FMA
FLORIDA MEDICAL ASSOCIATION
1430 Piedmont Drive E., Tallahassee, FL 32308

September 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445–G
200 Independence Avenue, SW
Washington, D.C. 20201

Re: File Code CMS–1693–P; Medicare Program: 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

Dear Administrator Verma,

On behalf of the Florida Medical Association (FMA), I appreciate the opportunity to provide input on this proposal. As an organization representing more than 22,000 members in a state that is home to millions of Medicare beneficiaries, we are keenly aware of the impact that changes to the Medicare Physician Fee Schedule (PFS), the Quality Payment Program (QPP), and other aspects of Medicare payment policy can have on the practice of medicine and the lives of individual patients.

We also recognize the urgent need to reduce the excessive regulatory burdens impacting medical practices. We applaud CMS for adopting the Patients over Paperwork initiative, which has the potential to increase efficiencies across the health care system while improving the experience of Medicare beneficiaries. As researchers have found, it is not unusual for physicians to spend nearly two hours performing administrative work for every hour with patients[i]. The excessive regulatory burdens driving much of this administrative work have contributed to the epidemic of physician burnout and tragically require the most highly trained members of our health care system to perform unnecessary clerical functions at the expense of patient care.

As CMS is aware, the Medicare program is a crucial part of Florida's health care system. Florida has the second largest Medicare population in the country, with more than four million residents relying on Medicare for coverage[ii]. In addition, state forecasters project that close to 50 percent of Florida's population growth between 2010 and 2030 will be driven by seniors 65 and older[iii]. At the same time, Florida suffers from a physician shortage, with researchers estimating that the state will have a shortfall of 3,690 physicians by the year 2025[iv]. This substantial shortage is complicated by Florida's expansive geography, which includes numerous rural and underserved communities.

In addition, there is evidence that a combination of diminishing payment rates and excessive red tape are inhibiting the ability of some Florida physicians to meet the needs of Medicare patients. State licensure survey data indicates that approximately 4,900 Florida physicians are not accepting new Medicare patients

either because of low compensation or excessive administrative and billing requirements[v]. The FMA is concerned that the number of physicians unable to serve additional Medicare patients could climb higher in future years because of a lack of statutory payment updates that keep pace with inflation[vi] and the growing complexity of Medicare payment policy.

For these reasons, the FMA reviews and evaluates CMS's regulatory proposals with great care and interest. Changes made by CMS to Medicare payment policy can substantially affect the delivery of health care across the nation, and no state feels the effects of those changes more acutely than Florida.

Comments and Recommendations:

The FMA submits the following comments and recommendations with respect to CMS's proposal.

Collapsing payment rates for E/M visits

The FMA strenuously opposes collapsing payment rates for level 2 through 5 E/M visits as described in the proposal. The FMA believes that the payment reductions for more complex patient visits that would result from this proposal would produce several unintended and harmful consequences.

First and foremost, the FMA is concerned that this proposal would have a significant, detrimental impact on access to care in Florida. Collapsing payment rates for E/M visits in the manner proposed by CMS would significantly undervalue the time and expertise of physicians who deliver care to complex patients and thereby disproportionately harm practices that serve the sickest and most vulnerable seniors. Given that statutory payment updates to the PFS already fail to keep pace with inflation, there are likely few, if any, physician practices that can sustain further reductions in their Medicare fees. These concerns were echoed at the FMA Annual Meeting in August, where physicians representing numerous specialties and regions of the state testified that this proposal would adversely affect their ability to care for Medicare patients.

In addition, the FMA believes that the "add-on" codes CMS is proposing for primary care services, certain specialist visits, and extended visits are inadequate to offset cuts to physicians who treat complex patients. While some of the add-on codes proposed by CMS might have merit when considered in isolation, these additional payments are vastly insufficient to rectify the flaws with the underlying proposal to collapse payment rates for E/M visits.

Further, the reduced documentation requirements included in this proposal are completely inadequate to justify the implementation of a flawed payment system. While addressing onerous and duplicative documentation requirements is one of the many ways that CMS can help improve existing Medicare policy, such a modest burden reduction cannot serve as recompense for significantly reduced fees. Physicians, after all, do not document their medical records solely for regulatory purposes, and will continue to thoroughly document their clinical findings, assessments, and care plans irrespective of what CMS requires. CMS seemed to acknowledge as much in announcing this proposal, stating, "practitioners could choose to document additional information for clinical, legal, operational or other purposes, and we anticipate that for those reasons, they would continue generally to document medical record information consistent with the level of care furnished". Moreover, as outlined further in this letter, the FMA believes that CMS can

make immediate improvements to existing documentation requirements without overhauling payment rates for E/M visits.

The FMA urges CMS to not adopt this deeply flawed proposal, and to instead work with physicians to address coding and billing issues related to the PFS. To that end, the FMA strongly supports the American Medical Association's proposal to convene a workgroup of physicians and other professionals to assist CMS with improving Medicare payment policy while mitigating unintended consequences. If CMS takes the approach of working with physicians, the FMA believes it will be possible to craft policy that will strengthen the Medicare program to the benefit of patients and caregivers.

Payment reductions for certain same-day services

CMS proposes to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on a claim by an appended modifier -25. The FMA strongly opposes this reduction in payments.

First, as other organizations have noted, there appears to be no rational justification for this reduction other than to provide a financial offset for other aspects of CMS's proposed overhaul of payments for E/M visits. Existing service valuations already appropriately account for the provision of same-day procedures.

Additionally, we believe the adoption of this proposal would have multiple harmful effects. First, this policy would further erode the value of Medicare payments to many physician practices, which could thereby force more physicians to limit their intake of additional beneficiaries. Such unwarranted payment reductions could also encourage consolidation in the health care industry by squeezing out smaller providers who frequently operate on thin margins. Additionally, this proposal may irrationally incentivize providers to schedule separate-day appointments for care that could otherwise be delivered more efficiently and expeditiously.

We urge CMS to not adopt this misguided proposal and to instead embrace the efforts of the AMA workgroup to develop mutually agreeable improvements to Medicare payment policy.

Reducing documentation burdens

Although the FMA opposes the aforementioned proposed changes related to payments for E/M visits, we continue to deeply appreciate CMS's interest in cutting red tape. To reiterate the requests in the letter that the FMA cosigned with the AMA and several other medical societies, we urge CMS to immediately adopt the following changes to existing Medicare E/M documentation requirements:

1. Changing the required documentation of the patient's history to focus only on the interval history since the previous visit;
2. Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient; and
3. Removing the need to justify providing a home visit instead of an office visit.

The FMA strongly supports these changes, which would constitute a small but important step in reducing the regulatory burden facing physicians. These changes would help address the redundancy and inflexibility of current documentation requirements and would align with CMS's Patients over Paperwork initiative.

Raising the MIPS performance threshold to 30-points

CMS proposes to raise the MIPS performance threshold from 15-points to 30-points. While the FMA recognizes that the Balanced Budget Act of 2018 (BBA) requires CMS to gradually increase the performance threshold to the mean or median value from a prior period by 2022, the FMA opposes doubling the performance threshold over the course of a single performance period.

Doubling the performance threshold at a time when physicians are just beginning to gain familiarity with MIPS would be particularly detrimental to smaller practices and those that lack experience with legacy pay-for-performance programs. The FMA therefore urges CMS to consider its options for instituting a more incremental increase to the performance threshold for 2019, and to adopt the smallest increase possible. CMS should consider that increasing the performance threshold by even 6 points would still constitute a 40-percent increase over the existing performance threshold.

Adding a third criterion to the low-volume threshold and allowing certain clinicians to opt-in to MIPS

CMS proposes to include a third criterion for determining MIPS eligibility under the low-volume threshold. Under this proposal, to be excluded from MIPS under the low-volume threshold, clinicians and groups would need to meet one of the following three criteria: have ≤ $90,000 in Part B allowed charges for covered professional services, provide care to ≤ 200 beneficiaries, or provide ≤ 200 covered professional services under the PFS.

In addition, CMS is proposing to allow clinicians and groups to opt-in to MIPS if they meet or exceed one or two, but not all three of the low-volume threshold criteria.

The FMA supports these proposed changes, which would provide physicians with more flexibility under MIPS.

Increasing the weight of the cost performance category to 15 percent of the MIPS composite score

The FMA is concerned by CMS's proposal to increase the weight of the cost performance category to 15 percent of the MIPS composite score. The cost performance category of MIPS remains highly complex and insufficiently tested, and physicians should be given additional time to acquire experience and feedback under the cost performance category before its impact on payments is increased. Rather than move forward with this proposal, CMS should exercise its statutory authority to retain the weight of the cost performance category at 10 percent of the MIPS composite score.

Quality reporting period

CMS proposes to maintain a 12-month reporting period for the quality performance category. This is highly unfortunate and represents a missed opportunity to reduce the administrative burden facing physicians. Physicians regularly identify the current full-year quality reporting requirement as one of the most burdensome aspects of MIPS. The FMA joins other major medical societies in urging CMS to establish a minimum 90-day reporting period for the quality performance category. This would help streamline MIPS reporting requirements, improve the opportunity for practices to incorporate prior year MIPS feedback when reporting quality data, and advance CMS's Patients over Paperwork initiative.

Bonus points for small practices

The FMA strongly supports continued flexibility for small practices that participate in MIPS. However, the FMA urges CMS to retain its current methodology of assigning 5 bonus points to the final MIPS composite score of small practices in lieu of adopting its proposal to add 3 bonus points to the numerator of the quality performance category. Retaining the existing bonus structure would provide a greater benefit to small practices that remain at a disadvantage under MIPS.

Provisions related to Advanced APMs and the Medicare Advantage Qualifying Payment Arrangement (MAQI) Demonstration

When MACRA was enacted, Congress envisioned a system under which physicians could choose to participate in MIPS or in Advanced APMs. Unfortunately, as we enter the third year of the QPP, this choice remains more illusory than real. Due to the limited number of Advanced APMs, many physicians will continue to miss out on the substantial incentives offered for participating in these payment models, including significant payment bonuses and an exemption from MIPS. Instead, many physicians will have no choice but to participate in MIPS unless they are otherwise exempt from the program. This is highly unfortunate. The FMA continues to advocate for the creation of additional Advanced APMs, particularly provider-driven Advanced APMs supported by the Physician-focused Payment Model Technical Advisory Committee (PTAC) and physician specialty societies.

The FMA is, however, encouraged by certain aspects of CMS's proposal that could help make Advanced APMs a more viable pathway under the QPP in the future. First, the FMA supports CMS's proposal to maintain the 8-percent revenue-based financial risk requirement for Advanced APMs. This will continue to aid the development of Advanced APMs that do require providers to assume unmanageable levels of financial risk. The FMA is also encouraged by CMS's efforts to reduce the compliance burden on Other Payer APMs that operate under multi-year arrangements. The FMA urges CMS to continue to implement recommendations from the AMA and other physician stakeholder groups aimed at making Advanced APMs a more viable payment pathway under the QPP.

Finally, the FMA supports CMS's proposed Medicare Advantage Qualifying Payment Arrangement (MAQI) Demonstration. While this demonstration does not address the need for additional Advanced APMs that physicians can participate in to attain QP status, the MAQI would allow certain physicians who participate in innovative payment models with Medicare Advantage plans to qualify for an exemption from MIPS. The impact of this proposal could be more substantial in Florida than in many other regions of the nation. More

than 40 percent of Florida Medicare beneficiaries are currently enrolled in a Medicare Advantage plan, including more than 60 percent of beneficiaries in Miami-Dade County[vii]. The FMA believes that this proposal would further encourage the adoption of payment arrangements similar to Advanced APMs under the Medicare Advantage program.

Evaluating input from physicians

The FMA is one of several medical associations interested in helping CMS improve this important proposal. Other organizations, including the American Medical Association, Texas Medical Association, California Medical Association, and numerous other state medical associations and physician specialty societies are also likely to submit feedback to CMS during the comment period. We urge CMS to listen to our partners in medicine as they submit recommendations and feedback aimed at improving Medicare payment policy. Physicians, as the leaders of our health care system, are in the best position to help CMS improve Medicare policy for the benefit of more than 58 million beneficiaries who rely on the program.

Sincerely,

Corey L. Howard, M.D.
President, Florida Medical Association

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[ii] CMS Medicare Enrollment Dashboard https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html

[iii] Florida: An Economic Overview, August 17, 2018, Florida Legislature Office of Economic and Demographic Research http://edr.state.fl.us/content/presentations/economic/FlEconomicOverview_8-17-18.pdf

[iv] Florida Statewide and Regional Physician Workforce Analysis: Estimating Current and Forecasting Future Supply and Demand, IHS Global Inc. https://ahca.myflorida.com/medicaid/Finance/finance/LIP-DSH/GME/docs/FINAL_Florida_Statewide_and_Regional_Physician_Workforce_Analysis.pdf

[v] 2017 Physician Workforce Annual Report, Florida Department of Health. Estimate derived from figures 13 and 15. http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2017-doh-physician-workforce-report.pdf

[vi] Estimated Financial Effects of the Medicare Access and CHIP Reauthorization Act of 2015 (H.R. 2), CMS Office of the Actuary https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/2015HR2a.pdf

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