November 20, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8013

Re: Request for Information on the Future of Program Integrity

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am pleased to share our thoughts on the Centers for Medicare and Medicaid Services' (CMS) Request for Information (RFI) on the Future of Program Integrity. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians, related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. The College appreciates CMS's efforts to ensure the integrity of the Medicare program while ensuring that benefits are paid judiciously and that beneficiaries have timely access to care. At the same time, we urge the agency to work with stakeholders in the medical community to ensure that any changes in the Medicare program are structured in a manner that does not inappropriately target physicians who are proving quality care based on recommended guidelines or add additional burden without meaningful reason.

We are pleased to provide our comments below:

Program Integrity in Value-based payment programs

The College has long supported healthcare payment and delivery models that emphasize value over volume. These new and innovative payment models are essential to transitioning care from fee-for-service (FFS) to a system of care that is focused on quality. At the same time, these models are increasingly complex and many remain unfamiliar to physicians and their teams. The unfamiliarity with these models potentially increases the chances that CMS may deem physicians to be violating program integrity standards while these occurrences may be simply due to the sheer complexity of these new payment arrangements. Additionally, physicians and their teams are increasingly required to use multiple systems to report data and information to

payers. These systems are very often not interchangeable and lack mechanisms to communicate important information that would further the health of the patient, while maintaining program integrity. We stand ready to work with CMS to address these shortcomings.

Medicare Advantage (MA)

In 2017, ACP produced a position paper titled *"Promoting Transparency and Alignment in Medicare Advantage"* which offered a number of recommendations about improving the MA program.[1] One focus of the paper was on understanding how MA plans capture beneficiary risk through comprehensive diagnoses documentation. This came to be a key example pointing to the need for increased transparency within the MA program. As you know, risk-adjustment is an integral component of developing value-based payment models. Cost and outcomes weigh heavily on physician payment. For the most part, sicker beneficiaries are more likely to have higher cost and worse outcomes than healthier patients. As a result, some plans may be more inclined to only enroll healthier beneficiaries as a way to enhance quality and cost scores, and risk-adjustment addresses these concerns as a way not to disadvantage sicker beneficiaries.

As we noted in our position paper, the Hierarchical Condition Categories (HCC) risk-adjustment methodology allows CMS to calculate a risk score for each MA beneficiary based on various demographic characteristics and health status through the use of ICD-10 codes.[2] These calculations determines how much the plan is paid for each beneficiary. Sicker patients receive higher risk scores and plans receive higher payments for those beneficiaries. The use of this model has been shown to reduce favorable beneficiary selection in the MA Program. ***ACP recommends that all MA plans capture disease severity in a transparent manner to ensure that beneficiaries are not cared for differently based on differing HCC-specific documentation requirements across MA plans.***[3]

Additionally, ACP believes it is imperative that CMS address issues of fraud and abuse in the MA Program. As we detailed in our report, organizations such as The Center for Public Integrity discuss allegations that some MA plans overbill CMS by exaggerating illness severity in some of their patient populations. To address these allegations, **ACP recommends that CMS require MA plans to have transparency and specifically require publication of how the plan captures illness severity through use of the HCC risk adjustment methodology to help in identifying areas of potential fraud and promote a more cohesive method of capturing severity across all MA plans.**[4] The College recommends that CMS's Center for Program Integrity, the OIG, and such external independent organizations as the Medicare Payment Advisory Commission (MedPAC) and the Government Accountability Office (GAO) take the lead in investigating potential situations of fraud by MA plans to increase profitability by misusing the risk-stratification process. Taking a closer look at these potentially fraudulent practices as well as

[1] American College of Physicians. Promoting Transparency and Alignment in Medicare Advantage. Philadelphia: American College of Physicians; 2017: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)
[2] Ibid
[3] Ibid
[4] Ibid

gathering general information on how risk is captured across MA plans will also help to provide insight into the intent of MA plans' benefit design. It will also foster clinically homogenous care to all Medicare beneficiaries as opposed to providing care based on the coding or quality metric requirements of the specific MA plan.

Prior Authorization (PA) and Burden Reduction in Medicare FFS

In our August 2019 letter to CMS, ACP highlighted the use of our Administrative Tasks and Best Practices Data Collection Tool hosted on ACP's Patients Before Paperwork webpage. The College has used this tool to collection information and examples from physicians about the burdensome nature of prior authorization and its chilling impact on the ability of physicians to provide care for their patients. As we stated then, PA continues to be a leading concern for our members. Some physicians and their team members spend an average of 30 minutes on a PA request. At the same time, PA continues to be a direct cost burden. Some practices have reported hiring a full time staffer just to deal with PA requests. Not to mention, each minute a physician spends on completing PA requests is a minute that is subtracted from providing direct patient care. Additionally, patients sometimes spend days waiting to hear whether their PA request has been approved. This fact undermines the ability of physicians to work with their patients to improve their health outcomes. Despite this information, it appears that the use of PA continues to increase.

As stated in our earlier communications, ACP supports CMS' recent efforts to promote the use of a specific technical standard (National Council for Prescription Drug Program's SCRIPT standard) for electronic PA, which we agree is the appropriate standard to use for further implementation of and improvement to the electronic PA process. Furthermore, standardizing PA reporting requirements, data and structure definitions across payers would reduce the burden of PA requests dramatically. Health information technology (health IT) can and should be an integral tool in facilitating this. The College has responded at other times to CMS's request for information regarding ways to reduce administrative burden while continuing to ensure that patients receive care at the appropriate care at the right place and at the right time. As we have said before, CMS should, at a minimum, establish parameters to improve the usefulness of and limit the immense burden currently imposed by PA requests. **At a minimum, (1) all PA requirements should be proven to have a clinical basis and achieve a net savings; (2) PA requirements should only be imposed on medications, tests or products that meet a minimum cost threshold; (3) payers must comply with all prior authorization requests and appeals within a certain timeframe; and (4) renewals of the same drug or device for the same patient should be automatically approved, as should medications or items that are directly related to already approved medications or items.**[5]

ACP urges CMS to collaborate with the Office of the National Coordinator for Health Information Technology (ONC), private payers, EHR vendors, physician organizations, and other necessary stakeholders to establish a standardized set of clinical definitions for data elements and report formats for PA requests so that health IT can be programmed to generate and send this data automatically. Updating and synchronizing of beneficiary plan information by payers and pharmacy benefits managers must happen in real time and be

[5] American Medical Association. (2017). Prior authorization and utilization management reform principles.

complete before the information is incorporated into the EHR functionality and clinical workflow.

ACP appreciates additional efforts that CMS has made to reduce physician burden. For example, the recently finalized proposal to allow the choice of medical decision making or time to decide the level of office/outpatient E/M visit is a crucial change that will reduce the time that physicians must spend documenting them, freeing up time for physicians to spend with their patients to provide high quality care. At the same time, there are number of critical next steps are needed in order to fully operationalize and achieve the desired outcomes of these updates. A key concept to consider when addressing documentation reform is that the guidelines themselves are burdensome, but there is also a great deal of burden associated with the lack of clarity and resulting differing interpretations around what is required.

Given the lack of clarity and consistency around what will actually be accepted for these various options, the College fears that these updates will not be utilized due to fear of audits and financial penalty, resulting in little substantive change. **ACP continues to recommend that CMS provide additional clarity around what will be accepted for both time-based and MDM-based documentation through sub-regulatory guidance.** Useful clarification should include a clear understanding of what is needed within the note to qualify to bill a certain level of code (and whether data stored within other areas of the EHR will qualify), as well as a baseline for what will be considered clinically appropriate. Moreover, ACP recommends CMS work to ensure that the auditing guidelines and procedures are updated and aligned to focus on both time-based and MDM-based notes and that they are applied consistently by all auditing organizations.

In our comments on the 2020 proposed rule on the Medicare Physician Fee Schedule, ACP included a number of clarifying questions aimed at providing further clarity to assist physicians with fully realizing these documentation changes and burden reduction. We have included those questions below for CMS' consideration.

Clarifying Questions:

- For time-based documentation, must the note itself include the time audit or meta-data features from the EHR? Alternatively, could the time-based note that includes a physician attestation of time and describes the data that exists in other sections of the EHR (without replicating it in the note) suffice?
- For MDM-based documentation, what will CMS accept as information within other sections of the EHR that could substantiate an MDM-suggested code level (without the need for physicians to manually click a box)?
- Will CMS permit EHR vendors to develop and build functionalities that capture both time-based and MDM-based requirements simultaneously? For example, a clinician cares for a patient and writes their note based on what is clinically important. Ideally, an EHR could indicate: "Based on your use of the EHR during the visit, this visit would qualify for a 99213 based on time OR a 99214 based on MDM. Click to choose or modify a note or attestation."

Thank you for considering our recommendations for address program integrity in the Medicare program. We hope our recommendations will assist CMS in providing benefits to beneficiaries while also protecting the Medicare trust fund and enabling physicians to focus their time on caring for their patients. Please contact Corey Barton, MPH, Associate at cbarton@acponline.org if you have any questions or need additional information.

Sincerely,

Ryan D. Mire, MD, FACP
Chair, Medical Practice and Quality Committee
American College of Physicians