September 6, 2016

Submitted electronically via Regulations.gov

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building, Room 445-G
Attention: CMS-1654-P
200 Independence Avenue SW
Washington, D.C. 20201

Re: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2017; Medicare Advantage Pricing Data Release; Medicare Advantage and Part D Medical Low Ratio Data Release; Medicare Advantage Provider Network Requirements; Expansion of Medicare Diabetes Prevention Program Model

Dear Acting Administrator Slavitt:

The American College of Rheumatology (ACR), representing over 9,500 rheumatologists and health professionals, appreciates the opportunity to respond to the 2017 Medicare Physician Fee Schedule Proposed Rule. We welcome the opportunity to provide our concerns on the impact these proposals will have on our ability to provide quality care to the 50 million Americans living with rheumatic diseases.

Rheumatologists provide ongoing care for Medicare beneficiaries with complex chronic and acute conditions that require specialized expertise. Rheumatologists provide face-to-face, primarily non-procedure-based care, and serve patients with serious conditions that can be difficult to diagnose and treat, including rheumatoid arthritis, systemic lupus erythematosus, and other debilitating diseases. Early and appropriate treatment by rheumatologists slows disease progression, improves patient outcomes, and reduces the need for costly downstream procedures and care that is complicated and made more expensive by advanced disease states.

The viability of providing this care for Medicare beneficiaries must be protected. The ACR is very concerned about growing shortages of rheumatologists. A recent comprehensive workforce study predicted workforce shortages will become more acute because of the increasing population of Medicare beneficiaries who will need rheumatology care and the influx of patients resulting from the Affordable Care Act. If the expertise rheumatologists and other cognitive specialists bring to their patients is not valued appropriately, then the numbers of
rheumatologists and other cognitive specialists will be inadequate to meet the growing demands for these services, restricting Medicare beneficiaries’ access to appropriate health care.

**Key Issues**

I. **Determination of Professional Liability Insurance (PLI) Relative Value Units (RVUs)**

We have concerns about the high level of variation within the PLI RVUs proposed for CY2017 for low volume services. In particular, a mixed payment methodology used to address the variation can potentially lead to larger problems with payment errors, as many payers use Medicare utilization data to set premiums. We ask that CMS review the methodology for implementing PLI RVUs, especially for low Medicare volume services. To reduce large variations in year-to-year PLI RVUs, we ask that CMS accept the RUC recommended specialty overrides.

II. **Potentially Misvalued Services under the Physician Fee Schedule**

The ACR appreciates CMS’s efforts to conduct periodic reviews to identify potentially misvalued services. We also appreciate CMS’s initiative to adopt our previous recommendation of hiring outside entities to observe and research what physicians and their clinical staff do on a daily basis. We look forward to the release of the Urban Institute’s data on the empirical time estimates it collected from health systems with multispecialty group practices.

CMS has proposed a list of 2017 potentially misvalued codes for review by the AMA/Specialty Society Relative Value Scale Update Committee (RUC), and possible adjustment in 2018. CMS stated that it identified 83 codes that have not been reviewed in the last five years, have greater than 20,000 allowed services, and are proposed as potentially misvalued codes for 2017. According to the Proposed Rule, the list of potentially misclassified codes in Table 7 is to exclude codes that have been reviewed in the last five years. In all there are 64 services that have been identified by the AMA RUC as not meeting the screen criteria or which have already been valued as typically being reported with an E/M service. **We are requesting that CMS condense and finalize the list of services for this screen to the 19 remaining services.**

As an example and in particular, we would like to call attention to the arthrocentesis codes 20600, 20604, 20605, 20606, 20610, 20611, and 20612, which were reviewed by the RUC in 2012 and should not be included on this list for five-year review. Additionally, the summary of recommendation (SOR) form indicated that these arthrocentesis services may typically be reported with an E/M and the RUC accounted for this in its valuation recommendation. Additionally, CPT codes 20550, 20552 and 20553 were surveyed and presented at the January 2016 RUC meeting. There were minor modifications to both the practice expense and work RVUs and these should be excluded from the table. The ACR will work within the process of the RUC to survey codes 20526 and 20551.
The ACR appreciates CMS’s attention to E/M codes and its initiative to develop ways to better recognize and compensate for care management services. As we commented last year, there continues to be much variability in the work completed by different specialties within the existing E/M service codes, in addition to a continued wide range of post-service work completed as a result of the encounter by different specialties. We specifically recognize CMS’s concerns regarding E/M service with Modifier 25. We note that an E/M service must be significant and separately identifiable according to the definition of the Current Procedural Terminology. The codes identified by CMS in Table 7 were reviewed extensively by the Practice Expense Committee and in the RUC’s report to ensure that any duplicative times with the E/M visit were removed.

Additional clinical work and skill beyond what is necessary to perform the procedure can be used to support a significant and separately identifiable E/M service on the same day. We believe it is important that CMS recognize the different resources, particularly in cognitive work, involved in delivering broad-based, ongoing treatment.

III. Collecting Data on Resources Used in Furnishing Global Services

The ACR supports the premise under which CMS proposes to collect data on the resources used and care delivered to patients during the 10 and 90 day global periods. As part of the Cognitive Care Alliance we have similarly proposed that CMS commit to developing an evidence base from which E/M services can be redefined and valued to more accurately describe and value the work performed by cognitive physicians. We appreciate that the agency has recognized the propriety of this approach, and agree with the proposed rule’s statement that, “It is essential that the RVUs under the PFS be based as closely and accurately as possible on the actual resources involved in furnishing the typical occurrence of specific services.”

We agree that an evidence base derived from health services research is necessary, and this applies equally to the services delivered as part of the global periods as to E/M services delivered by cognitive physicians. As the agency appropriately notes, the global periods rely on crosswalks to E/M services based on the assumption that the resources, including work, are similar.

We recommend that the follow-up work performed within the global periods and the continuity work performed by cognitive physicians should not be represented by the same codes. The care required by a patient recovering from a procedure is fundamentally different from the typical follow-up of an established outpatient or inpatient, especially when there are multiple simultaneous interacting conditions, a single metastable chronic illness or an acute or exacerbated chronic illness(es) that require inpatient care and specialty expertise. We anticipate that the data collected as part of the proposed research initiative will demonstrate that the available E/M codes are being used to represent substantially different types of work.
With respect to this proposed data collection and research effort, CMS asserts the authority to “…conduct surveys, other data collection activities, studies, or analysis, as the Secretary deems appropriate, to facilitate the review and appropriate adjustment of potentially misvalued services.” CMS also recognizes that, “To the extent that such mechanisms prove valuable, they may be used to collect data for valuing other services.” We believe that research focused on the global services will provide the agency with data that can help better describe E/M work that is typically performed in conjunction with procedural services, but this will not provide a complete picture of the E/M work being delivered to Medicare beneficiaries.

As we and others have noted, the E/M work typically performed by rheumatologists and other cognitive specialists is misvalued and must be revised based on a solid evidence base. We urge CMS to heavily weigh the input of the medical community as it engages in this effort and to consider the input of the Cognitive Care Alliance as studies are designed to evaluate the E/M code set.

IV. Improving Payment Accuracy for Primary Care, Care Management, and Patient-Centered Services

The Proposed Rule correctly recognizes that medical practice and patient complexity require physicians and their clinical staff to spend increasing amounts of time and effort to manage care of comorbid beneficiaries. In CY 2014 PFS, CMS took a step in the right direction by establishing a separate payment under the PFS for CPT Code 99490.

While we agree that a separate payment code like CPT Code 99490 is necessary, we believe the reporting and documentation requirements for this code are unduly burdensome and redundant. CPT Code 99490’s extensive list of requirements precludes its valid use by many physicians managing care for patients. Notably, the patients who require the type of chronic care management described by code 99490 do not typically require all the elements of CCM that CMS is requiring. We would welcome working with CMS to identify requirements that could be removed, so that these considerations do not continue to contribute to the code’s underutilization and so that many patients who could benefit from lower level CCM may receive it. Additionally, CPT guidance and CMS rules only allow a single practitioner to bill the CPT code per calendar month, despite the fact that the very nature of the patient’s comorbidities may require extensive care management by multiple physicians.

The ACR agrees with other stakeholders who have stated to CMS that the code is underutilized because it is underpaid relative to the resources involved in furnishing the services. Rheumatic diseases are by their very nature chronic conditions, which require extensive chronic care management. Unlike many other medical conditions, we lack the ability to provide our patients with a “quick fix.” Many of our patients would benefit from being able to receive additional care services if our physicians were not tangled by rules which prevent utilization of the CPT code. We share CMS’s goal of working to provide beneficiaries with
services that will improve their health outcomes, and not merely providing services for the sake of providing services. Further, the changes that CMS has proposed for CPT Code 99490 do not adequately address the actual treatment needs of our patients. Even with the implementation of these proposed changes the low utilization of the code will continue, depriving patients of meritorious care. We appreciate that CMS is proposing to revise its policies on CCM to make them more consistent with CPT guidelines and instructions, but we believe that these requirements are, in part, responsible for the low utilization of this service. The ACR along with other multispecialty coalition groups believe that 99490 will continue to be underreported as long as CMS requires reporting of all the elements listed in Table 11 of the proposed rule. Patients who receive CCM described by 99490 do not require all those elements every month.

The ACR also appreciates the CMS proposal to establish separate payment for non-face-to-face prolonged E/M service codes instead of the current bundled status. This is a critical proposal to ensure that many of the collaborative code sets can be implemented for quality patient care. We support CMS in their statement that revision of the current bundled status will help improve accuracy for cognitive service care:

- Work RVU of 2.10 for CPT code 99358, Prolonged evaluation and management service before and/or after direct patient care; first hour
- Work RVU of 1.00 for CPT code 99359, Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

Most critically, the ACR requests that CMS exercise its authority to ensure the accuracy of the fee schedule and conduct evidence-based research to redefine and value cognitive E/M services. There continues to be considerable variability in the work completed by different specialties within the existing E/M service codes and the wide range of post-service work completed as a result of these encounters. Some are relatively overpaid and some are relatively underpaid. Unfortunately, the existing E/M codes have not been meaningfully reviewed and revised since their inception nearly three decades ago.

Further, efforts to move toward value-driven models of care and delivery as outlined in the Medicare Access and CHIP Reauthorization Act (MACRA) will be substantially and meaningfully distorted and possibly ineffective unless the E/M service codes are adequately defined and provided with appropriate relative valuations. We believe that the required research will cost a fraction of the total amount paid by CMS annually for these services and should be viewed as a wise and necessary investment.

Finally, we support CMS’ proposal to not only reimburse for the non-face-to-face prolonged evaluation and management (E/M) services, but also to increase payment rates for these services. The ACR views this as an intermediate step until the E/M codes can be properly evaluated. While this proposal is an important one, it is not a permanent solution in part
because it does not provide recognition within the coding and reimbursement structure for the expertise and experience that cognitive specialists like rheumatologists bring to their patient encounters. We believe that new E/M codes must factor in this expertise to truly capture the value of the work being performed.

V. Target for Relative Value Adjustments for Misvalued Services

While we appreciate CMS’s initiative to revise its process for revaluing new, revised, and misvalued codes so that most misvalued codes are proposed and finalized during a single calendar year, we request clarification regarding the process that will be applied to codes for services with new technology. Specifically, there recently has been an increase in services with new technology that may not be familiar to physicians or CMS. We are uncertain about which codes fall within this category, and we request clarification regarding whether these proposals will go through a five year review process. The ACR recognizes the long-standing relationship between the AMA RUC committee and CMS to appropriately identify misvalued services. We recommend that CMS continue to work with the AMA and medical societies on a methodology that would be suitable for the valuation of each procedure and services.

VI. Phase-In of Significant RVU Reduction

We request clarification regarding CMS’s proposal to apply reductions for codes that do not fall into new or revised codes. The ACR requests that CMS be as transparent as possible with regard to the identification screens on which the codes on the list fall as having significant reductions for services can be a financial disruption to physician practices.

VII. Methodology for Proposing Work RVUs

We appreciate the agency’s attention to developing new calculations for codes which reflect activities that physicians, or clinical staff, are performing but for which they are not appropriately reimbursed. Specifically, the ACR supports CMS adopting RUC’s recommendations regarding recalculations for: (38) Prolonged Evaluation and Management Services (CPT codes 99354, 99358, and 99359), (39) Complex Chronic Care Management Services (CPT codes 99487 and 99489), and (44) Comprehensive Assessment and Care Planning for Patients Requiring Chronic Care Management (HCPCS code GPPP7). We appreciate CMS recognizing reimbursement for these codes as there are clinical cases in which the current E/M codes do not reflect the extensive work for complex cases. The ACR along with the AMA and other societies agree that the implementation of these collaborative code sets are an important step to ensure quality patient care and will help improve accuracy for cognitive service care.
VIII. Value-Based Payment Modifier (VM) and Physician Feedback Program

We are concerned about CMS’s proposal to update the VM informal review policies and the establishment of criteria for the quality and cost composites under the VM for the CY 2017 and CY 2018 payment adjustment periods in instances of unanticipated program issues. CMS has acknowledged widespread issues with calculating the quality component of the VM and has proposed to classify providers affected as having “average quality”. CMS has further proposed giving a provider 60 days from the release of the Quality Resource and Use Report (QRUR) to request a correction.

The ACR is concerned that such a proposal sacrifices accuracy for the sake of expediting review. Under CMS’s proposal, in instances where there are anomalies with data sets, CMS will use the average quality or cost composite. We believe that in order to best measure quality and cost it is important that where there are issues with data sets, that CMS use accurate composites, not average composites.

We also disagree with CMS’s proposal to require providers to take responsibility for the accuracy of QCDR vendors and Electronic Health Records. We strongly believe these requirements should fall on the vendor first and foremost, and not the provider. Vendors should be required to demonstrate to CMS that their product is tested rigorously and works correctly.

Additionally, in November 2015 we discovered that CMS vendors processing QCDR data were making errors running data sets. Our concern is that providers will not receive proper credit. If data sets are under review and blindly considered “average”, what will happen to those providers who actually submit high-quality data sets? In the case of a QCDR vendor that is not processing the data sets correctly, unbeknownst to the physician, the physician would in appropriately receive classification as “average” by CMS. As a result, the physician may find themselves in a neutral adjustment position, when in fact the physician should have received incentive money for performing at an above average level.

We request that CMS present a fix that accurately and fairly seeks to address these issues. We urge CMS to work diligently to identify the true source of data integrity issues and take actions to correct these mistakes, rather than accepting a methodology that improperly labels a physician’s performance as “average”.

We are also concerned that CMS’s proposal to limit request of a correction of a perceived error related to the VM calculation of 60 days from the release of the QRURs for the applicable performance period will not provide an adequate amount of time for a provider to request informal review. In reality, obtaining a QRUR is quite an extensive process. Further, if a provider does not already have access to the CMS portal, they will have to initiate the lengthy back and forth process required to access an EIDM account. Our members have reported that it has
sometimes taken weeks to set up accounts. We request that providers are permitted a longer
review window to more fairly reflect the process providers must navigate to access their
QRURs. We urge CMS to simplify the complicated and burdensome nature required to obtain
these reports.

Finally, the ACR has a number of additional, significant concerns with QRURs as they relate to
their practical use by providers. First, the methodology associated with the QRURs is complex,
and the explanations given have caused confusion for even seasoned analysts. We are
concerned that understanding these explanations may easily go beyond the capabilities of most
practicing physicians. We have seen evidence that the reports are causing confusion and are
likely not delivering the value intended.

With QRURs playing such an essential role moving forward, we recommend that CMS
redesign the breakdown of composite scores for cost and quality. We recommend providing a
detailed, step-by-step outline of how the calculations were performed and the results reached,
in a way that anyone could follow, and so that a provider can clearly see how the calculations
are derived and re-create them. If this is not provided, it is not clear to us how providers will
be able to understand their scores and leverage these data to implement changes moving
forward. If providing a detailed breakdown in a simplified step-by-step fashion is not possible,
we believe this may indicate that the methods are overly complex and need to be revisited.
Replication of the results is critical to demonstrating their validity. Overall, there is far too
much riding on these reports and their interpretation, and in their current form CMS cannot
expect a practicing physician to decipher them. The ACR would be willing to assist in any
reevaluation and review of QRURs that CMS undertakes to resolve these issues.

IX. Open Payments Program

The ACR strongly supports the exemption of independent certified and/or accredited CME
activities from open payment reporting, in part because robust requirements governing control
of educational content in commercially supported activities ensures learners receive up-to-date
educational content, free from commercial influence. CME is a critical component in a
physicians’ commitment to lifelong learning. However, as described in a June 2016 letter sent
by the ACR and other physician societies to Senator John Barrasso, M.D. (WY), the CMS rule has
“chilled the dissemination” of education materials:

The Sunshine Act was not passed to limit or construct additional barriers to the
dissemination of new medical knowledge that improves patient health outcomes. This
bill is needed to ensure patients benefit from the most up-to-date and relevant medical
knowledge.

We feel that in a program designed to promote transparency, the accuracy and reliability of
data is vital. The lack of a streamlined review process has prevented an overwhelming
majority of physicians from reviewing the reports and seeking corrections. Further, the data currently lacks validation and cannot be reasonably relied upon to provide information about physician and industry financial interactions.

We wish to assist in providing recommendations about how to streamline and improve accuracy of the program. First, we urge CMS to identify practical pathways to enable physician review, correction, and validation of reported data. Ideally these pathways would be readily accessible, data correction would be reliable, and the process to verify reported data would not be an additional burden on physicians’ time or other resources. We feel that this is an essential step.

The ACR recommends that CMS allow physicians to review manufacturer reports prior to submission to CMS. Furthering our recommendation for development of methods to enhance accuracy described above, the ACR also supports an annual schedule for reporting and review. Restructuring the review of reported data to an annual cycle could assist in achieving the goal of offering reliable data regarding interactions between physician and industry without creating unnecessary obstacles for those whose efforts help ensure data integrity.

The American College of Rheumatology appreciates the work that CMS does and the opportunity to respond to this proposal. We look forward to being a resource to you and to working with the agency as you address these and other matters. Please contact Adam Cooper, Senior Director of Government Affairs, at acooper@rheumatology.org or (404) 633-3777 if you have questions or if we can be of assistance.

Sincerely,

Joan M. Von Feldt, MD, MSEd
President, American College of Rheumatology