September 11, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1676-P
P.O. Box 8016
Baltimore, MD 21244-8013

RE: Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (CMS-1676-P)

Dear Ms. Verma:

On behalf of the Society of General Internal Medicine (SGIM), representing over 3,500 general internists across the country who are deeply involved in providing primary medical care to Medicare beneficiaries, as well as in training the primary care providers of the future and engaging in health services research, we appreciate the opportunity to provide comments on the CY2018 Physician Fee Schedule (PFS) proposed rule. As such, we submit the comments on the following issues:

Proposed Payment Rates for Non-excepted Items and Services Furnished by Non-excepted off-Campus Provider-Based Departments of a Hospital
Proposed Valuations of Specific Services
Evaluation & Management (E/M) Guidelines and Care Management Services
Medicare Diabetes Prevention Program

Proposed Payment Rates for Non-Excepted Items and Services Furnished by Non-excepted Off-Campus Provider-Based Departments of a Hospital

CMS was directed by the Bipartisan Budget Act of 2015 to implement a site neutral payment policy, paying for certain items and services in off-campus Provider-Based Departments (PBDs) under the PFS rather than the Hospital Outpatient Prospective Payment System (HOPPS). CY 2017 is marks the first year that the agency has adjusted payments, reducing reimbursement to these PBDs by 50 percent of the HOPPS payment rate. The agency is proposing to reduce reimbursement to 25 percent of the HOPPS payment rate in CY 2018 because of the concern that the CY 2017 adjusted amount was generally resulting in greater overall payments to these PBDs than they would otherwise be paid under the PFS.

SGIM recommends that CMS not implement this further reduction in reimbursement to these PBDs as proposed. Instead, we suggest that the agency implement the alternative included in the proposed rule to reimburse these PBDs at 40 percent of the HOPPS rate in CY 2018. We believe that this more measured approach will allow CMS to review a full year of claims data on the mix of services reported in these settings before making another significant change in reimbursement in a two-year period. If CMS chooses to cut reimbursement to 25 percent of

the HOPPS rate in 2018, these PBDs would see a 75 percent decrease in reimbursement in a two-year period. A cut of this magnitude in this period of time could have serious repercussions and should be based on actual data.

Proposed Valuation of Specific Services
CMS proposed a shift in approach to reviewing RUC recommendations and the valuation of specific services and states the following:

In developing proposed values for new, revised, and potentially misvalued codes for CY 2018, we considered the lack of alternative approaches to making the adjustments, especially since many stakeholders have routinely urged us to propose and finalize RUC recommended values. We also considered the RUC's consistent reassurance that these kinds of concerns (regarding changes in time, for example) had already been considered, and either incorporated or dismissed, as part of the development of their recommended values. These have led us to shift our approach to reviewing RUC recommendations, especially as we believe that the majority of practitioners paid under the PFS, though not necessarily those in any particular specialty, would prefer CMS rely more heavily on RUC recommended values in establishing payment rates under the PFS.

SGIM strongly disagrees with this approach. Our membership includes this country's leaders in general internal medicine care delivery and training, but we do not meet the American Medical Association's (AMA) requirements to have a seat in their House of Delegates and participate in the RUC. Our members choose not to become AMA members for a variety of reasons, some financial and some political. These choices have systematically excluded SGIM from active and independent participation in the RUC processes. Despite the extensive clinical and health services research capabilities of our members, we have no avenue to participate. This has contributed to the inadequacy of the RUC review of both existing and proposed service code valuations. In particular, the deficiencies in both the definitions and valuations of the evaluation and management (E/M) service codes has had a profound and lasting effect on the numbers of medical school graduates entering primary care.

SGIM clearly sees the deficiencies of the "convenience sampling" of RUC sponsored surveys. Though the RUC has taken steps to improve the rigor of their processes by increasing the minimum survey requirements, this in no way improves the generalizability of their results and the lack of unbiased sampling. In our opinion, data used in the RUC's survey and review process continues to fall short. SGIM strongly urges CMS to rely more heavily on independent, representational, and peer-reviewed health services research for the valuation of professional services within the PFS. Physician compensation policy should be based on the best knowledge base available, one that is publicly accessible and accountable to both all members of the profession and most importantly to the public at large.

CMS has commissioned numerous research efforts that clearly illustrate the deficiencies of the current valuation process, including the RAND study entitled, *Development of a Model for the Validation of Work Relative Value Units for the Medicare Physician Fee Schedule*, and the

Urban Institute study entitled, *Collecting Empirical Physician Time Data*. CMS is currently collecting data on the work delivered during 10- and 90-day global periods. These data, we believe, will begin to illustrate the profound distortions within the current PFS for the E/M service codes. SGIM believes the data will demonstrate that the E/M work included in the global periods is much less intense than the work provided by primary care and other specialty physicians using the very same E/M codes. We strongly encourage the agency to fully pursue the potential of this study and initiate a broader discussion on the best ways to ensure reliability within the PFS.

SGIM urges CMS to reverse the policy to accept more RUC-recommended values without change articulated in this rule and continue to closely scrutinize these recommendations, as has been the agency's recent practice. It is extremely important to all medical professionals and to Medicare beneficiaries that the agency maintains its independence and autonomy and fulfill its charge to maintain the accuracy and validity of the PFS. The service code definitions and valuations within the PFS must meet the highest standards of integrity and public accountability. If the agency reverses its position in the final rule, we would strongly encourage the agency not to pursue the same intention as an unwritten policy.

Evaluation & Management (E/M) Guidelines and Care Management Services

SGIM thanks CMS for the proposal to review and revise the E/M documentation requirements, which we have long argued are outdated and create unnecessary administrative burden. We agree that the requirements for history and physical exam are the most vulnerable to EHR manipulation and that these "inputs" can be incorporated with the medical decision making (MDM) itself. By simplifying these requirements, physicians will be allowed to focus on MDM, the prioritization of care, and careful resource allocation, which will result in an improved, more efficient healthcare system.

Despite this critical first step in addressing the issue of documentation guidelines, the focus on changing just the guidelines for the history and physical exam fail to fully account for the challenges facing those who deliver E/M services. The proposed rule states that MDM and time are the more significant factors in distinguishing E/M visit levels. While these factors are certainly important, the failure of existing E/M codes to fully capture all of the work conducted by physicians when delivering these services creates the more significant burden on cognitive physicians than the history and physical examination documentation requirements. SGIM has advocated for the creation of new E/M codes so that cognitive work is accurately described and valued, as well as revising the documentation requirements.

As long as the agency is focused on the documentation requirements, we remain concerned that there is no accurate accounting for the interactivity and the complexity of office visits with highly complex patients. Additionally, there is no recognition of the clinical expertise achieved with years of training and experience that creates the ability to instantly recognize a pattern and make a diagnosis of enormous clinical value in a matter of moments. We agree that MDM is key to determining the level of an E/M service. However, we believe that it is

critical not only to rework documentation requirements but also to properly define and value E/M services.

In order for reformed documentation expectations for E/M services to have their fully intended effect, they must be linked to correcting the deficiencies in both definition and valuation of these services. SGIM believes that CMS cannot afford to continue to delay a thorough re-examination of the E/M codes. Work values in the fee schedule must be evidence-based. The development of a reliable and representative knowledge-base for the definition and pricing of physician services will ensure the accuracy and reliability of physician payment for all E/M services. If the necessary research to define the full range of E/M services is conducted and used to develop new service codes that accurately capture the care delivered by physicians, and to establish appropriate documentation guidelines for these new codes, both the unnecessary administrative burden currently faced by cognitive physicians and the misvaluation of E/M services as a whole can be properly addressed and corrected. We urge CMS to correct the longstanding deficiencies of the PFS in order to understand fully what occurs during all E/M services. This will allow for service codes to be properly redefined and revalued. In addition, the documentation expectations for auditing and analytics can then be revised to improve communication and reduce administrative burden.

If the agency chooses to eliminate the history and physical examination stipulations for the E/M service codes, the net effect on the profound disparities in physician income between primary care and procedural specialties will not change unless the current MDM stipulations themselves are changed. Currently, the highest levels of MDM patient acuity and severity require patients who are extremely ill. As a result, for example, in the use of outpatient E/M service codes, physicians default to a level 4 (99214) for nearly all complicated patients. The level 5 (99215) is rarely employed because physicians fear that their coding choice will be rejected at audit because the patient is not at a dire level of medical instability. We would strongly encourage the agency to replace the 1995/1997 CMS E/M documentation guidelines such that the different MDM levels reflect either the number and activity of simultaneous concurrent medical conditions or the intensity of a single highly active medical condition. For example, established outpatient level 4 (99214) could be changed to require up to 3 active concurrent medical conditions and level 5 (99215) could be changed to require 4 or more active concurrent medical conditions.

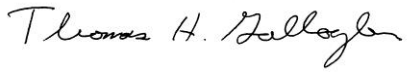
Medicare Diabetes Prevention Program

CMS outlined in detail its implementation plan for the Medicare Diabetes Prevention Program (MDPP), with a maximum payment per beneficiary of $810 over 3 years for the set of MDPP core and maintenance sessions, as well as a two-year time limit on Medicare coverage for ongoing maintenance sessions. Providers are also given the opportunity to receive performance-based payments if patients meet weight-loss targets over a longer period of time. CMS proposes to delay the start date of the MDPP for three months until April 1, 2018. SGIM is pleased that CMS is continuing with its plans to implement the MDPP and work to reduce the progression of pre-diabetes to diabetes nationwide. Data show that the number of people that will be diagnosed with diabetes over the coming years is unsustainable, and the

development of the MDPP will help in staving off what would be the costly progression of the disease. Continuing to move the healthcare delivery system toward emphasizing prevention will have an indelible effect on both patient health and the cost of care. Creating performance-based incentives will assist in both reaching the overall goals of the program and rewarding physicians for providing high-quality care.

SGIM appreciates the opportunity to provide comments to CMS on this proposed rule. Please do not hesitate to contact Erika Miller at emiller@dc-crd.com or (202) 484-1100, if we may provide any additional information or assistance as CMS moves forward in this process.

Sincerely,



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