

December 31, 2019

The Honorable Seema Verma, MPH
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21224

Submitted via regulations.gov

RE: [CMS–1715–F and IFC]; Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule

Dear Administrator Verma:

The American College of Rheumatology (ACR), representing over 7,700 rheumatologists and rheumatology interprofessional team members, appreciates the opportunity to respond to the CY 2020 Physician Fee Schedule and Quality Payment Program final rule as published in the *Federal Register* on November 15, 2019. We welcome the chance to share our concerns about the impact of these policies 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, and rheumatology physician assistants and nurse practitioners, provide face-to-face, primarily non-procedure-based care, and serve patients with severe conditions that can be difficult to diagnose and treat, including rheumatoid arthritis and other forms of inflammatory arthritis, vasculitis, systemic lupus erythematosus, and multiple other debilitating diseases. Rheumatologists and rheumatology professionals also work closely with physical therapists to maximize the ability of patients to achieve and maintain independence outside of health care settings. Compared to treatment and therapies provided solely by primary care, early and appropriate treatment by rheumatologists and rheumatology professionals can control disease activity and prevent or slow disease progression, improve patient outcomes, and reduce the need for costly surgical or interventional procedures.

ACR appreciates the finalized proposal to improve the valuation of Evaluation and Management (E/M) codes for rheumatologists. We strongly support the CMS proposals to reduce the administrative burden to providers, the inclusion of a complex care code, and efforts to increase the utilization of care management codes. We do have concerns about other finalized proposals within the rule including 1) the reduced

reimbursement for physical therapists as they are integral members of the rheumatic disease care team, 2) the implementation of MIPS Value Pathways (MVPs), 3) concerns that Part B drugs are still calculated as part of the cost performance category, and 4) qualified clinical data registry (QCDR) measure testing timeline and approval. We elaborate on our support and concerns below.

Evaluation and Management (E/M)

ACR strongly supports the agency's continued effort to reduce administrative burden and improve the valuation of E/M services that our members bill. We appreciate the agency's efforts to revise the E/M documentation and payment policies finalized in last year's Physician Fee Schedule (PFS) and to adopt the revised E/M code definitions developed by the American Medical Association (AMA) CPT Editorial Panel and RUC-recommended values for these services in place of the single payment rate policy for level 2-5 services previously finalized.

ACR is confident that the revised outpatient code family will both reduce providers' documentation burden and accurately value these services. We also appreciate the agency's proposal to adopt the RUC recommended work RVU for the prolonged service code, 99XXX, which can be billed with level 5 E/M codes when a provider chooses to bill by time.

Physical Therapy as Part of the Rheumatic Disease Care Team

ACR is concerned with the final policy to cut reimbursement rates for physical therapy evaluation and management visits. The projected 8% cut to our colleagues is detrimental to our patients, as physical therapy is an integral part of treating several rheumatic diseases. Without adequate reimbursement for their services, we fear that access to physical therapists will decrease, putting our patients in jeopardy. We urge CMS to reconsider this policy and more appropriately value the role of physical therapists as part of the care team.

Add-on Code GPCX1

We support the adoption of the single complexity add-on code, GPCX1, which will be available to all specialties for visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. This code will capture additional resource costs required to deliver certain types of rheumatologic and musculoskeletal care to complex patients. ACR would welcome the opportunity to work with CMS and other specialty societies to accurately define this service to verify that the code is used appropriately for the most complex patients.

Care Management Services

CMS finalized its proposed policy to separate coding and payment for Principal Care Management (PCM) services. These services describe care management services for one chronic severe condition. They are typically expected to last between 3 months to 1 year, or until the death of a patient, the cause of recent hospitalization, and/or a significant risk of death, acute exacerbation, or functional decline. CMS expects that these services will be billed by specialists who are focused on managing patients with a single chronic condition who require substantial care management. **ACR appreciates efforts to increase the utilization of care management services by adopting these new care management codes.**

Rheumatologists have not widely adopted these services because of the various billing requirements imposed on their use. In particular, the ACR recommends that CMS implement its proposal to create two G-codes for Principal Care Management (PCM) services. Several rheumatologic conditions will meet the

requirements of the service expected to last between three months and a year, or until the death of the patient, acute exacerbation/decompensation, or functional decline. We welcome the opportunity to work with CMS and other cognitive specialties to define the utilization and documentation requirements for the new PCM G-code.

Review and Verification of Medical Record Documentation

ACR continues to support the policy in the 2020 PFS that allows a physician, resident, or nurse to document that the teaching physician was present at the time the service was delivered. We appreciate that the policy eliminates the requirement for the teaching physician to document the extent of his participation in the review and direction of the services furnished to each beneficiary and instead allowed the resident or nurse to document the scope of the teaching physician's involvement.

Accordingly, ACR supports the CMS policy to provide added flexibility for non-physician practitioners authorized to deliver Part B services, including Nurse Practitioners, Clinical Nurse Specialists, and Physician Assistants, to document teaching physician involvement.

CY 2020 Quality Payment Program

MIPS Value Pathways (MVPs)

ACR appreciates that CMS recognizes the need for an additional pathway in the Quality Payment Program (QPP) as the complex Merit-based Incentive Payment System (MIPS) continues to frustrate many of our members. However, **ACR strongly urges CMS to delay implementation of the MVPs to allow physicians and qualified clinical data registries more time to understand this new pathway and to work with CMS to develop meaningful MVPs to capture quality rheumatologic care.**

ACR strongly believes that the proposed MVP is not ready to be implemented or even phased in without more robust stakeholder input and greater clarity on the operations of the pathway. We support the overall goal of optimizing and streamlining the MIPS program to capture quality patient care. However, to ensure that providers are successful in the pathway, ACR strongly believes that if the MVP program moves forward, it must be voluntary and focus on measures that are meaningful to clinical care versus administrative claims or population health measures.

We urge CMS to view the first few years of MVP implementation as, at minimum, a pilot period, and we recommend against implementation without vetting and stakeholder input. The physician community continues to adjust to the ongoing requirements of the MIPS program. Mandating another program will be extraordinarily resource-intensive with uncertain gains. Therefore, **ACR urges CMS to allow the MVP to be an opt-in option for providers to participate in a CMS-suggested MVP or alternative MVP or continue in the MIPS program that would be more representative of their practice.**

Cognitive specialists, including rheumatologists, have unique patient and practice measurement needs that differ from those of other specialties because of the chronic and complex nature of rheumatic diseases. Therefore, **we urge CMS to work with ACR and other stakeholders to ensure that the measures and existing infrastructure, such as the ACR's RISE qualified clinical data registry, be included in any rheumatology-specific MVP.** We welcome the opportunity to work with CMS to develop these MVPs.

Cost Performance Category

ACR appreciates the agency's reasoning to postpone increasing the weighted value of the cost performance category. As previously noted, the cost of healthcare is often not in the provider's control. Providers are not responsible for the cost of the use of technology or therapeutics. Therefore, we **continue to urge CMS to exclude Part B medication costs from the cost performance category or at least include both Part D and Part B costs for a fair comparison.** The calculation of resource use (i.e., costs) as currently proposed includes medication costs from Part B, but not Part D, and so would result in inaccurate MIPS scoring. The current proposal incentivizes physicians to prescribe Part D medications instead of Part B medications, with the unintended negative consequence of increasing patient cost-sharing. The ACR continues to advocate for addressing this inaccuracy. Additionally, the ACR suggests that costs incurred outside of specialists' control should not be attributed to them, as happens when attributing patients to specialty providers when they do not have a primary care provider.

Additionally, the final rule states that specialists will be exempted from the Total Per Capita Cost measure and will solely rely on the Medicare Spending Per Beneficiary measure to determine the cost score for specialists, such as rheumatology. **ACR is deeply concerned with this policy, as depending on one measure to determine the total cost score for all specialists is unreasonable. It will not accurately measure the cost component for most providers. We urge CMS to reconsider this policy and work with specialty associations to better identify meaningful cost measures for future rulemaking.**

Qualified Clinical Data Registry Measure Testing

In the final rule, CMS reiterated its policy to require that all qualified clinical data registry (QCDR) measures must be thoroughly vetted and tested at the clinician level at the time of self-nomination. ACR continues to urge CMS to provide leniency within the CMS Blueprint. Without leniency in the process, measure innovation and development will be stifled. Measure development is a resource-intensive process, particularly for specialty organizations. Without leniency, we fear the process will become overwhelming and will exacerbate the problem of smaller specialties not having enough measures to successfully participate in the Quality Payment Program (QPP). We encourage CMS to continue to work closely with measure developers to fully understand, accommodate, and provide guidance on the developer's measure development pathway and timeline.

QCDR measure approval

CMS finalized the policy not to approve measures if a QCDR measure is not available to MIPS eligible clinicians, groups, and virtual groups reporting through other QCDRs. **ACR is deeply concerned about this policy.** Developing rheumatology-specific measures within the QCDR creates a program that is more meaningful to rheumatologists, allows for more granular data for quality improvement purposes, and creates increased interest in the QCDR. Should QCDRs be forced to share measures with competitors, QCDRs will lose relevance in the healthcare system. While ACR appreciates the need for coordination among all stakeholders in the healthcare system, we fear the requirement to share our measures with competitors is detrimental to our QCDR and future data collection activities.

In conclusion, the ACR is dedicated to ensuring that rheumatologists and rheumatology interprofessional team members have the resources they need to work with CMS and to provide patients with high-quality care. We believe that for CMS, clinicians, and patients to all achieve their objectives, payment programs must be designed to reflect the way practices treat patients. We look forward to serving as a resource to

you and to working with the agency. Please contact Amanda Grimm Wiegrefe, MScHSRA, Director of Regulatory Affairs, at awiegrefe@rheumatology.org or (202) 991-1127 if we can be of assistance in this regard, or if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Ellen M Gravalles MD". The signature is written in black ink on a light-colored background.

Ellen Gravalles, MD
President, American College of Rheumatology