799 9th Street NW
Suite 210
Washington, DC 20001

T (202) 354-2600
vizientinc.com

vizient®

September 27, 2019

Submitted electronically via the Federal eRulemaking Portal: http://www.regulations.gov

The Honorable 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

Re: RIN 0938-AT72: Revisions to Payment Policies under the Medicare Physician Fee Schedule, Quality Payment Program, and Other Revisions to Part B for CY 2020 (CMS-1715-P)

Dear Administrator Verma,

Vizient, Inc. appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) calendar year (CY) 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule, as many of the proposed policies have a significant impact on our members and the patients they serve.

Background

Vizient, Inc. provides solutions and services that improve the delivery of high-value care by aligning cost, quality and market performance for more than 50% of the nation's acute care providers, which includes 95% of the nation's academic medical centers, and more than 20% of ambulatory providers. Vizient provides expertise, analytics, and advisory services, as well as a contract portfolio that represents more than $100 billion in annual purchasing volume, to improve patient outcomes and lower costs. Headquartered in Irving, Texas, Vizient has offices throughout the United States.

Recommendations

In our comments, we respond to various issues raised in the proposed rule and offer recommendations to constructively improve the final rule. We thank you for the opportunity to share our views on CMS's proposal. Vizient believes the following areas are important for CMS to consider when finalizing the provisions for the calendar year (CY) 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Proposed Rule.

Evaluation and Management (E/M) Coding and Payment

Clinicians of nearly every specialty and practitioner type furnish E/M services to Medicare beneficiaries, and E/M services comprise roughly 40 percent of PFS allowed charges. For 2019, CMS proposed extensive office E/M service changes intended to reduce administrative burden and better reflect current medical practice, such as a code addition for primary care visit complexity and application of a single, "blended" payment rate to level 2-5 visits.

CMS finalized two proposals, effective in 2019: 1) eliminating added documentation of medical necessity for home visits, and 2) allowing clinicians to review and update previously recorded history and physical exam information at subsequent visits, rather than requiring complete reentry.

In the CY 2020 proposed rule, CMS opted not to move forward with adopting the final CY 2019 policy of collapsing codes 2-4 for new and established patients. **We applaud CMS for proposing to reevaluate the proposal and moving back to the five-tier system under this proposed rule for established patients.**

Under the CY 2020 proposed rule, CMS proposes moving to a four-tier coding system for new patients effective in CY 2021. It suggests adopting the revised E/M code definitions developed by the American Medical Association's (AMA) CPT Editorial Panel for use beginning Jan. 1, 2021. These CPT code changes would revise the time and decision-making guidelines for each level, and they would require documentation of patient history and a medical exam only when clinically appropriate. They would allow physicians to select the appropriate level of visit based on the extent of decision-making in the exam or based on time spent with the patient. In adopting the revised CPT codes and RUC recommendations, CMS would drop its blended payment rates for new and established patient level 2-4 visits, as previously finalized for 2021. Instead, CMS proposes to return to distinct payment rates for each office visit level for 2021.

The new valuations that go into effect in 2021 will dramatically increase the work relative value units (RVU) for some of the E/M codes. For instance, the work RVUs for 99212 would rise from 0.48 to 1.18. Conversely, work RVUs for 99214, the most frequently reported office code, would fall from 1.50 to 1.18, according to the proposed fee schedule. Additionally, specialties will be impacted based on the mix of E/M services they bill. Because the revised office visit codes and values would not become effective until 2021, CMS does not include their estimated impacts in the CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty (Table 110 of the rule). CMS does, however, provide for illustrative purposes an impact analysis (Table 111) of the E/M value changes as if those changes were proposed for 2020 implementation. According to Table 111, specialties and practices that bill higher level established patient visits will see the most significant increases, as those codes were revalued higher relative to the rest of the office/outpatient E/M code set. The specialties and practices that do not generally bill office/outpatient E/M visits may experience greater decreases. Table 111 shows a significant reduction for many specialists if the 2021 proposals were implemented in 2020. Further, CMS indicated that there might be considerable uncertainty in its estimated impacts due to the many factors involved and the considerable number of unknowns regarding other changes that will occur in CY 2021.

Given our concerns with the potential effect of these proposed cuts for a number of specialists, we ask that you consider postponing this proposal until more definitive information on impact can be ascertained. We fear that the proposed cuts could potentially restrict access to care for many Medicare patients. Additionally, as most state Medicaid programs base their reimbursement on federal Medicare schedules, the cuts would have the added effect of potentially limiting access to care for the most vulnerable patients across the country.

Physician Supervision for Physician Assistant (PA) Services

CMS is proposing to modify current regulations around the physician supervision of physician assistant (PA) services. CMS clarifies that the physician supervision requirement under Medicare is met as long as PAs deliver their services in accordance with state law and state scope of practice rules, with medical direction and appropriate supervision as provided by that state law. In the absence of state law, physician supervision would be evidenced by including documentation in the medical record describing the PA's approach to working with physicians in delivering their services. **We support the need for this proposed policy in an effort to align existing requirements for Nurse Practitioners and PAs.**

Review and Verification of Medical Record Documentation

Vizient applauds CMS for building on their recent policy changes that have reduced documentation burden for teaching physicians. First, CMS issued a clarification that allows a teaching physician to rely on medical student documentation. Specifically, the teaching physician can verify medical student documentation for an evaluation and management (E/M) service by providing a signature and date, rather than having to re-document the service.[1] Further, in the CY 2019 Medicare PFS and QPP final rule, CMS finalized a policy that would allow physicians, residents, or nurses to document the presence of a teaching physician during E/M services performed by residents. We appreciate the multiple clarifications CMS provided to this policy through their updates to the CMS Manual System in Transmittal 4283.

In this year's rule, CMS proposes to further streamline documentation requirements for physician oversight of non-physician care of a patient in E/M services. Specifically, the agency would allow for the review and verification of notes by the physician (rather than a recreation of documentation) for medical students, PAs, and advanced practice registered nurses. **We believe that this broad flexibility will significantly reduce administrative burden and urge CMS to finalize this proposal.**

Care Management Services

CMS is proposing to increase payment for Transitional Care Management (TCM) and implement a set of Medicare-developed HCPCS G codes for particular Chronic Care Management (CCM) services. Additionally, CMS is proposing to create new coding for Principal Care Management

[1] MLN Matters, "Medical Review of Evaluation and Management (E/M) Documentation," available at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10627.pdf.

(PCM) services, which would pay clinicians for providing care management for patients with a single serious and high-risk condition.

We support these proposals, as we believe that the care management included in many of the E/M services do not adequately describe the typical non-face-to-face care management involved for treating patients with one or multiple chronic conditions.

Payment for Medicare Telehealth Services

CMS is proposing to add three new telehealth codes, which describe a bundled monthly episode of care for treatment of opioid use disorders (GYYY1, GYYY2, GYYY3). This treatment includes care coordination, individual therapy, and group therapy and counseling. These proposed reforms will increase access to care for many people struggling with opioid use disorder (OUD). **We strongly encourage CMS to finalize this policy and allow physicians providing OUD treatment to be able to bill for these services, both in-person and via telehealth.**

Proposed Updates to the Quality Payment Program (QPP) for CY 2020

We appreciate CMS' continued gradual implementation of the QPP, such as the gradual increase in the Merit-Based Incentive Payment System (MIPS) performance threshold, as well as CMS' proposal to permit facility-based reporting for hospital-based clinicians and groups. We are committed to working with CMS to ensure that the program promotes improvements in delivery of care to patients and is not overly burdensome to clinicians and the organizations for which they work.

MIPS Value Pathways (MVPs) – Request for Information

In the proposed rule, CMS outlines a new framework for the MIPS program—MVPs—for the performance year 2021. The MVP would redesign how clinicians participate in the MIPS. We support the concept of the alignment of measure options relevant to a clinician's scope of practice and meaningful to patient care by connecting measures and activities across the four MIPS performance categories. Allowing clinicians to report on one set of measures and receive credit in multiple categories of MIPS will help reduce the burden of reporting for physicians and also link elements of the program together into one cohesive function. **However, CMS must ensure that participation in the MVP is voluntary.**

Further, many physicians at our member institutions are eager to transition to Advanced APMs. Therefore, we are encouraged by the proposed introduction of the MIPS Value Pathways (MVP) framework in the rule. However, we are generally concerned about the implementation timeline CMS is proposing. While CMS is proposing the MVP concept in this year's rule, the agency is seeking comment on a plethora of the structural details in a request for information (RFI). Therefore, while CMS can finalize the MVP concept in this year's rulemaking cycle, the agency will have to wait until the CY 2021 rulemaking cycle to propose and finalize the details. Since CMS is proposing to start transitioning clinicians to MVPs in CY 2021, this gives little to no time for clinicians to fully understand the MVP framework and make the practice changes necessary to successfully participate. **Therefore, we recommend that CMS slow down their implementation**

timetable, allowing an additional year for CMS to continue to flesh out the details, receive additional public input, and propose and develop the first cohort of voluntary MVPs.

Conclusion

Vizient welcomes CMS' extensive discussion of options and its emphasis on requesting comments, which provides a significant opportunity for stakeholders to inform the agency on how specific proposals will impact our members.

Vizient membership includes a wide variety of hospitals ranging from independent, community-based hospitals to large, integrated health care systems that serve acute and non-acute care needs. Additionally, many are specialized, including academic medical centers and pediatric facilities. Individually, our members are integral partners in their local communities, and many are ranked among the nation's top health care providers. In closing, on behalf of Vizient, I would like to thank CMS for providing us the opportunity to comment on this important proposed rule. Please feel free to contact me at (202) 354-2607 or shoshana.krilow@vizientinc.com, if you have any questions or if Vizient may provide any assistance as you consider these issues.

Respectfully submitted,

Shoshana Krilow
Vice President of Public Policy and Government Relations
Vizient, Inc.