American College of Physicians
Leading Internal Medicine, Improving Lives

August 12, 2019

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

Re: Request for Information; Reducing Administrative Burden to put Patients over Paperwork

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am pleased to share our comments on the Centers for Medicare and Medicaid Services' (CMS) Request for Information (RFI) on reducing administrative burden. 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.

We commend CMS' continued commitment to addressing and reducing administrative and regulatory burden in our healthcare system through initiatives like *Patients Over Paperwork* and *Meaningful Measures*. We appreciate Agency efforts to solicit input from stakeholders through listening sessions, face-to-face meetings, stakeholder calls, and opportunities for comment. Feedback from stakeholders and frontline physicians is critical to the success of these efforts.

ACP has long advocated for reducing overly burdensome regulations and policies through our own *Patients Before Paperwork Initiative*. Since launching this effort in 2015, ACP has been collecting testimonials from physicians from our Administrative Tasks Survey Tool and robust network of policy committees, councils and multispecialty societies, much of which is captured in this letter. We appreciate this opportunity to offer feedback and look forward to elaborating on these points and continuing to partner with CMS to reduce administrative obstacles to care, freeing physicians to spend more face-to-face time with their patients and deliver more innovative, patient-centered care at a lower cost.

Background

Physicians and their staff spend upwards of 20 hours per week on administrative tasks including billing and insurance related activities, quality reporting, and complying with federal regulations.[1] One study found that ambulatory physicians spent nearly half of their time on electronic health record (EHR) and desk work, versus a third on direct clinical face time with patients and staff.[2] Administrative tasks account for one quarter to one third of U.S. healthcare expenditures,[3][4] which were upwards of $3.5 trillion in 2017.[5] The Center for American Progress estimates nearly $500 billion are spent on billing and insurance-related costs alone.[6] This is not the case in other countries. The U.S. is number one in the world for spending on administrative tasks. Its next closest competitor the Netherlands spent over 5% less and reported much better patient outcomes, while every other country spent at least 10% less.[7]

As explained in greater detail in ACP's 2017 position paper on reducing administrative tasks in healthcare, excessive administrative tasks can have an adverse, potentially dangerous effect on patient care and negatively impact the healthcare system as a whole. First, they divert time and focus from direct patient care, potentially harming patients by delaying services or treatments. In a 2013 nationwide survey, 73% of medical residents reported documentation requirements directly compromised patient care.[8] They also add excess costs for patients, practices and taxpayers alike. Administrative costs for billing and insurance-related activities alone account for an estimated $68,000 to $85,000 per full time physician and 10-14% of net practice revenue every year.[9] Another important concern, burdensome tasks are one of the leading drivers behind physician burnout and contribute to the widening shortage of physicians, particularly in primary care, which could create access issues and more delays to care. In a 2018 Medscape report, 42% of physicians reported feeling burned out, while 15% reported some kind of depression, which lead to being less engaged with patients. Family physicians and internists reported some of the highest rates of burnout at 47% and 46% respectively. The most commonly cited contributor was excess bureaucratic tasks.[10] Most alarming perhaps is the fact that paperwork and red tape is only increasing.[11]

Recommendations

Reducing unnecessary administrative burden is essential to restoring the patient-physician relationship, improving the efficiency of practice, promoting innovative care delivery and value-

[1] annals.org/aim/fullarticle/2614079/putting-patients-first-reducing-administrative-tasks-health-care-paper
[2] annals.org/aim/article-abstract/2546704/allocation-physician-time-ambulatory-practice-time-motion-study
[3] advisory.com/daily-briefing/2018/07/23/administrative-costs
[4] nejm.org/doi/full/10.1056/NEJMsa022033
[5] cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html
[6] americanprogress.org/issues/healthcare/reports/2019/excess-administrative-costs-burden-us-healthcare-system
[7] advisory.com/daily-briefing/2018/07/23/administrative-costs
[8] jgme.org/doi/full/10.4300/JGME-D-12-00377.1
[9] healthaffairs.org/doi/full/10.1377/hlthaff.2009.0075
[10] medscape.com/slideshow/2018-lifestyle-burnout-depression
[11] .mgma.com/MGMA-Regulatory-Relief-Survey-2018.pdf

based reforms, as well as a key component to lowering health care costs, reducing physician burnout, and addressing concerns over the pipeline of future internal medicine specialists trained to provide primary and comprehensive care. In addition to the College's detailed policy and ongoing advocacy work, ACP worked with its members and subspecialty partners to identify the following primary causes of excess burden on physicians and their care teams and compiled recommendations to help reduce those burdensome tasks.

Clinical Documentation Requirements

ACP commends CMS' efforts to transform clinical documentation requirements and firmly believes these changes will lead to a tangible reduction in time spent on administrative tasks that will allow practices to redirect resources back to patients and improve care. To effectively transition to these new policies, sufficient time is needed to engage the physician community in developing and pilot-testing alternatives that appropriately reimburse evaluation and management (E/M) services and improve the clarity and value of documentation while simultaneously decreasing burden, furthering EHR usability and interoperability, improving patient care, and ensuring program integrity. ACP looks forward to working alongside CMS as active partners to develop guidelines to improve clinical documentation and participate in the ongoing governance of these documentation requirements once established. ACP's Board of Regents is forming a task force titled, "Restoring the Story Task Force," focused on developing resources to promote clinical documentation that tells the patient's story in a meaningful manner, as well as developing strategies for the effective dissemination and uptake of best practices in documentation. Another component of ACP's work in this area includes developing specific examples of modifications to EHRs and health IT to improve clinical documentation.

Specifically, ACPs applauds and supports CMS' proposals to remove auditing requirements associated with the history and physical exam elements of the 1995 and 1997 E/M documentation guidelines and strongly supports providing physicians the option to focus documentation on medical-decision-making (MDM) requirements or use time-based billing, and encourages CMS to continue building on these important improvements to continue seeking more opportunities to meaningfully reduce burden on clinicians while protecting the integrity of the Medicare trust funds. Instead of requiring the burdensome documentation of history and physical exam at every visit, there is potential to reduce burden in measurable and appreciated ways. In addition to creating a more efficient and effective documentation process, these efforts could reduce and in some cases eliminate the need for coding instruction tools, consultants, etc. and allow practices to reallocate those resources to other important elements of practice like care management services. The College also supports waiving further clinical documentation requirements for Advanced Alternative Payment Model (APM) participants, which are already held accountable for quality and cost outcomes. Finally, we implore CMS to actively ensure that new auditing criteria and procedures are clear and consistently applied across auditing organizations, ideally through a single auditing standard or tool.

Prior Authorization and the Appropriate Use Criteria Program

Consistently one of the top complaints we hear about from our members is the increasing prevalence of prior authorization (PA) tactics across payers because of the disproportionate amount of time it takes away from direct patient care and immense cost it imposes on practices for little benefit.[12] Moreover, the process is burdened due to the varying requirements and procedures for collecting the data needed to complete the PA request among both private and public payers. Over half of physicians report frequent or constant care delays as a direct result of PA and an astounding 92% reported a negative impact on clinical outcomes, while 84% rank burden associated with PA as high or extremely high. On a weekly basis, practices field 29 PA requests per physician on average, which absorbs 15 hours to complete. One third of physicians had dedicated staff who work exclusively on fielding PA requests. The prevalence of PA is only increasing. Half of physicians reported that burden in the last five years had increased significantly, while only 14% reported no change or a decrease.[13]

Even same day approvals are impractical in a busy practice environment in which physicians have back-to-back patient visits, which can result in prescribing alternative, potentially inferior medications not subject to PA, or not prescribing at all, hindering patient access to viable treatments that could improve their health. 64% of physicians wait at least one business day for a PA decision from a health plan, while 7% wait over a week. This delay can have major negative implications for patient health. Over 75% of patients abandon their course of treatment at least some of the time as a result of PA.[14] This also assumes the request is approved, which many are not. Over one third of physicians have 20% of their first time requests for tests and procedures rejected, while over half have 20% of their first time requests for drugs denied. Meanwhile, the majority of PA denials are appealed and won[15] and our members report that peer-to-peer approvals are "almost always approved." In addition to causing potentially dangerous delays in patients getting the medications, devices, or treatments they need, the hassles that come along with submitting a PA request sometimes require unnecessary in-person appointments, adding burden on the patient and cost to the system.

Requests for durable medical equipment (DME) include similar frustrations. Many require the physician to fill out a paper form or submit specific data for approval, and each company has its own specific data requirements for submission. ACP has received numerous complaints of predatory DME companies that seek out patients to request devices the physician did not order or requests submitted directly to the physician by the DME company without expressed patient consent. One of the most frequent examples of low-value PA policies is diabetic supplies, including test strips, which start at just 15 cents. Related items such as diabetic shoes are also each subject to their own approval, even if a patient has already been approved for testing strips or another product or service related to the same diagnoses. With the disease impacting over 30 million Americans, eliminating prior authorization requests around diabetic supplies could save countless hours of physician and staff time and millions of dollars. Even medications

[12] medicaleconomics.com/modern-medicine-feature-articles/prior-authorization-predicament
[13] ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf
[14] ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf
[15] rand.org/pubs/research_briefs/RB9039/index1.html

or equipment that has previously been approved for the same patient are often subject to PA. Eight in ten physicians are sometimes, often or always required to repeat PA requests for medications that a patient is already stable on for treatment of a chronic condition.[16]

In line with a set of guiding principles[17] developed by the American Medical Association (AMA) with the support of ACP and other stakeholders, **CMS should, at a minimum, establish parameters to improve the usefulness of and limit the immense burden currently imposed by PA requests** including but not limited to: 1) all PA requirements must 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; 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.

CMS should also establish new standards of transparency across payers for posting which mediations and devices are subject to PA and the associated documentation requirements to lower the number of denials. The College strongly supports efforts for payers to disclose publicly, in a searchable electronic format, a payer's requirements (including prior authorization requirements and patient cost-sharing information) for coverage of medical services. This publicly available information will be useful and necessary for health IT vendors to begin to automate the process. Additionally, the various portals of data transmission across payers are a significant burden and there is not only a need for standardization in processes and requirements, but also standardization of methods of data transfer across payers.

Standardizing PA reporting requirements, data and structure definitions across payers would reduce the burden of PA requests dramatically. EHRs can and should be an integral tool in facilitating this. **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.** This agreement and process should be done in a transparent manner and include input from all necessary stakeholders. This harmonization would reduce practice costs for data interfaces; reduce the time physicians and their staff spend completing additional forms; and reduce the time payers spend reviewing requests – freeing up time and resources to promote high-value patient care such as care management services. The adoption and consistent implementation of standards will reduce variability across EHRs and health IT systems – and ensure the functionality meets necessary requirements and does not end up decreasing EHR usability and increasing physician burden.

However, industry standards and agreed upon value sets for these processes will not alone reduce burden – as it is not useful if the data received through these transactions is inaccurate or incomplete. **Updating and synchronizing of beneficiary plan information by payers and pharmacy benefits managers must happen in real time and be complete before the**

[16] ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc/prior-auth-2017.pdf
[17] ama-assn.org/practice-management/sustainability/prior-authorization-reform-initiatives

information is incorporated into the EHR functionality and clinical workflow. Payers and pharmacy benefit managers must maintain and synchronize beneficiary plan information to keep accurate formularies and provide up-to-date beneficiary information so that everyone in the care continuum has the exact same information at the same time. One method could be requiring insurance plans to provide the medication prior authorization and formulary information for beneficiaries that change insurance plans at the beginning of every plan year. The need for this alignment becomes even more necessary as CMS continues to focus on electronic PA and streamlining the process altogether. Moreover, if there is no requirement for the other participants in the exchange (e.g., health information exchanges, pharmacies, pharmacy benefits managers) to implement the standard consistently or even implement the standard at all, then the process will not function as it is intended and will likely increase unnecessary burden. **It is vital that pharmacies, pharmacy benefit managers, and other stakeholders involved in the prior authorization exchanges be held to the same certification and standards requirements as physicians, health systems, and EHR vendors.**

Medicare's own Appropriate Use Criteria (AUC) program, developed to reduce the number of expensive and unnecessary imaging tests, is unnecessarily restrictive and risks causing negative downstream consequences given its lack of flexibility and adequate clinician education and training. While the intent of the program is valid, it creates a barrier to communicating with other physicians and an additional hurdle within the clinical workflow. Moreover, the Medicare AUC Program was established prior to the Merit-Based Incentive Payment System (MIPS) and is largely redundant and duplicative of that program and due to limited resources, education has been extremely limited, despite the fact that the program is currently set to take effect in 2020 and begin impacting payments in 2021. Without a delay and further education around these changes, ACP fears a major disruption to physician payments and therefore patient care. **Short term, ACP urges CMS to delay the impending implementation of the AUC Program to prevent widespread disruptions to patient care. Longer term, ACP recommends CMS incorporate the stand-alone AUC Program within MIPS in the form of improvement activities and quality measures to accomplish the same goals of the program without causing unnecessary delays in patient care or imposing undue burden on physician practices.**

PA and AUC stand directly at odds with this administration's goals to restore the patient-physician relationship. In addition to delaying and denying patients' access to critical health services, these restrictions absorb thousands of staff hours and add millions in unnecessary system costs per year and should be eliminated, if not severely reigned in. As the health care system continues to evolve to a value-based payment system, it is our hope that the need for PA will decrease, particularly for physicians held accountable for quality and financial outcomes through risk-bearing APMs.

Billing Requirements for Care Management and Non-Face-to-Face Services

Care management and non-face-to-face services play an increasingly important role in a value-based payment and delivery environment that focuses on population management and keeping patients healthy. **ACP appreciates CMS recognizing and affording new billing flexibilities for telehealth and home health services for Medicare Advantage (MA) plans,** including allowing

patients to receive certain services in their homes, rather than requiring them to go to a healthcare facility, as well as lifting geographic limitations for virtual check ins. **We strongly urge CMS to expand these same flexibilities to traditional Medicare and to continue exploring new flexibilities for home health and telehealth services.** Lifting restrictions like these will help to expand access to these critical services that can particularly benefit patients that are frail, live in urban regions, or experience other barriers to care, including transportation restrictions. CMS should also expand the list of codes that are permitted to be furnished in a virtual or remote setting, particularly those that would benefit patients who are frail or otherwise clinically complex or have transportation issues. For example, oxygen saturation could be performed in the home and would positively benefit these often complex patients.

Documentation requirements for transitional care management (TCM) services, chronic care management (CCM) services, extended office visits, and primary care add-ons should be drastically streamlined. Often, physicians do not bill these codes because payment does not justify the burden or time it takes to comply with the substantial documentation requirements. Reducing the burden of documentation would increase uptake of these critical services so they can provide these valuable services to patients for which they were intended. CMS should also do more physician education related to billing these services.

ACP reiterates its past calls[18] to lift patient copays for CCM and other services that improve patient care and reduce adverse outcomes. One of the single largest barriers to uptake of CCM is the fact that it requires a patient copay, which is confusing and frustrating to patients to the point where physicians opt not to bill for the services**.** If CMS is unable to eliminate the copay entirely, another option is to allow physicians to obtain approval from patients once a year for any type of non-face-to-face service they may provide over the course of that year. CMS could compile a list of the potential non-face-to-face service codes available and physicians could present this list to patients and communicate that they offer these services but there is a copay associated with them, and based on the patient's plan, the individual would be responsible for that copay if they were to request the service. This would alleviate the need for the physician or their care team to request approval from the patient before each individual non-face-to-face service (i.e., emailing a medical photograph, messaging through the patient portal, etc.).

Beneficiary Enrollment and Coverage Determinations

Physicians and their care teams are spending an increasingly exorbitant amount of time confirming beneficiary enrollment and coverage information. There is a range of information that is critical to managing a patient's care, including overlapping medications, checking to see whether annual services such as wellness visits and vaccinations have already been performed. For a high performing medical practice, coverage and patient history information must be available at the point of care to prevent delays, or even potential medical errors. Not having real-time coverage information at the beginning of the appointment can impact or delay which labs and services are performed during a visit and which medications are prescribed, and create a host of billing issues on the back end that require hours of additional physician and staff time

[18] acponline.org/acp_policy/letters/commentlettertocmsrecy2018medicarepfsproposedrule2017.pdf

to resolve. **To improve the accuracy of this information at the point of care, it is paramount that relevant information about coverage and past services rendered be integrated into EHR and practice management systems (PMS) and/or easily looked up on a CMS developed website.** Multi-payer data, including MA plans, should be included to the maximum extent possible. We have heard from members that MA plans in particular have complex and confusing coverage determinations which is perplexing to patients.

Making this information available at the point of care would allow CMS to proactively monitor predatory businesses that profit from billing annual wellness visits or perform unnecessary vaccinations without consulting the patient's record or primary care physician to see if they are necessary nor taking responsibility for any follow up care. At best, this adds unnecessary costs to the system while exacerbating the underpaying of primary care practices. At worse, it could put patients' health at risk in receiving duplicative treatments such as vaccinations. Maintaining up to date enrollment information is also critical from the perspective of maintaining accurate patient attribution for APMs, participation in which is becoming increasingly common. Developing and finalizing patient relationship codes could be a critical way to establish patient-physician relationships and improve patient attribution for purposes of evaluating performance for value-based programs and models.

Policies and Requirements for Dual-Eligible Beneficiaries

MA and Medicaid coverage rules vary by state and frequently change. Often, practices hire additional, dedicated staff to guide patients through the complex billing process. **Incorporating Medicare, MA, and Medicaid coverage rules into a central system where physicians could look up coverage information including how they overlap would save physicians and their staff countless hours and the practice substantial costs.** Having a unified enrollment database would also make it much easier for general internists to make referrals to specialists who accept both traditional Medicare and Medicaid coverage, which can often be a struggle. Knowing up front which patients are covered by Medicaid would ensure physicians to bill properly, since coverage rules can change if a patient is dual Medicare and Medicaid eligible. For instance, physicians who are not aware that their Medicare patients are also eligible for Medicaid may balance bill those patients, which causes unnecessary anxiety for those patients and absorbs practice staff time rectifying the situation. In general, more support for patients in understanding which coverage options they are eligible for, what services are covered, and how traditional Medicare, MA, and Medicaid differ and overlap with one another would go a long way to reducing stress and wasted time on behalf of patients, practice staff, and payers alike.

Performance Measurement and Feedback

The processes used for creating, implementing, and reporting performance measures are unnecessarily complex. Quality reporting should be based on metrics that are collected during clinical workflow because they are intrinsically useful, not a variety of check the box metrics completed after the fact, or worse, during the actual patient visit. ACP continues to reiterate the need for more relevant, accurate, and effective performance measurements, particularly measures based on patient outcomes. **We are encouraged by CMS's ongoing *Meaningful***

Measures Initiative **and encourage CMS to consider ACP's framework for analyzing new and existing tasks outlined in our position paper *Putting Patients First by Reducing Excessive Administrative Tasks in Health Care* as it continues to reform performance measures in the context of burden reduction and clinical value.**

ACP further implores CMS and others to consider the findings and recommendations of ACP's Performance Measurement Committee (PMC) when considering internal medicine performance measures. The committee assessed and provided detailed recommendations on many MIPS performance measures with a focus on those applicable to internal medicine. The recommendations are based upon a scientific review process that involves five domains: importance, appropriateness, clinical evidence, specifications, and feasibility/applicability. Of measures considered relevant to general internal medicine, only 37% were rated as valid, 35% were rated not valid, and 28% were rated uncertain validity. The PMC assessed a number of additional performance measures reaching similarly mixed reviews. Based on these findings, the committee made several recommendations to improve the measure development process so measures can drive high quality patient care without adverse unintended consequences.

The College further recommends that any measures outside the scope of the PMC recommendations be endorsed or recommended by an independent entity such as the Core Quality Measures Collaborative (CQMC) or Measure Application Partnership (MAP). ACP remains concerned that a majority of new MIPS measures finalized for 2019 have received only conditional support from the MAP, and previously adopted measures remain despite being recommended for "continued development" by the MAP, a designation reserved for measures that lack evidence of strong feasibility and/or validity. The College further recommends that any measure recommended for continued development be resubmitted to the MAP once redevelopment is initiated. It is imperative that the process to evaluate all measures used in its program be transparent and include all necessary stakeholders. The National Quality Forum (NQF) for instance evaluates measures against four critically important criteria: importance to measure, scientifically acceptable, usable and relevant, and feasible to collect.

ACP recommends CMS, ONC, and private payers collaborate with specialty societies, frontline physicians, patients, and EHR vendors in the development, testing, and ongoing implementation of performance measures with a focus on decreasing physician burden, ensuring patient- and family-centeredness, and integrating the measurement of and reporting on performance with quality improvement and care delivery. Further, the criteria and processes CMS use to make its final decisions regarding which measures to remove and which to continue using should be fully transparent. This would allow stakeholders to better plan their efforts in terms of measure development and provide more meaningful feedback to the Agency in the future. This alignment, harmonization, and transparency would also allow health IT to better support the collection of data and reporting on performance measures.

Timely, actionable performance data and feedback are vital to a system that aims to continuously improve patient outcomes, ideally at a lower cost. As CMS works up to making real time claims data available at the point of care, MIPS performance reports should be issued quarterly, at a minimum. Offering clinicians performance up to 18 months after a

service has been rendered is hardly a way to curb clinician behavior, enhance quality improvement within a practice, or drive innovation, particularly in an industry as fast changing as healthcare. Establishing a consistent, 90-day reporting period across all MIPS performance categories would help to facilitate this and would also drastically reduce MIPS reporting burden outright. Health IT can better support these feedback reports and there are multiple functional capabilities within EHR systems that could promote useful feedback mechanisms including workflow management, data analysis, data visualization, shared decision making, and data aggregation. Through the use of application programming interfaces (APIs), which are now a required element of for health IT certification, third-party tools have the capability to add these needed functionalities without further complicating the existing EHR system.

MIPS and Other Quality Reporting Programs

The College appreciates CMS' efforts to establish a more streamlined MIPS reporting and scoring approach known as the MIPS Value Pathways, which is responsive to many ACP past recommendations, including more synergy between performance categories, a reduced number of individual metrics to reduce reporting burden, and more actionable, frequent data. However, ACP has concerns, chief among these the fact that CMS intends this new pathway to be mandatory, particularly given the lack of information at this point. We look forward to providing more detailed comments in our response to the rule, and to continue to have a conversation with CMS about how to most effectively streamline and reduce physician burden within MIPS without unintended consequences.

One simple solution would be to assign point values for each measure proportionate to their overall value relative to the MIPS composite score. The Promoting Interoperability (PI) Category would total 25 to correlate with its 25% worth of the total score, for example. This methodology would allow CMS to continue distinguishing high-priority measures and categories with more value while creating a more intuitive, streamlined scoring approach. For example, reporting performance measures or improvement activities through an EHR system demonstrates meaningful use of EHR technology and should therefore automatically count toward the PI Category. Taking simple opportunities like this will create synergy between the various performance categories and align incentives to drive meaningful improvement in critical priority areas, rather than spreading practice resources thin across too many metrics. This will lead to better patient outcomes, and less burden on physicians and practice staff.

Beyond creating synergy across the various MIPS performance categories, we encourage CMS to reduce the burden of reporting within each of the performance categories by reducing the overall number of required measures while offering a choice from a robust set of accurate, relevant, actionable measures so that physicians can select the measures that are most relevant and appropriate for the unique needs of their practice and patient population. ACP members have expressed feeling concerned and overwhelmed regarding the burden in having to review CMS' website to select from the numerous performance measures necessary to meet the requirements for a successful claims-based submission and the additional burden in revising these selections on an annual basis to accommodate changes in code numbers, deletions, or definitions. In particular, we urge CMS to reduce the overall number of measures within the PI

and Quality Categories. By virtue of meeting the certified EHR criteria, physicians already meet robust EHR standards and should not have to report eight additional measures. We continue to have major concerns about the continued use of mandatory, all-or-nothing measures within the PI Category. The College does not support the idea that a single misstep should eliminate any opportunity to score well in the category. Moreover, allowing some choice between a diverse offering of available measures or health IT activities is the only way to accurately capture performance for a range of specialties, practice sizes, and unique patient demographics while minimizing burden on practices and allowing physicians to deliver innovative patient-centered care uniquely tailored to their unique patient populations.

Reducing the overall number of measures would allow CMS to address accuracy and validity concerns with a number of existing MIPS measures, including concerns raised by ACP's PMC.[19] As it stands, the program is riddled with "check the box" measures that disrupts the clinical workflow and detracts from patient care, and also makes the information the measures are capturing less valuable. **CMS should focus on patient-centered, actionable, and evidence-based measures that align within existing clinical workflows and set performance targets in a prospective, transparent manner.** These concepts align and support the goals of CMS' own Meaningful Measures Initiative, which ACP strongly supports.

The College supports CMS' efforts to reduce the burden of electronic Clinical Quality Measurement (eCQM) reporting. ECQMs rarely strike the balance between being meaningful, capturing the complexity of care delivered, and having readily available data sources to populate the measure. Moreover, these measures are costly to build and validate and require significant time and cost for any updates. **ACP recommends new eCQMs be constructed based on a standard model, including standard structures, vocabularies, expression language, and value-sets that express real-world practice.** This would allow measures to be certified based on their underlying components, rather than against each version of the individual measure.

Policies to Improve Interoperability and Patient Access to Data

In CMS' Interoperability and Patient Access proposed rule (CITE) released earlier this year, the Agency proposes requiring covered payers to adopt and implement an openly published API that allows third-party software applications to access claims data and clinical data that the payer manages, including lab results within one business day of the claim being processed. As CMS moves forward with these regulations, and payer claims-based data are made available to patients via APIs, the College has concerns with data quality issues within the claims data that may contradict the clinical information maintained by the patient's physician and other health care professionals. Moreover, the claims data itself may be difficult for patients to interpret and understand. As proposed, it is not determined who patients should contact with questions or to report incorrect claims-based data. The College is concerned that the responsibility to examine and correct such data, potentially out of context, which is problematic in and of itself, could fall to a patient's primary care physician, adding to existing administrative burden that is increasingly interfering with the patient-physician relationship. **In making claims and clinical**

[19] acponline.org/acp-newsroom/acp-calls-for-a-time-out-to-assess-and-revise-approach-to-performance-measurement

data available directly to patients through an API, CMS must make it clear that it is the duty of payers to correct and update any inaccurate information and should require a mechanism that allows for patients' concerns regarding inaccurate information to be addressed.

When discussing interoperability more broadly, including clinical data exchange outside of routine care delivery, (e.g., Health Information Exchange [HIE] repositories, clinical data registries, private payer billing and payment requests, and patient requests), there is a fundamental misconception that sending all data everywhere is promoting or enhancing interoperability. From a technical perspective, once the full set of clinical data is sent from the source, it is considered historical data. Something may have changed since the latest copy was received that would cause a change in decision making about the patient. It would be unsafe to make clinical decisions based upon the latest Consolidated-Clinical Document Architecture (C-CDA) without re-checking for new, relevant information. Moreover, securely sending and receiving a 300-page summary of care document and skimming through those pages to find the key elements of important information does not promote interoperability. It is important to recognize that access to every aspect of a patient's information does not help with the issue of access to useful and actionable information at the point of care**. Interoperability should *not* be measured by large volumes of data moved from place to place; data overload and data without context is burdensome and potentially dangerous. A better approach, and one that ACP strongly recommends, is for CMS to account for clinical utility in improving and measuring interoperability and to focus measurement on physicians being able to query other health IT systems for specific and up-to-date answers to their specific clinical questions.**

Alignment across Payers

While noted in other sections of this letter, we want to emphasize the importance of facilitating alignment across payers, including establishing a single patient enrollment and coverage verification system, aligning billing and documentation requirements, aligning performance metrics across programs and models, and developing multi-payer APMs. Navigating a myriad of divergent policies and requirements across payers is commonly cited as one of the most time consuming elements of interacting with payers. A 2010 AMA survey found that interactions with insurers cost practices just under $83,000 per physician per year.[20] If payers are working toward the common goal of transitioning our healthcare system to one centered on patients and value, there is no reason for the myriad of metrics and requirements. It only creates unnecessary complexity and cost and divides staff time and practice resources in dozens of directions, which detracts from patient care and actually undercuts practices' abilities to meet quality targets because resources are split in so many directions. Quality performance programs and APMs would be more successful if practices could work toward a unified set of goals and metrics. Moreover, the countless hours previously devoted to learning requirements, reporting data, and satisfying billing and documentation requirements could be reinverted to restoring the patient-physician relationship and would save billions of dollars per year.
To truly overhaul billing and insurance related tasks will require a more whole scale change not just within Medicare but across all payers, public and private. We urge CMS to explore ways to

[20] ama-assn.org/sites/ama-assn.org/files/corp/media-browser/premium/psa/prior-authorization-toolkit.pdf

encourage other payers to simplify and align quality reporting criteria, clinician enrollment, and billing and documentation protocols. CMS should encourage private payers to adopt similar new MDM and time-based billing options and reduced documentation requirements and require this of Medicaid and MA plans.

Barriers and Challenges for Rural Practices

Rural, small, and independent practices have the same desire as large hospital systems to deliver innovative care for the communities they serve. However, they often face a unique set of challenges that hinder their ability to report data and compete in tournament style models and programs on fair footing with larger health systems that have much larger support staffs, technologies, and financial resources at their disposal to support data collection and reporting. ONC reports that prices to purchase and install an EHR system range from $15,000 to $70,000 per clinician. This figure only incorporates the five-year total cost, not ongoing maintenance, security, workflow add-ons, and additional system upgrades.[21] Larger health systems benefit from economies of scale to bring the cost down per clinician. Meanwhile, a vast majority of smaller practices simply cannot afford this financial insult to their bottom line. It should come as no surprise that 85% of those that reported quality data via EHR were group practices, compared to only 12% of individual reporters. Similarly, 86% of registry reporters were groups, compared with 13% of individual reporters. In contrast, 99% of claims-based reporters were individual reporters. Groups in turn had a median score that was over 30 points higher than individual reporters.[22] Without the same tools, rural, small and independent practices cannot be expected to reasonably compete with their larger, more urban, and better funded peers.

Providing opportunities for upfront funding support would help put small, rural, and independent practices on more of an even foot, enabling them to make the investments in staff support, health IT, and other infrastructural support necessary to complying with complex data requirements to succeed in value-based programs and models. In addition, CMS should consider separate, lower nominal risk and Qualified APM Participant thresholds for rural, small and independent practices that participate in Advanced APMs and evaluate them under a separate, lower MIPS performance threshold or against comparable peer groups.

APM Participation

Because participating physicians are held accountable for cost and quality outcomes, APMs present a real opportunity to drastically reduce administrative burden on physician practices. ACP has repeatedly urged CMS to fully leverage its waiver authority to remove administrative barriers, including those elaborated on in this letter. Specifically, we have called for lifting fraud and abuse restrictions, barriers to billing non-face-to-face services, and flexibilities to use supplemental model payments to support beneficiaries.

To promote the development and adoption of APMs more generally, ACP has underscored the importance of refining patient attribution, risk adjustment, and performance

[21] healthit.gov/faq/how-much-going-cost-me
[22] qpp-cm-prod-content.s3.amazonaws.com/uploads/2017QPPExperienceReportAppendix.zip

measurement methodologies, including benchmark setting, as elaborated on more fully in our comments responding to the 2019 Physician Fee Schedule rule. If physicians are not confident in the underpinnings of how their performance is evaluated, they will not have confidence to join APMs, particularly risk bearing APMs. Patient attribution should be as frequent as possible, ideally real time, to avoid being attributed costs for services furnished at other practices. Patient relationship codes would help to facilitate accurate, timely patient attribution. Risk adjustment methodologies must be meticulously refined to account for characteristics that are not currently accounted for in HCC risk scoring, but have a real impact on patient outcomes, including socioeconomic status, severity of condition, and any comorbidities.

Beyond this, CMS should look to expand APM participation by expanding the current offering of models, particularly Advanced APMs. ACP is encouraged by the recent announcement of new models such as the Primary Cares Initiative, but there is still a long way to go. CMS should seriously consider adopting models from the private sector, especially those that have already undergone rigorous screening and been recommended by the Physician Focused Payment Model Technical Advisory Committee (PTAC**).** Working more collegially with PTAC and model developers throughout the evaluation and approval process would help to increase the speed and success of approving more physician-led models. Moreover, modifying high barriers to entry such as lowering the risk threshold to a truly nominal amount in line with original Congressional intent would help to ensure more APMs qualify as Advanced APMs. CMS should also avoid restricting participation through arbitrary size caps and the use of control groups.

Development and Communication of New Policies

Internal medicine specialists and other physicians witness the impact that burdensome regulatory and billing restrictions have on the efficiency of their practices and its downstream impact on patients firsthand every day. No one is more equipped to better understand where regulations and policies are most crippling and how to address it. Input from internal medicine specialists and other stakeholders is critical to better understanding and reducing burden on practices, as well as policies and regulations that effect the delivery of healthcare in general. It is important that input from internal medicine specialists and other stakeholders is solicited not only at the initial stages such as this comment solicitation, but frequently and consistently throughout the development and implementation of new policies.

Physicians, technology vendors, and other stakeholders need adequate sufficient advance notice and educational support in order for the implementation of any new policy to be successful. Even small, technical changes to individual performance measures require time for vendors to develop, test and implement these changes in their systems, in addition to training clinical staff on the changes, which can take months. Larger design changes require more time. If policy changes are rushed, practices will be ill-prepared and lead to a chaotic transition, or worse, will devote a disproportionate amount of their resources to meeting these new standards in time, which could negatively impact and take away time for clinical patient care.

Adequate support and education around key policy changes is vital to any successful transition. While ACP appreciates the multitude of resources available at the Quality Payment

Program resource library, often resources are not updated until halfway through a performance year. As ACP and other stakeholders have noted,[23] education around the impending Appropriate Use Criteria requirements has been limited, which we fear may lead to a disorganized transition when payments start being impacted in 2021. CMS has another major transition on its hands with the impending changes to E/M documentation and payment, during which educational resources about how to properly bill and document services under new requirements, as well as knowledgeable CMS staff on hand to answer questions will be critical to preventing a massive disruption in the delivery of medical services to patients.

Moreover, if CMS is trying to solicit physician interest in value-based programs, physicians need to establish and retain confidence in the programs and models. If CMS rushes rapid changes, they risk losing physician support, which would be detrimental to the success of these programs. With profit margins in many APMs already razor thin, even seemingly small changes can make a world of difference when it comes to meeting a performance target and achieving savings. As an example, CMS announced drastic changes to the specifications for ACO measure 17 (preventive care and screening, tobacco use-screening and cessation intervention measures) that drastically impacted the scoring of the measure for the 2018 performance year, but these changes were not announced until 2019, after the performance year had already concluded and reporting was already underway. The National Association of ACOs wrote a letter[24] noting that numerous ACOs experienced a 30% or greater decrease in their performance on this measure. Seven Next Generation ACOs dropped out of the program in early 2018, shortly after a unilateral lowering of all risk adjustment scores by nearly 5%.[25] **Even small changes can have a measureable impact on performance evaluation and be the difference in whether a practice participates or drops out of a model, so it is paramount that even technical changes are communicated well in advance of the performance year in which they will take effect.**

III. Conclusion

We appreciate CMS' ongoing efforts to reduce physician burden, including this opportunity to offer comments. We look forward to continuing to support the Administration in these important efforts to reduce bureaucracy in healthcare billing and delivery so that physicians can stop filling out an abundance of paperwork and get back to innovating more efficient, patient-centered, and effective ways to deliver better patient care, all while achieving system wide savings and improving physician well-being and satisfaction. Please contact Suzanne Joy at sjoy@acponline.org or 202.261.4553 with any questions or to discuss further.

Sincerely,

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Chair, Medical Practice and Quality Committee
American College of Physicians

[23] acponline.org/acp_policy/letters/physician_joint_letter_to_cms_on_auc_program_2019.pdf
[24] naacos.com/naacos-letter-to-cms-on-aco-qualitymeasure-17
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