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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 Infectious Diseases Society of America (IDSA) appreciates the opportunity to provide comments on the Proposed Rule for the 2019 Physician Fee Schedule. IDSA represents more than 11,000 infectious diseases (ID) physicians and scientists devoted to patient care, prevention, public health, education, and research in infectious diseases. Our members care for patients of all ages with serious infections, treating meningitis, pneumonia, tuberculosis, HIV/AIDS, health care-associated infections, antibiotic resistant bacterial infections, as well as emerging infections such as the Middle East Respiratory Syndrome coronavirus (MERS-CoV), Ebola virus and Zika virus diseases.

In October of 2017, CMS announced a new initiative called *Patients Over Paperwork*, with the goal "to reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience."[1] CMS has made considerable efforts to understand the extent of the administrative burden placed on physicians through various engagements (e.g., focus groups, listening sessions) over the past year. Informed by this outreach activity, CMS has proposed significant changes to outpatient Evaluation & Management (E/M) codes as detailed in the recently released 2019 Physician Fee Schedule Proposed Rule. In general, these changes collapse the number of codes used to describe an encounter with a new patient from five codes to two codes and does the same for the codes used to describe an encounter with an existing patient (again, from five codes to two codes). CMS proposes to reduce the documentation requirements associated with the use of the revised codes but also proposes to cut the reimbursement for these codes. CMS also proposes three new add-on codes (for primary care, specialty complexity, and prolonged services) to allow for payment adjustments to account for cases of higher patient complexity.

Furthermore, CMS has proposed the application of the Multiple Procedure Payment Reduction (MPPR) policy to E/M visits conducted on the same day as another procedure, resulting in a 50% payment reduction for the less costly physician service provided. Finally, CMS has proposed creating an outpatient E/M-specific, standard practice expense hourly rate (PE/HR) that creates distortions in the Indirect Practice Cost Indices, causing significant additional reduction in payment rates for certain specialties.

IDSA strongly supports the *Patients Over Paperwork* initiative. We appreciate that CMS understands the administrative burden endured by providers under the current documentation requirements which apply to all E/M service codes and applaud CMS for its desire to address these issues. We agree with CMS that the current E/M coding structure places emphasis on the wrong parts of care, encourages bloated patient notes and medical records and as well as creating inaccuracies via a "copy-paste" mentality. We support the proposal to allow the use of medical staff (MAs, RNs, etc.) documentation of the patient's history and chief complaint to suffice with an attestation by the physician, that history and chief complaint information were reviewed during the patient encounter. We view this proposal as a productivity gain for the ID physician. We also commend CMS for initiating what we hope will be a meaningful effort to correct longstanding deficiencies in both the descriptions and the valuations for office visits. However, IDSA has significant concerns about aspects of the proposed rule that link documentation changes to payment reductions as well as the use of the proposed add-on codes, the MPPR proposal, and the creation of a new PE/HR rate for the proposed E/M codes. IDSA implores the Agency to postpone the implementation timeline as indicated in the proposed rule and work with the physician community to refine the simplification of relevant E/M codes and address the issues related to the MPPR and PE/HR proposals.

IDSA members are committed to improving the safety and quality of patient care in hospitals and health systems across the nation. Our members provide treatment both for in-patients and out-patients and tend to see patients that are, on average, of higher clinical complexity given their multiple co-morbid conditions while also battling severe infections coupled with challenging socio-demographic factors. According to CMS, the specialty of infectious diseases is ranked 2nd out of 67 specialties when assessing average Hierarchical Condition Category (HCC) risk score and 7th when assessing Medicare-Medicaid Dual Eligible Patient Ratios, (both HCC and Dual eligibility are measures of patient complexity that CMS uses in the Merit-based Incentive Payment System).[1] Given this, it is not surprising to see that ID physicians tend to bill for outpatient encounters that are of higher complexity and that require more time, (i.e., level 4 and level 5).[2]

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[1] Medicare Program; CY 2018 Updates to the Quality Payment Program, Proposed Rule. Federal Register / Vol. 82, No. 125, p.30137. Available at https://www.federalregister.gov/documents/2017/06/30/2017-13010/medicare-program-cy-2018-updates-to-the-quality-payment-program

[2] Song Z, Goodson JD. "The CMS Proposal to Reform Office-Visit Payments." N Engl J Med. August 15, 2018. DOI: 10.1056/NEJMp1809742

We ask for a delay in implementation of the proposed E/M changes for the following reasons:

1. Our analysis of the proposed changes regarding financial impact on practicing infectious diseases physicians finds that the proposal would result in significant financial losses to ID physicians who, typically code level 4 and level 5 E/M codes because of the complexity of cases ID physicians treat daily. Whereas CMS indicates in the proposed rule that the impact of the proposed changes would result in a modest increase in overall payments to the specialty of infectious diseases, our analysis of the data indicates the impact to be -5.1% of total payments for ID physicians who see patients in the office setting.[3] In a separate analysis conducted by the AMA, the estimated financial impact on ID of the CMS proposed E/M changes and including the impact of the MPPR proposal is -9%.[4]

2. The proposed rule as written suggests that add-on codes for complex care may only be reported by a set of eligible providers yet, in several in-person meetings with CMS staff, more information has been provided that suggests the add-on codes are more widely applicable. A delay in the timeline would allow for the Agency to put forth clarifying information for the benefit of all stakeholders. Should these proposals be finalized as presented in the rule, we are concerned that implementation may present additional administrative burden, due to a lack of clarity.

3. The proposed rule is put forth on the assumption that a reasonable proxy for the complexity of a patient is the measure of the time the physician spends with the patient. This is a fundamentally flawed assumption that could have dire consequences as to how medicine is practiced if the proposal is finalized. It also fails to recognize that over time a skilled physician takes less time than a junior physician to do complex work simply by the level of experience gained. Using time as the only measure of value fails to recognize this concept that is well recognized in many other professions.

4. We are concerned that this proposal if finalized, will have the unintended consequence of allowing a level of documentation for complex patients that fails to capture the complexity in sufficient detail to inform effective communication between clinicians and support longitudinal care of the patient through transitions of sites of service and between providers.

5. We are concerned about the precedent that these changes, should they be finalized, would set for future physician services valuation conducted by CMS that lacks formal and meaningful input from the physician community.

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[3] The Moran Company. Infectious Disease Specialists - Impact Summary. Data analysis of 2016 Medicare Physician and Other Supplier Public Use File (PUF), 2018 RVU File (Q4), 2019 Proposed PFS Addendum B. August 2018.

[4] AMA. Estimated Impact of CY2019 Evaluation and Management Proposed Policy by Medicare Specialty. 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. August 2018.

6. The proposed timeline for implementation would pose serious administrative burdens on physicians and group practices to adjust their billing systems as well as modify financial forecasts that are already set for the 2019 fiscal year.

Below we provide further detail and rationale for our request of the Agency to delay implementation of the proposal related to outpatient E/M codes and the use of add-on codes.

Simplifying the Outpatient E/M Code Set

We support the Agency's efforts to simplify coding but believe that four codes (2 code set for new patients, 2 code set for existing patients) will not provide enough granularity to capture the complexity of many of the patients that ID physicians treat. We would prefer to explore the suitability of a 3-code structure (3 code set for new patients, 3 code set for existing patients) to allow for differentiation of encounters that involve truly complex patient care. We also take this opportunity to state our belief that non-face-to-face work such as record review often constitutes a significant part of the work effort for complex patients. As we mentioned above, we hope that CMS will collaborate with IDSA and other medical specialty societies to correct longstanding deficiencies in both the descriptions and the valuations for office visits that recognizes all the work involved in treating complex patients.

Improving Documentation Requirements

Documentation requirements, particularly in subsequent care visits, should focus on capturing diagnostic/medical complexity and uncertainty, risk and impact of the care, data management and care coordination. Elements in the record that we think can be used effectively to document complexity and communicate care include the following:

a. The complexity of pertinent patient history and comorbidities (ICD-10-CM)
b. Record review of past clinician notes
c. Radiology review (may involve review with radiology colleagues)
d. Laboratory review and interpretation (may involve communication with lab)
e. Testing request and interpretation
f. Interventions/treatment arranged – drainage, surgery, timing, potential risks and side effects, etc.
g. Follow-up assessments and comparison to prior status via exam, radiology, etc.
h. Care coordination with others, arranging care transitions

Assigning Complexity at the Patient-level, not by Specialty

IDSA, through its involvement with the Cognitive Care Alliance, has advocated for an improved methodology to be adopted to appropriately value cognitive care delivered in E/M services. Over the past two years, the CCA has engaged CMS in discussions around funding research to explore more accurate inputs that adequately capture patient complexity. Given the window of

opportunity that CMS has presented, we would propose that CMS work with IDSA, the CCA, and other medical societies to explore the application of CMS Hierarchical Condition Categories (CMS-HCC, which are derived from ICD-10-CM coding) and the related Risk Adjustment Factors to assess medical complexity at the patient level. We are hopeful that these available measures of complexity, currently used by CMS in the Quality Payment Program as well as in the Medicare Advantage Program, might prove useful as a means of capturing patient complexity in association with a simplified E/M code set. Should a 3-code set structure be established, then HCC Risk Adjustment Factor ranges could be assigned to each code, with reimbursement reflecting the higher payment for treating more complex patients.

IDSA appreciates the opportunity to provide input to CMS at this critical time, with an opportunity to make meaningful improvements to the valuation of cognitive services in E/M and to simplify documentation requirements to truly put *Patients Over Paperwork*. We recognize the work put forth by the Agency to bring the proposed changes to this point and hope to honor that effort by refining the end-product to a usable and auditable format. This long wished-for goal would improve patient care and access, but we feel strongly that it will require a commitment of an amount of time commensurate with the significant effort involved.

We look forward to future collaborations with CMS in this endeavor.

Sincerely,

Paul G. Auwaerter, MD, MBA, FIDSA
President