The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Chief Executive Officer
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September 27, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1715-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Re: CMS-1715-P; Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations

Dear Administrator Verma:

The American College of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners in women's health, appreciates the opportunity to provide comments on the Centers for Medicare and Medicaid Services' (CMS) proposed rule on the CY 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP). As physicians dedicated to providing quality care to women, ACOG appreciates CMS's willingness to continue seeking input from the physician community to implement sound policies for Medicare, both in terms of ongoing implementation of QPP and the proposed changes to documentation for Evaluation and Management (E/M) outpatient services. Below are recommendations to further improve beneficiaries' access to quality health care services.

Section II.B.3.b: Equipment Recommendations for Scope Systems

In response to the CMS request for detailed pricing information for several new scope equipment codes, ACOG has provided invoices in Attachment A. ACOG requests that ES071 *rigid scope, hysteroscopy* be updated to read *"rigid, channeled, hysteroscopy"* and that the hysteroscopy codes (i.e. 58555, 58562, 58565) be valued with ES071.

ACOG further requests that the Current Procedural Terminology (CPT) codes impacted by the updated scope pricing information in CY 2021 be outlined in a table, similar to TABLE 6: Proposed Scope Equipment Replacement in the CY 2020 Proposed Rule. ACOG continues to have concerns about the organization of scopes and scope accessories and encourages CMS to continue their work with the AMA's Practice Expense Subcommittee on issues related to scopes.

ACOG Recommendations:

- Update ES071 *rigid scope, hysteroscopy* to read *"rigid, channeled, hysteroscopy"*
- Value hysteroscopy codes (i.e. 58555, 58562, 58565) with ES071.
- Outline the CPT codes impacted by the updated scope pricing information in CY 2021 in a table, similar to TABLE 6: Proposed Scope Equipment Replacement in the CY 2020 Proposed Rule.

Section II.B.3.d(1): Market-Based Supply and Equipment Pricing Update

In CY 2019, CMS proposed to update pricing for over 2,000 supply and equipment items currently used as direct practice expense (PE) inputs based on their contract with StrategyGen. CMS proposed to update supply and equipment pricing over a 4-year phase-in. In the Proposed Rule for CY 2020, CMS received invoice submissions for approximately 30 supply and equipment codes from stakeholders as part of the second year of the market-based supply and equipment pricing update. ACOG appreciates CMS' willingness to review updated pricing throughout this 4-year phase-in. However, ACOG requests that CMS make available the components that make up the supply packages for the direct practice expense calculations. This will allow stakeholders (i.e., AMA/Specialty Society Relative Value Scale Update Committee (RUC) Practice Expense Committee) to assist CMS and its contractors (i.e. StrategyGen) analyze pricing information.

ACOG Recommendation: Make publicly available the components that make up the supply packages for the direct practice expense calculations to allow stakeholders to assist CMS in analyzing pricing information.

Section II.C.: Determination of Malpractice Relative Value Units (RVUs)

CMS is seeking comment on the proposed methodological improvements to the development of the professional liability insurance (PLI) premium data. For CY 2020, CMS uses a broader set of PLI filings, available online from the System for Electronic Rates & Forms Filing (SERFF) Filing Access Interface and largest market share insurers in each state to obtain a more comprehensive data set. ACOG appreciates CMS' willingness to improve its PLI source data.

Imputation Strategy

The updated malpractice premium data and new methodology for determining malpractice RVUs includes the use of the CMS regulation specialty impact tables to map CMS specialties for imputation. ACOG disagrees with this methodology for imputation.

CMS' proposed mapping compares specialties regardless of practice patterns, risk, and intensity. One example of this problematic application includes the proposed mapping of gynecologic oncologists (CMS Specialty 98) to impact specialty obstetrics/gynecology (surgical) for full imputation as opposed surgical oncology (CMS Specialty 91). Surgical oncologists, like gynecologic oncologists, preform surgeries on cancer patients to remove cancer and possibly the organs to which the cancer is attached. Gynecologic oncologists have a similar practice pattern and case mix to surgical oncologists. General ob-gyns perform surgeries on patients with benign disease, not cancer. The outcomes for a cancer surgery are inherently riskier than the outcomes for a general hysterectomy due to abnormal bleeding for the gynecologic

oncologist. For the specialty of gynecologic oncology, imputing malpractice cost to obstetrics/gynecology creates a situation where the malpractice risk of treating cancer is no longer considered when calculating the malpractice RVUs. This is significant as seen in the difference in risk factors and national premiums:

Specialty	2020 Service Risk Group	2020 Risk Factor	2020 National Premium
16 – Obstetrics/Gynecology	Surgical	3.716	$33,052
91 – Surgical Oncology	All	6.456	$57,430

ACOG strongly urges that CMS continue to crosswalk gynecologic oncology (i.e., risk factors and premiums) to surgical oncology (CMS Specialty 91) for purposes of calculating malpractice RVUs, as has been the case in previous years and methodologies. ACOG requests that the crosswalks continue under this new imputation methodology for the calculation of CY 2020 Malpractice RVUs and until CMS can collect a larger sample of gynecologic-oncology specific malpractice premium data.

Minor vs Major Surgeries

CMS proposes to change the development of the surgical risk factors for PLI RVU to combine minor surgery and major surgery premiums instead of using only premiums for major surgeries. CMS considers surgical services with physician work values greater than 5.00 as "major surgeries" for its analysis. ACOG appreciates that CMS is considering methods to calculate surgical risk factors, although we are concerned that the method CMS uses to classify surgeries as either minor or major is arbitrary and inconsistent with other CMS policy. For example, in the global surgical packages, the definition of minor surgeries are those where care generally concludes within a 10-day (global) period, and major surgeries are those that generally require a one-day preoperative and a 90-day global period. The definition of minor surgeries and major surgeries should be consistent and developed with a consensus methodology among physician specialties. Broadly, ACOG strongly recommends that CMS work with the physician community to more accurately define major and minor surgeries.

We also share concerns stated by the American Medical Association (AMA) that defining major and minor surgery based on the work RVU does not adequately take into consideration codes with global periods. In addition, the PLI RVUs should be specifically applied to codes defined as minor vs. major surgery to account for the various premium rates within a specialty. Until the definition of minor and major surgery is agreed upon by CMS and stakeholders, CMS should not adjust the malpractice RVU (PLI RVU) methodology and continue to collect distinct premium data for both major and minor surgery.

ACOG Recommendations:

- Crosswalk gynecologic oncology (i.e., risk factors and premiums) to surgical oncology (CMS Specialty 91) for purposes of calculating malpractice RVUs, as has been the case in previous years and methodologies.
- Work with the physician community to more accurately define major and minor surgeries.
- Specifically apply the PLI RVUs to codes defined as minor vs. major surgery to account for the various premium rates within a specialty.
- Continue to collect distinct premium data from both major and minor surgery.
- Do not adjust the malpractice RVU (PLI RVU) methodology until the definition of minor and major surgery is consistent.

Section II.G: Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs)

As required by the SUPPORT Act, CMS has proposed new bundled payment codes for opioid use disorder (OUD) treatment services that are furnished by OTPs. The bundles CMS proposes include medications approved by the Food & Drug Administration (FDA) for use in the treatment of OUD, the dispensing and administration of such medication, substance use counseling, individual and group therapy, and toxicology testing. In addition to the bundled payment codes for OTP services, CMS proposes to create an add-on code that can be billed for each additional 30 minutes of counseling or therapy. ACOG applauds CMS's efforts to establish payment methodologies and improve access to OUD treatment services.

ACOG is concerned that the bundled payment rates and proposed add-on code for OTPs that CMS proposed may not adequately support the level of care required by some complex patients, such as pregnant and postpartum women. According to ACOG guidance, management of medication assisted treatment (MAT) in pregnant and postpartum women requires more intensive care coordination, medication management services, and counseling. For example, women who are on a stable methadone dose before pregnancy may require dose adjustments or split dosages, especially during the third trimester of pregnancy. If a woman begins methadone treatment during pregnancy, her dosage will need to be titrated until she is asymptomatic. The timeliness of these adjustments is essential for pregnant and postpartum women with OUD, because an inadequate maternal opioid agonist pharmacotherapy dosage may result in opioid withdrawal signs, fetal distress, and an increased likelihood of relapse.[1] ACOG is concerned that the payment rates proposed do not account for this level of complexity.

In a bundled payment arrangement, the OTP may be forced to absorb the cost of more intensive care for pregnant and postpartum patients. ACOG believes that some OTPs will be unable to take on this financial burden and may choose to turn away pregnant and postpartum women. While pregnant and postpartum women make up a small proportion of Medicare beneficiaries, it is essential CMS consider their role as a facilitator of appropriate care and a model for other payers. If Medicaid programs and commercial insurers decide to implement a bundled payment arrangement for OTP services based on the Medicare model, it could lead to widespread barriers in access to care for these women. Evidence indicates that pregnant and postpartum women already face significant barriers to accessing MAT.[2,3] ACOG recommends that CMS work with OTPs to determine whether the add-on code that CMS is proposing will sufficiently cover the needs of pregnant and postpartum women who seek care at OTPs. We also urge CMS to work with SAMSHA to evaluate access to OTP services for pregnant and postpartum women and subsequently take any steps needed to maintain and improve access to this care.

In the proposed rule, CMS did not specify when a patient is considered to have entered or left an OTP. ACOG recommends that CMS clarify how it will determine when OTP services, and therefore the bundled payment for those services, is initiated and concluded. This will be particularly important for patients who are pregnant, postpartum, or have recently had surgery and therefore may be receiving other services that are part of a global package. CMS should also clarify whether there will be additional payment (e.g. through an add-on code) for ob-gyns and surgeons who engage in care coordination activities for pregnant, postpartum, or postoperative patients entering OTPs or whether this extra work will be included in the global surgical and obstetric packages.

ACOG urges CMS to ensure that treatment for substance use disorders in pregnant and postpartum women is not considered part of the existing global obstetric care packages. Additional services that may be unique to pregnant women, such as repeatedly adjusting MAT dosages throughout the prenatal period, should be provided through the OTP bundled payment and the applicable add-on codes. To maintain and improve access to treatment for pregnant women and postpartum women with OUD, it is critical that OTPs not face payment denials or other billing issues associated with the global codes. As mentioned previously, we remain concerned that OTPs will not accept pregnant patients under a bundled payment system, since pregnant and postpartum women with OUD often require more intensive care and coordination. We recommend that CMS provide OTPs with additional guidance on how to properly code and bill for services provided to pregnant and postpartum women, including how to avoid duplicating services that another provider may be billing under the global obstetric code.

Additionally, CMS should clarify whether there will be an additional payment (e.g. through an add-on code) for ob-gyns providing obstetric or postoperative care to women who are being treated in OTPs or whether this work will be part of the global surgical and maternity care packages.

ACOG Recommendations:

- Work with OTPs to determine whether the add-on code that CMS is proposing will sufficiently cover the needs of pregnant and postpartum women who seek care at OTPs.
- Partner with SAMSHA to evaluate access to OTP services for pregnant and postpartum women and subsequently take any steps needed to maintain and improve access to this care.
- Clarify how CMS will determine when a patient has entered and exited the care of an OTP.
- Ensure that treatment for OUD in pregnant and postpartum women is not considered part of the existing global obstetric care packages.
- Provide OTPs with additional guidance on how to properly code and bill for services provided to pregnant and postpartum women, including how to avoid duplicating services that another provider may be billing under the global obstetric code.
- Clarify whether there will be additional payment (e.g. through an add-on code) for ob-gyns and surgeons who engage in care coordination activities for pregnant, postpartum, or postoperative patients entering OTPs or whether this extra work will be included in the global surgical and obstetric packages.

Section II.H: Bundled Payments Under the Physician Fee Schedule (PFS) for Substance Use Disorders

CMS is proposing to establish bundled payments for office-based OUD treatment and create two new HCPCS codes to describe monthly bundled payment for services that include overall management, care coordination, individual and group psychotherapy and counseling for office-based OUD treatment. As requested by ACOG and other medical societies, CMS proposes one code to be billed for the month in which treatment was initiated to account for additional costs. The second code would be billed for ongoing office-based OUD treatment. Further, CMS proposes to create an add-on code to be used for each additional 30 minutes of treatment services beyond 120 minutes. ACOG commends CMS for working to expand access to office-based OUD treatment services. We also appreciate CMS's efforts to solicit feedback from physicians and other stakeholders, as well as incorporating that feedback into the final rule.

The proposed bundled payments do not include payment for medications used in MAT. Payment for medically necessary toxicology testing would not be included in the proposed bundle and will continue to be billed separately under the Clinical Lab Fee Schedule. ACOG appreciates efforts from CMS to expand access to office-based care for OUD.

CMS is not proposing to require consultation with an addiction specialist as a condition of payment for these codes. ACOG agrees that ob-gyns, family-medicine physicians, and other providers who obtain waivers to provide office-based buprenorphine treatments should be able to bill the proposed codes without the assistance of an addiction specialist. We believe that this will improve access to care, particularly for patients in rural and underserved areas where there may not be a practicing addiction specialist.

We commend CMS for creating separate codes for the initiation and ongoing maintenance of OUD treatment, as ACOG and other members of the physician community recommended during the comment period for the interim final rule for CY 2019. The month in which care is initiated includes intake activities and development of a treatment plan, and therefore requires a separate code from that of ongoing treatment.

ACOG also appreciates the creation of an add-on code that could be billed when effective treatment requires additional resources for a particularly patient that substantially exceed the resources included in the base codes. However, we are concerned that the proposed bundled and add-on codes do not adequately recognize real differences in patients' needs and the different mix of services that may be required to meet those needs. For instance, according to ACOG guidance, pregnant and postpartum women often require more frequent medication adjustments, counseling, and/or therapy. It is also likely that, if a pregnant woman is being treated by an addiction specialist, that physician will need to spend significantly more time coordinating with the woman's ob-gyn, primary care physician, and other providers. To ensure that all beneficiaries who seek treatment for OUD are able to access it, payments for OUD treatment must be risk stratified to support a higher level of services that may be required by beneficiaries with more complex needs.

ACOG recommends that each of the proposed codes for office-based OUD treatment be proposed to the CPT Editorial Panel and surveyed by the RUC. This will ensure these codes are made permanent and are properly valued. ACOG continues to believe that establishing proper payment for OUD treatment services is essential to ensuring beneficiaries' access to quality care.

As we stated previously, ACOG strongly recommends that office-based treatment for OUD in pregnant and postpartum women not be considered part of the existing global obstetric codes. Ob-gyns who are providing antepartum, intrapartum, and/or postpartum care, as well as providing office-based OUD treatment must be able to bill both the global obstetric code and the proposed bundled code for OUD treatment.

ACOG Recommendations:

- Risk stratify payments for OUD treatment to support a higher level of services that may be required by beneficiaries with more complex needs.
- Propose all new G-codes for office-based OUD treatment to the CPT Editorial Panel and have them surveyed through the RUC process.

- Ensure that physicians providing maternity care and office-based OUD treatment services to a single patient are able to bill both the OB global code and the bundled OUD treatment code at the same time.

Section II.J: Review and Verification of Medical Record Documentation

ACOG supports the proposal to establish a general principle to allow the physician who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team. ACOG seeks confirmation from CMS that only physicians are responsible for signing and verifying the documentation of the residents and medical students. Eliminating and streamlining reporting, monitoring, and documentation requirements will improve the health care delivery system by reducing unnecessary burdens for physicians and making the health care system more effective, simple, and accessible. We also agree that this general principle should be applied across the spectrum of all Medicare-covered services paid under the physician fee schedule.

ACOG Recommendations:

- Finalize the proposal to establish a general principle to allow the physician who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team.
- Confirm that only physicians are responsible for signing and verifying the documentation of the residents and medical students.

Section II.K: Care Management Services

CMS has worked with the CPT Editorial Panel and others to expand codes for care management services. In order to close gaps that remain, CMS has proposed several provisions to encourage care management services. For example, CMS proposes to allow Transitional Care Management (TCM) services to be billed concurrently with 14 codes previously considered to overlap TCM. Additionally, CMS has accepted the RUC recommended work RVUs of 2.36 for CPT code 99495 and 3.10 for CPT code 99496. ACOG commends CMS for accepting the RUC recommendations and considering barriers to TCM services.

The addition of temporary G-codes, as proposed by CMS to increase the time billed for chronic care management codes, will allow providers to bill for additional time in CY 2020. Again, ACOG commends CMS in their consideration of time needed by patients with multiple chronic conditions for care management. We recognize, along with CMS, the potential confusion as a result of temporary G-codes and would encourage CMS to avoid their use when feasible.

ACOG appreciates the recognition that one chronic condition can require significant resources and time for care management. With the development of Principle Care Management (PCM) services, CMS proposes that a significant gap in care management will be closed and an estimated $125 million will be spent annually. ACOG recommends that the PCM services are proposed at the CPT Editorial Panel and expedited for consideration in CY 2021. This will ensure the codes are not duplicating the work captured in E/M services and that the values are captured by survey in the RUC process.

ACOG strongly encourages CMS to continue coordination with the CPT Editorial Panel regarding the care management codes and we look forward to working with CMS and the CPT Editorial Panel to develop permanent codes for use in CY 2021.

ACOG Recommendations:

- Finalize the proposals to allow TCM services to be billed concurrently with 14 codes that were previously considered to overlap with TCM.
- Finalize the proposal to accept the RUC recommended values for CPT codes 99496 and 99496.
- Propose the PCM codes to the CPT Editorial Panel for expedited consideration in CY 2021.

Section II.N: Valuation of Specific Codes

ACOG has significant concerns regarding CMS's proposal to reject certain recommendations of the RUC and the use of Harvard codes that have never been surveyed as comparable codes. The methodology used in the original valuation of the Harvard codes is not resource-based, and therefore it is not an accurate comparison the surveyed time and work. For many diagnostic services in the Harvard study, total time rather than intra-service time was captured. Therefore, comparing Harvard codes to the modern RUC surveyed codes is not appropriate. In addition, the use of time ratio is not a valid methodology for valuation of physician services. The CMS "time/ratio methodology" does not consider intensity, which is a key component of evaluating services. The inconsistent application of approved valuation methodologies is undermining the very nature of the relative value system. ACOG urges CMS to adopt the CY 2020 RUC recommendations, which have been surveyed and follow a consistent methodology.

Drug Delivery Implant Procedures (CPT Codes 11981, 11982, 11983, 206X0, 206X1, 206X2, 206X3, 206X4, and 206X5)

CPT codes 11980-11983 were identified as potentially misvalued because the primary specialty billing the codes in recent claims data differs from the two specialties that originally surveyed the codes. The current valuation of CPT code 11980 *Subcutaneous hormone pellet implantation (implantation of estradiol and/or testosterone pellets beneath the skin)* was reaffirmed by the RUC as the physician work had not changed since the last review. ACOG thanks CMS for accepting the recommendations of the RUC for 11980.

The CPT Editorial Panel revised the other three existing codes in the family and created six additional add-on codes to describe orthopaedic drug delivery. These codes were surveyed and reviewed for the October 2018 RUC meeting.

The comments provided below are specific to codes related to obstetrics and gynecology services.

CPT Code 11981

CMS disagreed with the RUC recommended work RVU of 1.30 for CPT code 11981, stating that since CPT code 11981 incurs a 23 percent reduction in the survey total physician time (30 minutes) and with reference to CPT code 67500 *Retrobulbar injection; medication (separate procedure, does not include*

supply of medication) (work RVU = 1.18 and 33 minutes total time), CMS is proposing a work RVU of 1.14, by taking the current work RVU of 1.48 and reducing it by 23 percent.

The RUC recommended the survey 25th percentile work RVU of 1.30, which is a 12 percent decrease and is supported by codes 67515 *Injection of medication or other substance into Tenon's capsule* (work RVU = 1.40), 12013 *Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.6 cm to 5.0 cm* (work RVU = 1.22) and 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44).

CPT code 11981 is not comparable to the CMS referenced code 67500. The typical patient undergoing a retrobulbar injection of medication is a 50-year-old male with posterior scleritis. The typical patient undergoing CPT Code 11981 is an elderly male with metastatic prostate cancer. These patients will typically have poor nutritional status and poor wound healing characteristics adding to the intensity of placing a non-biodegradable device in a specific location in the upper arm. Thus, during insertion of the implant in the typical patient with poor muscular tone, careful attention must be given to avoid damage to the muscles and vasculature of the upper arm. CPT code 11981 involves two injections and delivery of two medications, local anesthesia first and the implant second. The CPT code CMS references (67500) has just one injection. The procedure also requires a pressure dressing that is not required for CPT code 67500.

As proposed, CPT Code 11981 will only be 0.04 more than CPT code CPT Code 11980. The RUC noted that CPT code 11981 is a different procedure compared to CPT Code 11980 and involves more physician work. CPT code 11980 is the subcutaneous implantation of a biodegradable compounded pellet that can be placed anywhere in the body with a needle and trocar. CPT code 11981 is the insertion of a non-biodegradable implant that must be placed in a specific location in the arm in which the physician must avoid the nerve and vascular bundle in the arm. CPT code 11981 is the placement of a silastic capsule with a trocar system and removal of the placement device. Therefore, the physician time and work are significantly different than that in CPT Code 11980, and a 0.04 work RVU difference does not accurately depict the relativity of these two services. The typical patient undergoing CPT code 11980 is a middle-aged male with testosterone deficiency. These patients are relatively healthy with excellent wound healing characteristics. There are multiple locations in the body that the biodegradable pellets described in 11980 can be placed including the subcutaneous tissues of the buttocks. The nonbiodegradable drug delivery device described in CPT Code 11981 can only be placed in the upper extremity. Specific care must be taken to avoid damage to the upper arm musculature while placing the device. The typical patient undergoing 11981 has metastatic cancer, has been on androgen deprivation therapy, and has poor muscular tone making safe and successful placement of the drug delivery device significantly more intense than the placement of a biodegradable pellet in a relatively healthy, middle-aged male. To reiterate, a work RVU difference of 0.04 does not accurately account for this substantial difference in intensity. ACOG strongly urges CMS to accept the original recommendations from the RUC.

CPT Code 11982

CMS disagreed with the RUC recommended work RVU of 1.70 for CPT code 11982, stating that since CPT code 11982 incurs a 25 percent reduction in the new total physician time (33 minutes) and with reference to CPT code 64486 *Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)* (work RVU = 1.27 and 35 minutes total time) CMS is proposing a work RVU of 1.34, by reducing the current work RVU of

1.78 by 25%. CMS accepts the RUC recommended 10 minutes for intra-service time and 33 minutes of total time.

The typical patient undergoing CPT Code 11982 is an elderly male with metastatic prostate cancer. The typical patient for the CMS referenced code 64486 is a 25-year-old healthy male undergoing an appendectomy. CPT code 64486 describes the injection of local anesthetic in the transversus abdominis place under image guidance. There is no procedural similarity to the removal of a nonbiodegradable implant, adherent to a subcutaneous capsule, in an elderly patient with metastatic cancer. It is unreasonable for CMS to disregard the RUC recommendation and reference CPT code 66486 based on time alone.

The RUC recommends the survey 25th percentile work RVU of 1.70 for CPT code 11982. This is supported by CPT codes 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90) and 12004 *Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 7.6 cm to 12.5 cm* (work RVU = 1.44). Again, ACOG strongly recommends CMS reconsider and accept the work RVU recommended by the RUC.

CPT Code 11983

CMS disagreed with the RUC recommended work RVU of 2.10 for CPT code 11983, stating that since CPT code 11983 incurs a 42 percent reduction in the new total physician time (40 minutes) and with reference to CPT code 62324 *Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance* (work RVU = 1.89 and 43 minutes total time) CMS is proposing a work RVU of 1.91, and to accept the RUC recommended 15 minutes for intra-service time and 40 minutes of total time.

The RUC recommends the survey 25th percentile work RVU of 2.10 for CPT code 11983, which is a 36% decrease and is supported by CPT codes 55700 *Biopsy, prostate; needle or punch, single or multiple, any approach* (work RVU = 2.50), 54150 *Circumcision, using clamp or other device with regional dorsal penile or ring block* (work RVU = 1.90) and 52281 *Cystourethroscopy, with calibration and/or dilation of urethral stricture or stenosis, with or without meatotomy, with or without injection* procedure for cystography, male or female (work RVU = 2.75). The intensity of the work required to perform CPT code 11983 is not comparable to CMS's reference to injection of anesthetic code 62324. In the removal of these devices, CPT code 11983, the patient must be localized, sometimes under fluoroscopy. Then the patient must be adequately mobilized for safe extraction, ensuring no damage to local tissues or surrounding structures. An assessment is necessary to ensure complete device removal. Finally, tissues mobilized during the removal must then be re-secured. The work required for 11983 is significantly more intense than code 62324.

The proposed work RVU for CPT code is based on flawed time. CMS's proposals for CPT codes 11981, 11982 and 11983 dismisses the input from the physicians who perform these services and distorts the intensity and relativity among this family of services. ACOG urges CMS to accept a work RVU of 2.10 for CPT code 11983.

<u>Somatic Nerve Injection (CPT Codes 64400, 64408, 64415, 64416, 64417, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, and 64450)</u>

In May 2018, the CPT Editorial Panel approved the revision of descriptors and guidelines for the codes in this family and the deletion of three CPT codes to clarify reporting. This family of services describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve, or branch; reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number of injections performed along the nerve plexus, nerve, or branch described by the code. ACOG is providing comments below on the CPT codes relevant to obstetrics and gynecology.

CPT Code 64430

CMS disagrees with the RUC recommended work RVU of 1.15 and proposes a work RVU of 1.00 based on a bracket of CPT codes 45330 *Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)* (work RVU= 0.84, 10 minutes of intra-service time, 41 minutes to total time) and 31576 *Laryngoscopy, flexible; with biopsy(ies)* (work value= 1.89, 10 minutes of intra-service time, 45 minutes to total time). CMS cited a time ratio as support for their decision, however, did not note that the current time for 64430 is from the Harvard study.

The RUC recommendation was based on the current work RVU which is supported by the 25th percentile work RVU from robust survey results, as well as careful review of all underlying clinical attributes of the procedure. The RUC strongly supported its recommendation with favorable comparison to CPT code 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (work RVU = 1.24, intra-service time of 10 minutes, total time of 40 minutes) and CPT code 32562 *Instillation(s), via chest tube/catheter, agent for fibrinolysis (e.g., fibrinolytic agent for break up of multiloculated effusion); subsequent day* (work RVU = 1.24, intra-service time of 10 minutes, total time of 40 minutes). ACOG urges CMS to accept a work RVU of 1.15 for CPT code 64430.

Biofeedback Training (CPT Codes 908XX and 909XX)

CPT code 90911 *Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry* was identified as potentially misvalued on a RAW screen of codes with a negative IWPUT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS or other source codes. In September 2018, the CPT Editorial Panel replaced this code with two new codes to describe biofeedback training initial 15 minutes of one-on-one patient contact and each additional 15 minutes of biofeedback training.

CMS is proposing the RUC-recommended work RVU of 0.90 for CPT code 908XX *Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry when performed; initial 15 minutes of one-on-one patient contact*, as well as the RUC-recommended work RVU of 0.50 for CPT code 909XX *Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry when performed; each additional 15 minutes of one-on-one patient contact*.

CMS is proposing to refine the equipment time for the power table (EF031) equipment in CPT code 908XX to conform to CMS established standard for non-highly technical equipment. CMS is also proposing to designate CPT codes 908XX and 909XX as "sometimes therapy" procedures which means that an appropriate therapy modifier is always required when this service is furnished by therapists.

ACOG commends the CMS acceptance of the RUC recommended values for biofeedback training codes.

> **ACOG Recommendation**: adopt the CY 2020 RUC recommendations, which have been surveyed and follow a consistent methodology.

Section II.O: Comment Solicitation on Opportunities for Bundled Payments under the PFS

CMS is soliciting information on opportunities to expand bundled payments within the PFS for services that are commonly furnished together. Many of the services that ob-gyns provide are already bundled into codes with assigned global periods that include all of the services commonly provided within that period. For instance, there are 17 maternity codes (MMM global) that describe the bundled services in obstetrical care, such as CPT Code 59400 *Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care,* which begins with the first visit of antenatal care and continues through labor and delivery and then all postpartum care.

Another example is CPT Code 58260 Vaginal hysterectomy, for uterus 250 g or less, which includes a 90-day global period and all pre-operative work performed within 24 hours of the surgery, the surgery itself, all post-operative work on the day of the procedure and for 90 days following the procedure, including hospital and office visits. These codes were approved by the CPT Editorial Panel and valued by the RUC. This valuation is critical to ensuring that relativity is maintained within the PFS and physicians are fairly compensated based on the time and expense incurred to furnish services. ACOG supports the work done by both the CPT Editorial Panel and the RUC and encourages CMS to work with both panels to develop additional bundled codes that may be suggested in response to this request for information.

> **ACOG Recommendation**: Work with the CPT Editorial Panel and the RUC to develop additional bundled codes that may be suggested in response to this request for information.

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

ACOG commends CMS for proposing to align E/M office visit coding and payment with the framework adopted by the CPT Editorial Panel; however, we are extremely concerned that CMS did not propose to incorporate these changes into the E/M visits valued in the global codes.

CMS proposes to retain five levels of E/M coding for established patients, reduce the number of levels to 4 for new patients (by deleting 99201), and revise the code definitions and guidelines. Physicians can choose the level of E/M visit based on either medical decision making (MDM) or time, and history and physical exams would no longer be a consideration for code level selection. ACOG supports these proposals. CMS also proposes to implement a new CPT code for extended office visit time. ACOG commends CMS for working to reduce administrative burden associated with E/M documentation requirements. We also appreciate CMS's willingness to work with the medical community through the AMA CPT/RUC process. ACOG urges CMS to finalize the proposal to accept the CPT codes, CPT guidelines, and RUC recommendations.

Proposed Add-On Code (GPCIX)

CMS is proposing an add-on code for E/M office visits describing the complexity associated with visits that serve as a focal point for all ongoing medical care related to a patient's single, serious, or complex chronic condition. ACOG agrees with the Medicare Payment Advisory Commission that the add-on code is problematic because it does not clearly define the types of visits that require additional resources and may lead to complexity and additional documentation burden.[4] As such, ACOG recommends that CMS delay the implementation of this add-on code and allow the CPT Editorial Panel to better define the service to meet its intended purpose.

ACOG also requests that CMS explain the projected use of this code. Although the codes descriptor implies that all physicians may report the code, only a subset of specialties are projected to receive payment for the service in the CMS published impact tables. The application of this new add-on code is not clear. If CMS plans to proceed with this code, the agency should explain the projected use of this code in detail, as well as articulate all of the underlying assumptions regarding the potential use of this code.

Office Visits Included in Global Payment

CMS is proposing to not apply the office visit increases to the visits bundled into global payment codes utilized for surgery and maternity care (MMM). CMS cites their continued efforts with RAND to collect information on global surgery codes as the reason for not applying the updates to the global surgical visits. ACOG is opposed to CMS failing to incorporate into the global codes the adjusted values for the revised office/outpatient E/M codes. By failing to adopt all of the RUC-recommended work and time values for the revised office visit E/M codes for CY 2021, including the recommended adjustments to the 10- and 90-day global codes, CMS improperly proposes to implement these values in an arbitrary and piecemeal fashion. If CMS plans to move forward with the proposal to adopt the RUC-recommended values and times for office/outpatient E/M codes, it is inappropriate to not also apply the incremental RUC-recommended changes to global codes. It is imperative that CMS take this crucial action because to do otherwise will:

- Disrupt the relativity in the fee schedule. Applying the RUC-recommended E/M values to stand-alone E/M services, but not to the E/M services that are included in the global surgical package since the inception of the fee schedule, will result in disrupting the relativity between codes across the Medicare physician fee schedule. Changing the values for some E/M services, but not for others, disrupts this relativity, which was mandated by Congress, established in 1992, and refined over the past 27 years. Indeed, since the inception of the fee schedule, E/M codes have been revalued three times — in 1997 (after the first five-year review, in 2007 (after the third five-year review) and in 2011 (after CMS eliminated consult codes and moved work RVUs into the office visit codes). When the payments for new and established office visits were increased in these instances, CMS also increased the bundled payments for corresponding post-operative visits in the global period.

- Create specialty differentials. Per the Medicare statute, CMS is prohibited from paying physicians differently for the same work, and the "Secretary may not vary the . . . number of relative value units for a physicians' service based on whether the physician furnishing 2 the service is a specialist or based on the type of specialty of the physician."[5] Failing to adjust the global codes is tantamount to paying some doctors less for providing the same E/M services, in violation of the law.

- Conflict section 523(a) of the Medicare Access and Chip Reauthorization Act of 2015 (MACRA)[6]. CMS refers to the ongoing global code data collection effort as a reason for not applying the RUC-recommended changes to office visit E/M codes to global codes. In addition, the agency states that it is required to update global code values based on objective data from all of the resources used to furnish the services included in the global package. These arguments conflate two separate issues. The issue that CMS raises regarding MACRA legislation is not related to maintaining relativity across the fee schedule based on current data in the CMS work/time file. In fact, section 523(a) specifically authorizes CMS to adjust surgical services, notwithstanding

the mandate to concomitantly undertake the MACRA-mandated global code data collection project.

- Ignore recommendations endorsed by nearly all medical specialties: The RUC, which represents the entire medical profession, voted overwhelmingly (27-1) to recommend that the full increase of work and physician time for office visits be incorporated into the global periods for each CPT code with a global period of 10-day, 90-day and MMM (maternity). The RUC also recommended that the practice expense inputs should be modified for the office visits within the global periods.

Office Visits and Obstetric Care

ACOG believes that this proposal is going to have a disproportionate impact on women's health care services. The MMM global codes are outliers in the fee schedule as they do not have a typical Medicare global period of 10 or 90 days and include several E/M visits to cover almost a year of services. Below is a list of services that are valued within global maternity codes 59400, 59510, 59610, and 59618.

The global obstetric codes include:

Antepartum services (approximately 13 visits):

- the initial and subsequent history
- physical examinations
- recording of weight, blood pressure, and fetal heart tones
- routine urine dipstick analysis
- monthly E/M visits up to 28 weeks gestation
- biweekly E/M visits up to 36 weeks gestation
- weekly E/M visits from 36 weeks gestation until delivery

Delivery services:

- admission to the hospital
- admission history and physical examination
- management of uncomplicated labor
- vaginal or cesarean delivery

Postpartum services (traditionally 6 weeks after delivery; 90 days for Medicare for a cesarean delivery, 60 days in Medicaid statute)[7]

- routine hospital visits
- routine E/M office visits

The number and timing of E/M office visits valued within the global codes is based on evidence-based guidance from ACOG and the American Academy of Pediatrics. The *Guidelines for Perinatal Care* state that "a woman with an uncomplicated first pregnancy is examined every 4 weeks for the first 28 weeks of gestation, every 2 weeks until 36 weeks of gestation, and weekly thereafter."[8] This guidance is reflected in the included services listed above and is widely considered a standard of care.

In addition to those CPT codes that include the entire continuum of maternity care - antenatal, labor and delivery, and postpartum care - there are also global CPT codes that can be billed when an ob-gyn only provides some of the services listed above. For instance, CPT code 59425 is billed when an ob-gyn only

provides 4-6 prenatal care visits and is valued to include 5 E/M office visits. On the other hand, CPT code 59410 is used when an ob-gyn only performs a vaginal delivery and provides postpartum care and is valued to include 2 postpartum E/M office visits. These codes allow for flexibility in billing when women initiate prenatal care later in pregnancy or change obstetric care providers partway through their pregnancy.

We have provided a comprehensive list of the 17 MMM codes and the number of E/M office visits valued in each below:

CPT Code and Abbreviated Description	Phases of Care Included	E/M Visits Valued
59400 – Routine obstetric care for a vaginal delivery	Prenatal, intrapartum, postpartum	13
59409 – Vaginal delivery only	Intrapartum	0
59410 – Vaginal delivery and postpartum care	Intrapartum, postpartum	1
59414 – Delivery of placenta (separate procedure)	Intrapartum	0
59412 – External cephalic version with or without tocolysis	Intrapartum	0
59425 – Reported for 4-6 prenatal care visits	Prenatal	4
59426 – Reported for 7+ prenatal care visits	Prenatal	9
59430 – Postpartum care only		2
59510 – Routine obstetric care for cesarean delivery	Prenatal, intrapartum, postpartum	14
59514 – Cesarean delivery only	Intrapartum	0
59515 – Cesarean delivery and postpartum care	Intrapartum, postpartum	2
59610 – Routine obstetric care for vaginal delivery after previous cesarean delivery	Prenatal, Intrapartum, postpartum	13
59612 – Vaginal delivery after previous cesarean delivery only	Intrapartum	0
59614 – Vaginal delivery after previous cesarean delivery and postpartum care	Intrapartum, postpartum	1
59618 – Routine obstetric care for cesarean delivery after attempted vaginal delivery after previous cesarean delivery	Prenatal, intrapartum, postpartum	14
59620 - Cesarean delivery after attempted vaginal delivery after previous cesarean delivery only	Intrapartum	0
59622 – Cesarean delivery after attempted vaginal delivery after previous cesarean delivery and postpartum care	Intrapartum, postpartum	2

An analysis of CPT code 59400 *Routine obstetric care including antepartum care, vaginal, delivery (with or without episiotomy, and/or forceps) and postpartum care* revealed that the 13 units of the E/M codes included in the total Work RVUs accounts for almost 40% of the total work. In addition to the units above, CPT codes 99204 or 99215 may be billed within the global code for the first visit. The tables below illustrate the difference in Work RVUs and Medicare Facility National Payment with 2019 values and 2020 values with the updated E/M visits. The calculations assume no additional changes to PE or PLI and use the conversion factor $36.09.

E/M Work RVUs:

CPT Code	Units in Global	2019 Work RVUs	Total 2019 Work RVUs	2020 Work RVU (updated E/M)	Total 2020 Work RVUs (updated E/M
99212	2	.48	.96	.70	1.40
99213	9	.97	8.73	1.30	11.70
99214	2	1.50	3.00	1.92	3.84
Total	**13**		**12.69**		**16.94**

Work RVUs and Payment for 59400:

	Total Work RVUs for E/M	Total Work RVUs	Total Facility RVU	Medicare Facility National Payment
2019	12.69	32.16	60.43	$2,177.84
2020	16.94	36.41	64.68	$2,344.30

If this rule is finalized as proposed, ob-gyns and other obstetric care providers will be paid less for thirteen E/M office visits than they would be if those visits were standalone E/M services. These services are critical to the health and wellbeing of women and their fetuses and should be valued as such in the Medicare Physician Fee Schedule.

ACOG is particularly concerned with the unintended consequences that may result from the agency's failure to incorporate these changes into global codes. To put this in perspective, the National Vital Statistics System of the National Center for Health Statistics reported 3,855,500 births in 2017, and women covered by Medicaid accounted for 43 percent of all births nationally.[9] California, having 471,358 births and one of the lowest reimbursement rates for obstetric care, pays $1,390.14 for 59400.[10] Texas, the state with the second-highest birthrate of 382,050, does not use the global code.[11] The rural state of Iowa pays 70% of the national fee schedule,[12] and the urban District of Columbia's Medicaid program currently pays providers 80%.[13] If Medicare payment for obstetric care is reduced over time, Medicaid rates will also decrease. Due to the relative nature of the fee schedule, we expect overall payments for obstetric care to decrease if this rule is implemented as proposed.

Data show that payment is a deterrent to physician participation in Medicaid.[14] Despite this evidence, states often set Medicaid payment rates far below Medicare rates. This leads to providers choosing not to participate in the Medicaid program, as well as to the closure of rural obstetric units and hospitals. Evidence indicates that closures of rural obstetric units and entire hospitals have affected access to care or more than 28 million women of reproductive age (18-44) living in rural America.[15] We are concerned that by failing to incorporate these E/M changes into the global maternity codes, this proposed rule could lead to increasingly insufficient Medicaid payment rates, forcing providers out of the program and jeopardizing patients' ability to access health services.

Now more than ever, maintaining and improving women's access to high-quality maternity care is critical as our country faces a maternal health crisis. The CDC reports a steady increase in pregnancy-related deaths in the United States from 7.2 deaths per 100,000 live births in 1987 to 17.2 deaths per 100,000 live births in 2015.[16] Secretary Azar has publicly stated that the Administration is prioritizing rural and maternal health,[17] and at the National Rural Health Association's (NRHA) Annual Conference, Seema Verma announced the CMS/NRHA co-sponsored Maternal Health Forum to explore options for improved maternal health outcomes.[18] Accepting the E/M values in the MMM global codes is congruent to this Administration's health care priorities, consistent with statute, and will encourage obstetricians and obstetric care providers to continue providing care to mothers covered by Medicaid.

Gynecologic Care

ACOG is also concerned that by failing to incorporate the increases in payment to postoperative visits, CMS is undervaluing gynecologic surgery care. Data from the Medicare Procedures File indicate approximately 122,000 women Medicare beneficiaries received pelvic surgery in 2017.[19] Hysterectomies, the most common of the surgeries for the Medicare population, require at least 2 office visits. It is imperative that the work provided by physicians during office visits, preventing post-operative complications and ensuring long-term improved health outcomes, is equally recognized across patient populations and physician specialties.

Further, evidence indicates that women beneficiaries of Medicare and Medicaid experience care delays in receiving treatment for gynecologic cancer, as compared to their privately insured counterparts.[20] The care delays were longest in patients covered by Medicaid, indicating that payment rates have a direct impact on access to care for Medicare and Medicaid beneficiaries. Accordingly, CMS's devaluing of surgical and obstetric care may result in care delays for women seeking surgical treatment for malignant disease.

ACOG is extremely concerned that this proposal will threaten the financial sustainability of ob-gyn practices and create barriers for women beneficiaries of Medicare and Medicaid who are seeking both obstetric and gynecologic services. We urge CMS to consider the full range of potential impacts to this proposal, and again recommend that the agency incorporate the increases for E/M services into the global codes.

<u>Total Time</u>

CMS proposes to adopt the new time ranges indicated in the CPT code descriptors as revised by the CPT Editorial Panel. The agency indicates that it also intends to adopt the new CPT guidelines in full. However, the language in the proposal and guidelines appear to conflict. The CPT guidelines state that time for these services includes both face-to-face and non-face-to-face time spent by the physician and/or qualified health professionals (QHPs).[21] However, CMS states in the rule the total time personally spent by the reporting practitioner on the day of the visit should be used to bill for E/M services. It is not clear if CMS intended that the total time includes all related encounters with the physician and QHPs, or only the reporting provider (i.e., physician or QHP). ACOG requests that CMS clarify the definition of total time.

ACOG Recommendations:

- Finalize the proposal to adopt the CPT codes, CPT guidelines, and RUC recommendations exactly as implemented by the CPT Editorial Panel and submitted by the RUC.
- Delay the implementation of the proposed add-on code GPCIX and work with the CPT Editorial panel to further define its intended use.
- Explain the projected use of the GPCIX add-on code in detail.
- Apply the proposed payment increases to E/M office visits to those E/M services valued in global maternity and surgical codes.
- Clarify how CMS intends to define total time for the purposes of E/M billing and documentation.

<u>Section III.K.: CY 2020 Updates to the Quality Payment Program</u>

Section III.K.3.a: Transforming MIPS: MIPS Value Pathways Request for Information

Eligibility

ACOG strongly urges CMS to maintain the low-volume threshold for MIPS participation throughout the implementation, transition period, and ongoing development of MVPs. It is our understanding that some MVPs may be episode-based or procedure specific. If this is the case, ACOG strongly recommends against determining MIPS eligibility based on a different threshold, such as a case minimum for a particular MVP. Instead, physicians who do not meet or exceed the low-volume threshold should not be required to report to MIPS. Clinicians who are eligible to opt-in should be able to choose to report through either an MVP or the traditional pathway.

Participation

CMS proposes to assign MVPs to MIPS eligible clinicians to reduce the administrative burdens associated with choosing from various MIPS measures and reporting options. ACOG appreciates CMS's efforts to reduce administrative burden, but instead recommend that CMS adopt an opt-in policy. This alternative approach would allow physicians to opt-in to an MVP that CMS suggests, or choose an alternative MVP, or continue to report measures through the traditional MIPS pathway. ACOG strongly believes that ob-gyns and other physicians are in the best position to determine which clinical area and reporting option will be most meaningful to their practice.

CMS should base its suggested MVP for each clinician or group practice based on past MIPS reporting data, physician specialty designation, and claims history. CMS should also inform clinicians of their suggested MVP using several avenues, including the QPP Participation Status Tool, QPP submission portal, and the performance feedback report provided to clinicians regarding their previous years' data. Additionally, physicians should be able to easily choose their MVP from the QPP Participation Status Tool or QPP submission portal.

ACOG recommends that CMS incentivize participation in MVPs instead of requiring physicians to participate in them. For instance, physicians reporting to the program through an MVP should be able to report on fewer patients and should receive more timely feedback from CMS on their performance. CMS should also ensure that participation in MVPs is less burdensome than the traditional reporting pathway. We strongly recommend that CMS not require participation in MVPs, particularly during the transition period when MVPs are being implemented and refined.

Reporting

The MVP framework CMS outlined in the proposed rule groups measures together into bundles within a specific clinical area but still requires physicians to report in each performance category. When implementing MVPs, ACOG recommends that CMS eliminate the need for physicians to report in four separate performance categories.

For example, physicians should automatically get credit for the IA category when reporting through an MVP, similar to how MIPS APMs and recognized Patient Centered Medical Homes are currently scored in the IA performance category. Ob-gyns and other physicians who reports quality measures through an EHR, qualified registry, or QCDR, they should receive automatic credit for the PI category. Additionally, a physician should be able to attest that they (or at least 75% of the eligible clinicians in their group) are using CEHRT or health IT that interacts with CEHRT, rather than reporting on individual Promoting

Interoperability measures. When reporting on quality measures through the EHR or a registry, practices are automatically utilizing CEHRT. This reduced reporting will create a hybrid approach between MIPS and Advanced APMs to better help physicians prepare to participate in APM models, as CMS intends to achieve with MVPs. The approach described above would also incentivize participation in MVPs by greatly reducing the reporting burden.

ACOG Recommendations:

- Maintain the low-volume threshold for MIPS participation throughout the implementation, transition period, and ongoing development of MVPs.
- Refrain from assignment MVPs to eligible clinicians and requiring that they report to that MVP.
- Adopt an opt-in approach for MVPs, whereby a clinician can participate by reporting to an MVP suggested by CMS, a different MVP, or the traditional MIPS pathway.
- Incentivize participation in MVPs instead of requiring it.
- Provide eligible clinicians with information on their suggested MVP through several avenues, including the QPP Participation Status Tool, QPP submission portal, and the performance feedback report provided to clinicians regarding their previous years' data.
- Eliminate the need for physicians to report in four separate performance categories when reporting through an MVP.
- Provide automatic credit for the IA category when physicians report through an MVP.
- Provide automatic credit for the PI category when physicians report quality measures through an EHR, qualified registry, or QCDR.

<u>Section III.K.3.c(1): Quality Performance Category</u>

CMS proposes to weigh the Quality performance category at 40 percent for the 2020 MIPS performance period, 35 percent for the 2021 performance period, and 30 percent for the 2022 MIPS performance period. ACOG does not support these proposed changes or the associated increases to the weight of the Cost performance category. It is not required in statute and moreover, there remain issues with the Cost performance category further noted in our comments below.

CMS is seeking comment on whether the CAHPS for MIPS survey should collect data at the individual eligible clinician level. ACOG recommends that CMS not move to collect data on the individual clinician level through the CAHPS for MIPS survey. There have been few studies evaluating the reliability and validity of CAHPS in patient visits with specialists, and more testing of the appropriate questions is needed.[22] ACOG recommends that CMS work with the Agency for Healthcare Research & Quality (AHRQ) and specialty provider societies to adapt CAHPS so it is consistent among specialists and meaningful to Medicare beneficiaries.

ACOG Recommendations:

- Do not finalize the proposal to increase the weight of the Quality performance category to 40 percent for the 2020 performance period.
- Do not implement data collection at the individual eligible clinician level in the CAHPS for MIPS survey.

<u>Section III.K.3.c(2): 2: Cost Performance Category</u>

CMS proposes to increase the weight of the Cost performance category from 15% in 2019 to 20% in 2020, 25% in 2021, and to 30% in 2022. CMS also proposes significant changes to the Cost category in 2020, including adding 10 episode-based cost measures and revising the existing total per capita cost (TPCC) and Medicare Spending per Beneficiary (MSPB) measures.

ACOG urges CMS to maintain the weight of the Cost category at 15% of the final MIPS score for at least the 2020 performance period. CMS needs to address concerns with the cost measures, attribution issues, provide physicians with feedback about their resource use, and develop the MVP framework. It is premature to increase the weight of this performance category while continuing to make significant changes to it.

To date, physicians have only received detailed feedback on cost measures for one performance year – 2018. While ACOG appreciates that the 2018 feedback reports included demographic and clinical characteristics for attributed beneficiaries, costs related to services billed by the clinician, and utilization of hospital and acute care, comparison data to assist physicians with unwarranted variation in spending and individual patterns of care were not available. Additionally, physicians have not received feedback about the first wave of episode-based cost measures which went into effect in 2019. As proposed for 2020, CMS intends to significantly revise the measures that physicians received feedback on for 2018. Given the limited information available to physicians on their past performance, as well as the major changes CMS is proposing in this category for performance year 2020, ACOG does not believe it would be appropriate to increase the weight of the Cost category. In addition, ACOG recommends that future reports include comparison information useful for individual physicians to evaluate their own performance and improve from year to year.

CMS has proposed ten new episode-based cost measures in the proposed rule. ACOG believes that CMS should work to create a softer glide path for these new measures by setting higher reliability and minimum episode thresholds for the first year and reducing the threshold in later years as appropriate. This methodology will ensure that new episode-based cost measures are reliably and consistently measuring resource use during an episode of care.

ACOG requests that CMS clarify how it plans to maintain and update the growing number of episode-based cost measures. For instance, we expect that these measures would change as Medicare payment, the ASC-payable list, and other policies change. ACOG urges CMS to work with specialty societies throughout the maintenance process to ensure continuous input from the provider community.

ACOG remains concerned about the use of the TPCC and MSPB measures, which both hold physicians accountable for costs outside their control. While we appreciate the adjustments CMS has made to the TPCC measure to eliminate the problem of attributing costs that occurred before the physician ever saw the patient, we are concerned that the new prospective attribution methodology will still hold physicians accountable for costs that they cannot control. The revised measure methodologies, particularly attribution and risk adjustment, remain problematic. These measures also double count the same costs, which will be exacerbated by the introduction of new episode-based cost measures that will count the same procedure and inpatient costs.

ACOG Recommendations:

- Maintain the weight of the Cost category at 15% of the final MIPS score.
- Remove the TPCC and MSPB measures that hold physicians accountable for costs outside their control.

- Include comparison information in future detailed feedback reports so that physicians can determine the extent to which unwarranted variation in spending exists.
- Create a softer glide path for these new measures by setting higher reliability and minimum episode thresholds for the first year and reducing the threshold in later years as appropriate.
- Clarify how CMS plans to maintain and update episode-based cost measures as policies change.
- Work with specialty societies throughout the maintenance process to ensure continuous input from the provider community.

Section III.K.3.c(3): Improvement Activities Performance Category

In response to feedback from various stakeholders, CMS proposes to remove specific entity names from their criteria for qualification as a medical home. ACOG commends CMS for being responsive and broadening its criteria of a medical home.

CMS proposes to increase the minimum number of clinicians in a group or virtual group who are required to perform the same improvement activity to 50 percent for the same continuous 90 days with the 2020 performance year. ACOG is concerned this proposal will be significantly burdensome to providers. In multi-specialty practices, there may be improvement activities that are not appropriate for 50 percent of the physicians and QHPs. The addition of scheduling conflicts creates further barriers to the ability to comply to the 50 percent threshold in the 90-day timeframe.

Physicians within multi-specialty practices and virtual groups should elect the improvement activity or activities that are most relevant to them and complete them in a 90-day window of the calendar year that best works with their patient, surgical, call and delivery schedule. ACOG strongly opposes the restrictive requirements of the same activity within the same 90-day window for group or virtual group IA reporting.

ACOG Recommendations:

- Finalize the proposal to remove specific entity names for qualification as a medical home.
- Do not finalize the proposal to require clinicians in a group or virtual group to report the same activity within the same timeframe.

Section III.K.3.c(4): Promoting Interoperability (PI) Performance Category

CMS does not propose to make any major changes to the Performing Interoperability performance category. ACOG appreciates efforts to maintain consistency throughout the MIPS program and thanks CMS for this consideration.

ACOG recommends that CMS adopt the proposal for a 90-day reporting period in 2021. Many physician practices, particularly those that are small and have limited resources, require a significant amount of time to upgrade their EHR technology, conduct tests and training, and change workflows after the EHR has passed certification. We appreciate CMS's recognition that a day-day reporting period will provide flexibility in reporting PI measures.

In the proposed rule, CMS seeks comments on a potential metric "to improve efficiency of providers with EHRs." ACOG is concerned that CMS is looking to use the MIPS program to incentivize efficiency in EHR usage. Ob-gyns and other health care providers are already incentivized to be efficient EHR users, because documentation in the EHR has such a significant impact on clinical workflow. ACOG Fellows consistently report, through surveys and focus groups, that EHRs as time-consuming and burdensome. ACOG strongly urges CMS to work closely with the Office of the National Coordinator for Health IT (ONC) to require EHR developers to improve the interfaces and usability of EHR systems. ACOG feels strongly that the ONC Health IT Certification Program is the appropriate program to focus attention on EHR efficiency and usability.

In recent meetings, CMS has suggested that CMS is considering allowing physicians who use other types of health information technology besides CEHRT to receive credit in the PI performance category. ACOG strongly supports the expansion of the PI category to include the use of patient portals or application programming interfaces (APIs) to share health data with patients.

ACOG Recommendations:

- Adopt the proposal for a 90-day reporting period in 2021.
- Refrain from incentivizing efficiency in EHR usage on the individual provider level through the MIPS program.
- Work closely with ONC to improve usability of EHR systems and ultimately improve efficiency.
- Expand the types of health IT that providers can demonstrate use of to achieve points in the PI performance category.

<u>Section III.K.3.e(2) Establishing the Performance Threshold</u>

CMS proposes to increase the performance threshold to avoid a negative payment adjustment from 30 points in the 2019 performance year to 45 points for the 2020 performance period. CMS also indicates that the threshold will be 60 points for the 2021 performance year. ACOG has significant concerns that small and rural practices will be unable to perform well in the MIPS program if this change is finalized, and we urge CMS to reconsider.

CMS cites the mean final score of 74.01 for the 2017 MIPS performance year as a justification for increasing the performance threshold. However, in the 2017 performance year, the mean total MIPS score for clinicians in small practices was 43.46 points; 20 points lower than the mean score for clinicians in rural practices, and 30 points below the national mean for all MIPS eligible clinicians.[23] While CMS has pledged to work with small and rural practices to help them be successful in the MIPS program, additional consideration should be given to the small and rural practices that struggle with resources, low payment and high patient demand. ACOG fears the steep increases to the performance threshold will penalize clinicians providing quality care in underserved areas.

We are also concerned that the proposed changes to the Performance category weights and Cost performance category were not considered in the estimates and assumptions for achieving a 45-point threshold. Given these major concerns, ACOG urges CMS not to finalize this proposal.

ACOG Recommendation: Do not finalize the proposal to increase the performance threshold to 45 points for the 2020 performance year and 60 points for the 2021 performance year.

Section III.K.4 Advanced APMs

ACOG is very concerned that CMS has not yet paid the five percent lump-sum incentive payments for physicians who achieved Qualifying APM Participant (QP) status for the 2017 reporting period. The announced plan for this aspect of the QPP was to pay the incentive payments in mid-2019. Many physicians invest significant financial and other resources in APMs, and the QP incentive payments are supposed to help physicians with the cost of transitioning into these new models of care delivery. ACOG urges CMS to make the payments as soon as possible.

CMS proposes to amend financial risk standards to require that the "expected expenditures" for which an APM Entity is responsible under an APM be no higher than the "expenditures that an APM Entity would be expected to incur in the absence of the APM," and to exclude the "excess expenditures" when considering whether the APM meets the financial risk standards for Advanced APM status. ACOG opposes this proposal. The proposed rule is unclear, but it seems that an APM Entity could be penalized even if it is managing patient care in a way that holds expenditures below the target price specified in the APM. If CMS or someone else estimates that expenditures would have been even lower in the absence of the APM, CMS could financially penalize the APM Entity or it could determine that the APM Entity is not part of an Advanced APM.

ACOG strongly believes that in a properly designed APM, the benchmarks and target prices can be set in a way that requires lower spending where current spending is too high and permits higher spending where it is currently too low, with a net reduction in overall spending, but the proposed regulation appears to preclude that. In addition, participants in APMs need to know in advance what level of spending they need to achieve to avoid risk-based penalties and need to be assured that spending targets will be adequate to meet their patients' needs. ACOG recommends that CMS not finalize the proposal to amend financial risk standards.

ACOG Recommendations:

- Make the five percent lump-sum incentive payments as soon as possible to physicians who achieved QP status in 2017.
- Do not finalize the proposal to amend financial risk standards to require that the "expected expenditures" for which an APM Entity is responsible under an APM be no higher than the "expenditures that an APM Entity would be expected to incur in the absence of the APM," and to exclude the "excess expenditures" when considering whether the APM meets the financial risk standards for Advanced APM status.

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Thank you for the opportunity to comment on the proposed rule for the CY 2020 MPFS and QPP. We look forward to working with CMS to implement policies that improve beneficiaries' access to high-quality health care services. Should you have any questions, please contact Meredith Yinger, Health Policy Analyst, at myinger@acog.org or 202-863-2544.

Sincerely,

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