September 4, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1693-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

SUBMITTED ELECTRONICALLY VIA http://www.regulations.gov

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 (CMS–1693–P)

Dear Administrator Verma:

The Society of General Internal Medicine (SGIM), representing approximately 3,500 general internists, appreciates the opportunity to provide comments on the CY2019 Physician Fee Schedule (PFS) proposed rule. Our members provide clinical services and conduct research and educational activities to improve the health of adults, often with multiple complex, chronic conditions. As such, we will provide comments on the following sections of the proposed rule:

- Evaluation & Management Services: SGIM appreciates CMS' interest in reducing administrative burden and recognition that the existing evaluation & management (E/M) services do not represent the complex work delivered by our members. However, we urge the agency not to implement this policy as proposed. Instead, CMS should implement documentation changes that can be uncoupled from the payment changes and take additional time to work with stakeholders to develop a more appropriate payment policy.

- Teaching Physician Documentation Requirements for Evaluation and Management Services: SGIM supports the agency's proposal to revise the teaching physician documentation requirements for E/M services and urges CMS to evaluate the interplay between the new proposal and the teaching physician regulation (including the primary care exception).

- Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services: SGIM supports the agency's proposal to pay for these non-face-to-face services.

- Quality Payment Program/Merit-based Incentive Payment System: SGIM is generally supportive of the agency's proposals for year 3 of the Quality Payment Program. However, we believe additional work is needed on the program's risk adjustment methodology in order to properly evaluate the quality of care physicians provide.

Evaluation & Management Services

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SGIM commends the Centers for Medicare and Medicaid Services (CMS) for recognizing the documentation burden associated with the existing E/M codes and strongly support the "Patients Over Paperwork" initiative. E/M document and payment changes, if evidence-based, have the potential to improve patient access and satisfaction, as well as reduce physician burden and address the primary care and other cognitive workforce shortages. Furthermore, the development of new payment models demands the accurate pricing of all services. We appreciate that the agency's recognition that the existing outpatient E/M services and their documentation requirements do not accurately reflect current medical practice.

It was upon this premise that the Cognitive Care Alliance (Alliance), of which SGIM is the founding member, recommended that CMS develop an evidence-based understanding of the work "intensity" of the current outpatient E/M services based on representative research to better understand the resources required to deliver high quality, patient-centered cognitive care. The results of this study would then be used to develop new CPT codes, valuations, and documentation requirements that reflect the realities of contemporary medical practice.

The existing documentation requirements are over 20 years old and do pose real challenges for physicians. However, these challenges cannot be completely divorced from the payment inequities that we attribute to the under recognition of the cognitive intensity of the work of primary care and other cognitive specialties. The current outpatient E/M codes undervalue the purely cognitive physician work relative to that captured in the thousands of procedure codes. The failure of the current codes to capture the most complex E/M activities and the resultant relative undervaluation of these critical services must both be addressed to ensure that Medicare beneficiaries have continued access to appropriate cognitive care.

Therefore, SGIM opposes all of the proposed payment changes for E/M services that the agency states are "intrinsically linked" to the documentation changes. The agency proposed collapsing 99202-05 and 99212-15 and creating a single rate for these services, developing new G codes for primary and certain specialty care, a new G code for prolonged E/M service, and a multiple procedure payment reduction. These changes will do nothing to address the patient access problems and physician workforce shortages driven by the compensation gap for cognitive care driven by the outdated E/M codes. Instead, collapsing five levels of E/M codes into two will exacerbate the existing compensation disparities by disproportionally overcompensating short, focused visits and undercompensating longer visits required for the provision of complex, comprehensive, = high quality primary care. <u>The proposed reductions in payment for the very services provided by SGIM members will further exacerbate the primary care workforce shortage, depriving Medicare beneficiaries of the very services required to improve the value of health care expenditures.</u>

<u>Instead, we urge CMS to work with stakeholders to develop an alternative evidence-based approach to E/M payment and documentation that will reduce burden, be appropriate for inclusion in new models of health care delivery, address the compensation inequity perpetuated by the existing E/M valuations, and support the delivery of high quality patient care that can be included in the proposed CY 2020 Physician Fee Schedule.</u>

As an alternative payment scheme is being devised, we urge the agency to implement the following documentation changes that are not tied to E/M payment changes on January 1, 2019:

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- Allow physicians to document visits based solely on the level of medical decision making or the face-to-face time of the visit as an alternative to the current 1995/1997 guidelines;
- If physicians choose to continue to document under the current guidelines, limit required documentation of the patient's history to the interval history since the previous visit (for established patients);
- Eliminate the requirement for physicians to re-document information that has already been included in the medical record by practice staff or by the patient; and
- Remove the need to justify providing a home visit rather than an office visit.

We understand that the agency's decision to adopt a single payment level for new and established patient services was in part driven by the need to ensure program integrity with a simplified auditing process. However, we would encourage the agency to work with the physician community to develop meaningful, less burdensome documentation requirements that will allow service codes to be documented reliably. We offer suggestions related to problem oriented charting below.

Finalizing these 4 documentation changes is a significant first step towards CMS' stated goal of reducing administrative burden. They can also easily be adopted by commercial payers who the agency correctly recognizes tend to adopt Medicare payment policies. This will also eliminate the possibility that physicians will be forced to document E/M visits under two sets of requirements, one for Medicare and the other for private payers, representing an increase in physician burden, if only for the short term.

- *Documentation*

CMS proposed to allow physicians to document medical necessity and medical decision making, time, or the current 1995/1997 guidelines to a level 2 visit. The program integrity concerns that would result from potential upcoding required the agency to propose the E/M payment changes. However, SGIM members are not convinced that this proposal will reduce burden in the way the agency hopes and intends.

Some of our members felt the proposed changes would not significantly impact the time they spend on documentation since electronic health records have enabled them to document their notes quickly. Others reported that they spend time on nights and weekends completing the documentation for their office visits. Regardless of whether a member is able to complete their notes quickly or spends time outside of business hours, there is unlikely to be significant time during the workday that is liberated to see new patients or spend additional time with existing patients.

Also, our members do not document just to fulfill CMS' billing guidelines. There are also patient care and legal reasons driving this documentation that will not change even if CMS' requirements do. There are medical reasons for documenting a higher visit level, particularly the medical decision making component. These notes are a key component of providing high quality care for complex patients. For these reasons, it is unlikely our members will be able to just document a level 2 visit for many of the patients they treat.

The impetus for this E/M documentation and payment proposal was reducing the administrative burden associated with the documentation of E/M services. Again, SGIM strongly supports the agency's goal of reducing burden. However, we believe the agency ultimately must explore a completely new approach

to documentation that will be meaningful to the provider, other members of the care team, and his consulting colleagues. As part of the Cognitive Care Alliance, SGIM has argued that CMS must develop new E/M codes to describe cognitive work and the associated documentation requirements. Even if the agency does not take that approach, we recommend that the agency explore another method of documentation, Problem Oriented Charting (POC). POC could serve as the paradigm for the additional documentation that could be combined with the choice of time plus level 2 documentation option that the agency might establish to allow a mechanism to audit services provided at the different code levels.

Problem Oriented Charting aligns with one of the most daunting challenges of the Quality Payment Program (QPP), risk adjustment. The Medicare Advantage experience with risk adjustment and the Hierarchical Condition Category (HCC) has highlighted the importance of problem list curation. The challenge for the QPP as the implications of payment adjustments ripple through the physician community is to ensure that expectations for all quality measures are adjusted to reflect an individual physician's patient panel and each patient's unique circumstances, medical and social.

From the agency's perspective, there are two major advantages to POC. First, this is how medical students are taught, so it is very familiar to all clinicians. Second, POC offers an information organizational tool that aligns fully with what is required by clinical practice. The organization of information in the medical record around the "problems" is precisely the way that the practitioners of E/M services create order from the broad array of clinically relevant inputs to medical decision making. Problem Oriented Charting will focus clinicians on the importance of problem curation.

In addition, POC offers ways to develop the social and other risk adjustors that are needed for the QPP. Dual eligibility is a very rough proxy for social and other factors that powerfully complicate an individual patient encounter. POC will allow the evolution of auditing tools that can ensure that the time claimed for a given visit are supported and that there is documented assessment and planning for each billed ICD diagnosis.

- *Single Payment Level Proposal*

CMS proposed a single payment amount for codes 99202-25 and 99212-15 of $135 and $93 respectively. These values were determined by a weighted average of the work RVUs based on specialty utilization for levels 2-5. To address the reimbursement shortfalls that some specialties would experience as a result of the code collapse, the agency proposed to create complexity add-ons for primary care of $5 and for certain specialty care of $13.70. These add-on codes were funded by a multiple procedure payment reduction for any E/M service billed with modifier 25 on the same day as a procedure to remain budget neutral.

In the proposal, CMS states that "E/M visits comprise approximately 40 percent of allowed charges for PFS services, and office/outpatient E/M visits comprise approximately 20 percent of allowed charges for PFS services." Given the significant amount of PFS spending represented by these services, SGIM, with its longstanding commitment to health services research, has recommended an evidence-based approach to changes that would reallocate such a large portion of PFS spending. The proposed payment changes were made to comply with the budget neutrality requirement and the program integrity concerns that resulted from the proposal to allow physicians to document medical necessity and either medical decision making, time, or the current 1995/1997 guidelines for a level 2 visit, not evidence.

Furthermore, these proposed changes to E/M coding and payment are not resource based, which may be a violation of the Social Security Act.[1]

We are deeply concerned about unintended consequences for patients that may result from these payment proposals. These payment changes will result in provider behavioral changes for which it is not clear from the rule that the agency has fully considered, although they are described by the CMS Office of the Actuary.[2,3] The impact of these behavioral changes pose particular challenges for the dual eligible population. The single payment proposal could incentivize health systems to schedule shorter visits for patients and encourage the provider to only address 1-2 problems per visit. Many of these patients suffer from 4 or more chronic medical conditions and still require the occasional "sick" visit. Bringing these patients back at a greater frequency to address their medical conditions would place extreme burden on patients and their caregivers. For patients who are non-salaried workers, time literally equals money and this proposal will place a tremendous financial burden on them to miss work and pay extra co-pays for more visits. Additionally, many of these patients receive transportation to their appointments from their family members who would also need to take off from work. Others may need to keep paying for public transportation for each subsequent visits and, for patients on limited income, these fees could impact their budget.

The reduced reimbursement may also drive some institutions and providers to “cherry pick” their patients because E/M reimbursement will no longer recognize the resources required to treat them. Academic medical centers and other large referral centers may end up being the only institutions that will treat the sickest and most complex Medicare beneficiaries. Besides the financial strain it may place on these institutions, it will likely create an additional burden on patients who may be forced to travel longer distances to find a physician who will treat them.

SGIM members typically care for patients who require level 4 and 5 visits to receive optimal care, and who will be disproportionately impacted by this proposal. The agency provided their estimated impact in Tables 21 and 22 of the rule, but this differed significantly from the analysis conducted by the American Medical Association (AMA) included in Appendix A. CMS should delay implementation of this payment proposal until the CMS model can be successfully replicated, these discrepancies can be further studied, and a policy with consistent impacts regardless of who conducts the analysis is developed.

CMS’ model of the proposal’s impact is very broad by specialty, but there may be differential impacts within a specialty that must be better understood. Our own analysis, based on projections from the 2015 Medicare payment database show that there are some specialties that will have considerable intra-specialty variations. For example, for medical oncology, the physicians with the lowest usage of outpatient E/M codes will have a 3.84% loss of income while those with the highest usage will have a 11.18% loss of income. For rheumatology, the difference is even more striking. For the lowest users, there would be an 8.65% increase in income as compared to a 7.34% loss of income for the highest

[1] Social Security Act - Sec. 1848. [42 U.S.C. 1395w–4]
[2] Song Z, Goodson J. The CMS Proposal to Reform Office-Visit Payments. N Engl J Med 2018; DOI: 10.1056/NEJMp1809742
[3] https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/downloads/PhysicianResponse.pdf

users. CMS must defer payment changes until the impact of such vast shifts of payment within a given specialty are fully understood and fully accounted (see Appendix B).

SGIM believes that the existing E/M code set does not accurately reflect the cognitive intensity required to care for the most complicated, challenging, and vulnerable patients our members treat. Preliminary analysis of this proposal confirms our belief. For specialties like general internal medicine that provide many level 4 and 5 visits, significant reimbursement decreases could be devastating to patients and providers. We believe the more demanding work load coupled with lower payments for this high intensity work will be another reason that medical students with growing student debt choose not to enter primary care. We cannot support a proposal that has not been fully vetted and will exacerbate the workforce shortages facing our members and patient access challenges.

For all of these reasons, SGIM does not support the single payment rate for both 99202-05 and 99212-15.

- *Add-on Proposals*

SGIM recognizes that the agency proposed the primary care and specialty complexity add-on codes (GPC1X and GCG0X) to address the cuts to reimbursement for certain services that would have resulted from collapsing the level 2 through 5 office visits. However, SGIM cannot support the add-on services as proposed because they do not capture the added work inherent in primary care and other cognitive services and imply that the added work associated with some specialties is greater than others. We also believe the application of both these codes as defined by the agency is arbitrary. For GPC1X, 0.07 work RVUs vastly underestimate the time and complexity required to deliver primary care services, particularly to Medicare beneficiaries with multiple complex chronic conditions. Also, the agency does not provide a clear rationale for why GPC1X can only be applied to established patient visits, not new patient visits.

A better measure of complexity must be developed and must be captured by any new E/M coding and payment scheme. The complex cognitive work our members deliver to patients is not reflected by the existing E/M codes or the proposed primary care add-on. A complexity adjuster may more appropriately represent this work if it were tied to the complexity of the patient rather than the specialty. This will recognize that complexity is primarily driven by the patient's condition. A better measure of complexity must be developed and must be captured by any new E/M coding and payment scheme. If CMS were to devise an alternative method of complexity based on this concept, SGIM would welcome the opportunity to work with the agency to appropriately value it.

The agency also proposed the creation of a new 30 minute prolonged service G code (GPRO1) that can be billed with longer visits. SGIM appreciates the agency's intent to recognize there are circumstances where longer visits are necessary, as this add-on could be particularly relevant for our members. However, we had difficulty determining when and how this code could be billed because of the lack of clarity around the time required for the single payment rate for E/M services.

The agency requested feedback on the time required for the collapsed codes, either the weight averaged times of 38 and 31 minutes for the new and established level 2-5 services or the existing times for the individual codes. Evaluating how often a practice or specialty will utilize GPRO1 is dependent upon knowing how to account for the time of the base E/M code. We have significant concerns that

some individuals might game the system and bill the add-on code for level 2 visits that last 26 minutes: the first 10 minutes would satisfy the time requirement for a level 2 visit and the additional 16 would meet the add-on code time requirement. We do not think this was the agency's intent and believe that the add-on code was intended to compensate physicians for longer visits required to treat medically complex patients. We request that the agency clearly articulate the time requirements for any new E/M and add-on codes that may be considered in future rulemaking.

We have created our own modeling for the possible effect on overall Medicare spending if there is a modest 5% increase in outpatient E/M billing for just the established patients that develops as a consequence of higher payments for short, level 2 visits. Assuming a 5% growth only in established outpatient visits, the total added cost to Medicare would be $900 million, based on 2015 Medicare payment data (see Appendix C). Higher payments for shorter visits will provide an incentive for all physicians to exploit this lucrative option, which in turn would create a fiscal crisis that would ripple throughout all Part B payments.

- *Practice Expense Methodology*

CMS proposed to create a single PE/HR value for E/M visits of approximately $136 based on an average of the PE/HR across all specialties billing the E/M code set and proposed add-ons weighted by the volume of those specialties' allowed E/M services. If the agency had not taken this approach, they recognized that "establishing a single PFS rate for new and established patient E/M levels 2 through 5 would have a large and unintended effect on many specialties." However, the proposal did have a significant impact on the Indirect Practice Cost Index (IPCI) for many specialties even though the agency was attempting to minimize any unintended consequences. CMS should mitigate against unintended consequences such as these that cause significant, non-resource based decreases in the services upon which cognitive physicians rely.

Also, SGIM is working with a large coalition of physician specialties that has retained a data analyst to reverse engineer the agency's proposal and then model other payment options. However, the analyst has been unable to replicate the PE methodology. CMS should not implement this proposal until it can be replicated and fully vetted by stakeholders.

- *Multiple Procedure Payment Reduction and Surgical Global Study*

CMS proposed a multiple procedure payment reduction (MPPR) which would require the reimbursement for the lower value service to be reduced by 50 percent when a procedure is billed on the same day as an E/M service with modifier 25. The RVUs saved by this MPPR were used to fund the primary can complex care add-on codes.

The overlap in billing that the agency intended to address with the proposed reductions through the application of the MPPR process needs more thorough analysis. The AMA Relative Value Update Committee has asserted that the overpayment for procedures combined with same day E/M services has already been addressed. We appreciate the agency's skepticism but also acknowledge that for our members, there are situations when a full E/M service is required on the same day as a procedure.

The Medicare Access and CHIP Reauthorization Act required CMS to implement a process to collect data on the number and level of postoperative visits and to use this data to assess the valuation of surgical globals. SGIM supports the agency's work to understand the current state of practice related to these

procedures and potentially make policy changes based on the data collected during this process. We see the further study of the E/M activities that are currently bundled with the 10 and 90 day global payments and the combined billing for same day procedures and E/M services are all part of the larger question of how procedural work interacts with E/M work, when they overlap and when one is a derivative of the other (as is post-operative care).

SGIM urges the agency to evaluate the relative work intensity of the E/M services provided during the global payment periods and to consider these insights as E/M policy changes are being considered and implemented. There are many concurrent interactions that must be acknowledged. For example, if CMS were to unbundle the follow up office visits from the surgical globals, more standalone E/M services would likely be billed as a result. As we highlighted above, behavioral changes result when there are significant changes in payment. It is imperative the CMS appropriately define and value post-surgical office and cognitive office visits, two distinct types of physician work.

- *A Path Forward*

SGIM cannot support coding and payment changes that reduce reimbursement for level 4 and 5 office visits that our members bill to see medically complex patients and would exacerbate primary care workforce shortages and create new patient access challenges. We stand ready to work with CMS to develop a new coding and payment scheme for E/M services that both reduces administrative burden and equitably reimburses physicians for the services they provide to Medicare beneficiaries. We propose that CMS implement the 4 documentation changes outlined earlier in these comments on January 1, 2019.

Rather than implement the payment changes outlined in the rule that will have many unintended consequences, including limiting patient access to appropriate primary and cognitive care, SGIM urges CMS to collaborate with stakeholders to consider a range of coding and payment option that will accurately reflect the breadth and depth of the clinical care provided by all specialties, including general internists. We will work with other stakeholders to present a new coding payment structure in time to be included in the CY 2020 Physician Fee Schedule proposed rule.

Teaching Physician Documentation Requirements for Evaluation and Management Services

In response to feedback that the documentation requirements for E/M services provided by teaching physicians are burdensome and duplicative of notes previously made by residents or other members of the team, CMS is proposing to require that the medical record must document that the teaching physician was present at the time the service is delivered and it can be documented in the note made by the physician, resident, or nurse. They are also proposing to eliminate the requirement for the teaching physician to document the extent of his own participation in the review and direction of the services furnished to each beneficiary and instead allow the resident or nurse to document the extent of the teaching physician's participation as well.

Remembering that some of the most complex of patients are seen at academic medical centers, SGIM members are responsible for teaching residents and have expertise on the impact of changes to Medicare regulations on the medical teaching enterprise -- both for students and residents. We support CMS' goal of reducing documentation and other administrative burdens associated with physician training included in this proposal. We are also supportive of the recent changes that CMS incorporated in the Teaching Physician Guidelines related to student documentation.

We would like to address the interplay between the new proposal and the teaching physician regulation (including the primary care exception). It is hard to fully understand the interplay of the changes included under the "regular" non-teaching physician E/M coding and payment changes and the teaching physician rules. They are in two separate areas of federal regulation, so a change in one does not impact the other – unless there are specific conforming changes that explicitly say they apply to other areas. A great deal of the implementation of the teaching physician rule, including the codes that apply, is sub-regulatory – which means it wouldn't appear in a proposal. In fact, the proposed rule states that "We note that we are proposing a relatively broad outline of changes in this proposed rule, and we anticipate that many details related to program integrity and ongoing refinement would need to be developed over time through subregulatory guidance." We would like to raise several areas where we believe there is need for subregulatory clarification and change, as well as some that may require additional rulemaking or subregulatory conforming changes:

Documentation Relief Related to Team-based Care
In section J. *Teaching Physician Documentation Requirements for Evaluation and Management Services* CMS makes changes to documentation requirements that allow the inclusion of residents and nurses to document for billing purposes for E&M codes. One change relates to the Teaching Physician (TP) requirements as a whole, the other to the Primary Care Exception. We support these changes for two reasons. Not only do they reduce the documentation burden on the TP, but they recognize the need for inclusion of other care team members in the delivery and documentation of care.

We request that CMS provide for additional team members to document for billing purposes in the teaching situation, including the primary care exception. For example, students in disciplines other than medicine, such as nurse practitioners and physician assistants, commonly rotate/train with teaching physicians as part of their education. We believe this should be applied more broadly than just the situation of documenting the presence of the TP, or in the case of the exception, the extent of the TP's participation in the review of services furnished to each beneficiary, but they should also be allowed to document additional parts of the note, similar to the change CMS included in its February 2 transmittal (Pub 100-04 Medicare Claims Processing Manual (updated May 31), that "allows the teaching physician to verify in the medical record any student documentation of components of E/M services, rather than redocumenting the work."

- *Resident Involvement with Student Documentation*

In keeping with the above request, and to further reduce documentation burden on the TP, we request that CMS will also explicitly permit residents to use student documentation without redocumenting the work, as long as they verify the documentation. We request that the manual instructions be revised to eliminate the requirement for personal documentation of an E/M service by the TP when a resident is involved in the service as follows:

- If a student and a resident are involved, the TP must attest to the accuracy and content of the student note as reviewed and revised by the resident, be physically present with the resident during the key or critical part of the service, and participate in the management of the patient.
- If only a resident and TP are involved, the TP must attest to his/her physical presence during the key or critical part of the service, participation in the management of the patient, and that the resident note was reviewed and he/she agrees with (or has revised) that note.

When billing under the primary care exception, current CMS policy requires that the TP review the care provided by the resident either during or immediately after each visit and document the extent of his/her participation in the review and direction of the services furnished to the patient. We ask CMS to consider whether documentation in the medical record by the resident may include a student's documentation. The TP must review and attest to the accuracy of the student note, as reviewed and revised by the resident.

- *Physical Presence Documentation Requirement Clarification Regarding Student Involvement*

In clinical education, students usually first enter the room with a patient to perform a history and physical exam. This allows the student to progressively gain the independent experiences he or she will need as a resident or licensed PA or NP. The TP is always providing appropriate supervision and can enter the room to take over care at any time. The TP always reconfirms and personally re-performs the history, physical exam, and medical decision making services in the physical presence of the patient. We request that CMS explicitly include in its subregulatory guidance that a TP can use appropriately verified student documentation to support an E&M charge if the student first performs the history and examination without the TP, then discusses the case with the TP outside the patient's room, they both return to see the patient where the TP verifies all student documentation in the medical record and personally re-performs the physical exam, and medical decision making services used to support an E&M charge**.**

In a slightly different scenario, the student does not always return to the room with the TP. When the student does not return, the TP has heard the full presentation by the student and always verifies student documentation in the medical record and personally performs or re-performs the physical exam, and medical decision making activities. We request that CMS specify in its subregulatory guidance that this scenario also allows the TP to use the student documentation for billing purposes.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

SGIM applauds CMS for its proposals to expand medical care using telecommunications technology, specifically for the creation of the Brief Communication Technology-based Service, e.g. Virtual Check-in (GVCI1) and Remote Professional Evaluation of Recorded Video and/or Images (GRAS1). We believe that these codes will increase patient access and provide new options for our members to treat patients. Our members frequently consult in this manner with patients outside of office visits and do not receive separate compensation for those services; this proposal is a step towards improving compensation for the care our members already provide.

We request that CMS provide clarification about whether these services can be billed during the same time period that a physician may be providing Chronic Care Management (CCM) services. As we understand the proposal, GVCI1 and GRAS1 would be considered separate from the care provided as part of the CCM service and could be billed, but would appreciate further guidance from the agency on this point.

Quality Payment Program/Merit-based Incentive Payment System

SGIM thanks CMS for its continued efforts to reduce the administrative burden associated with the Medicare payment system through its "Patients Over Paperwork" initiative. We recognize that many of the provisions in the proposed rule are designed to reduce administration burden and enhance patient

care, but we are concerned that there may be unintended consequences that could be detrimental to providers, and ultimately, patients. Also, the agency is proposing many policies that streamline participation and reduce reporting burden. However, SGIM remains concerned that the complexity of the program still poses challenges for small practices and rural providers. We urge CMS to continue to focus on reducing burden for these practices in particular.

- *Low-Volume Threshold*

CMS proposes to add a third low-volume threshold criterion: a clinician provides 200 or fewer covered professional services under the PFS. SGIM supports the proposal to add this third criterion. Its addition will help ensure that small practices and rural providers who do not have the correct systems in place can be excluded from MIPS.

The agency also proposes an opt-in policy for MIPS eligible clinicians who are excluded based on the low-volume threshold determination. If a clinician meets or exceed one or two of the exclusion criteria, he or she can opt into the program. However, clinicians who meet all three exclusion criteria (e.g. $90,000 or fewer Part B allowed charges, 200 or fewer beneficiaries, and 200 or fewer covered professional services) will not have the option to opt into the program. While the overall goal of including more providers is laudable, SGIM believes that an opt-in approach, with limited amounts of Medicare data, will not lead to a meaningful improvement in the ability to measure and discern physician quality. Therefore, we urge CMS not to finalize this opt-in option.

- *Increased Performance Threshold*

The Balanced Budget Act of 2018 provided CMS with the authority to gradually increase the performance threshold that determines whether MIPS eligible clinicians earn a bonus, are subject to a penalty, or are held harmless. Under this authority, CMS proposes to increase the performance threshold from 15/100 to 30/100. SGIM opposes this aggressive increase and instead recommend that CMS either maintain the current threshold of 15/100 or increase it more gradually.

We believe that providers are still adjusting to and understanding how the program applies to their practice. We are still only in the second year of the program, and providers do not yet have a complete picture of how successful their participation has been to date. SGIM is extremely appreciative of the steps CMS has taken to gradually implement this program to date, but this also means that the only complete performance data we have is from year 1 of the program during which providers were able to "pick their pace" and avoided a penalty by reporting a single piece of quality information.

- *Increased Weight of the Cost Category*

CMS proposes to increase the weight of the Cost Performance Category to 15 percent, an increase of 5 percent. While this is a modest increase, the Bipartisan Budget Act of 2018 (BBA) granted CMS the authority to more gradually increase the weight of this performance category. SGIM continues to have significant reservations about the application of this category to practitioners and does not believe providers and CMS are ready for the increased weight of this category.

The agency also proposes 8 new episode-based measures. We also urge caution in advancing too rapidly prior to having more experience with cost performance. Of the 8 proposed new measures, only 1 pertains to internal medicine - inpatient admissions for pneumonia. There will be a limited impact of

these proposed measures, and cost performance will still be determined by the existing 2 measures. Our members have very limited ability to impact Medicare Spending per Beneficiary and the Total per Capita Spending measures. As CMS may be working with consulting companies to offer expert analysis, we would request that CMS ensure there is representation by hospitalists and primary care providers on these committees.

Also, CMS proposed no changes to the attribution methodology, which is based on the plurality of E/M services. As such, SGIM has concerns that in many instances providers will be assessed on patients for whom they cannot actually impact care and outcomes. As it is currently constructed, the attribution methodology used by the agency will put enormous pressure on individual physicians, particularly hospitalists, who will be held accountable for the performance of all others who also treat the patient. Even when a patient may be admitted for a procedure or evaluation by a sub-specialist, the patient is often admitted to a hospitalist who is the primary attending of record despite not having much power over the scheduling of procedures, timing of consultants' evaluations, etc. The attribution methodology must be carefully designed so that a link is established between patient and provider. Requiring annual patient attestation could accomplish this. If attribution is based solely on the assignment of costs and usage patterns, the potential for inappropriate linkages of patients to providers increases. Inappropriate attribution could be potentially devastating to individual providers and small groups. We urge CMS to carefully consider this issue as it formulates the required regulations to give all providers the greatest chance to succeed.

- *Promoting Interoperability Performance Category*

CMS proposes to require use of 2015 certified electronic health record technology (CEHRT) by all eligible providers in year 3 of the program. The agency had previously granted providers with the flexibility to either use the 2014 or 2015 CEHRT. While more providers may now be using 2015 CEHRT, the vast majority of providers are likely still using 2014 technology. Requiring all eligible providers to switch to 2015 CEHRT before January 1, 2019 is unrealistic and will place a significant financial burden on providers who may not have budgeted for such an expense. We support CMS' intention behind this proposal, to reduce burden by better streamlining workflows and utilizing more comprehensive functions to meet patient safety goals and improve care coordination, but we believe that providers must be given at least a full year's notice before requiring use of 2015 CEHRT. SGIM strongly recommends that CMS delay this requirement for a full year until 2020.

CMS is also proposing a new simplified scoring methodology for this category as clinicians have expressed frustration with the overly-complicated methodology currently used for this category's scoring. SGIM supports efforts to reduce the complexity of the scoring methodology, and we favor a system that provides the flexibility for eligible providers to select the measures that are most relevant to their practice and patient population and are the least burdensome to implement.

- *Future Approaches to Scoring the Quality Performance Category*

SGIM commend CMS for their ongoing efforts to improve the quality performance category to produce more meaningful data, increase value, and reduce burden of reporting. However, in these ongoing efforts to be everything – flexible, meaningful, and non-burdensome, SGIM feels CMS is still missing the mark, and the resulting data will neither provide an accurate reflection of provider performance nor a useful comparison of providers for patients to use. Also, it will not meaningfully reduce the burden on providers.

CMS proposes in future years to group quality measures into tiered categories - gold, silver and bronze based, with different weights for different measures. While this would incentivize reporting of higher priority measures and provide a mechanism to phase out those of low value, the ongoing self-selection of measures would continue to bias overall quality scores and lead to a comparison of apples to oranges.

Similarly, allowing providers to select from different measures and collection types increases provider flexibility, but creates confusion and burden for providers. To meaningfully evaluate quality, we suggest the following:

- Further standardization and simplification of quality measures and reporting, driven by specialty society input. SGIM represents general internists across outpatient and inpatient settings, and there are 63 MIPS quality measures in the internal medicine set, including 6 new measures and 11 proposed for removal. Many of these measures come from other specialties, some of these measures overlap with Healthcare Effectiveness Data and Information Set (HEDIS) and National Quality Forum (NQF) endorsed measures, while others do not. Overall, an extensive measure set provides options, but at too high a cost paid in confusion, burden and loss of meaningful data to compare quality. Direct specialty society input to help create a smaller set of measures (or a few sets of measures, e.g. one for hospitalists, another for primary care physicians, and a third for internists who serve as consultants) endorsed by a consensus-based organization (e.g. NQF) could help to right this imbalance.

- CMS proposes inclusion of POS 22 (with at least 1 POS 21/inpatient claim) to determine eligibility for facility based measurement. With this change, on campus primary care physicians who practice some inpatient medicine (as is the predominant model for internists at academic medical centers across the country) will have their quality judged on inpatient measures alone, which limits the ability to measure and incentivize performance to prevent hospitalizations in the first place. While CMS did not see comment on this, SGIM recommends evaluation of this change to ensure there are not unintended consequences that devalue and de-emphasize primary care.

- Continued support of all-payer measures, given the large number of providers who see too few Medicare patients to have meaningful performance data solely on Medicare patients.

- CMS seeks comment on the ongoing and renamed Study on Factors Associated with Reporting Quality Measures. In this proposed rule, there is no discussion of how the data will be analyzed and publicized. SGIM requests this to be included, and specifically that the data be openly reported with opportunity for public review and comment.

- *Risk Adjustment, including Social Determinants of Health*

CMS proposes no significant changes this year, aiming to maintain the complex patient bonus (which relies on HCC for clinical risk adjustment, and dual eligible status for social risk adjustment) and further address social and clinical risk adjustment in future years. The proposed rule does refer to the NQF study on social risk adjustment, citing less than expected initial relationship demonstrated between social risk factors and measured outcome for some measures, also noting the limited availability of robust social

risk factor data, and the extension of the study which is ongoing. While CMS clearly acknowledges this important issue and plans to address it in future years, SGIM believes the current status quo while awaiting further studies and rulemaking is inadequate and detrimental to care for vulnerable populations, particularly dual eligibles. As such, we provide the following comments:

- While Medicaid status is accounted for in the complex patient bonus, this strongly disadvantages providers and groups that care for poor patients in states that have limited Medicaid eligibility, and gravely risks disincentivizing providers to care for this highly vulnerable group.

- While the proposed rule cites the NQF report on the social risk factors trial, it does not cite NQFs subsequent overarching final report on disparities[4], which states in multiple strong recommendations the need to ensure that safety net providers are not unfairly financially penalized for caring for vulnerable populations, as is currently the case through MIPS (and the Physician Fee Schedule). A small sample of verbatim excerpts from the final report:
    - *Recommendation 5: Health plans can implement pay-for-performance payment models that reward providers for reducing disparities in quality and access to care.*
    - *Recommendation 7: Support closing disparities by providing additional payments to providers who care for patients with social risk factors.*
        - *Support outpatient and inpatient services with additional payment for patients with social risk factors.*
        - *The fundamental concept is that social risk factors are like clinical risk factors in the sense that they require more time and effort on the part of providers in specific encounters to achieve the same results. If an office visit is more complex (and billed and paid at a higher level) because of clinical complexity in a patient, the same concept could extend to the incorporation of social risk factors and "social complexity" as a payment concept. This recommendation could shift payment from costly avoidable care to upfront payments that prevent development of downstream conditions*
    - *Recommendation 8: Ensure organizations disproportionately serving individuals with social risk can compete in value-based purchasing programs.*

  The NQF final report also specifically comments on the role of primary care in caring for socially complex and vulnerable populations:

  Under recommendation 4: *"People with low health literacy, limited eHealth literacy, limited access to social networks for reliable information, or who are challenged with navigating a fragmented healthcare system often rely on continuity with a trusted primary care physician. Equitable access starts with unconstrained access to primary care. Robust systems of primary care are associated with improved population health and reduced disparities[5]. Primary care's capacity to care for people (rather than diseases) across medical, behavioral, and psychosocial dimensions while providing*

[4] A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. Final Report, September 14, 2017. National Quality Forum.

[5] Shi L, Starfield B, Politzer R, et al. Primary care, self-rated health, and reductions in social disparities in health. Health Serv Res. 2002;37(3):529-550.

resources and services to align with these needs is vital to improving health equity. This requires minimizing key access barriers to primary care."

SGIM supports these statements from NQF, and encourages CMS to help remove barriers to primary care by properly supporting providers to care for these vulnerable populations, by accounting for social risk factors in MIPS incentives and payments without delay.

Thank you for the opportunity to provide these comments. If you require any further information or require additional information, please contact Erika Miller at emiller@dc-crd.com or (202) 484-1100.

Sincerely,

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APPENDIX A: AMA Estimated Impact of CY2019 Evaluation and Management Proposed Policy by Medicare Specialty

**Includes CPT Codes 99201-99215, GCG0X, GCG1X, GPD0X and GPD1X, but does not include GPRO1 - prolonged service Analysis uses Estimated CY2017 Medicare Utilization and CY2019 Medicare CF for both "Current Method" and "Proposed Method"; E/M MPPR Estimate based on 2016 Medicare Carrier 5% Standard Analytic File Excludes specialties with less than $1 million in CY2017 allowed charges for 99201-99215 or claims with unknown specialty designation*

Medicare Designated Specialty	Total Medicare Payment for Office Visits w/o Policy Changes (Using CY2018 Total RVUs)	Change in Payment Due To Proposed E/M Collapse Policy (includes G codes*)	Additional Change in Payment Due to E/M MPPR Policy	Net Change Due to E/M Collapse and E/M MPPR Policies	Total Medicare Payment for Office Visits Under Proposed Method (E/M Collapse and E/M MPPR) (Using Proposed CY2019 Total RVUs)	Percent Change in Payment for Office Visits (Both E/M Collapse and E/M MPPR Policies)
TOTAL	$ 23,298,623,446					
HOSPICE	$ 6,491,871	$ (1,278,816)	$ (21,072)	$ (1,299,888)	$ 5,191,983	-20%
HEMATOLOGY	$ 35,814,877	$ (5,616,074)	$ (76,952)	$ (5,693,026)	$ 30,121,850	-16%
GYNECOLOGY/ONCOLOGY	$ 28,857,336	$ (3,997,258)	$ (547,163)	$ (4,544,421)	$ 24,312,915	-16%
MEDICAL ONCOLOGY	$ 217,094,796	$ (31,098,224)	$ (182,736)	$ (31,280,960)	$ 185,813,836	-14%
NEUROPSYCHIATRY	$ 3,342,298	$ (410,887)	$ (23,423)	$ (434,310)	$ 2,907,988	-13%
NEPHROLOGY	$ 366,158,222	$ (47,203,589)	$ (302,888)	$ (47,506,478)	$ 318,651,744	-13%
NUCLEAR MEDICINE	$ 3,261,367	$ (405,925)	$ (12,208)	$ (418,133)	$ 2,843,234	-13%
CARDIAC ELECTROPHYSIOLOGY	$ 123,640,581	$ (15,324,933)	$ (146,856)	$ (15,471,789)	$ 108,168,792	-13%
CRITICAL CARE (INTENSIVISTS)	$ 35,990,339	$ (4,325,639)	$ (100,505)	$ (4,426,144)	$ 31,564,195	-12%
RADIATION ONCOLOGY	$ 85,243,662	$ (9,893,434)	$ (574,960)	$ (10,468,394)	$ 74,775,268	-12%
PODIATRY	$ 645,600,644	$ (10,733,858)	$ (65,687,368)	$ (76,421,226)	$ 569,179,418	-12%
INTERVENTIONAL CARDIOLOGY	$ 230,977,054	$ (25,262,896)	$ (255,653)	$ (25,518,549)	$ 205,458,505	-11%
PULMONARY DISEASE	$ 519,566,122	$ (56,585,347)	$ (692,200)	$ (57,277,547)	$ 462,288,575	-11%
CARDIAC SURGERY	$ 23,265,687	$ (2,414,967)	$ (60,075)	$ (2,475,041)	$ 20,790,646	-11%
THORACIC SURGERY	$ 34,448,176	$ (3,351,307)	$ (95,221)	$ (3,446,528)	$ 31,001,648	-10%
SLEEP MEDICINE	$ 18,791,073	$ (1,820,388)	$ (3,618)	$ (1,824,006)	$ 16,967,067	-10%
INFECTIOUS DISEASE	$ 87,007,974	$ (7,183,264)	$ (765,556)	$ (7,948,821)	$ 79,059,153	-9%
GERIATRIC MEDICINE	$ 62,649,142	$ (5,263,125)	$ (425,824)	$ (5,688,949)	$ 56,960,193	-9%
COLORECTAL SURGERY	$ 32,609,046	$ 2,177,018	$ (4,743,104)	$ (2,566,086)	$ 30,042,961	-8%
SURGICAL ONCOLOGY	$ 18,788,106	$ (1,078,188)	$ (285,170)	$ (1,363,357)	$ 17,424,749	-7%
PHYSICAL MEDICINE AND REHABILITATION	$ 296,738,502	$ (4,498,950)	$ (11,065,012)	$ (15,563,961)	$ 281,174,540	-5%
DERMATOLOGY	$ 883,036,919	$ 209,244,544	$ (251,123,409)	$ (41,878,865)	$ 841,158,054	-5%
NEUROLOGY	$ 670,721,588	$ (24,948,472)	$ (5,341,041)	$ (30,289,513)	$ 640,432,075	-5%
PERIPERAL VASCULAR DISEASE	$ 3,031,756	$ (80,774)	$ (35,394)	$ (116,168)	$ 2,915,588	-4%
OPHTHALMOLOGY	$ 515,715,805	$ 3,971,043	$ (23,714,332)	$ (19,743,289)	$ 495,972,516	-4%
ANESTHESIOLOGY	$ 169,519,002	$ (204,291)	$ (5,065,536)	$ (5,269,827)	$ 164,249,175	-3%
SPORTS MEDICINE	$ 42,181,673	$ 3,583,247	$ (4,861,167)	$ (1,277,920)	$ 40,903,753	-3%
GERIATRIC PSYCHIATRY	$ 5,170,221	$ (156,210)	$ -	$ (156,210)	$ 5,014,011	-3%
CERTIFIED CLINICAL NURSE SPECIALIST	$ 29,322,926	$ (747,025)	$ (17,505)	$ (764,530)	$ 28,558,397	-3%
EMERGENCY MEDICINE	$ 164,829,846	$ (37,175)	$ (3,767,129)	$ (3,804,304)	$ 161,025,541	-2%
GASTROENTEROLOGY	$ 494,407,166	$ (9,707,187)	$ (1,359,395)	$ (11,066,582)	$ 483,340,584	-2%
PREVENTIVE MEDICINE	$ 6,380,418	$ 107,663	$ (244,648)	$ (136,985)	$ 6,243,434	-2%
CERTIFIED REGISTERED NURSE ANESTHETIST	$ 1,206,868	$ (17,505)	$ (6,755)	$ (24,260)	$ 1,182,608	-2%
ADDICTION MEDICINE	$ 4,621,434	$ (63,406)	$ (6,164)	$ (69,570)	$ 4,551,864	-2%
PATHOLOGY	$ 2,881,831	$ 331,366	$ (373,663)	$ (42,297)	$ 2,839,534	-1%
RHEUMATOLOGY	$ 375,417,278	$ 13,205,481	$ (17,540,236)	$ (4,334,755)	$ 371,082,523	-1%
PEDIATRIC MEDICINE	$ 25,857,819	$ 269,554	$ (484,578)	$ (215,024)	$ 25,642,796	-1%
ENDOCRINOLOGY	$ 374,423,628	$ (1,129,450)	$ (186,831)	$ (1,316,281)	$ 373,107,347	0%
INTERNAL MEDICINE	$ 3,871,679,750	$ 31,325,279	$ (24,729,341)	$ 6,595,938	$ 3,878,275,688	0%
INTERVENTIONAL RADIOLOGY	$ 9,484,370	$ 469,734	$ (413,873)	$ 55,861	$ 9,540,231	1%
NEUROSURGERY	$ 116,272,265	$ 1,791,395	$ (323,774)	$ 1,467,620	$ 117,739,886	1%
HEMATOLOGY/ONCOLOGY	$ 697,545,442	$ 10,699,495	$ (986,631)	$ 9,712,865	$ 707,258,306	1%
FAMILY MEDICINE	$ 3,606,747,571	$ 113,138,550	$ (56,711,076)	$ 56,427,473	$ 3,663,175,044	2%
OSTEOPATHIC MANIPULATIVE MEDICINE	$ 20,490,031	$ 761,315	$ (365,507)	$ 395,808	$ 20,885,840	2%
ORTHOPEDIC SURGERY	$ 947,571,929	$ 121,325,332	$ (94,947,028)	$ 26,378,304	$ 973,950,233	3%
CARDIOLOGY	$ 1,673,787,386	$ 50,259,515	$ (1,261,621)	$ 48,997,894	$ 1,722,785,281	3%
PSYCHIATRY	$ 428,733,813	$ 13,881,946	$ (31,113)	$ 13,850,833	$ 442,584,645	3%
GENERAL SURGERY	$ 331,303,718	$ 24,316,111	$ (9,332,412)	$ 14,983,698	$ 346,287,416	5%
NURSE PRACTITIONERS	$ 1,441,181,453	$ 93,149,384	$ (25,035,363)	$ 68,114,021	$ 1,509,295,474	5%
HAND SURGERY	$ 61,951,012	$ 10,538,938	$ (7,241,524)	$ 3,297,414	$ 65,248,426	5%
DIAGNOSTIC RADIOLOGY	$ 12,237,942	$ 907,940	$ (232,960)	$ 674,980	$ 12,912,923	6%

PHYSICIANS ASSISTANT	$ 880,931,609	$ 100,911,145	$ (51,442,398)	$ 49,468,747	$ 930,400,356	6%
OTOLARYNGOLOGY	$ 483,766,537	$ 120,847,876	$ (92,891,766)	$ 27,956,110	$ 511,722,647	6%
ORAL SURGERY	$ 8,519,498	$ 808,496	$ (304,336)	$ 504,160	$ 9,023,658	6%
GENERAL PRACTICE	$ 181,231,116	$ 13,894,726	$ (3,084,777)	$ 10,809,949	$ 192,041,065	6%
VASCULAR SURGERY	$ 115,959,089	$ 9,653,737	$ (1,658,179)	$ 7,995,558	$ 123,954,646	7%
PAIN MANAGEMENT	$ 166,806,512	$ 21,764,031	$ (6,627,973)	$ 15,136,058	$ 181,942,570	9%
OPTOMETRY	$ 273,100,554	$ 26,752,277	$ (1,697,949)	$ 25,054,327	$ 298,154,881	9%
INTERVENTIONAL PAIN MANAGEMENT	$ 168,203,323	$ 22,545,559	$ (6,788,185)	$ 15,757,374	$ 183,960,697	9%
PLASTIC AND RECONSTRUCTIVE SURGERY	$ 55,565,227	$ 10,280,479	$ (4,526,105)	$ 5,754,374	$ 61,319,601	10%
UROLOGY	$ 752,497,473	$ 126,343,272	$ (41,574,022)	$ 84,769,250	$ 837,266,723	11%
ALLERGY/IMMUNOLOGY	$ 95,801,235	$ 13,194,385	$ (603,585)	$ 12,590,800	$ 108,392,035	13%
CERTIFIED NURSE MIDWIFE	$ 2,144,561	$ 312,479	$ (20,735)	$ 291,744	$ 2,436,305	14%
OBSTETRICS/GYNECOLOGY	$ 225,275,520	$ 47,309,295	$ (9,018,841)	$ 38,290,454	$ 263,565,974	17%
MAXILLOFACIAL SURGERY	$ 4,558,435	$ 978,386	$ (146,599)	$ 831,787	$ 5,390,222	18%

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APPENDIX B: The variable impact of the proposed single payment levels for either new or established outpatient E/M visits within select specialties

Findings: The impact from the proposed payment changes will vary within specialties. For some, the reduction of E/M income is relatively consistent across all levels of overall outpatient E/M usage. However, there are notable exceptions. For example, within Dermatology, those with the highest usage of outpatient E/M are projected to have nearly 30% higher payment. In contrast, within Medical Oncology, those with the highest usage of outpatient E/M are projected to have an 11% decline in payment. For Infectious Disease, there is a 7% decline in payment for the middle two quartiles.

Net loss or gain in OP E/M payment within select specialties.

Within each specialty, NPIs were rank ordered and separated into quartiles based on the proportion of total 2015 Medicare payments derived from outpatient new and established patient care. The first quartile has the highest usage.

Specialty	First	Second	Third	Fourth
Addiction Med	+1.37	+5.90	-5.07	+9.80
Allergy/Immunology	+2.00	-5.63	-3.13	+6.74
Cardiology	-7.87	-8.08	-7.46	-5.60
Dermatology	+29.54	+19.62	+22.88	+7.41
Endocrine	-11.15	-10.97	-10.08	-12.19
Geriatric Med	-10.19	-10.94	-12.04	-9.61
Hematology	-11.26	-13.30	-15.32	-12.93
Heme/Oncology	-9.44	-9.75	-9.19	-4.15
Hospice/Palliative Care	-16.20	-6.37	-16.78	-17.15
Infectious Diseases	-2.61	-6.64	-6.14	-0.92
Internal Med	-2.40	-1.42	-0.82	-0.92
Interventional Rad	+6.76	+4.15	+2.49	+11.44
Med Oncology	-11.18	-10.80	-11.23	-3.83
Neurology	-13.91	-13.67	-14.34	-13.60
OB/GYN	+6.68	-7.73	-7.38	+16.50
Pulmonary	-8.33	-9.10	-8.53	-7.35
Rheumatology	-7.34	-4.93	-9.53	+8.65

= Quartiles with the greatest loss of income

Notes: For this table, we have rank ordered 2015 Medicare payments for each NPI within a given specialty based on the percentage of overall Medicare payments derived from the outpatient E/M codes 99202-05 and 99212-15. We then divided the providers within each selected specialty into quartiles. The top quartile is the group of specialists that are most dependent on outpatient E/M payments.

For purposes of this comparison, we only assessed the impact of the proposed changes based on E/M billing. We did not add the specialty specific bonus payments, the complexity adjustment payment. We

did not model the impact of the extended service payment because add on codes are not universally utilized.

This modeling is based on the work RVU payments and does not factor in practice expense. If this were done, the variation from top to bottom would have been greater.

Modeling: We used 2015 Medicare payment data to predict payment per NPI if there were no changed in the current service code fee structure. We than took the billing patterns for each NPI and projected the change in income based on the proposed single payments for new and established outpatient E/M care and the historical patterns of new and established outpatient payment from 2015.

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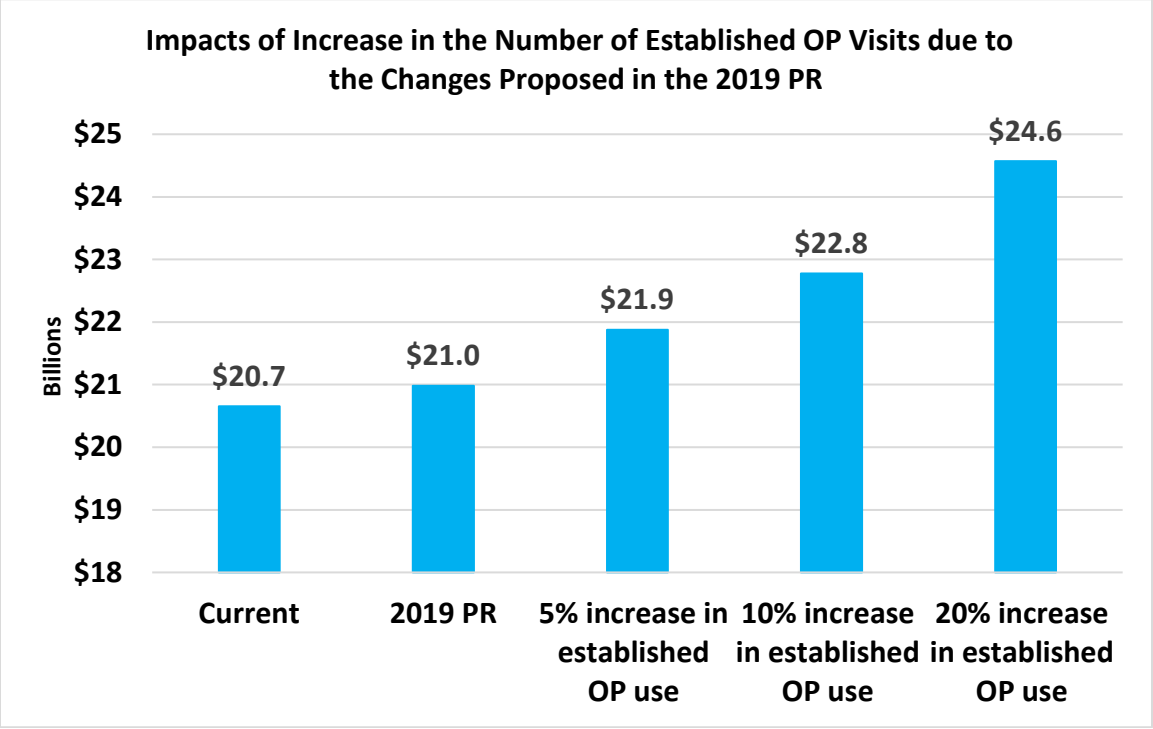
Appendix C: The impact of a modest volume increase in overall E/M service code billings

Findings: Thought it is hard to predict the behavioral response of the physician community to the ability to easily increase visit volume due to the simplification of documentation expectations, even a modest 5% increase in Medicare volume among established patients would increase Medicare E/M overall costs by $900 M. A 10% increase in volume would increase costs by $1.8 B and a 20% increase in volume by $3.6 B.



Modeling: For this table, we projected 2019 Medicare payments (including PE and malpractice) for new and established outpatient E/M visits based on 2015 Medicare payment data using the current E/M service code valuations ("current') and those proposed ("2019 PR'). We then projecting the Medicare payments with 5-10-20% increases in established patient volume based on Medicare 2015 payment patterns ("5-10-20% increases in established OP use").

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