September 6, 2016

Andy Slavitt, Acting Administrator  
Centers for Medicare & Medicaid Services  
Department of Health & Human Services  
Attention CMS1654–P  
Mail Stop C4–26–05  
7500 Security Boulevard  
Baltimore, MD 21244–1850


Dear Acting Administrator Slavitt:

The Wisconsin Medical Society (Society) appreciates the opportunity to offer comments to the Centers for Medicare & Medicaid Services (CMS) regarding the proposed rule for the 2017 Physician Fee Schedule (PFS). We believe this proposed rule has very important implications for physicians, as well as for patients.

Comprised of more than 12,600 physicians, residents and medical students, the Society is committed to value-based health care and supports efforts to create a more sustainable Medicare system through incentivizing high-value care. We are the largest association of medical doctors in Wisconsin; nearly 65 percent of licensed physicians in the state are Society members. We believe that properly structured incentives to provide high-value care (i.e., high-quality, low-cost care) will result in better care for patients at a lower cost for payers. We believe value-based payment policies can drive better quality, lower the cost of care and reduce overall costs for the Medicare program.

The Society writes to provide general comments on the CY 2017 Medicare PFS proposed rule with specific comments regarding advance care planning (ACP), Appropriate Use Criteria (AUC), the Geographic Practice Cost Index (GPCI), primary care coordination, add-on payment for services provided to patients with mobility-related disabilities and global surgical reporting. Overall, the Society supports the conceptual development of the value initiatives at CMS.

**Telehealth Advance Care Planning Codes**

Since 2012, Honoring Choices Wisconsin (HCW), an initiative of the Society, has worked to make ACP a routine and standard part of the care across Wisconsin.
In last year’s PFS rule, CMS began to fund ACP CPT Codes 99497 and 99498 beginning in CY 2016. This was an important step forward for better ACP, and the Society strongly supported the codes and reimbursement for ACP conversations under these codes.

The Society appreciates CMS’s continued support of ACP and its proposal to add two ACP services to the telehealth list. With reimbursement for ACP telehealth services, clinicians will be compensated for the time it takes to have an ACP conversation and be in a better position to coordinate care for Medicare beneficiaries. We also urge CMS to develop a far more expansive set of telehealth strategic proposals that are cohesive and forwarding-looking in order to expand coverage and access to telehealth services for Medicare beneficiaries.

The Society continues to advocate that the completion of forms should not be required. Legal documents are very important tools for appointing health care agents and documenting patients’ wishes. However, they are not necessary to a productive ACP conversation and, in fact, a focus on document completion can detract from quality conversations. Some documentation that conversation happened is necessary, with notes about wishes and values expressed. However, completion of a legal document should not be required for reimbursement. We ask that services provided by ACP facilitators that do not result in completed advance directive forms but that are documented in the patient’s medical record be reimbursed if the clinician is providing services to patients from an established ACP program.

**Strengthening Primary Care Coordination**

The Society appreciates that CMS made significant strides to strengthen primary care coordination by reducing barriers to caring for patients with chronic illnesses and for patients with mental or behavioral health conditions. These changes will improve payment for physicians investing time and resources to provide more coordinated and patient-centered care. CMS laid out a number of proposals including new codes for complex chronic care management and improvements for existing codes, greatly expanding the diabetes program aimed at prevention and patients who are at risk of developing diabetes, and team-based care reimbursement for behavioral health care services. These proposals will help to increase the time a physician can spend listening, advising and coordinating the care of their patients.

**Add-on Payment for Mobility-Related Disabilities**

The Society opposes CMS’s plan to eliminate the 2017 physician payment increase Congress provided in the Medicare Access and CHIP Reauthorization Act (MACRA) in order to fund an add-on payment for services provided to patients with mobility-related disabilities. While the Society supports payment policies that improve access to care for patients with these and other impairments, there is no justification for funding these services with an overall cut in physician payment rates. Following years of threats of significant payment reductions under the sustainable growth rate (SGR) formula, physicians expect to receive a 0.5 percent update in 2017, as provided in MACRA. Proposals such as this one, which wipe out physician fee schedule updates based on perceived issues and solutions that are derived with virtually no input or validation from patients and physicians, will erode physician support for the Quality Payment Program prior to its full implementation.

We also believe the proposal raises program integrity questions, creates unequal coverage for care of disabled patients, covers costs for which physicians already have been at least partially reimbursed, and increases out-of-pocket costs for patients with disabilities.
The Society urges CMS to work with stakeholders to conduct additional studies that will provide information on why younger Medicare patients have more difficulty finding a physician, and why certain quality measure scores may be lower among patients with disabilities. Once further studies have been completed to diagnose the root cause of these issues, the Society asks that CMS work with the Current Procedural Terminology (CPT) Editorial Panel and the Relative Value Scale Update Committee (RUC) to develop an appropriate solution.

**Appropriate Use Criteria**

Use of AUC, which the Society supports, was included in the Protecting Access to Medicare Act of 2014. When fully implemented, it will apply to every physician who orders applicable diagnostic imaging services. The Society supports inclusion of AUC because there is a need for CMS to distinguish spending from costs that result from recommended care versus rarely appropriate care. AUC can be used as a tool to better measure quality and costs, which is important because rarely appropriate care results in wasteful spending and conceivably could harm patients. Clinical decision support is one of the best ways to bring value into the Medicare program.

In the proposed 2017 rule, CMS proposed:

- Requirements and processes for specification of qualified clinical decision support mechanisms (CDSM) under the Medicare AUC program
- An initial list of priority clinical areas
- Laid out exceptions to the requirement that ordering professionals consult specified applicable AUC when ordering applicable imaging services
- Proposed delaying the implementation date due to insufficient identification of mechanisms for consultation by April 1, 2016, and failure to specify or publish the list of qualified CDSMs by January 1, 2017

**Priority Clinical Areas Included**

CMS listed eight clinical groupings (by volume of procedures) as the initial priority clinical areas. The eight clinical areas account for roughly 40 percent of Part B advanced diagnostic imaging services paid for by Medicare in 2014. The priority clinical areas are based on an analysis of claims data alone. Those clinical groupings are included in table 34 below.

<table>
<thead>
<tr>
<th>Proposed priority clinical area</th>
<th>Total services</th>
<th>% Total services</th>
<th>Total payments</th>
<th>% Total payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Pain (includes angina, suspected myocardial infarction, and suspected pulmonary embolism)</td>
<td>4,435,240.00</td>
<td>12</td>
<td>$470,995,545</td>
<td>14</td>
</tr>
<tr>
<td>Abdominal Pain (any locations and flank pain)</td>
<td>2,973,331.00</td>
<td>6</td>
<td>235,424,592</td>
<td>7</td>
</tr>
<tr>
<td>Headache, traumatic and non-traumatic</td>
<td>2,107,669.00</td>
<td>6</td>
<td>89,582,087</td>
<td>3</td>
</tr>
</tbody>
</table>

**Table 34—Proposed Priority Clinical Areas With Corresponding Claims Data—Continued**

<table>
<thead>
<tr>
<th>Proposed priority clinical area</th>
<th>Total services</th>
<th>% Total services</th>
<th>Total payments</th>
<th>% Total payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical or neck pain</td>
<td>1,045,381.00</td>
<td>3</td>
<td>83,899,299</td>
<td>3</td>
</tr>
</tbody>
</table>

1 Percentage of 2014 Part B non-institutional claim line file for advanced imaging services from Medicare claims for beneficiaries who are enrolled in the fee-for-service (FFS) program (source: CMS Chronic Conditions Data Warehouse).
The Society encourages CMS to place its focus on variability of appropriate utilization. The focus of the AUC program should be on identifying outliers in clinical areas where there is wide variance in appropriate ordering patterns. The Society suggests as CMS alluded to in the proposed rule that CMS should consider factors other than volume when proposing priority clinical areas, including incidence and prevalence of disease, variability of use of particular imaging services, strength of evidence supporting particular imaging services, and the applicability of a clinical area to various care settings. We note that CMS itself appears to have some doubts about the use of volume as the sole determinant. The Society shares that doubt and urges CMS to sooner rather than later pursue an approach that also considers variation in treatment and quality of the evidence in determining priority areas.

**AUC Implementation Delay**

CMS proposed delaying the implementation date due to not identifying mechanisms for consultation by April 1, 2016 and not specifying or publishing the list of qualified CDSMs by January 1, 2017. CMS has indicated that it doesn’t expect to have a list of approved CDSMs until approximately summer 2017.

The Society is generally fine with CMS’s plan to delay AUC for one year as we wouldn’t want the implementation rushed, and giving health care providers more time increases the likelihood of getting CDSMs and appropriate use criteria right the first time. That said, we do not support delaying AUC beyond 2018 until 2019 when the MIPS program begins redistributing reimbursement based on prior data. There are already robust, evidence-based and established criteria in the market, and there are mechanisms embedded in the major electronic health records (EHR) which means that in many important ways AUC should be ready for implementation. Instead of delaying until 2019, AUC implementation should be phased in over time, starting with a list of conditions that could be tailored by specialty. Earlier implementation and testing will be critical.

AUC will be a critical tool to deliver high-quality care and better value and further delay past 2018 would be disappointing for Medicare patients who would not get the benefit of this quality tool like they were originally scheduled to. A further delay also means that it’s another year of radiology benefits managers as the solution instead of clinical decision support. While the timeline is aggressive, the Society feels that it is doable and encourages CMS to delay this no further than 2018, which is already delayed.

**Requiring a Furnishing Professional to include information on Medicare claim**

CMS is proposing that under the applicable payment system, the furnishing professional should include on the Medicare claim information about the ordering professional’s consultation with a qualified CDSM. CMS proposes a number of new items that must be included on the claim form in order for the furnishing professional to be paid. In any case where consultation of the AUC is followed by an order, the furnishing professional must supply the ordering physician’s AUC-use information to CMS. As currently proposed, furnishing providers would be required to include (a) which qualified CDSM was consulted before ordering the imaging service, (b) whether or not the order adheres to the AUC, and (c) the NPI of the ordering physician.

The Society encourages CMS to test the system before implementation as there likely will be significant modifications needed on the claims form. The inclusion of AUC-related data on all imaging claims will require that physicians and vendors have had time to modify and test new systems, and potential modifications in the claims form have been considered and moved through the existing process before full implementation and withholding of any payments begin.

**Definition of Provider Led Entities (PLE)**

In last year’s final rule, CMS defined the term provider led entity (PLE) to include national professional medical societies, health systems, hospitals, clinical practices and collaborations of such entities such as the High Value Healthcare Collaborative or the National Comprehensive Cancer Network. The Society
appreciates that CMS used an approach that incorporates national professional medical specialty societies whose members are actively engaged in delivering care in the community and eliminates the need to establish a separate definition for professional medical specialty societies.

In late June, CMS posted an initial list of 11 organization that are qualified entities. These include American College of Cardiology Foundation, American College of Radiology, Brigham and Women’s Physicians Organization, CDI Quality Institute, Intermountain Healthcare, Massachusetts General Hospital Department of Radiology, National Comprehensive Cancer Network, Society for Nuclear Medicine and Molecular Imaging, University of California Medical Campuses, University of Washington Physicians, and Weill Cornell Medicine Physicians Organization.

The Society thanks CMS for not including a pharmacy benefit manager (PBM) or like entity that has a physician advisory panel in the initial list of qualified entities. However, we have concerns that at least one of the approved PLEs appears to be a radiology benefits manager in disguise, which, if true, would undermine physician support for AUC and subvert the program’s intent.

The Society is concerned that in last year’s final rule, CMS’s modified definition of PLEs does not limit the participation of third parties such a radiology benefits managers in the AUC development process or marketplace. CMS wrote, “There may be opportunity for third parties to collaborate with PLEs to develop AUC.” This is troubling given that once a PLE is qualified under 1834(q)(2)(B) of the act, the AUC that are developed or endorsed by the entity are considered specified applicable AUC. PBMs and other like entities have an inherent conflict. Whether real or perceived, the primary purpose of such benefit managers’ AUCs would be to limit costs, which is their primary purpose in the marketplace now. CMS doesn’t need or want the inherent conflict to be tied to the implementation of its AUC rulemaking, which also is supposed to be about quality, as well as ensuring that appropriate care gets delivered more often.

The Society believes that the practice of medicine and specialty societies should be the default group to offer AUC. Given the rigor required for AUC development, AUC developers should be limited mostly to professional societies. If a specialty or practice of medicine entity does not present a set of AUC for a defined priority area of CMS, then it would be acceptable for CMS to seek another source and could do so from the private market. Ideally though, AUC should be authored and developed by physicians and select specialty societies that practice medicine in the defined priority areas. It makes sense to defer to medical societies; they tend to be the experts in the field and have clinical data registries, so they’re a natural choice.

It can also be appropriate for health systems to create AUC and in Wisconsin there are several large health systems that have successfully done so. They have worked with the Wisconsin Department of Health Services’ (DHS) Medicaid program to allow for delegated systems to handle how the system wanted to address AUC outliers instead of being subjected to prior authorization. The key is that CMS requires a defined process that would need to be approved by CMS. If CMS were to allow for a similar model, it must ensure that the AUC used is significantly similar to those developed by a specialty society. How the health systems implement the AUC into the work flow may be different, but the concept of the AUC must be significantly the same to maintain a national consensus on the clinical utility of an AUC.

AUC Integration

In the proposed rule, CMS stated that the ideal AUC is an evidence-based guide that starts with a patient’s specific clinical condition or presentation (symptoms) and assists the clinician in the overall patient workup, treatment and follow-up. The Society couldn’t agree more. The Society adds that in order for AUC to work best, it is important that physicians and other health care providers use point-of-care decision support tools embedded in the EHR from the initial patient presentation through final treatment.
AUC differs from lengthy clinical guidelines in that it makes a discrete comment when there is diagnostic uncertainty and is suitable for adoption into the EHR. This will help to fulfill the promise of meaningful use (MU). Using point-of-care decision support tools will improve high rates of appropriateness for imaging and invasive studies, and also will ensure more cost-effective selection of procedural medications and devices. These tools can better identify patients who are at greatest risk for future events, allowing for more proactive secondary prevention to help further lower costs and improve quality. Over time a more durable diagnostic/therapeutic plan for patients and a new standard for quality will be achieved.

**Accurate Geographic Practice Cost Index Data**

The Society continues to be concerned about the inaccuracy of the GPCI data as indicated in comments for prior rulemaking, as the released CY 2017 Physician Fee Schedule Proposed Rule contains no policy changes for the majority of GPCI payment localities.

We have ongoing concerns regarding the GPCI proxy inputs that result in downward payment adjustments to Society members that are not reflective of the actual cost of physician practices. The Medicare Payment Advisory Commission (MedPAC) has affirmed issues with inaccuracy in the use of selected proxies for physician cost adjustment, which currently extracts compensation data for other professionals such as architects. The Society has also long objected to the use of residential rents as a proxy for physician office space costs and strongly encourages CMS to explore the opportunity to improve the accuracy of the practice expense (PE) GPCIs using commercial rent data instead of residential rent data.

Until CMS takes action on correcting issues identified by MedPAC with the use of geographic adjustment, price standardization methodology used in the physician Value-Based Modifier (VBM) will be directly impacted, and we are very concerned it may be carried over in the cost measures in the future MIPS program. While the MIPS program is designed to reverse the application of GPCIs, it does not cure the inaccuracies of the front-end inputs to the GPCI that continue to push payments to Wisconsin physicians downward. As the resource use component of the MIPS program increases to 30 percent, this problem becomes more significant.

Additionally, we are at a loss to understand how CMS would hold harmless Puerto Rico and the Virgin Islands for flawed data but not for other payment localities such as Wisconsin and Iowa, especially when the evidence is just as compelling. It should also be noted that for states like Wisconsin better data exists for measuring the real rate of physician work, such as recruitment compensation surveys and cost data of physicians employed at federally qualified health centers. In the proposed rule, CMS raised concerns regarding the applicability of proxy data in Puerto Rico. Whether Puerto Rico’s data is relative to their applicability elsewhere should not be the underlying principle – the underlying principle should be whether CMS should be applying proxy data it knows is inaccurate.

In an effort to provide greater consistency in the calculation of GPCI data regarding the validity of proxy data for physician work and to provide greater transparency regarding the practice expense data, we propose CMS assign a national average of 1.0 to each GPCI PE and PW index for Wisconsin. If the rationale of moving Puerto Rico to a national average of 1.0 because of the lack of accurate data is good for Puerto Rico, it should be good for Wisconsin.

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Global Surgical Reporting Mandate

In 2015 CMS finalized a policy that would have made all 10- and 90-day global codes 0-day codes. However, MACRA prohibited CMS from implementing the policy and required CMS to collect data on global codes starting in 2017 and to use it to revalue the codes starting in 2019. In this proposed rule, CMS sets forth a plan for data collection that would require all practitioners who furnish 10- and 90-day global services to submit a claim(s) providing information on all services furnished within the relevant global service period. The Society believes that the proposal to require all practitioners to report data to the agency significantly diverges from the MACRA statute language that mandated CMS only collect data from a sample that is representative of physicians who perform 10- and 90-day global services codes. The Society opposes CMS’s proposed policy to collect data on post-operative visits and resources used in furnishing global services, and urges CMS not to finalize this proposal but to work with stakeholders, including the American Medical Association (AMA) and the RUC, to develop a reasonable solution.

The Society asks that CMS use only a representative sample. The Society is appreciative of CMS’s proposal to not implement the withhold payment of up to five percent of the payment for services on which the practitioner is required to report. If CMS moves to collect data from only a representative sample, the Society asks that the imposition of this payment withhold be delayed as CMS has already proposed under the current scheme. CMS is right to not implement this withhold unless needed in future years.

Furthermore, the complexity of the plan, as proposed, will create undue burden on physicians during a period of significant Medicare payment system changes as MACRA is implemented, with relatively little benefit to actual payment accuracy. The proposal is inconsistent with the Acting Administrator’s goal to reduce administrative burden on physicians.

Collection of Time per Patient is not Feasible

CMS proposes that physicians will bill the new G-codes in 10-minute increments for every task that physicians and their clinical staff perform throughout the day. Physicians will be required to both learn the reporting requirements of these new codes and begin monitoring their time in 10-minute increments. The Society believes that CMS may not understand the significant negative impact this proposal will have on physicians. Asking physicians and their staff to use 10-minute timed increments to document all their non-operating room patient care activities is by itself an incredible burden, especially when system-wide changes in Medicare reporting requirements are being implemented under MACRA. In addition, using 10-minute timed increments is not consistent with the Acting Administrator’s goal to reduce physicians’ administrative burden.

Conclusion

The Society appreciates the opportunity to comment on this important proposed rule. We look forward to continuing to provide feedback. Please contact us if we may be of any assistance as CMS further refines the proposed rule.

Sincerely,

Rick Abrams, JD
CEO, Wisconsin Medical Society