September 7, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–1693–P, P.O. Box 8016
Baltimore, MD 21244–8016

Filed Electronically

To: Centers for Medicare & Medicaid Services (CMS), HHS

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program.

INTRODUCTION
On behalf of over 11,300 physician and medical student members of the Harris County Medical Society (HCMS), thank you for the opportunity to participate in commenting on the proposed rule regarding the "Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program" published in the *Federal Register* on Friday, July 27, 2018.

PLATFORM BEHIND OUR COMMENTS
HCMS represents grassroot physicians in all medical, surgical and behavioral specialties who transact with Medicare compliance and health care delivery processes daily. Our comments are reflective of the feedback we receive from our members and their staff.

Comments

Evaluation & Management (E/M) Visits

Lifting Restrictions Related to E/M Documentation

- Eliminating Extra Documentation Requirements for Home Visits

Comment: We appreciate CMS removing this documentation requirement and agree that since the patient need not be confined to the home to be treated in the home, the Claims Processing Manual instructions requiring documentation of the medical necessity of the home visit is

confusing. Removing this documentation provision clears up any confusion about when a home visit can be billed.

- Providing Choices in Documentation for Office or Other Outpatient E/M Visits and Home Visits – Medical Decision-Making, Time or Current Framework

Comment: We urge CMS to move forward with the proposed simplification in E/M documentation guidelines and continue to work to relieve physicians of the administrative burdens created by outdated, excessive, and overwhelming E/M documentation guidelines.

- Removing Redundancy in E/M Visit Documentation

Comment: We thank CMS for addressing the redundant and burdensome documentation required for E/M visits. The relevant information necessary to assess a patient's condition efficiently and effectively is often buried in the plethora of documentation associated with even the simplest visit. We urge CMS to move forward with the proposed simplification in E/M documentation guidelines and continue to work to relieve physicians of the administrative burdens created by outdated, excessive, and overwhelming E/M documentation guideline.

- Public Comment Solicitation on Eliminating Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty

Comment: We thank CMS for addressing this matter. We support CMS eliminating this policy.

- Minimizing Documentation Requirements by Simplifying Payment Amounts – CMS proposes to pay a single rate and single set of RVUs for the level 2 through 5 E/M visits, one for new ($135) and one for established ($93).

Comment: HCMS supports the decisions of the specialty societies on this payment policy issue. HCMS does not support CMS' conclusion that decreasing the burden on E&M documentation will assist in increasing physician revenue since the overburdensome documentation was inappropriate at its implementation.

HCMS would like to note that we *oppose* any decrease in payment to any physician, especially those who care for Medicare's most fragile beneficiaries. We remain very concerned that Medicare payment rates are not keeping pace with the rising costs of operating a medical practice. Our members' operating costs continue to increase, but unlike hospitals, nursing homes, and other facilities our Medicare payment rates have stagnated for 20 years (**Exhibit A**). Physicians' Medicare fees measured in real dollars have decreased by 25 percent since 2001.

Recognizing the Resource Costs for Different Types of E/M Visits

- Separately identifiable visits furnished in conjunction with a procedure

Comment: HCMS strongly *opposes* the proposal to reduce payments for E/M services billed with Current Procedural Terminology (CPT) modifier 25 when reported with a minor surgical procedure code or a preventive/wellness exam on the same day. We urge CMS not to adopt this proposal. By allowing physicians to be paid fully for unscheduled, same-day, medically necessary care, modifier 25 supports prompt diagnosis and streamlined treatment — which in turn promote efficient, high-quality, and patient-centric care. This proposal represents a

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substantial pay cut for physicians nationwide, across medical specialties and geographic regions. It would force patients to schedule multiple visits (with additional copayments) to receive necessary treatment.

Implementation dates
Comment: HCMS urges CMS not to make any changes to E&M payment policy until such time the specialty societies can research and agree on a change. Also, this change will require substantial modifications in EHRs, billing systems, workflows, etc. As such, we feel January 1, 2020 be considered the earliest date to possibly implement a change.

CY 2019 Updates to the Quality Payment Program

MIPS Program Details

- MIPS Determination Period

Comment: HCMS *opposes* the shift in determination period dates unless the eligibility tool on the QPP website is updated in a timely fashion prior to the performance year. In the two years of MIPS the QPP website has yet to have all tools and information needed for a physician to be prepared on Jan. 1 of performance year (**Exhibit B**). In addition, it needs to be made clear to practices that there is a chance that their TIN/NPI may become ineligible to participate during the second determination period due to falling below the low-volume threshold even if they were required to participate after the first determination period (unless they opt-in).

Question: If a new TIN is created during the second determination period will it show up in the QPP look-up tool, if not how will they know if they are eligible due to exceeding the low-volume threshold?

Low-Volume Threshold

- Additional criterion to the low-volume threshold determination

Comment: HCMS appreciates that CMS maintained the low-volume thresholds at $90,000 and 200 patients. We urge CMS to continue the low-volume threshold at this level as it greatly assists small practices to participate in MIPS. As for the addition of the covered professional services to the low-volume threshold, HCMS is not opposed. However, since CMS announced that this aspect is being added mainly for the ability to allow physicians to opt-in, why not allow any physician to opt-in despite if they exceed one of the low-volume thresholds (i.e. opt-in is available to all clinicians that fall below any level of the low-volume threshold). Due to CMS's current proposal of requiring the opt-in to be a manual election and not automatic, we believe that if a physician, despite their low-volume threshold levels, chooses to actively participate in MIPS and opts-in, this third aspect of adding covered professional services should not make a difference on if they would be allowed to do so.

- Opt-in Requirements/Process

Comment: HCMS supports the proposed election requirement for MIPS opt-in because as CMS currently stated there are many practices with automatic systems that add QCD's to

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claims (especially those that participated in PQRS) and are unaware of it. However, HCMS *opposes* making the decision to opt-in irrevocable. Physicians that manually elect to opt-in should be afforded the option to opt back out if they are no longer able or comfortable reporting. A possible fail-safe idea CMS could consider would be to not penalize a physician who has opted-in but does not submit any data (CMS received no reporting data for the year chosen to opt-in). Additionally, CMS should allow physicians to change their opt-in status until the end of the performance year but prior to the reporting year. Also, in the event that a data submission is received and an opt-out was not initiated (after the original opt-in) then the clinician would be scored as a standard MIPS participant.

Wire-frame drawings

Comment: Based on the wire-frame drawings CMS has presented regarding the MIPS opt-in web page, HCMS feels it is unnecessary to include the "Voluntary Participation" option. We believe this option could possibly be confused with the opt-in and instead should be combined with the "No Participation" as this is the current process and is working fine.

Question: When will the opt-in election need to be made, is there an established deadline?
Question: How will the second determination period for the low-volume threshold affect the opt-in elections? For example, what if during the first determination period a physician falls below the low-volume threshold for two out of the three elements and chooses to opt-in, but during the second determination period is found to be below all three elements? Will their opt-in election still stand or are they no longer eligible?
Question: Will there be time for physicians to elect to opt-in after the second determination period? This would be beneficial for cases where the physician is required to participate in MIPS after the results of the first determination period, but after the second determination period is no longer able to participate due to falling below any number of the low-volume threshold levels. In these cases, since the second determination period is not concluded until the end of the performance year, these physicians have already participated most of the year to then be notified they are ineligible for a payment adjustment.

MIPS Performance Period

- Improvement Activities Category

Comment: HCMS supports the proposal to establish a minimum continuous 90-day performance period for the 2022 MIPS payment year and all future program years.

- Promoting Interoperability Category

Comment: HCMS supports the proposal to establish a minimum continuous 90-day performance period for the 2022 MIPS payment year and all future program years.

- Quality Category

Comment: HCMS does not support the proposal to create a full calendar year performance period for the Quality category for the 2022 MIPS payment year and believes this should be

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changed to a minimum continuous 90-day performance period as well as retroactively changed for all previous MIPS payment years.
CMS says that stakeholders have stated that "a 90-day performance period is necessary in order to enable clinicians to have a greater focus on the objectives and measures that promote patient safety, support clinical effectiveness, and drive toward advanced use of health IT". HCMS strongly believes this is the same case for the Quality category. For practices to effectively select and implement meaningful measures (rather than low value measures just to be able to check boxes for the sake of avoiding a penalty) year to year they require a lot of time and review of performance for necessary adjustments. Since feedback isn't provided until half-way through the performance year a 90-day reporting requirement for the Quality category would be the most effective way to allow practices to prepare and make their reporting more meaningful than would be possible with a full year requirement.
Additionally, CMS has been unable to update the QPP website with eligibility information and updated measure information prior to or even at the start of the performance year. Attached is a timeline detailing the lack of timeliness and availability of crucial information clinicians would have needed to report Quality for a full year in 2018. Therefore a 90-day requirement would not only allow CMS more time and flexibility with updating the QPP site, but it would not place undue burden on clinicians when they do not have the information they need to comply with a full year reporting requirement.
Lastly, a 90-day reporting period would align all the MIPS categories (excluding Cost), creating less confusion and a more aligned MIPS program which is one of the original goals of MIPS and a large part of why the old PQRS and EHR incentive programs were replaced. Similar to the PI and IA categories, 90-days of data is sufficient to exemplify quality care and clinician/practice efforts in quality reporting.

MIPS Performance Category Measures and Activities

- Performance Category Measures and Reporting

Comment: HCMS supports the proposal to allow flexibility for CMS to alter submission deadlines. However, we *oppose* this flexibility being used to shorten the deadline. The earliest deadline should be set at March 31.

Quality Performance Category

- Limiting Medicare Part B Claims Submission Type

Comment: HCMS strongly supports the inclusion of small groups that can report through claims, however, we *oppose* the proposal to limit claims reporting for physicians that are a part of small practices. If a clinician chooses to report individually through claims, the size of the practice should not have any weight on the reporting option.

- Removal of Quality Measures

Comment: HCMS has recognized that there has already been a significant issue with a delay of availability of updated information and measures prior to the performance period on the QPP site. Many physicians continue reporting measures from previous years through systems that are

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integrated into heir EHR or billing processes. Constant change and removal of measures only causes unintended errors by physicians in their reporting and makes MIPS even more burdensome for physicians to keep up with from year to year. The need for consistency is dire for physicians to properly participate in any quality data reporting.

If CMS chooses to continue with the change and removal of large numbers of quality measures, then it is even more important for CMS to adopt a 90-day performance period for the Quality category, to give physicians sufficient time to adjust to these drastic changes.

Additionally, HCMS would like to suggest that CMS implement an alert system within the QPP site in where CMS would review past submissions and identify if a clinician or group has submitted a measure or activity that is now changed or removed. Once CMS identifies these cases the QPP site will prepare an alert within the clinician's profile and when they log-in to the QPP site a pop-up or alert of some kind is initiated.

- Use of more than one Submission Mechanism

Comment: HCMS fully supports the proposal to allow for more than one submission mechanism per measure.

Promoting Interoperability (PI) (previously known as the Advancing Care Information)

- Certification Requirements beginning in 2019

Comment: HCMS understands the need for 2015 CEHRT to be implemented due to its improved interoperable functionality, although we ask CMS to ensure that all efforts are made to help make the transition from 2014 to 2015 CEHRT seamless for physicians and practices and not interrupt their current work flows.

Request for PI Exemptions – 1. The EHR vendor community is not aligned when it comes to charging additional fees for major upgrades. Therefore, CMS should maintain a PI exemption for physicians who would face significant hardship when upgrading their EHR from 2014 to 2015 CEHRT. 2). HCMS also recommends that CMS and ONC continue to monitor EHR vendor readiness during the 2014 to 2015 CEHRT transition period. HCMS urges CMS to provide a MIPS exclusion for physicians unable to comply with 2019 MIPS due to EHR vendor readiness issues.

In addition, physicians must not bear the cost of this required change. CMS needs to work with EHR vendors to not only ensure that these conditions are met, but that any system upgrades or transitions come with proper education for physicians/staff on how workflow and reporting process may need to change and how to continue to effectively report to MIPS through the new system/platform.

- Scoring Methodology

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Comment: HCMS agrees with CMS's proposal to simplify the PI scoring methodology, but we strongly discourage CMS's continued requirement of making certain measures mandatory to receive a category score. Although the base measures section of PI would be eliminated, this is still an all or nothing scoring methodology even if they can claim exclusions to certain measures.
HCMS recommends that CMS remodel the PI category to match the Quality category where each measure is scored individually, and a score is given based on the points achieved per measure performance. If necessary, CMS could then add a plethora of other PI measures that clinicians can choose from provided they meet a minimum number. By doing this CMS affords clinicians the opportunity to report on PI measures and EHR functionalities that relate to their specialty, and how they can best use their EHR to assist their patients.

Promoting Interoperability Performance Category Measure Proposals for MIPS Eligible Clinicians
Addition of EPCS Measures:

- Query of Prescription Drug Monitoring Program (PDMP)

Comment: HCMS does not currently support the use of this measure. As it stands PDMP platforms are not commonly integrated into EHR systems therefore clinicians are required to go outside their EHR to query the PDMP, this disrupts workflow processes and adds significant time to a clinician's day to day operations. Since this action is being utilized outside the normal functions of the EHR it is inappropriate to implement this measure within the PI category until the query of PDMP through CEHRT is fully integrated and automated. Additionally, as stated by CMS, many states already mandate the use of State PMP's therefore this measure would be redundant and burdensome to clinicians.

- Verify Opioid Treatment Agreement

Comment: HCMS supports the use of opioid treatment agreements but believes this measure will cause undue burden on physicians. Due to the innate lack of interoperability between EHRs, and the inability of physicians to connect to a patient's record beyond what they have within their own medical records, or have been provided by the patient, identifying treatment agreements from other providers is presently not easily achievable.

2019 Promoting Interoperability (PI) Measures Comparison			
2016 Meaningful Use Measures	**2018 PI Transition Measures**	**2018 PI Measures**	**2019 PI Measures (proposed)**
e-Prescribing	e-Prescribing	e-Prescribing	e-Prescribing
Patient Electronic Access	Provide Patient Access	Provide Patient Access	Provide Patients Electronic Access to Their Health Information

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Health Information Exchange	Health Information Exchange	Request/Accept Summary of Care	Support Electronic Referral Loops by Receiving and Incorporating Health Information*
		Send a Summary of Care - previously included in "Health Information Exchange" measure	Support Electronic Referral Loops by Sending Health Information
Medication Reconciliation	Medication Reconciliation	Clinical Information Reconciliation	*Combined with "Request/Accept Summary of Care" measure
Protect Patient Health Information	Security Risk Analysis	Security Risk Analysis	Security Risk Analysis (attestation statement)
		Patient Generated Health Data	
View, Download and Transmit (VDT)	View, Download and Transmit (VDT)	View, Download and Transmit (VDT)	
Patient-Specific Education	Patient-Specific Education	Patient-Specific Education	
Secure Electronic Messaging	Secure Messaging	Secure Messaging	
			Query of Prescription Drug Monitoring Program (PDMP)
			Verify Opioid Treatment Agreement
Immunization Registry Reporting	Immunization Registry Reporting	Immunization Registry Reporting	Immunization Registry Reporting
Specialized Registry Reporting	Specialized Registry Reporting	Public Health Registry Reporting	Public Health Registry Reporting
Syndromic Surveillance Reporting	Syndromic Surveillance Reporting	Syndromic Surveillance Reporting	Syndromic Surveillance Reporting
		Electronic Case Reporting	Electronic Case Reporting
		Clinical Data Registry Reporting	Clinical Data Registry Reporting
Clinical Decision Support			
Drug-Drug and Drug-Allergy Interactions			
Computerized Provider Order Entry (Medication, Laboratory, Radiology)			

Commentary: The chart above demonstrates the lack of meaningful changes to the EHR reporting programs and measures beginning with the EHR Incentive Program (Meaningful Use).

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With each program all that seems to change is the name. It is very important that CMS re-evaluate the Promoting Interoperability category and find a way to make it meaningful to all physicians without burdening them with aspects out of their control such as the capabilities (or lack thereof) of their EHR.
CMS stated reasoning for overhauling the Promoting Interoperability category, as shown below, are important goals that need to be achieved. Unfortunately, the ability to make it easier for patients to retrieve their medical records and exchange the information between provider and patient, is not promoted by the measures currently used in the PI category except for "Provide Patients Electronic Access to Their Health Information". The remainder of measures rely entirely on the ability of the EHR to properly report and integrate patient records into other EHRs or registries. Until this can be done without exceptional burden or cost to the physician the physician will be unable to provide patients with their comprehensive medical records.

It is clear CMS recognizes the lack of interoperability between EHR systems based off the work on the Draft Trusted Exchange Framework. HCMS encourages CMS to continue working on fixing the problem at the source.

Improvement Activities Bonus Score Under the Promoting Interoperability Performance Category and Future Reporting Considerations
Comment: HCMS supports the idea of creating a streamlined approach to reporting by creating combined measures that would cover at least two, if not all categories. This would reduce the reporting burden of having to report for separate performance categories as well as provide CMS with meaningful data on how physicians are incorporating all aspects of MIPS to provide true quality care to their Medicare patients.

- MIPS Final Score Methodology – Small Practice Bonus:

Comment: HCMS *opposes* the proposal to change the small practice bonus from five points to 3 points in a clinician's final score to the quality performance category. As shown by the calculations below, 3 points to the quality category will give small practices 2.25 points towards their final score, not even half of what is currently provided.

3 quality bonus points out of 60 possible quality points = 3/60 = .05 or 5%

.05 x 45 (weight of Quality category) = 2.25 points to the MIPS final score

The requirements for MIPS are continually increasing and the administrative challenges small practices face remain unchanged and even more burdensome.

HCMS recommends that CMS consider adding a clause to the small practice bonus that would limit small practices from achieving an exceptional performance bonus due to the addition of the small practice bonus on their final score. For example, if a physician's final MIPS score without the small practice bonus is 78 points, the physician would not be eligible for the small practice

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bonus because this would place their score above the exceptional performance threshold of 80. HCMS supports physicians receiving the exceptional performance payment without the assistance of the small practice bonus.

MIPS Payment Adjustments

- Establishing Performance Threshold

Comment: Despite how CMS chooses to estimate the performance threshold for the 2024 payment year (based on either mean or median), we would like CMS to keep in mind the struggles that small practices face when trying to meet the performance thresholds. Larger practices that have more resources to perform well within MIPS will drive these numbers up, forcing smaller practices maintain a pace of participation that is unsustainable.

Telemedicine

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

- Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1)

Comment: HCMS *opposes* a "virtual check-in" being bundled if an E/M visit results from the evaluation of the information obtained from the check-in. We support a separate reimbursement for this service. Physician and qualified health care professional time and expertise is required to determine if a visit is warranted and should be reimbursed. The physician must analyze the information provided by the patient, review the patient's medical record, and conduct medical decision making to determine if a visit is warranted.

- Interprofessional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449)

Comment: We appreciate the unbundling of these codes for reimbursement to both the treating and consultative provider and agree that it is necessary to address the changing landscape of healthcare delivery. However, we *oppose* that they should be bundled if an E/M visit results from the consultation. Physician and qualified healthcare professional time and expertise is required for medical decision making and to formulate a treatment plan and should be reimbursed. The physician must confer with the consulting physician, review and discuss the patient's medical record, HPI, relevant ROS, and conduct medical decision making after considering the consulting physician's recommendations or observations to determine the appropriate course of action.

Expanding the use of Telehealth under the bipartisan Budget Act of 2018

CMS is proposing to revise its regulation at § 410.78(b)(3) to add a renal dialysis facility and the home of an individual as Medicare telehealth originating sites, but **only** for purposes of the home dialysis monthly ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act.

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CMS proposes to amend § 414.65(b)(3) to reflect the requirement in section 1834(m)(2)(B)(ii) of the Act that there is no originating site facility fee paid when the originating site for these services is the patient's home. Additionally, CMS is proposing to add new § 410.78(b)(4)(iv)(A), to reflect the provision in section 1834(m)(5) of the Act, added by section 50302 of the BBA Start Printed Page 35730of 2018, specifying that the geographic requirements described in section 1834(m)(4)(C)(i) of the Act do not apply with respect to telehealth services furnished on or after January 1, 2019, in originating sites that are hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, or the patient's home, respectively under sections 1834(m)(4)(C)(ii)(VI), (IX) and (X) of the Act, for purposes of section 1881(b)(3)(B) of the Act.

Comment: HCMS agrees with this proposed amendment, especially including the 'home' as a Telehealth Originating Site (TOS) for purposes of the home dialysis monthly ESRD-related clinical assessment in section 1881(b)(3)(B) of the Act. HCMS does not agree that the 'home' is a TOS ONLY for this instance. There are several other specialties, i.e., Psychiatry and Oncology, that also warrant home telehealth visits for their Medicare patients. Therefore, HCMS recommends that CMS further amend its regulations to implement the enhancement of 'home' as a TOS for Medicare beneficiaries with ailments in other specialties to the final rule.

HCMS appreciates the opportunity to comment on these very important CMS proposed rules. If CMS has any questions about our comments, please email or call Pat Harris, Senior Vice President, at *pat_harris@hcms.org* or 713-524-4267.

Sincerely,

George D. Santos, MD
2018 President

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