greater efficiency (e.g., product, measures, CMS regulations)?
- What are specific technologies, capabilities, or system features that can increase the efficiency of provider interactions with technology systems (e.g., alternate authentication technologies that can simplify provider logon)? How could CMS reward providers for adoption and use of these technologies?
- What are key administrative processes that can benefit from more efficient electronic workflows (e.g., conducting prior authorization requests)? How can CMS measure and reward providers for their uptake of more efficient electronic workflows?
- Could CMS successfully incentivize efficiency? What role should CMS play in improving efficiency in the practice of medicine?

AAFP Response

The AAFP strongly opposes the addition of efficiency measures to this category or any other category. Every physician wants to be more efficient with their EHR and adding this measure would only increase administrative burden (which would only be increased by the addition of absurd metrics such as these) and not address the root cause of the problem, which are EHR design flaws that decrease efficiency. **Payers and EHR vendors—not physicians—should be held to efficiency standards to ensure EHRs support patient-centered care.**

III.K.3.c(4)(g)(iv)(A) Request for Information on the Provider to Patient Exchange Objective: Immediate Access

Summary

CMS is seeking comment on whether MIPS ECs should make patient health information available immediately through an open, standards-based application programming interface (API) no later than one business day after it is available to the MIPS EC in their CEHRT. CMS seeks comment on the barriers to more immediate access to patient information, whether there

are specific data elements that may be more or less feasible to share no later than one business day. CMS seeks comment as to when implementation of such a requirement is feasible.

AAFP Response

The AAFP supports timely access of patients to all of their information. All ECs are subject to the pending information blocking regulations. Restricting access to patients is prohibited by the proposed information blocking regulations. There are likely many clinical and business scenarios where patient access within one business day would not be feasible or within the best interest of the patient (i.e., for a patient to find out they have cancer). Therefore, we strongly encourage CMS to not require one business day for patient access, but rather enforce the pending information blocking requirements for ECs that have demonstrated a pattern of behavior of restricting timely access for patients.

III.K.3.c(4)(g)(iv)(B) Persistent Access and Standards-based APIs

Summary

The existing measure does not specify the overall operational expectations associated with enabling patients' access to their health information.

CMS is seeking comment on whether they should revise the measure to be more specific with respect to the experience patients should have regarding their access. For instance, in the *ONC 21st Century Cures Act* proposed rule, there is a proposal regarding requirements around persistent access to APIs, which would accommodate a patient's routine access to their health information without needing to reauthorize their application and reauthenticate themselves. CMS seeks comment on whether the promoting interoperability category measure should be updated to accommodate this proposed requirement for persistent access.

CMS is seeking comment on whether stakeholders would support a possible bonus under the promoting interoperability category for early adoption of a certified fast healthcare interoperability resource (FHIR)-based API in the immediate time before ONC's final rule's compliance date for implementation of a FHIR standard for certified APIs.

AAFP Response

Eligible clinicians are extremely dependent on their CEHRT to enable interoperability via APIs. We have concern that establishing a bonus for adoption of APIs where all CEHRT are not required currently to support would disenfranchise some ECs, especially smaller size practices where their CEHRT does not yet support that activity. We do not believe that CMS needs to be more specific around requirements to adopt APIs, including persistent access, as we believe the vast majority of ECs will enable the default CEHRT API capabilities. CMS should work with ONC to further these API adoption policies through CEHRT, not through MIPS.

III.K.3.c(4)(g)(iv)(C) Available Data

Summary

CMS is seeking comment on an alternative measure under the provider-to-patient exchange objective that would require clinicians to use technology certified to the electronic health information (EHI) criterion to provide patients their complete electronic health data contained within an EHR.

CMS specifically seeks comment on the following questions:

- Do stakeholders believe that incorporating this alternative measure into the provider-to-patient exchange objective will be effective in encouraging the availability of all data stored in health IT systems?
- In relation to the provider-to-patient exchange objective, as a whole, how should a required measure focused on using proposed total EHI export function in CEHRT be scored?
- If this certification criterion is finalized and implemented, should a measure based on the criterion be established as a bonus measure? Should this measure be established as an attestation measure?
- In the long term, how do stakeholders believe such an alternative measure would impact burden?
- If stakeholders do not believe this will have a positive impact on burden, in what other way(s) might an alternative measure be implemented that may result in burden reduction?
- Which data elements do stakeholders believe are of greatest clinical value or would be of most use to health care providers to share in a standardized electronic format if the complete record was not immediately available?
- Do stakeholders believe CMS should consider including a health IT activity that promotes engagement in health information exchange (HIE) across the care continuum that would encourage bi-directional exchange of health information with community partners, such as post-acute care, long-term care, behavioral health, and home- and community-based services to promote better care coordination for patients with chronic conditions and complex care needs? If so, what criteria should CMS consider when implementing a HIE across the care continuum in the promoting interoperability category?
- What criteria should be employed, such as specific goals or areas of focus to identify high-priority health IT activities for the future of the performance category?
- Are there additional health IT activities they should consider recognizing in lieu of reporting on existing measures and objectives that would effectively advance priorities for nationwide interoperability and spur innovation?

AAFP Response

The AAFP is highly supportive of the work under the *21st Century Cures Act* to support switching EHRs. The lack of substitutability among EHR systems is a large missing market force to improve competition among developers and support the emergence of new solutions for ECs and patients. We are concerned that adding a measure to promote interoperability would add burdens on ECs to report on the measure. Given that access for patients to EHI is guaranteed under the *Health Insurance Portability and Accountability Act* (HIPAA) and that restricting such access is information blocking under the new proposed regulations, we recommend that CMS not add such a measure under MIPS. As we have stated in the past, AAFP strongly urges CMS to reduce the complexity of the existing program and category requirements before it considers developing new measures.

III.K.3.c(4)(g)(v) Request for Information on Integration of Patient-generated Health Data into EHRs using CEHRT

Summary

CMS invites stakeholder feedback on the following questions:

- What specific use cases for capture of patient-generated health data (PGHD), as part of treatment and care coordination across clinical conditions and care settings, are most promising for improving patient outcomes?

- Should the promoting interoperability category explore ways to reward providers for engaging in activities that pilot promising technical solutions or approaches for capturing PGHD and incorporating it into CEHRT using standards-based approaches?
- Should health care providers be expected to collect information from their patients outside of scheduled appointments or procedures? What are the benefits and concerns of doing so?
- Should the promoting interoperability category explore ways to reward health care providers for implementing best practices associated with optimizing clinical workflows for obtaining, reviewing, and analyzing PGHD?

AAFP Response

If implemented well, PGHD integrated into the EHR could improve health, reduce documentation burden, and improve patient engagement. Though, if implemented poorly, it could lead to dramatic increases in documentation burden and not improve health or patient engagement. Development stages of PGHD integration is too immature to know how to implement well across all ECs. While we support integration of PGHD and encourage the Department of Health and Human Services to promote more research in implementation, we believe CMS should not include a PGHD measure within the promoting interoperability category at this time.

Regarding exploring ways to reward piloting promising technical solution or approaches, we have concerns that establishing a bonus for technical solutions where all CEHRT are not currently required to support them would disenfranchise some ECs, especially smaller size practices where their CEHRT does not yet support that technical solution.

III.K.3.c(4)(g)(iv) Request for Information on Engaging in Activities that Promote the Safety of the EHR

Summary

CMS is seeking comment on ways the promoting interoperability category may reward MIPS ECs for engaging in activities that can help to reduce errors associated with EHR implementation.

CMS is requesting comment on a potential future change to the performance category under which MIPS ECs would receive points toward their promoting interoperability score for attesting to performance of an assessment based on one of the ONC SAFER Guides.

CMS is also inviting comments on alternatives to the SAFER Guides, including appropriate assessments related to patient safety, which should also be considered as part of any future bonus option. CMS is inviting stakeholders to suggest other approaches CMS may take to reward activities that promote reduction of safety risks associated with EHR implementation as part of the promoting interoperability category.

AAFP Response

The AAFP has recommended to CMS in the past to focus promoting interoperability solely on patient safety and interoperability. Also, we have asked CMS to focus on reducing the complexity of the QPP program before expanding to new measures. CMS could focus on patient safety and reduce complexity of promoting interoperability by replacing the health IT utilization measures with attesting to engaging in ONC SAFER Guide activities. At first, CMS could establish a bonus for such attestation to ensure the guides are an effective measure,

before future changes to replace current promoting interoperability measures with that attestation.

(5) APM Scoring Standard for MIPS Eligible Clinicians Participating in MIPS APMs

Summary

The APM scoring standard is designed to reduce reporting burden for such clinicians by reducing the need for duplicative data submission to MIPS and their respective APMs, and to avoid potentially conflicting incentives between those APMs and MIPS. MIPS final scores are calculated at the APM entity level and applied at the TIN/NPI level. Category weights are: quality is 50%, cost is 0%, improvement activities is 20%, and promoting interoperability is 30%.

CMS anticipates the following MIPS APMs to qualify as MIPS APMs in 2020:

- Comprehensive ESRD Care Model (all Tracks);
- Comprehensive Primary Care Plus Model (all Tracks);
- Next Generation ACO Model;
- Oncology Care Model (all Tracks);
- Medicare Shared Savings Program (all Tracks);
- Medicare ACO Track 1+ Model;
- Bundled Payments for Care Improvement Advanced;
- Maryland Total Cost of Care Model (Maryland Primary Care Program);
- Vermont All-Payer ACO Model (Vermont Medicare ACO Initiative); and
- Primary Care First (All Tracks).

After several years of implementation, CMS has found that for participants in certain MIPS APMs it is difficult to collect and score APM quality measures for purposes of MIPS because APMs run on different timelines that do not always align with the MIPS performance periods and deadlines for data submission, scoring, and performance feedback. CMS is considering new approaches to quality performance scoring.

CMS proposes to allow MIPS ECs in MIPS APMs to report on MIPS quality measures like the established policy they have for the promoting interoperability category. They will receive a score for quality either at the individual or TIN level based on regular scoring rules for MIPS. CMS would allow reporting at both levels, but would attribute only the highest score. CMS would then use the average of the highest scores to determine the APM entity score for quality.

CMS proposes to apply a minimum score of 50%, or an “APM quality reporting credit” under the MIPS quality performance category for certain APM entities participating in MIPS. They believe APMs require a greater investment in improvement activities. They believe MIPS APMs require a greater investment in quality, which cannot always be reflected in the quality score. They propose APM entity groups that are in MIPS APMs receive a minimum score of half the highest potential score for quality. These would be additive scores. CMS would calculate the APM entity score, then add it to the 50% credit, capping at 100%.

AAFP Response

The AAFP would like to point out that most MIPS APMs are large practices. These practices have the infrastructure to report quality and likely will not need the additional credit in the quality category. If MIPS APMs get this preferential scoring, it will continue to skew the program as favorable to large practices, leaving the small/solo physician on the losing end—and could further slow the movement of these large practices into the Advanced APM track. This is demonstrated in the 2017 QPP experience report. MIPS APMs had an average final score of

87.64 and a median final score of 91.76. Whereas, small practices had average and median final scores of 43.46 and 37.67, respectively. **The AAFP believes MIPS APMs should be assessed on their performance on quality metrics the same as all other MIPS ECs and should not be given additional preferential treatment.**

(D) Bonus Points and Caps for the Quality Performance Category

Summary

CMS believes it would be inappropriate to calculate bonus points at the APM entity group level when an APM entity's group quality score is reported by its composite individuals or TINs.

AAFP Response

The AAFP supports this proposal as it would be duplicative and inappropriate to apply bonus points at the individual/TIN-level and the APM entity group level.

(E) Special Circumstances

Summary

Since it is proposed MIPS ECs participating in MIPS APMs can report MIPS quality measures and be scored for the MIPS quality performance category based on the generally applicable MIPS rules for the quality performance category, CMS wants to apply the same extreme and uncontrollable circumstances policies that apply to other MIPS ECs with regard to the quality performance category to the MIPS APM participants.

AAFP Response

The AAFP would support application of MIPS policies in a uniform way across the program.

(v) Other Options

Summary

CMS seeks comment on other ways to modify the APM scoring standard to encourage MIPS ECs to join APMs.

AAFP Response

The APM scoring standard is applied, for the most part, to large practices. This preferential scoring has given large practices a scoring advantage in MIPS and has disadvantaged small/solo practices. The AAFP would also suggest reasons ECs are not moving from MIPS to APMs is the lack of program availability, uncertain program stability, and primary care payments that do not support APM participation.

III.K.3.d(1)(b)(i)(C) Modifying Benchmarks to Avoid the Potential for Inappropriate Treatment

Summary

CMS is proposing to establish benchmarks based on flat percentages in specific cases where they determine the measure's otherwise applicable benchmark could potentially incentivize treatment that could be inappropriate for a particular patient type. CMS proposes that CMS medical officers would assess if there are patients for whom it would be inappropriate to achieve the outcome targeted by the measure benchmark. CMS would propose the modified benchmark for the applicable MIPS payment year through rulemaking. This policy would be effective beginning with the CY 2020 performance period. CMS seeks comment on future actions they should take to help in determining which measures to apply the flat percentage benchmarking to (e.g., convening a technical expert panel).

CMS has identified two measures for which they believe they need to apply benchmarks based on flat percentages—MIPS #1 (NQF 0059): Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) and MIPS #236 (NQF 0018): Controlling High Blood Pressure.

CMS is proposing to use the flat percentage benchmarks as an alternative to the standard benchmarking method by a percentile distribution of measure performance rates under for all collection types where the top decile for any measure benchmark is higher than 90% under the performance-based benchmarking methodology. CMS seeks comment on whether they should use criteria different than applying it to collection types where the top decile would be higher than 90% if the benchmark was based on distribution.

CMS is seeking comment on whether they should consider different methodologies for the modified benchmarks, such as excluding the top decile or increasing the data completeness for the measure to a very high level and use performance period benchmarks rather than historical benchmarks.

AAFP Response

The AAFP is not supportive of changing the benchmarking methodology to flat percentages, although we do recognize that highly-skewed measures result in vastly different deciles for similar performance. On the same measure, physicians who perform very similarly, even within the same standard deviation of performance, would be awarded very different points for the same measure. Additionally, the current benchmarking methodology has limited protection against the effect of random variation, especially for small practices. As such, we encourage CMS to evaluate other methods of setting benchmarks, such as using a combined manual and data-driven approach. One example of this would be to manually set the top and bottom cutoffs, while allowing data to drive the cut points in between. This combined methodology would impact practices in several positive ways. First, it would allow practices to have an absolute threshold to work towards year over year and would limit incentivization for inappropriate treatment to reach performance thresholds, which is a concern CMS outlined in the request for proposal (RFP). Second, it would ensure that practices with similar high performance are adequately scored. Finally, it would negate the effects of random variation and performance within normalized standard deviation, allowing practices to focus less on improving performance by one or two percentage points that do not drastically improve health outcomes. We acknowledge that there may be other ways to set benchmarks that address our concerns and are willing to work with CMS to find a methodology that is statistically sound and clinically relevant.

III.K.3.d(1)(b)(ii) Request for Feedback on Additional Policies for Scoring the CAHPS for MIPS Survey Measure

Summary

CMS is not proposing any changes to the scoring of the CAHPS for MIPS survey measure. CMS is considering expanding the information collected in the CAHPS for MIPS survey measure. CMS is interested in feedback on scoring narrative information.

AAFP Response

CMS does not make any proposals regarding the CAHPS for MIPS survey this year, but seeks comment on items to add to the survey in future years, such as expanding the survey to add patient narratives. We urge CMS to not collect narrative data using open-ended questions and publicly reporting these comments. There are existing websites for patients to share their comments regarding their physicians and such comments are not scientifically validated and are not representative of the overall care provided by a clinician. Since comments would be very

extensive, CMS would need to establish a process for determining which comments to post and in what format as to not overwhelm patients reading the comments.

We agree the CAHPS survey could be strengthened by focusing on patient experience instead of satisfaction. However, the length, timeliness, small sample size, and cost of the survey are major concerns. CMS may wish to draw questions from existing patient-reported surveys that have already been validated (e.g., PROMIS) or replace CAHPS completely with another instrument (e.g., the person-centered primary care measure). The [Person-Centered Primary Care](#) measure, developed by Virginia Commonwealth University, is patient-reported, addresses eleven primary care domains, and is more relevant than the current CAHPS measure for primary care. The measure has been thoroughly tested, is currently approved as a QCDR measure, and will be submitted to NQF for endorsement consideration in 2020.

The length of a patient survey should be short (no more than 10-15 questions) to avoid patient survey fatigue and a larger sample should be drawn to improve reliability. Finally, CMS should seek a means to administer a patient survey immediately following an encounter to strengthen the reliability of the patient response. Timely physician feedback would add actionability and meaningfulness. The survey should be available to a practice at no cost for administration.

Clinicians appreciate hearing the patient voice so they can make changes to improve their care. We encourage CMS to seek a method of gathering patient-reported outcomes that is valid, timely, short, provides frequent meaningful to the clinician, covers a larger sample of patients, and free.

III.K.3.d(2)(b)(ii)(A) Reweighting Performance Categories due to Data that are Inaccurate, Unusable, or Otherwise Compromised

Summary

CMS believes reweighting may be appropriate when a MIPS EC's data are inaccurate, unusable, or otherwise compromised due to circumstances that are outside of the control of the MIPS EC or its agents.

CMS is proposing a new policy to allow reweighting for any performance category if, based on information CMS learns prior to the beginning of a MIPS payment year, CMS determines data for that performance category are inaccurate, unusable, or otherwise compromised due to circumstances outside of the control of the MIPS EC or its agents. CMS will take into account both what control the clinician had directly over the circumstances and what control the clinician had indirectly through its agents. CMS solicits comments on this approach and possible alternatives for balancing efforts to allow reweighting in circumstances in which clinicians are not culpable for compromised data while maintaining financial incentives for clinicians, third-party intermediaries, and other parties to prevent and correct compromised data.

CMS recognizes there may be scenarios when a MIPS EC or one or more of its agents becomes aware of potential data issues prior to data submission and seeks comment on whether and how the proposed reweighting policy should apply to these circumstances.

CMS proposes to determine whether the requirements for reweighting are met by assessing if 1) the MIPS EC's data are inaccurate, unusable, or otherwise compromised; and (2) the data are compromised due to circumstances outside of the control of the MIPS EC or agent. Factors relevant to whether the circumstances were outside of the control of the clinician and its agents include: whether the affected MIPS EC or its agents knew or had reason to know of the issue; whether the affected MIPS EC or its agents attempted to correct the issue; and whether the

issue caused the data submitted to be inaccurate or unusable for MIPS purposes. CMS seeks feedback on these factors and whether there are additional factors they should consider to determine if there should be reweighting based on compromised data.

CMS is interested in feedback on whether there are other factors they should consider when adopting a timeline for reweighting due to compromised data and whether the period should be broader. CMS seeks comment on whether they should restrict the reweighting due to compromised data to instances when they learn the relevant information prior to the beginning of the MIPS payment year and whether there are incentives for MIPS ECs to alert CMS to concerns about compromised data.

AAFP Response

MIPS ECs should be held harmless in instances where their data is compromised or unusable because of issues/errors on the part of a third-party intermediary. MIPS ECs should be held accountable if they knowingly submitted compromised or unusable data and should not qualify for reweighting. The AAFP believes it would be appropriate to restrict the reweighting to instances where CMS learned of the errors prior to the beginning of the MIPS payment year. However, if CMS was made aware of an issue, but did not respond or react in a timely manner (i.e., prior to the applicable payment year), a MIPS EC should be able to request reweighting.

III.K.3.e(2) Establishing the Performance Threshold

Summary

CMS is using the mean final score (74.01) from the 2017 performance period to estimate the performance threshold for the 2024 MIPS payment year. CMS anticipates the mean and median data points for the 2020 MIPS payment year will be available for consideration prior to the publication of the final rule and seeks comment on whether and how they should use this information to update their estimates. CMS will propose the actual performance threshold for the 2024 MIPS payment year in future rulemaking.

CMS is proposing a performance threshold of 45 points for the 2022 MIPS payment year and a performance threshold of 60 points for the 2023 MIPS payment year. CMS invites comment on the proposals. CMS also seeks comment on whether they should adopt a different performance threshold in the final rule if they determine that the actual mean or median final scores for the 2020 MIPS payment year are higher or lower than their estimates for the 2024 MIPS payment year. CMS also seeks comment on whether the increase should be more gradual for the 2022 MIPS payment year. CMS seeks comment on alternative numerical values for the 2022 and 2023 MIPS payment years' performance thresholds.

CMS is proposing an additional performance threshold of 80 points for the 2022 MIPS payment year and 85 points for the 2023 MIPS payment year. These thresholds require a MIPS EC to participate and perform well in multiple performance categories.

CMS invites comment on these proposals and any alternative thresholds CMS should consider. CMS also seeks comment on whether they should adopt different thresholds should they finalize a performance threshold that is different than what has been proposed. CMS seeks feedback on how the distribution of the additional MIPS payment adjustments across MIPS ECs may impact exceptional performance by ECs participating in MIPS.

AAFP Response

CMS should update the performance and additional performance thresholds should the actual mean or median final scores for the 2020 MIPS payment year be lower than their estimates for

the 2024 MIPS payment year. CMS should not increase the thresholds, regardless of if the actual mean or median scores are higher. To maintain transparency, CMS should, however, make public the actual mean and median scores when they are available.

III.K.3.g(1) Proposed Requirements for MIPS Performance Categories That Must Be Supported by Third-party Intermediaries

Summary

CMS proposes, beginning with the 2021 performance period and all future years, for the MIPS categories identified in the regulation, QCDRs, and qualified registries must be able to submit data for each category, and HIT vendors must be able to submit data for at least one category. CMS solicits feedback on the benefits and burdens of this proposal, including whether the requirement to support all three identified categories of MIPS performance data should extend to HIT vendors.

A QCDR or registry that represents only ECs that reweighted the promoting interoperability category would not be required to support the promoting interoperability performance category. CMS is proposing to revise § 414.1400(a)(2)(iii) to state that for the promoting interoperability category, the requirement applies if the EC, group, or virtual group is using CEHRT. However, a third-party could be excepted from this requirement if its MIPS ECs, groups, or virtual groups fall under the reweighting policies at § 414.1380(c)(2)(i)(A)(4) or (5) or § 414.1380(c)(2)(i)(C)(i)-(7) or § 414.1380(c)(2)(i)(C)(9).

CMS solicits comments on this proposal, including the scope of the proposed exception from the promoting interoperability reporting requirement for certain types of QCDRs and qualified registries. Specifically, CMS seeks comment on whether they should more narrowly tailor, or conversely broaden, the proposed exceptions for when QCDRs and qualified registries must support the promoting interoperability category.

AAFP Response

The AAFP is supportive of this proposal as it can reduce administrative burden and potential costs associated with having to use multiple reporting mechanisms for different categories.

III.K.3.g(3)(a)(iii) Enhanced Performance Feedback Requirement

Summary

CMS is proposing that beginning with the 2023 MIPS payment year, QCDRs must provide performance feedback to their clinicians and groups at least four times a year and provide specific feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the QCDR. QCDRs will be required to attest during the self-nomination process that they can provide performance feedback at least four times a year.

CMS is seeking comment for future notice and comment rulemaking on whether they should require MIPS ECs, groups, and virtual groups who utilize a QCDR to submit data throughout the performance period, and prior to the close of the performance period (December 31). CMS is also seeking comment on whether clinicians and groups can start submitting their data starting April 1 to ensure the QCDR is providing feedback to the clinician or group during the performance period.

AAFP Response

The AAFP believes ECs should maintain the flexibility to submit data within their own timeline. QCDRs should provide at least quarterly feedback to all ECs who have submitted data. ECs

who do not submit data should be notified that this would prevent them from receiving regular feedback.

III.K.3.g(3)(c)(i)(C) Measure Rejections

Summary

CMS is proposing QCDR measure rejection criteria that generally aligns with finalized removal criteria for MIPS quality measures in the CY 2019 MPFS final rule. All previously approved and new QCDR measures would be reviewed on an annual basis to determine whether they are appropriate for the program. CMS proposes beginning with the 2020 performance period to reject QCDR measures with consideration of, but not limited to:

- QCDR measures that are duplicative or identical to other QCDR measures or MIPS quality measures that are currently in the program;
- QCDR measures that are duplicative or identical to MIPS quality measures that have been removed from MIPS;
- QCDR measures that are duplicative or identical to quality measures used under Physician Quality Reporting System (PQRS) that have been retired;
- QCDR measures that meet the “topped-out” definition. If a measure is topped out and rejected, it may be reconsidered in future years if the QCDR can provide evidence through additional data and/or recent literature that a performance gap exists and show the measure is no longer topped out;
- QCDR measures that are process based, with considerations to whether the removal of the process measure impacts the number of measures available for a specific specialty;
- Whether the QCDR has potential unintended consequences to a patient’s care;
- Considerations and evaluation of the measure’s performance data;
- Whether the previously identified areas of duplication have been addressed as requested;
- QCDR measures that split a single clinical practice or action into several QCDR measures;
- QCDR measures that are “check box” with no actionable quality action;
- QCDR measures that do not meet the case minimum and reporting volumes required for benchmarking after being in the program for two consecutive years;
- Whether the existing approved QCDR measure is no longer considered robust;
- QCDR measures with clinician attribution issues, where the quality action is not under the direct control of the reporting clinician;
- QCDR measures that focus on rare events or “never events” in the measurement period.

AAFP Response

Insofar as CMS proposes to reject QCDR measures because they do not meet the case minimum and reporting volumes for benchmarking for two consecutive years, the AAFP encourages CMS to monitor why a measure is not meeting such thresholds and assess each measure on a case-by-case basis.

III.K.3.g(4)(a)(ii) Enhanced Performance Feedback Requirement

Summary

CMS is proposing to revise § 414.1400(c)(2) to state that beginning with the 2022 MIPS payment year, the qualified registry must have 25 participants by January 1 of the year prior to the applicable performance period. Additionally, beginning with the 2023 MIPS payment year, qualified registries must provide the following as part of the performance feedback given four times a year: feedback to their clinicians and groups on how they compare to other clinicians who have submitted data on a given measure within the qualified registry. If the registry does

not receive the data from their clinician until the end of the performance period, the registry will be excepted from this requirement. CMS seeks comment on other exceptions that may be necessary under this requirement.

CMS is seeking comment on whether they should require MIPS ECs, groups, and virtual groups who utilize a qualified registry to submit data throughout the performance period, and prior to the close of the performance period (December 31). CMS is also seeking comment on whether clinicians and groups can start submitting their data starting April 1 to ensure the qualified registry is providing feedback to the clinician or group during the performance period.

AAFP Response

The AAFP believes ECs should maintain the flexibility to submit data within their own timeline. Qualified registries should provide at least quarterly feedback to all ECs who have submitted data. ECs who do not submit data should be made notified that this would prevent them from receiving regular feedback.

III.K.3.h(4) Quality

Summary

CMS is seeking comments on adding patient narratives to the Physician Compare website. CMS seeks comment on the value of and considerations for publicly reporting such information to assist patients and caregivers with making health care decisions. CMS seeks comment on the value of collecting and publicly reporting information from narrative questions and other patient-reported outcomes measures (PROMs), as well as publishing a single “value indicator” reflective of cost, quality, and patient experience and satisfaction with care for each MIPS EC and group on the Physician Compare website.

AAFP Response

Clinicians appreciate hearing the patient voice so they can make changes to improve their care. We encourage CMS to seek a method of gathering patient-reported outcomes that is valid, timely, short, provides frequent meaningfulness to the clinician, covers a larger sample of patients, and free.

We agree the CAHPS survey could be strengthened by focusing on patient experience instead of satisfaction. However, the length, timeliness, small sample size, and cost of the survey are major concerns. CMS may wish to draw questions from existing patient-reported surveys that have already been validated (e.g., PROMIS) or replace CAHPS completely with another instrument (e.g., the person-centered primary care measure). The [Person-Centered Primary Care](#) measure, developed by Virginia Commonwealth University, is patient-reported, addresses eleven primary care domains, and is more relevant than the current CAHPS measure for primary care. The measure has been thoroughly tested, is currently approved as a QCDR measure, and will be submitted to NQF for endorsement consideration in 2020.

The length of patient survey should be short (no more than 10-15 questions) to avoid patient survey fatigue and a larger sample should be drawn to improve reliability. Finally, CMS should seek a means to administer a patient survey immediately following an encounter to strengthen the reliability of the patient response. Timely physician feedback would add actionability and meaningfulness. The survey should be available to a practice at no cost for administration.

We urge CMS to not collect narrative data using open-ended questions and publicly reporting these comments. There are existing websites for patients to share their comments regarding their physicians and such comments are not scientifically validated and are not representative of

the overall care provided by a clinician. Since comments would be very extensive, CMS would need to establish a process for determining which comments to post and in what format as to not overwhelm patients reading the comments.

We do not believe CMS should publish data at the individual clinician level. Individual scores and personal comments could be very disheartening for a physician workforce that is already struggling with burnout resulting from excessive oversight and intrusion on professionalism.

III.K.4.c(2)(b) Expected Expenditures

Summary

In the 2017 QPP final rule, CMS finalized a definition of expected expenditures to mean the beneficiary expenditures for which an APM entity is responsible under an APM. CMS is concerned the total-risk portion of the benchmark-based nominal amount standard may not always be sufficient to ensure the level of average or likely risk under an Advanced APM that is actually more than nominal for participants.

CMS is proposing to amend the definition of expected expenditure to define it as the beneficiary expenditures for which an APM entity is responsible under an APM. For episode payment models, expected expenditures means the episode target price. For the purposes of assessing financial risk for Advanced APM determinations, the expected expenditures under the terms of the Advanced APM should not exceed the expected Medicare Parts A and B expenditures for a participant in the absence of an APM. If expected expenditures under the APM exceed the Medicare Parts A and B expenditures an APM entity would be expected to incur in the absence of the APM, such excess expenditures are not considered when CMS assesses financial risk under the APM for Advanced APM determinations.

AAFP Response

The AAFP supports this proposal.

III.K.4.d(2) Application of Partial QP Status

Summary

CMS currently applies partial qualified participant (QP) status at the NPI level across all TIN/NPI combinations. While a partial QP may wish to be excluded from the MIPS reporting requirements with respect to the TIN/NPI that relates to the APM entity in an Advanced APM, the same partial QP may benefit from reporting and receiving a MIPS payment adjustment with respect to some of all of their other TIN/NPI combinations because they anticipate receiving an upward MIPS payment adjustment.

CMS proposes beginning with the 2020 QP performance period, partial QP status would apply only to the TIN/NPI combination(s) through which an individual EC attains partial QP status. An EC who is a partial QP for only one TIN/NPI combination may still be a MIPS EC and report under MIPS for other TIN/NPI combinations.

AAFP Response

The AAFP is supportive of this proposal.

III.K.4.d(3)(b) APM Entity Determination

Summary

Under the terms of some Advanced APMs, APM entities can terminate their participation while bearing no financial risk after the end of the QP performance period for the year (August 31). Under current regulations, such termination would not affect the QP or partial QP status of all

ECs in the APM entity. CMS does not believe it is appropriate to grant QP or partial QP status if an APM entity did not actually bear any financial risk.

CMS is proposing beginning with the 2020 QP performance period that an EC is not a QP for a year if: (1) the APM entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP performance period; or (2) the APM entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP performance period occurs. CMS is making the same proposal for ECs that participate in multiple APM entities and for partial QPs.

AAFP Response

The AAFP agrees a QP or partial QP should not retain their status if the APM entity terminates from an Advanced APM before the end of the QP performance period and does not bear any financial risk. However, we also note that the decision to join or leave an APM is often made by an administration—not the participating ECs. For that reason, we believe ECs in an APM entity that terminates from an Advanced APM and did not bear any financial risk should be held harmless from any MIPS payment adjustments.

However, if an APM entity terminates from an Advanced APM before the end of a QP performance period, but is responsible for bearing risk for the portion of the performance period in the AAPM, the QP or partial QP should retain their status.

III.K.4.e(2)(a) Aligned Other Payer Medical Home Models – Definition

Summary

CMS proposes to add the term “aligned other payer medical home model” to mean a payment arrangement (not including a Medicaid arrangement) operated by an other payer that formally partners with CMS in a CMS multi-payer model that is a medical home model through a written expression of alignment and cooperation, such as a memorandum of understanding, and is determined by CMS to have the following characteristics:

- Has a primary care focus with participants that primarily include primary care practices or multi-specialty practices that include primary care physicians and practitioners and offer primary care services;
- Empanelment of each patient to a primary clinician; and,
- At least four of the following: planned coordination of chronic and preventive care; patient access and continuity of care; risk-stratified care management; coordination of care across the medical neighborhood; patient and caregiver engagement; shared decision-making; and/or payment arrangements in addition to, or substituting for, FFS payments.

CMS is proposing to limit the aligned other payer medical home model definition to other payer arrangements that are aligned with CMS multi-payer models that are medical home models because CMS can be assured these arrangements are similar to medical home models and Medicaid medical home models for which they have already made a similar determination. CMS believes applying the aligned other payer medical home model definition to all other payer arrangements would create potential new opportunities for gaming in commercial settings where CMS does not have control over the design of such models.

AAFP Response

We support CMS' proposed definition of Aligned Other Payer Medical Home Model. However, we feel it may be too restrictive and exclude many private sector models. **We strongly urge CMS to also review and consider models that are not aligned with a CMS Multi-Payer Model to ensure there are ample opportunities for ECs to meet the increasing QP thresholds.**

III.K.4(e)(2)(c) Determination of Aligned Other Payer Medical Home Model and Other Payer APM Status

Summary

CMS proposes that payers may submit other payer arrangements for determination as aligned other payer medical home models and other payer Advanced APMs through the payer initiated process, effective January 1, 2020, for the 2021 performance year. CMS proposes that APM entities and ECs can submit other payer arrangements for CMS to determine whether they are aligned other payer medical home models or other payer Advanced APMs through the EC initiated process.

AAFP Response

The AAFP believes the onus of submitting relevant information on payer arrangements should be on the payer. As CMS proposes to limit aligned other payer medical home models to arrangements aligned with CMS multi-payer models, we believe this is not an unreasonable request. Further, we believe CMS should automatically make these determinations based on the information it has from the other payer's inclusion in a CMS multi-payer model.

III.K.4(e)(3)(b) Aligned Other Payer Medical Home Model Financial Risk and Nominal Amount Standards

Summary

As outlined earlier, CMS proposes to apply the Medicaid medical home model financial risk and nominal amount standards to aligned other payer medical home model arrangements. CMS is also proposing that an aligned other payer medical home model requires the direct payment by the APM entity to the payer. This aligns with the requirements for Medicaid medical home models.

AAFP Response

The AAFP supports this proposal.

III.K.4.e(3)(b)(ii) Marginal Risk

Summary

CMS has found certain other payer arrangements where the marginal risk met or exceeded the 30% nominal amount standard at lower levels of losses in excess of expected expenditures, but fell below 30% at higher levels of losses. As a result, these arrangements do not qualify as other payer Advanced APMs even though they include strong financial risk components. CMS proposes to update its policy to provide that in the event the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, the average marginal risk across all possible levels of actual expenditures would be used for comparison to the marginal risk rate, with exceptions for large losses and small losses. The proposed changes do not lower the standard, but allow for a new demonstration of how it can be met.

AAFP Response

The AAFP supports this proposal and hopes this flexibility will allow for the approval of more other payer Advanced APMs.

III.K.4.e(3)(c)(iii) Expected Expenditures

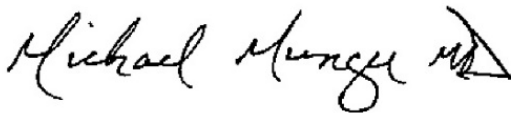
CMS is proposing to amend the definition of expected expenditures as the other payer APM benchmark. For episode payment models, expected expenditures mean the episode target price. For purposes of assessing financial risk for other payer Advanced APM determinations, the expected expenditures under the payment arrangement should not exceed the expenditures for a participant in the absence of the payment arrangement. If expected expenditures under the payment arrangement exceed the expenditures the participant would be expected to incur in the absence of the payer arrangement, such excess expenditures are not considered when CMS assesses financial risk under the payer arrangement for other payer Advanced APM determinations.

AAFP Response

The AAFP supports this proposal.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 or rbennett@aafp.org with any questions.

Sincerely,

A handwritten signature in black ink that reads "Michael Munger MD". The signature is written in a cursive style with a stylized "M" and "D".

Michael Munger, MD, FAAFP
Board Chair