American Association of Clinical Endocrinologists
245 Riverside Avenue • Suite 200 • Jacksonville, Florida 32202 • Phone: (904) 353-7878 • Fax: (904) 353-6755 • http://www.aace.com

September 7, 2018

Ms. Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 1813
Baltimore, MD 21244-8013

RE: 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 [CMS-1693-P]

Dear Administrator Verma:

The American Association of Clinical Endocrinologists (AACE) represents over 5,000 endocrinologists in the United States. AACE is the largest association of clinical endocrinologists in the world. Most AACE members are Board-Certified in Endocrinology and Metabolism and concentrate their work on the treatment of patients with endocrine and metabolic disorders including diabetes, thyroid disorders, osteoporosis, growth hormone deficiency, cholesterol disorders, hypertension, and obesity. AACE members are committed to providing the highest quality of care to the patients they serve.

AACE appreciates the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) proposed rule and revisions to Medicare Part B payment policies under the Medicare Physician Fee Schedule (MPFS or Proposed Rule) for Calendar Year 2019, published in the *Federal Register* on July 23, 2018.

Our comments pertain to the following issues:

1. **Proposed Changes to Documentation and Payment Rates for Evaluation & Management (E&M) Office Visits**
   a) **Documentation Requirements**
   b) **Single Blended Payment Rate for Established Patients and for New Patients**
   c) **Multiple Procedure Payment Reduction**
2. **Proposed New Codes for Communication Technology-Based Services**
3. **Proposed Valuation for CPT code 10021 and 10x12**
4. **Proposed Refinements to Direct Practice Expense (PE) Inputs for Continuous Glucose Monitors**
5. **Proposed Changes to the Quality Payment Program**
   a) **Cost Performance Category**
   b) **Promoting Interoperability Performance Category Certification Requirements**
   c) **MIPS Scoring/Small Practice Bonus**
   d) **MIPS Performance Threshold**

1. Proposed Changes to Documentation and Payment Rates for Evaluation & Management (E&M) Office Visits

a) Documentation Requirements

Proposed Rule: CMS has proposed the following changes relative to documentation and payment for E&M office visits:

1. Limit required documentation of an established patient's history to the interval history since the patient's previous visit, for physicians who choose to continue using the current guidelines;
2. Eliminate the requirement for physicians to re-document information included by practice staff or the patient in the medical record; and

3. Eliminate the requirement to document justification for a home visit instead of an office visit.

Medical records are intended to capture physicians' medical decision making for future reference or for relaying information to other providers during transfers of care. Current documentation guidelines require physicians to include a variety of additional information simply to justify code selection as opposed to prioritizing documentation relevant to the patient's current and future treatment. Current E&M coding documentation guidelines are complex, ambiguous, and lead to suboptimal patient care.

We commend CMS for its efforts to address the administrative burdens imposed by current documentation requirements and we fully support the changes for E&M documentation in the proposed rule listed above and urge CMS to work with vendors for electronic health record companies, now, to allow for the functionality copying over unchanged previous visit information and for the attestation of accuracy of information recorded by practice staff. Although these changes will decrease the documentation required for Medicare billing, physician records still must reflect the details of care provided for both professional and medicolegal reasons. Physicians may also be forced to juggle between different documentation protocols based on private insurer requirements. Consequently, the documentation changes will have essentially no impact on office overhead costs and will not compensate for the decreased reimbursement received by specialists who treat patients with complex chronic diseases under the proposed single blended E&M payment rate, as we discuss below.

AACE Recommendation: We support the implementation of the proposed documentation changes for E&M codes listed above in 2019 and recommend that CMS engage in a process with medical societies to better define the documentation requirements for medical decision making in conjunction with the development of an alternative payment proposal as we suggest below. The product of such a process could be proposed in the 2020 Medicare Physician Fee Schedule Rule continuing CMS' efforts to reduce physician's administrative burden.

b) Single Blended Payment Rate for Established Patients and for New Patients

Proposed Rule: CMS has proposed to eliminate the current E&M payment structure and apply a single blended payment rate for Level 2 through Level 5 office visits for new patients ($135) and for established patients ($93).

A review of 2017 Medicare utilization statistics indicates that endocrinologists have a higher level of E&M code visits than most other specialties. For example, seventy-seven percent (77%) of all E&M codes billed by endocrinology are Level 4 or Level 5, the highest of all the specialties. The overall average of Level 4 or Level 5 visits among all specialties is forty-nine percent (49%). Sixty-nine percent (69%) of all E&M codes billed by endocrinology are Level 4, the highest of all specialties, with the overall average percent of Level 4 visits among specialties being forty-five (45%). Finally, the ratio of Level 4 billing to Level 3 billing for endocrinology is the highest of all specialties at 3:1, compared to an overall average of approximately 1:1.

Based on these statistics, we are very concerned about the proposed blended payment rate and consolidation of E&M services and how it will impact patient access to the highly-specialized care that AACE members provide. The proposed payment cuts for office visits for the sickest, most complicated patients penalizes physicians who treat these patients, especially new patients. It will certainly impact access for patients with complex endocrine conditions that pose significant challenges, such as patients with uncontrolled diabetes and related comorbidities.

For a new patient with poorly controlled diabetes, an endocrinologist will typically spend more than an hour with the patient going through the following steps:

1. Review all notes, labs, etc. sent by referring provider or brought in by patient.
2. Obtain a complete history, including medical, surgical, social, and family histories, allergies, medications, review of systems, immunizations, etc.
3. Conduct an in-depth history of the diabetes, including date of diagnosis, current and previous medication efficacy and safety, diabetes education including dietary assessment received, and evaluation of current acute and chronic complications of the disease, including retinopathy, nephropathy, neuropathy, peripheral vascular disease, coronary artery disease, arteriosclerosis vascular disease. In addition, because of the importance of technology in managing diabetes, review of glucose log, meter download and continuous glucose monitoring devices.
4. Educate patient on critical aspects of diabetes self-care (for example, education on insulin management including injection procedure, treatment of hypoglycemia and insulin titration schedules.)
4. Perform a complete physical examination assessing all body systems, except for breasts and genitalia.
5. Order laboratory and ancillary testing.
6. Determine whether to order diabetes education.

7. Provide a comprehensive individualized treatment plan which involves the assessment and coordination of all elements previously mentioned. In addition, because other co morbidities such as management of lipids and hypertension are crucial to overall cardiovascular health, these elements are commonly managed in conjunction with diabetes control.
8. Determine how to follow-up on the plan (which could include review of blood glucose logs as soon as the next day).

Under the proposed E&M payment structure, endocrinologists will no longer be able to afford to spend the time they previously devoted to the care of complex patients. Despite the projection by CMS that the new E&M payment proposal will have a negligible impact on endocrinology, our internal projections applying the new payment rates suggest endocrinologists who see very complicated patients will experience a significant reduction in Medicare reimbursements for office visits. Payments from newly proposed add-on codes intended to protect physicians providing complex care by making up for severe cuts, would not be sufficient to ensure continued patient access for a practice that currently consists of mostly Level 4 and Level 5 patient encounters. Even if the newly proposed prolonged visit code is used for every patient encounter, an endocrinologist in private practice couldn't possibly cover office overhead costs with the resulting reduced patient volume.

This new payment scheme will potentially create a significant access to care issue as more individuals with diabetes and other complex chronic conditions age into Medicare. Currently three out of four Americans with Medicare have diabetes or prediabetes and one out of three Medicare dollars is spent on diabetes and diabetes-related conditions. Diabetes among the U.S. population continues to increase according to the Centers for Disease Control (CDC). There is a shortage of endocrinologists and many current beneficiaries have difficulty getting an appointment with an endocrinologist in their area. This reduction in payments will only make the access to care issue worse for Medicare beneficiaries.

We are also very concerned about the proposed timeline for implementing this sweeping payment reform of the E&M office visits. Implementation of any new coding structure requires substantial physician and office staff education and changes to electronic health records systems, as well as changes for Medicare contractors, commercial payers and auditor procedures. CMS must allow ample time for education and implementation of any new payment scheme, especially a profound change that has such a broad impact on the healthcare system.

AACE Recommendation: For the reasons stated above, AACE urges CMS not to implement the proposed single blended payment rates for E&M codes in January 2019, and instead work with medical specialty societies and other interested stakeholders to develop an alternative proposal for future implementation.

c) Multiple Procedure Payment Reduction

Proposed Rule: CMS has proposed to reduce payment by fifty percent (50%) for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes to a beneficiary on the same day as furnishing a separately identifiable E&M visit.

We vigorously oppose the proposed multiple payment procedure reduction. Because of previous work by the AMA RUC, the values of the affected codes already account for efficiencies realized from multiple services on the same day of service and should not be further reduced. Medicare reimbursement rates now barely cover office overhead, any further decrease in their allowances will make it even more challenging for Medicare patients with complicated chronic medical conditions to find a physician who is willing to serve them.

This proposal will have a significant adverse effect on practices, such as thyroid destination centers, that both diagnose and treat a specific disease or condition. The proposal will not change the patient volume significantly but will require a physician to insist that the patient make an extra trip for the procedural service on a separate day, which creates added costs for the patient and for the healthcare system and is inconsistent with goals to promote cost-effective patient-centered care.

AACE Recommendation: We urge CMS not to implement the multiple procedure payment reduction as proposed in the 2019 proposed rule.

2. Proposed New Codes for Communication Technology-Based Services

Proposed Rule: CMS is proposing to cover and value new CPT codes for communications technology-based services for Interprofessional Internet Consultation and for Chronic Care Remote Physiologic Monitoring.

AACE commends CMS for recognizing the significant cognitive work that is often involved, yet uncompensated, when providing evaluation and management services for patients with complex chronic conditions. Clinical endocrinologists

spend a great deal of time coordinating care and providing care for patients with diabetes in the intervals between face-to-face visits, when increased ability to improve coordination of care and patient safety is needed most. Reviewing blood glucose data, adjusting medications based on variations in blood glucose levels and modifying the patient treatment plan are all part of the ongoing management of the complex diabetes patients.

The newly proposed HCPCS codes for brief, non-face-to-face appointments via communications technology (virtual check-ins) and the proposal to value new CPT codes for Interprofessional Internet Consultation (CPT codes 994X6, 994X0) and Chronic Care Remote Physiologic Monitoring (990X0, 990X1, and 994X9) will provide compensation for previously uncompensated work, greater flexibility for physicians and improved access and improved quality of care delivered to patients.

AACE Recommendation: AACE urges CMS to implement the proposed coverage and payment of new CPT codes for communications technology-based services for Interprofessional Internet Consultation and Chronic Care Remote Physiologic Monitoring.

3. Proposed Valuation for CPT code 10021 and 10X12

Proposed Rule: CMS proposes reductions in the RUC-recommended work relative value units (RVUs) for CPT code 10021 (Fine needle aspiration biopsy; without imaging guidance; first lesion) and CPT code 10X12 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion).

AACE represents clinical endocrinologists who are experts in the prevention, diagnosis and treatment of thyroid cancer and thyroid disorders, and fine-needle aspiration is the cornerstone of thyroid cancer diagnosis. The chance of being diagnosed with thyroid cancer has risen in recent years and it is the most rapidly increasing cancer in the U.S. According to the National Cancer Institute, there are over 56,000 new cases of thyroid cancer in the U.S. each year. Thyroid cancer is the fifth most common cancer in women. Thyroid cancer can occur in any age group, although it is most common after age 30, and its aggressiveness increases considerably in older patients. As the Medicare population grows with the aging of the baby boomers, the need for proper thyroid cancer diagnosis and treatment will only grow.

For these reasons AACE requests that CMS adopt and finalize the RUC-recommended work RVUs for these codes (1.20 for CPT code 10021 and 1.63 for CPT code 10X12.). These recommendations were based on the 25th percentile of extremely robust surveys (158 respondents for 10021, 203 respondents for 10X12) from multiple specialties as well as reference to multiple comparator codes.

Proposed Reductions for CPT Code 10021 Based on Relative Changes in Work and Time

CMS has rejected the RUC recommended work RVU of 1.20 for CPT code 10021 and is instead proposing a work RVU of 1.03 (about a 15% reduction from RUC recommendation). The rationale stated is that in the RUC recommendation, the intra-service time and total time decreased by 2 minutes and 15 minutes respectively, which proportionately represents a greater decrease from current values than the decrease in the work RVU, equivalent to .07 RVUs, so that CMS argues that the RUC recommended work RVU is too high.

This rationale incorrectly implies that the decrease in time must equate to a one-to-one decrease in the valuation of work RVUs. As CMS notes, the components of work include time and intensity. Implying that the decrease in time as reflected in survey values must equate to a one-to-one decrease in the valuation of work RVUs, CMS incorrectly assumes that there are no differences in how work was valued in 1995 and how it is valued now. Differences in physician time now compared to 1995 cannot be trusted to be actual differences as evident by the inappropriately low intraservice time for this base code, CPT 10021.

In addition, we note that the time reduction for 10021 is predominantly in the pre-service and post-service time, which are valued much lower than the intra-service time. Consequently, it would be expected that the reduction in total time would not parallel the changes in work.

Inappropriate Choice of CPT Code 36440 as a Crosswalk for 10021

CMS states that the value for 10021 should be cross-walked from CPT code 36440 (Push transfusion, blood, 2 years or younger), We believe CPT code 36440 is an inappropriate crosswalk for CPT code 10021 for the following reasons:

1. Site of Service: CPT code 36440 is overwhelmingly performed on inpatients, while CPT code 10021 is done as an inpatient procedure less than four percent (4%) of the time.

2. Patient Population: CPT code 36440 is a code for neonates; CPT code 10021 is primarily for adults.
3. Utilization: CPT code 36440 has extremely low utilization (Medicare utilization is zero for last 3 years; 2012 Medicaid utilization 41). When CPT code 36440 was surveyed, the median performance rate for survey respondents was extremely low at 2 procedures a year, despite a highly targeted survey aimed at neonatologists.

Appropriate Crosswalks for CPT Code 10021

The chart below depicts several comparator codes for 10021 that we feel are more appropriate than the CMS-recommended 36440. These comparator codes all have similar times to the CMS-recommended times but have higher RVUs than 36440, consistent with the conclusion that 10021 is more complex than 36440. 70470 and 99283 were cited by the RUC as supporting their recommendation. We believe that these comparator codes serve to support the RUC recommendations for 10021.

CPT Code	Work RVU	Pre Time	Intra Time	Post Time	IWPUT
10021 (Current)	1.27	21	17	10	.0339
10021 (RUC Recommended)	1.20	10	15	8	.053
10021 (CMS Recommended)	1.03	10	15	8	.042
70470 (CT head or brain)	1.27	5	15	5	.0697
99283 (ER visit)	1.34	5	18	7	.0595
40490 **(**lip biopsy)	1.22	14	15	5	.0577
78451 (myocardial imaging)	1.38	10	15	5	.0621
95865 (needle EMG larynx)	1.57	10	15	7	.080
53855 (urethral stent insertion)	1.64	7	15	10	.0839

Comparison with Key Reference Code for 10021

Intra-service work per unit of time (IWPUT) is defined as the number of RVUs per minute during the intra-service period when the procedure is actually being performed. As such, IWPUT is a rough measure of the intensity/complexity of the procedure: the more complex, the more RVUs per minute are applied during the intra-service period. Two services which have similar complexity should have similar IWPUT.

The IWPUT for the RUC-recommended values for CPT code 10021 is 0.053. One reasonable comparator to CPT code 10021 as far as the similarity of the procedure is 32554 (Thoracentesis), which was picked by the FNA survey respondents as the top key reference service, the one most similar to 10021 in work and complexity. The IWPUT for 32554 is 0.054, almost identical to the IWPUT of 0.053 calculated for the RUC-recommended values for 10021, thereby supporting the accuracy of the selection of values for 10021. By comparison, the IWPUT for the CMS-suggested comparator code 36440 is much lower at 0.039, suggesting a much lower degree of complexity for this service.

CPT Code 10X12

CMS asserted that the work increment for adding ultrasound guidance to FNA was 0.43 RVU, calculated as the RUC-approved value for 10X12 of 1.63 minus the RUC-approved value for 10021 of 1.20. CMS then added this "ultrasound increment" of 0.43 to their new proposal for the 10021 base code of 1.03 to get a total of 1.46 work RVU for 10X12. CMS supported this selection by referring to two comparator codes: 99225 (subsequent observation care, per day) and 99232 (subsequent hospital care, per day), both of which have the same intra-service time as 10X12.

We do not object to the CMS designation of 0.43 RVUs as the increment over base FNA code for adding ultrasound guidance. However, as noted above, we strongly object to the assumption that the work value for 36440 offers an acceptable baseline. Rather, as outlined above, we believe that 10021 should be valued at 1.20 work RVU, the RUC-recommended value, and we do not object to addition of 0.43 work RVU to this baseline value to obtain 1.63 work RVU

for 10X12, as recommended by the RUC. This value for 10X12 is supported by the two crosswalk codes proffered by the RUC (93351 and 75572) as well as by 30905, 69642, and 64646 (see table below).

CPT Code	Work RVU	Pre Time	Intra Time	Post Time	IWPUT
10X12 (RUC recommended)	1.63	10	20	9	.060
10X12 (CMS recommended)	1.46	10	20	9	.052
93351 (Echocardiography)	1.75	10	20	10	.0651
75572 (CT heart)	1.75	10	20	10	.0651
30905 (control nasal hemorrhage)	1.97	14	20	10	.0752
64642 (Chemodenervation of one extremity)	1.65	15	20	5	.0601
64646 (destruction of neurolytic agent)	1.80	15	20	5	.0676

AACE Recommendation: AACE urges CMS to reconsider the work RVUs for CPT 10021 and CPT code 10X12 and adopt the RUC-recommended work RVUs of 1.20 (CPT code 10021) and 1.63 (CPT code 10X12).

4. Proposed Refinements to Direct Practice Expense (PE) Inputs for Continuous Glucose Monitors

Proposed Rule: CMS has proposed modifications to direct Practice Expense (PE) inputs for supplies and equipment based on a market-based analysis provided by an outside contractor. As part of this initiative, reductions in PE inputs are proposed for the "glucose monitoring interstitial sensor" (SD-114) and the" continuous glucose monitoring system" (EQ-125).

CMS has indicated that it will modify direct PE inputs for supplies and equipment according to a market-based analysis performed by StrategyGen, an outside contractor (Fed Register July 27, 2018; 83 FR 35719-21). The rationale for this initiative was stated to be the lack of comprehensive review of supply and equipment prices since 2004-2005. Our understanding is that this analysis encompassed a massive survey of over 2000 items.

The specific source of the pricing benchmark databases used by StrategyGen is not available for independent review and we are concerned that small physician practices may not be well represented in the benchmark databases used by StrategyGen. AACE encourages CMS to consider that there are vast differences in product and equipment pricing between physician groups around the country due to significant variability with respect to geography, practice size, purchasing method, procedure volume and bulk versus consignment purchasing arrangements. Practitioners of procedures in a non-facility setting are a heterogeneous group that ranges from multistate corporations to sole practitioners. Any methodology that more heavily weighs larger physician groups, group purchasing organizations (GPOs) or even hospital contract pricing would result in pricing that is significantly depressed when compared to those that could be obtained by an individual practitioner.

Furthermore, some equipment and supply prices have been reviewed in detail by CMS very recently, including within the last year. For example, in the 2018 Medicare Physician Fee Schedule Final Rule, which was released less than a year ago (82 FR 53069), CMS established a new price for "glucose monitoring interstitial sensor" (SD-114) of $53.08, based in part on its analysis of 19 invoices for this specific item. StrategyGen has proposed a further reduction in this price down to $43.95.

Similarly, in the 2018 Medicare Physician Fee Schedule Final Rule released last November (82 FR 53069), CMS indicated that it had conducted a detailed analysis of the cost of the continuous glucose monitoring system (EQ-125), including literature review and evaluation of vendor prices, and it established a new price of $1170.54 for EQ-125, which represented a cut of more than 50% from the previous allowed price. StrategyGen has proposed a further reduction in this price down to $835.53.

We believe in such instances it would be more appropriate for CMS to rely on its own detailed individual analyses of equipment costs, undertaken within the last year, to establish prices for supplies and equipment. Further, we assert the legitimacy of the CMS analysis and would question the validity of a market-based analysis provided by the outside contractor.

AACE Recommendation: AACE urges CMS to continue to use the current values for "glucose monitoring interstitial sensor (SD-114) and the continuous glucose monitoring system (EQ-125) for EQ-125, which it developed very recently after its detailed individual analysis of this item, rather than the contractor-suggested price that was developed as part of a broad survey-based market analysis.

5. Proposed Changes to the Quality Payment Program

a. Cost Performance Category

Proposed Rule: CMS proposes to increase the weight of the Merit-based Incentive Payment System (MIPS) Cost Performance Category from ten percent (10%) in the 2018 performance year to fifteen percent (15%) in the 2019 performance year and by five percentage points each year after until the required thirty percent (30%) weight in the 2024 MIPS payment year.

We object to the proposal to raise the weighting of the Cost performance category to fifteen percent (15%) of the MIPS final score calculation for the 2019 performance year. CMS' contractor, Acumen, Inc., is still working with a multi-specialty technical expert panel to refine the Medicare Spending per Beneficiary Measure (MSPB) specifically issues regarding attribution of this cost measure to individual physicians. We believe increasing the weight of this category is problematic for many physicians as the validity of the metrics for this category are still not fully tested regarding the changes that are being developed by the Acumen technical expert panel and are not generally understood by many physicians.

AACE objectives to CMS finalizing specific percentage increases in the cost category for future payment years in this CY 2019 rule. In part because the cost category is still new, with the measures have very limited field testing. Also, while CMS has increased its activity regarding the creation of episode-based cost measures, there are still many physician specialties, including endocrinology, not yet a priority.

AACE Recommendation: We urge CMS to reconsider this issue and maintain the current Cost category weight of ten percent (10%) of the MIPS final score. We also urge CMS to maintain flexibility in the cost category regarding the incremental increasing leading to up to the 2014 MIPS payment year and not finalize any specific interval in this CY 2019 rule.

b. Promoting Interoperability Performance Category Certification Requirements

Proposed Rule: CMS proposes to require that MIPS-eligible clinicians use the 2015 Edition Certified Electronic Health Record Technology (CEHRT) in the 2019 performance year.

We are concerned about this proposal because many physician practices have not yet successfully switched to the 2015 CEHRT, and to penalize them at this juncture provides a disincentive to transition to value-based payment models. The adoption and implementation of a new EHR, or the upgrade from one edition to another, requires considerable resources and time. Continuation of the bonus for physicians who transition to 2015 CEHRT adoption will help recognize physicians' investment in health IT and encourage moving to this more advanced technology.

We continue to be concerned about the lack of interoperability of EHR systems and their inadequacy in supporting workflows and objectives related to high quality patient care. Vendors should be held accountable for capturing data on quality metrics and for providing reports in a format suitable to satisfy physician-reporting requirements. Physicians should not be penalized for the failures of their EHR vendors. Allowing more time for the full transition to 2015 CEHRT will also provide more time to health IT vendors, particularly lending smaller developers additional time for upgrade development, testing, and certification. These developers often cater to the specific needs of medical specialties, and, without this increased timeline, specialists may encounter a limited number of products available on the market for their specialty or patient population.

AACE Recommendation: AACE urges CMS to continue to provide the option of using 2014 CEHRT in 2019 and to continue to provide a bonus to those physicians who transition to 2015 CEHRT.

c. MIPS Scoring/Small Practice Bonus

Proposed Rule: CMS proposes to reduce the small practice bonus from five (5) points in Year 2 to three (3) points in Year 3 and apply the bonus to the Quality Performance Category score only, which, as proposed will represent forty-five percent (45%) of the eligible clinicians total MIPS final score.

In our comment letter for the 2018 QPP rule, we applauded CMS for proposing a five percent (5%) bonus for small practices to apply to the calculation of their total MIPS performance score. We are very disappointed to see in this proposed rule that CMS seeks to reduce the small practice bonus to three (3) points and apply it only to a physician's Quality performance category score, which as proposed will represent only forty-five percent (45%) of a physician's total MIPS performance score. We believe that a goal that should be set throughout the MIPS program is to create stable requirements that do not change from year to year. This is the easiest way to ensure participants can learn about and prepare for the MIPS requirements. Accordingly, we urge CMS to avoid changes or short-term policies that disrupt understanding of the program. If such changes are necessary, they should generally be made in a fashion that protects participants as opposed to placing more individuals at risk for a financial penalty. If CMS adopts certain bonus points, these incentives should be maintained over time and
not be taken away from one year to the next. Throughout the scoring methodology, we encourage CMS to try and keep the program as consistent as possible so that physicians can learn the new requirements and successfully participate.

Temporary bonus points not only create complexity but will artificially inflate the performance threshold for participants. These participants will then be disadvantaged in future program years when the bonus points are removed or reduced, essentially creating greater hardship for the categories of participants who need the most assistance.

AACE Recommendations: We urge CMS not to adopt the proposed changes to the small practice bonus and instead make the current five percent (5%) small practice bonus permanent and apply the bonus to the total MIPS performance score.

d. MIPS Performance Threshold

Proposed Rule: CMS proposes to raise the MIPS performance threshold from fifteen (15) points in Year 2 to thirty (30) points in Year 3.

The proposed performance threshold of thirty (30) points for the 2019 performance year significantly increases the exposure of physicians to a penalty relative to the fifteen (15) point performance threshold during the current 2018 performance period.

We believe that CMS should maintain its transitional year policies and continue to set the performance threshold at an achievable level for all participants as they gain experience with the MIPS program. MIPS participants are still learning the program and will only have had one year of experience doing a full calendar year of reporting the different categories, scoring methodology, timelines, and other requirements. Gradually increasing the threshold for the third performance year ensures that participants can continue to become comfortable with the program and can work to restructure their practices to prepare for future MIPS reporting. Setting a lower threshold is especially important since we still do not have data from the first full calendar year performance year and are unsure how well physicians understand MIPS requirements and whether physicians are ready for a more challenging program. We believe CMS should delay implementing a significant increase in the performance threshold until a complete analysis of the 2018 data is performed. This data is an important metric of physician performance during the first full year of reporting in the MIPS program for many physicians. Constantly escalating the threshold will force physicians to change their reporting plan every year. Instead, the MACRA statute permits CMS to reassess the threshold every three years, creating a sense of consistency for participants.

AACE Recommendation: We disagree with CMS doubling the performance threshold to 30 points in the 2019 performance year and request that you increase the performance threshold by a more modest achievable level that would represent a stepwise approach to evaluating physician performance for 2019. We also again request that you consider utilizing specialty specific performance threshold for a fair comparison of services provided and of quality improvement.

Improvement Activities Bonus Score under the Promoting Interoperability Performance Category and Future Reporting Considerations

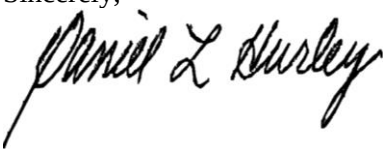
Proposed Rule: CMS proposes the creation of MIPS public health priority sets across the four MIPS performance categories (Quality, Improvement Activities, Promoting Interoperability, and Cost).

We are pleased that CMS has identified diabetes as one of the first few public health priority sets to develop, and we encourage the development of measures that move beyond hemoglobin A1c. AACE would be happy to serve as a resource as CMS moves forward with development of the diabetes public health priority set.

AACE Recommendation: We urge CMS to move forward with the creation of public health priority sets across the four MIPS performance categories. We also encourage CMS to consider a public health priority set that expands beyond a single condition, to those that are common comorbidities, such as prediabetes, diabetes, obesity and cardiovascular disease, and encourage a more holistic approach to identification and management of the set of conditions.

Once again, thank you for the opportunity to comment on the proposed rule for the 2018 Medicare Physician Fee Schedule. If you have any questions about the comments contained in this letter, please contact Sara Milo, AACE Director of Legislation and Government Affairs at smilo@aace.com or 904-353-7878 ext. 148.

Sincerely,



Daniel L. Hurley, MD, FACE
President