

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: (CMS-1717-P) Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies

Dear Administrator Verma:

On behalf of the Patient-Centered Primary Care Collaborative (PCPCC), a multi-stakeholder nonprofit coalition of organizations dedicated to strengthening primary care, I am writing to offer our comments on the proposed 2020 Physician Fee Schedule. We appreciate the opportunity for comment. PCPCC's 60 plus members – see the attached list – are dedicated to achieving a vision of primary care embodied in the [Shared Principles](#), which are endorsed by over 330 organizations.

Key High-Level Comments

The PCPCC strongly supports the proposed increases in evaluation and management (E/M) codes, and urges CMS to implement them in CY 2020, as we stated in our [letter](#) to you dated September 5, 2019.

For more than a dozen years, the PCPCC has been a stalwart advocate for re-orienting our health care system towards primary care, which evidence demonstrates is both more efficient and patient centered. We are advocates of leveraging advanced primary care to further the “quadruple aim”—better care, better health, lower costs, and greater joy for clinicians and staff in delivery of care.

We share the [concerns](#) of MedPAC that office/outpatient E/M services are undervalued. Together with our stakeholder members, we also share MedPAC's concerns that the 2019 final rule would collapse and blend payment rates for visit levels 2 through 4 (to begin in 2020) and would have had unintended consequences. We appreciate CMS's willingness to revise the 2018 proposal for E/M services in the proposed rule for 2020. We understand that the RUC conducted a thoughtful and detailed review, including extensive surveys of physician specialty societies, recommended increasing the work values of the E/M code set, and that CMS is proposing to adopt most of those recommendations.

The PCPCC is dedicated both to strengthening primary care and transforming it, and the re-valuation of E/M services has the potential to strengthen primary care.

To advance the transformation of primary care, the increased valuation of E/M services must be incorporated into the spending baselines for alternative payment models (APMs), particularly those focused on transforming primary care, such as the proposed Primary Care First model. We therefore request that you to move up the effective date of the E/M code changes to 2020.

The PCPCC is pleased to see other proposals in the rule that will strengthen the capacity of clinicians and practices to provide comprehensive primary care services to Medicare beneficiaries. These include:

- Improvements to Transitional Care Management (TCM), Chronic Care Management (CCM), and Remote Patient Monitoring (RPM);
- Defining new outpatient Opioid Use Disorder (OUD) services intended to expand access to treatment, including medication assistance treatment;
- Reducing the burden of medical record documentation;
- Clarifying supervision requirements for physician assistants to expand the ability of care teams to meet the needs of Medicare beneficiaries.

We have questions and concerns about whether other provisions would strengthen primary care, including:

- The potential for the proposed Principal Care Management (PCM) service to fragment and duplicate care for beneficiaries with chronic conditions;
- The aggressive timeline for revamping MIPs to the new MIPs Value Pathways;
- The risk that removing the accreditation organizations for Patient-Centered Medical Home for performance improvement under MIPs could dilute standards for PCMH;
- The criteria proposed for qualifying for advanced APM status through All-Payer option for the medical home model is too restrictive and not consistent with Congressional intent.

We offer additional comments on other provisions in the proposed rule that impact Medicare beneficiaries' access to robust primary care.

Key Provisions of Proposed 2020 Physician Fee Schedule for Strengthening and Transforming Primary Care

II.G. Medicare Coverage for Opioid Use Disorder Treatment Services. The 2020 proposed rule describes CMS's approach to implementing the new Medicare covered service, Opioid Use Disorder (OUD) treatment, which was authorized in the SUPPORT Act. CMS outlines two approaches to expanding access to OUD treatment services. The first approach would make it possible for opioid treatment providers (OTP) who are certified by SAMHSA, accredited, and meet other conditions of participation to become enrolled Medicare Part B providers and receive a

bundled payment that includes medication-assisted treatment. The second approach enables physicians and other health care providers who choose to provide OUD therapy outside of an OTP to be paid a similar bundled payment under the fee schedule.

The PCPCC supports expanding access in outpatient settings for beneficiaries with opioid use disorder, and believes it is important to foster interdisciplinary partnership and coordination between primary care and behavioral health professionals. We support the proposed waiver of copayments for this new benefit, as authorized in statute. We also support the clinically appropriate use of telehealth as a mode of providing counseling, therapy, and care coordination services for OUD treatment.

As proposed, the bundled payment methodology offers OUD providers new flexibility to deliver therapy and other supports tailored to the needs and preferences of beneficiaries. As with other newly covered services in Medicare, it is important for CMS and others to educate providers and beneficiaries about the new benefit, and to study and evaluate the number, type, and distribution of providers who begin to offer the service. The PCPCC is especially interested in monitoring whether the new benefit supports expanded capacity within, or in collaboration with, primary care practices to support access to OUD treatment. We would be happy to partner with CMS in disseminating information and engaging the primary care community as CMS implements the newly covered OUD services.

II.I. Physician Supervision for Physician Assistants

The PCPCC supports CMS's proposal to align physician supervision and collaboration rules and documentation for physician assistants with those for advanced nurse practitioners. We agree that CMS should defer to state scope of practice laws for supervision requirements. Where state law is silent, supervision requirements would be met by evidence of documentation in the medical record describing the PA's relationship with physicians in providing their services.

Value-based care models require clinical teams with members practicing at the top of their license, connected by information technology that allows patient data to be available at the right time at the point of care. In advanced primary care models, PAs, ANPs, behavioral health specialist, community health workers, pharmacists, nurses, and medical assistants often collaborate with physicians in carrying out the care plans of complex patients. These models optimize interdisciplinary expertise on behalf of beneficiaries, but they require supportive payment models and adequate payment levels that fee-for-service generally does not provide.

II. J. Review and Verification of Medical Record Documentation

CMS is proposing to change required documentation in the medical record in an effort to reduce documentation burden and align requirements across clinicians. The proposal would specify that, when furnishing professional services, the clinician may review and verify (sign/date) notes in a patient's 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.

The PCPCC supports this proposed change, which recognizes the “team sport” nature of delivering health care today, and the capacity of electronic medical records to document care comprehensively across team members. We appreciate CMS’s willingness to identify opportunities to reduce the burden of duplicative or excessive documentation, which contributes to clinician dissatisfaction and “burnout”.

II.K. Care Management Services

The relatively recent advent of new care management services for Medicare beneficiaries has given primary care practices new resources under the fee schedule to provide ongoing support for patients with chronic conditions and care coordination needs. While utilization of these services has been increasing each year since 2013, CMS indicates that the services remain underutilized relative to the size of the eligible beneficiary population. According to research by Bindman and Cox cited in the proposed rule, utilization of transitional care management (TCM) services is low when compared to the number of beneficiaries with eligible discharges. The researchers found that beneficiaries who received TCM services demonstrated reduced readmission rates, lower mortality, and decreased health care costs. Bindman and Cox identified two factors contributing to low utilization of TCM services: the administrative burden of billing and the low payment for the services.

The PCPCC is pleased to see CMS begin to address these shortcomings in the 2020 proposed rule, but we remain disappointed at the low relative values assigned to these highly effective services. It appears that CMS is preoccupied with the possibility that “overbilling” may occur in these types of office-based services where, frankly, a very small proportion of Medicare dollars are spent and where there is almost no evidence of inappropriate utilization. At this still early stage of experience with these new services and codes, we believe CMS should view certain “overlapping” services, such as inter-professional consultation services, as a positive development in the evolution from fragmented to coordinated care.

Transitional care management (TCM)

We appreciate CMS’ adoption of the RUC recommendations to increase the value of this service. We support removing the current restrictions on concurrently billing certain codes with TCM and believe that these restrictions may have contributed to the low uptake of TCM services. However, if the CPT guidelines are not also revised to reflect this change, other payers may not follow Medicare’s policy. If CMS finalizes this proposal, we recommend that CMS issue guidance that providers should not use multiple codes to describe the same service.

Chronic care management (CCM)

According to an [evaluation](#) conducted by Mathematica, utilization of CCM services is associated with lower per beneficiary total cost of care. In effect, CCM services are significantly undervalued relative to the value they generate for Medicare, to say nothing of the better patient outcomes and [satisfaction](#) also associated with these services in a separate Mathematica report. Nevertheless, the utilization of these services, while increasing, remains below CMS’s own projections.

The PCPCC supports CMS's proposal to recognize that some beneficiaries need intensive care management services, and additional codes are needed to distinguish the intensity and duration of services more precisely. The PCPCC also supports CMS's proposed approach to streamline the updating of care plans as part of ongoing CCM services.

(New) Principal care management (PCM)

CMS is proposing to introduce a new care management service available to beneficiaries with a single "high disease or complex chronic condition" that would have separate coding and payment rates. A qualifying condition would be expected to last between three months and one year, or until death, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

While the PCPCC agrees that there is a need for care management services for beneficiaries with a single, complex chronic condition, we are concerned about the approach proposed by CMS. The PCM benefit has the potential to result in fragmented and duplicative care coordination activities, confuse beneficiaries, and add to their out-of-pocket costs. To support beneficiaries with a single, complex chronic condition, we recommend instead that CMS promote the use of inter-professional consults and the sharing of electronic health information, in addition to specialist face-to-face visits when medically necessary.

Remote patient monitoring (RPM)

For 2020, CMS is proposing to designate remote patient monitoring as a care management service, with a base code and add-on code. In addition, CMS proposes to move the supervision requirement for RPM from direct to general. The PCPCC supports these changes, which firmly place RPM within the suite of services that comprise care management for beneficiaries with chronic conditions and enable clinicians to design workflows that optimize the roles of members of the care team.

II. O. Opportunity for Bundled Payments under the PFS

The PCPCC supports bundled payments that encourage care coordination, elimination of waste, and streamlining patient experience. The bundled payment approach for Opioid Use Disorder (OUD) services, for example, could support programs and therapies that offer a range of approaches and service intensity and modality to meet different needs of diverse beneficiaries. However, as a general principle, we believe that bundled payments—like all alternative approaches to fee-for-service—should be tested through the authority of CMMI, consistent with its statutory mission. Given that the opioid epidemic has reached a public health crisis, we support inclusion of this bundled payment in the physician fee schedule even though it has not gone through CMMI testing, evaluation and iteration.

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

Since our founding, the PCPCC has noted that Medicare's system of valuing physician services systematically undervalues the important work of patient evaluation and management (E/M),

which encompasses the foundational tasks of taking patient histories, conducting physical exams, making diagnoses and other decisions, and establishing and maintaining an ongoing patient relationship to provide counseling, education, care coordination, and other time intensive, patient-centered services. These services make up the majority of care provided by primary care clinicians and teams. We are pleased that CMS solicited the feedback of a wide range of stakeholders, including some of those who hold membership in the PCPCC, to revisit the policies that were finalized in the 2019 Physician Fee Schedule.

Under the new framework, if finalized, payments to primary care are estimated to increase 12% beginning in 2021. This long overdue “reset” will be accompanied by a documentation burden reduction that the primary care community also welcomes. As described in p. 40673 in the proposed rule, history and physical exam would no longer determine the level of code selection for E/M visits. Instead, these components would be included only when clinically necessary and medically appropriate. Level 1 visits would only describe or include visits performed by clinical staff for established patients. For levels 2 through 5 office/outpatient E/M visits, the code level would be decided based on either the level of medical decision-making (MDM), or the total time spent by the reporting practitioner on the day of the visit (both face-to-face and non-face-to-face time). When the practitioner selects to code the visit based on time spent, they would use a single add-on CPT code for prolonged office/outpatient E/M visits.

We also concur with CMS’s analysis that the revised code set still “does not adequately describe or reflect the resources associated with primary care and certain types of specialty visits.” (p. 40677). In particular, the ongoing comprehensive care related to patients with a serious single or complex chronic condition is not well captured by other codes. We support your proposal to increase the value associated with HCPCS code GPC1X, which as you note can be used when providing psychotherapy or psychiatric services, and to make this code eligible as an add-on for all E/M visits, for both new and established patients.

The PCPCC recognizes the magnitude and significance of the proposed changes to outpatient E/M codes, and strongly believes that CMS has demonstrated the rationale for these changes while engaging stakeholders and considering the feedback of recognized experts.

III. K. Updates to the Quality Payment Program

CMS is proposing significant changes to the MIPS program beginning in 2021, with the goals of integrating the components, simplifying reporting, increasing validity of the data reported, changing weights of performance categories, and raising the performance threshold. The new framework would be built on the foundation of interoperability and a smaller set of claims-based quality measures that focus on population health priorities. CMS solicits feedback on this new framework and poses several specific questions to stakeholders.

The PCPCC welcomes a simplified, more unified and integrated framework for MIPS, with a focus on interoperability and meaningful measures. We agree that the “bar should be raised” over time

so that more members (i.e. EPs) of physician groups or practices are engaged in the activities and data reporting for QPP.

We urge CMS to engage stakeholders as you develop the MVP framework and to delay implementation of MVPs beyond the 2021 performance period. Primary care may be too broad in its scope of services and patient populations to be captured by one MVP. We recommend that measures applied to primary care be aligned across payment models as much as possible, and we support CMS's call to third party registries and vendors to develop user friendly tools that support reporting on the three categories of quality, improvement activities, and promoting interoperability.

We are concerned, however, about the proposed change to remove the identification of accreditation organizations for Patient-Centered Medical Home designation as a qualifying practice improvement activity under the Quality Payment Program. We agree that there are other entities, beyond the four currently recognized, that have established rigorous, comprehensive medical home standards, e.g., some states, and some programs whose standards are not as rigorous. By removing the named entities, there is a risk that this spurs the development of more PCMH programs, some with below par standards. In order to maintain the integrity of this model, there should be CMS review of any programs beyond the four already named to make sure that they meet the same high standards for rigor. With support, PCPCC can assist CMS in convening experts to review these programs to ensure they are of the highest caliber. External validation is necessary; self-attestation as a Patient-Centered Medical Home (PCMH) is not sufficient and could undermine the very notion of this advanced primary care model among employers, health plans, state and federal leaders and patients themselves.

The development of evidence-based, formal criteria for the patient-centered medical home through accreditation has contributed to the awareness of the role of primary care in advancing value-based, patient-centered care and to employer and health plan confidence that achieving PCMH recognition is value-add. It has also helped to standardize effective practices and important attributes across physician practices, enabling payers to standardize payments, and compare performance and outcomes. While the PCPCC does not support mandating accreditation, we urge CMS to continue to play a vetting role for accreditation organizations in partnership with the PCPCC.

MIPs Performance Category Measures and Activities

CMS proposes to phase in a re-weighting of the MIPs performance categories, effectively raising the weight of the cost category as required in MACRA. CMS also proposes collecting CAHPS data at the individual clinician level and adding open-ended questions to allow patients to provide narrative, which CMS would publicly report. CMS proposes to increase the completeness threshold to 70%. Measure stewards would be expected to link their MIPs quality measures to related cost measures and improvement activities when feasible. In addition, CMS proposes changes to individual measures and new measures.

Overall, the PCPCC is generally supportive of these changes, which may bring more rigor and validity to the measurement categories. That said, we remain skeptical of efforts to evaluate individual clinicians based on small or incomplete samples. We are supportive of incorporating more patient reported outcomes measures. CAHPS is a well-tested, valid survey (if sample is large enough), but it reflects patient satisfaction more than patient-reported outcomes. It is also a costly and long survey.

We request that CMS consider a new survey that will be submitted for endorsement by NQF in 2020, called the [Person-Centered Primary Care measure¹](#) that could, in the future, augment or replace CAHPS. The 11-question instrument was developed by Virginia Commonwealth University, and our stakeholders believe it is very relevant for primary care and allows for patient-reported outcomes. Each of the 11 domains are represented by a single item: accessibility, advocacy, community context, comprehensiveness, continuity, coordination, family context, goal-oriented care, health promotion, integration, and relationship. These domains are closely aligned with the PCPCC's [Shared Principles of Primary Care](#), assessing the aspects of primary care though to be of high value by diverse stakeholders. The measure aims to bring attention to what matters most in primary care while also reducing measurement burden.

We are also concerned about the CMS proposal to publicly report patient responses to open-ended questions in CAHPS. We are concerned that these open-ended questions may not provide actionable feedback or reflect a “representative” patient experience. We request that CMS collect such feedback from beneficiaries and summarize cross cutting themes and analyze how representative the comments with respect to the overall beneficiary population. This information is important to have before embarking on a plan to publicly release such feedback.

MIPs Thresholds

CMS proposes to raise the performance threshold from 30 points to 45 points and the exceptional performance threshold from 75 to 80 points for PY 2020. The maximum penalty amount will rise from 7% to 9%, and the highest projected payment adjustment percentage is estimated to be 5.78% for a perfect score of 100 points.

The PCPCC supports the gradual increase in performance thresholds to reward high performers and to encourage more clinicians to participate in alternative payment models, in keeping with the intent of MACRA. For the same reason, we also urge CMS to signal its intent to lower the number of clinicians who are currently exempt from MIPs. By exempting so many providers, CMS has reduced the MIPs bonuses available to high performing clinicians and practices. At the same time, the PCPCC recognizes that accommodations should be made for small and rural practices, such as grouping them in a separate pool(s).

¹ Etz RS, et al. A New Comprehensive Measure of High-Value Aspects of Primary Care. *Ann Fam Med*. May/June 2019 vol. 17 no. 3: 221-230. doi: 10.1370/afm.2393

All-Payer Path for Advanced Alternative Payment Model (APM) Bonus Eligibility

CMS proposes to clarify the definition of an “aligned other payer medical home model” for purposes of qualifying by way of the All-Payer Combination Model advanced APM. It would require that the payer formally notify and partner with CMS through a written expression of alignment and cooperation. This arrangement must be determined by CMS to have certain characteristics related to medical home as defined under Section 1115A of the SSA, as well as financial risk standards similar to the Medicaid Medical Home Model.

The PCPCC is concerned that the proposed qualifying criteria for advanced APM bonus eligibility through the All-Payer Combination Model for advanced primary care payment models is too restrictive and contrary to Congressional intent in MACRA. While we want to encourage alignment between the Medicare primary care advanced APMs and commercially developed models, we also want to provide flexible options to clinicians and payers at this stage in the advanced APM implementation process for practices to seek advanced APM status. Without such flexibility, many practices may find difficulty in beginning the transformation process and opt not to seek advanced APM status. We also believe that since some medical home payment models have evolved between payers and providers over several years, these models have been tested and revised as both parties have learned and gained experience.

Conclusion

The Patient-Centered Primary Care Collaborative appreciates the opportunity to comment on the proposals developed by the Secretary, CMS, and your teams, and to engage directly with you through meetings, calls, and conferences. We welcome further opportunities to convene our diverse stakeholders to share perspectives and experiences as we jointly work to transform American health care to provide greater value to all of us.

If you have any questions, please feel free to contact me at agreiner@pcpcc.org.

Sincerely,



Ann Greiner
President & CEO
Patient-Centered Primary Care Collaborative

PCPCC Executive Members

Accreditation Association for Ambulatory Health Care (AAAHC)
Aetna
Alzheimer's Association
American Academy of Child and Adolescent Psychiatry (AACAP)
American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American Academy of Physician Assistants (AAPA)
American Association of Nurse Practitioners (AANP)
American Board of Family Medicine Foundation (ABFM Foundation)
American Board of Internal Medicine Foundation (ABIM Foundation)
American College of Clinical Pharmacy (ACCP)
American College of Lifestyle Medicine (ACLM)
American College of Obstetricians and Gynecologists (ACOG)
American College of Osteopathic Family Physicians (ACOFP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)
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Blue Cross Blue Shield Michigan
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Collaborative Psychiatric Care
Community Care of North Carolina
Community Catalyst
CVS Health
Doctor on Demand
Geisinger Health
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Johns Hopkins Community Physicians, Inc.
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Morehouse School of Medicine - National Center for Primary Care
National Alliance of Healthcare Purchaser Coalitions
National Association of ACOs (NAACOS)
National Association of Chain Drug Stores (NACDS) Foundation
National Coalition on Health Care
National Interprofessional Initiative on Oral Health (NIIOH)
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Pacific Business Group on Health (PBGH)
Permanente Federation, LLC
PCC EHR Solutions
Primary Care Development Corporation (PCDC)
Society of General Internal Medicine (SGIM)
Society of Teachers of Family Medicine (STFM)
Takeda Pharmaceuticals U.S.A.
The Verden Group's Patient Centered Solutions
University of Michigan Department of Family Medicine
UPMC Health Plan
URAC
YMCA of the USA