August 29, 2018

The Honorable Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1693-P
Mail Stop C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Re: File Code-CMS-1693-P; Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019 (July 27, 2018)

Dear Administrator Verma:

On behalf of the American Academy of Pediatrics (AAP), a non-profit, professional organization of 67,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults, I appreciate the opportunity to provide comments on the Centers for Medicare and Medicaid Services (CMS) Notice of Proposed Rule Making (NPRM) on the Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019 published in the July 27th, 2018 Federal Register. Although few pediatric services are included in the Medicare program, payment policies introduced in Medicare are frequently adopted by the Medicaid program and by private payers. Given that Medicaid and CHIP cover over 45 million US children, CMS has an important obligation to children and their providers to consider the impact of every policy on children, their families, and their physicians. Therefore, the Academy offers these comments on the proposed rule to ensure that all new policies reflect this important principle.

**Interprofessional Internet Consultative Services (CPT Codes 99446-99449 and 994X0, 994X6)**

**ITC Valuation**

The Academy applauds CMS for changing the Status Indicator to “A” (Active) and publishing the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC)-recommended values for the existing interprofessional internet consultative (ITC) codes, 99446-99449.

While we also strongly support CMS’ acceptance of the RUC recommendation for one of the two new ITC codes, 994X0, which is appropriately valued at 0.50 work relative value units (wRVU) based on robust survey results, we are disappointed that CMS did not accept the RUC recommendation for the other new ITC code (994X6).

Rather than accepting the RUC recommendation for code 994X6, CMS crosswalked it to code 994X0, citing a ‘similarity in intra-service times’ between the two codes.
<table>
<thead>
<tr>
<th>Code</th>
<th>Long Descriptor</th>
<th>CMS Proposed work RVU</th>
<th>RUC Recommended work RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>994X0</td>
<td>Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes</td>
<td>0.50</td>
<td>0.50</td>
</tr>
<tr>
<td>994X6</td>
<td>Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time</td>
<td>0.50</td>
<td>0.70</td>
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While the intra-service times for the two codes may be similar, the service reflected in code 994X6 is more intense than the service reflected in code 994X0.

Review of the Physician Fee Schedule (PFS) reveals that not all services with the same intra-service time have the same value. While codes 994X0 and 994X6 may share a similar intra-service time, the work is inherently different. The treating/requesting physician knows the patient and has determined the information and advice she seeks from the specialist. Therefore, her intra-service time is the actual time of call or internet communication. In contrast, the consulting physician is learning of the patient for the first time and must integrate patient history and other factors communicated by the treating/requesting physician, consider all the diagnostic possibilities, and recommend a management plan or a series of diagnostic tests in reaching a diagnosis. Components of consulting physician work that merit the higher valuation for 994X6 as recommended by the RUC include:

- 994X6 requires greater **physician effort and judgment** than 994X0: Physician effort and judgment necessary with respect to the amount of clinical data that needs to be considered by the consulting physician, the fund of knowledge required, the range of possible decisions, the number of factors considered in making a decision, and the degree of complexity of the interaction of these factors.
- 994X6 requires greater **technical skill** than 994X0: Technical skill required with respect to knowledge, training and actual experience necessary to perform the consulting service.
- 994X6 involves more **psychological stress** than 994X0: Psychological stress represents the weight of responsibility incurred when the outcome is heavily dependent upon skill and judgment and when a potentially adverse outcome has serious consequences faced by the consulting physician.
- The consulting physician (994X6) is **rendering recommendations** -- whereas the treating/requesting physician (994X0) is consolidating information into a focused patient story for the consultant to review. The consulting physician assumes more risk because she is the clinician making a recommendation.
- Similarly, there is more **medical judgement** required by code 994X6. The work of the consulting physician in 994X6 mirrors the work of the existing ITC codes, which describe only the work of the consultant (minus the phone call).
- The patient is **typically new** to the consultant, whereas the patient has likely already established a relationship (had at least one visit) with the treating/requesting physician before the consult is requested.

Furthermore, the RUC concluded that code 994X6 is equivalent in intensity to code 99447, which requires 11-20 minutes of medical consultative discussion, as well as both a written and verbal report. When the RUC valued code 99447 in October 2012, it used code 99442 (Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion; wRVU 0.50) as its key reference service, concluding that 99447 is a more intense procedure due to the fact that the patient is typically unknown to the consulting physician, making the service provided in a complex/urgent situation and the medical decision-making required more intense than 99442. These same concepts apply to code 994X6.

As with code 994X0, the RUC recommendations for code 994X6 are based on robust survey results and diligent consideration of relative values of similar services. CMS’ proposal devalues the consultant’s more intense work and creates a rank order anomaly within the code family. Therefore, the Academy urges CMS to accept a work RVU of 0.70 for CPT code 994X6.

Medicare, Medicaid and all payers seek to control health care costs while providing value added benefits to their beneficiaries. The interprofessional consultation services exemplify these efforts by avoiding unnecessary travel, absence from work, and costly clinic visits with the specialist. Representing a fraction of the cost of a patient visit to the specialist, the interprofessional consultation service represents an opportunity for CMS to allocate appropriate and representative payment for the consulting physician.

**ITC Consent and Co-Pay**
E-consult services are specific to the individual beneficiary and recorded in the beneficiary’s medical record by both the treating/requesting physician and the consultative physician. While it is not appropriate for either physician to use these services and the patient’s electronic health record solely to supplement physician education, it is appropriate for both to use the medical record to inform and process the consultation. The physician is expected to offer the e-consult to the beneficiary as an alternative to a face-to-face consult only after the decision is made that the patient’s condition requires referral to a subspecialist.

We agree that the treating/requesting physician should inform the beneficiary of the decision to consult with a specialist and then offer and explain the option of the e-consult. Only after the beneficiary agrees to the e-consult option should the requesting/treating physician commence with an e-consult. We do not agree with the added burden of requiring documentation of this consent in the medical record.

In addition, the Academy respectfully requests that CMS consider limiting the patient liability for the e-consultation service to a single co-pay. If such immunity is not granted, an unacceptable scenario might arise where a patient is charged two separate co-pays for a single e-consultation: one when the treating/requesting physician submits her code (994X0) and one when the consultative physician submits hers (994X6).
We recommend that code 994X0 be conferred immunity from patient financial liability because the treating/requesting physician has already collected a co-pay from the patient with provision of the face-to-face evaluation and management (E/M) service. Furthermore, allowing code 994X6 to trigger a co-pay reinforces that the care by the consultative physician is rendered for the benefit of the individual beneficiary and not for the sole benefit of the treating physician.

Evaluation and Management (E/M) Proposals
Given that Medicare payment policies are frequently adopted by the Medicaid program and private payers, CMS has an important obligation to children and their providers to consider the impact of every policy on children, their families, and their physicians.

E/M Documentation Guidelines
The Academy supports the CMS effort to simplify E/M documentation requirements for office visits, and CMS can implement many of its documentation revisions separate from CMS introduction of its blended rate proposal and without risking the integrity of physician CPT code selection. We outline below those recommendations that the Academy encourages CMS to implement for all office visit E/M including CPT consultation services:

- **Time as Controlling Factor:** Time is a reliable controlling factor in supporting E/M code level, and Time should be an available option to select code level regardless whether physician Time was expended in counseling, care coordination, or other patient-related activity such as history or examination. In addition, especially in pediatric and geriatric settings where direct patient communication may be compromised and as long as discussion focuses on the patient’s condition(s), Time should apply whether the physician is face-to-face with the patient or instead with the patient’s parent, guardian, or family without the patient present. CPT allows this use of time with patient and/or family member. Many other payers follow CPT and do not require the patient to be present. This payer discrepancy creates unnecessary burden on the provider to recognize when they can and cannot counsel parents without the patient present. Furthermore, in the office setting, if physician time is not otherwise allocated to another billable service, total billable time should relate not only to face-to-face but also to other physician non-face-to-face office time devoted to the patient during the visit. Since the office E/M codes all currently have associated typical times, the Academy encourages CMS to initiate these time recommendations in support of CMS’s intent to reduce regulatory burden in documenting of physician work. In alignment with this recommendation, while the physician must document total time and its representative activities in the medical record, supplemental attestations such as those that confirm domination by counseling or care coordination would no longer be necessary.

- **E/M Level Coding Options:** The Academy urges CMS to grant physicians flexibility and autonomy in selecting E/M code levels—whether that be by Time, key components, or solely by medical decision-making complexity—whichever allows for the highest E/M level that accurately reflects physician work devoted to the visit. Physician discretion in selection of the controlling factors maintains integrity of E/M level selection while reducing the administrative burden of clinically irrelevant documentation criteria. Since certain types of office encounters may be more conducive to coding of key components or decision-making rather than Time (such as in a team-based care environment where multiple office personnel are collaborating with the physician in care delivery), physician discretion and clinical presentation can guide selection of the controlling
factor(s). Furthermore, in recognition of CMS intent to reduce administrative burden, physician use of decision-making alone can accurately serve as a sole determinant in selection of E/M code level. Decision-making reflects evaluative and management complexity inherent in the patient encounter and represents physician knowledge and experience in choosing diagnoses, selecting diagnostic testing, and implementing management, while history and physical examination provide important support in generating appropriate decision-making. Designating decision-making as a sufficient sole determinant acknowledges the supporting role played by history and physical examination while avoiding clinically unnecessary, burdensome, complex documentation requirements.

- **Decision-Making Tools**: The Academy welcomes CMS interest in examining the relevance and appropriateness of current decision-making tools (such as the Marshfield grid) and appreciates the opportunity to create an approach that more effectively captures a full range of pediatric scenarios. While the three general decision-making categories of diagnostic/management options, data complexity, and risk provide a good foundation to capture a broad range of visits, there is opportunity to expand elements within those decision-making categories to achieve better clinical representation. For example, certain types of established problems representing sustained management complexity may be stable or changing as expected (such as care of a child with ADHD) while still requiring higher levels of decision-making in maintaining and assessing current status. The Marshfield grid does not currently acknowledge the role of this sustained management complexity in an established patient who is not otherwise worsening. In addition, the risk of managing new problems that eventually do not require prescriptive therapy upon visit conclusion may represent higher risk even though the physician eventually determines that pharmacologic therapy is not warranted. Additional elements that increase decision-making complexity yet are not represented in the Marshfield grid include the work of considering (and discussing) diagnostic tests which are subsequently not ordered, changes in caregivers such as occurs in pediatrics and geriatrics that then require enhanced communicative and coordinating physician work, and certain social determinants that have the potential to compromise health and require enhanced focus and evaluation. The Academy appreciates CMS interest in establishing a decision-making approach that can be validated consistently across visits whether by scoring or selection of category, and while the three current decision-making categories provide good clinical capture, there is opportunity to create a bedside tool that is more clinically intuitive while providing expansion of elements to better capture clinical scenarios. Since such decision-making tools additionally apply to other E/M settings beyond the office, the Academy would look forward to collaborating with CMS on tools that more effectively addresses the unique social, communicative, and clinical challenges in pediatric care.

- **Removing Documentation Redundancy**: In its proposal to remove redundancy in E/M documentation, CMS recognizes that current office workflow, typical clinical presentations, and EHR technology has rendered obsolete and burdensome certain restrictions on who can contribute to documented elements. CMS can incorporate these recommendations across all office E/M regardless of blended E/M rate implementation. While recognizing the clinical importance of documenting or re-confirming abnormal findings that may be unchanged from a previous visit, the Academy supports the modification of documentation guidelines to provide physician discretion in documenting only what has changed in history and physical examination for the established patient and also to allow ancillary office staff to enter elements of history on either new,
established, or consultation patients which then can be reviewed and verified by the physician. Furthermore, especially in pediatrics and geriatrics, caregivers, family members, and parents are an important source of history and with the advent of EHR portals and medical record access, can contribute valuable elements of history which can be subsequently validated by the physician. While we recognize that EHR copy-forward functionality allows for inclusion of various previously documented elements, appropriate physician editing or confirmation of physician review can validate the relevance and contribution of these elements as relates to the contemporaneous visit.

**E/M Same-Day/Same-Group Visits**

The Academy welcomes CMS acknowledgement that medically necessary same day E/M visits occur within the same group and specialty and that those visits merit separate payment. CMS provides the example of an endocrinologist practicing with a group of geriatricians, and similar examples occur in pediatric practice. For example, a patient visiting a pediatric cardiologist for post-operative follow-up of congenital cardiac disease may also need to see on the same day the group’s electrophysiologist because of arrhythmia. A pregnant patient seeking prenatal counseling with her pediatrician may also need to visit with the group’s infectious disease specialist to assess possible exposure to Zika virus. As long as medical necessity underlies the need for the additional visit, we encourage CMS to allow same-day, different-physician, same-specialty billing without need for additional, unnecessary regulatory restrictions. But while the Academy supports this CMS approach, we are concerned that CMS introduction of its 50 percent same-day reduction will erode the independent value inherent in same-day E/M services. While primarily addressing E/M with same-day global procedures, CMS should clarify that its intent is not to reduce E/M payment when more than one E/M service occurs on the same day among physicians of the same specialty. Since each separately reported E/M would be paid based on its individual coding criteria, and since there is no overlap of work when multiple E/M occur on the same day, there need be no reduction in these E/M payments.

**E/M Payment Simplification through Blended Rates**

While the Academy encourages CMS to expeditiously implement the revised documentation guidelines highlighted above, we recognize that the CMS proposal to simplify payment through blended rates represents the foundation upon which CMS is building its program of administrative simplification. While physicians have generally adapted their approach to office visit documentation to accommodate current E/M structure and payment, physicians would welcome the reduction in payer audits and elemental dissection of their records that accompanies the current 10-code system. In applying weighted averages in establishing blended rates, CMS recognizes that certain types of visits merit enhanced payment based on the increased work and expenses not otherwise embedded within the blended rate, and CMS has addressed this through creation of G codes for primary care and unique specialty assignment. To support its endeavor to reduce administrative burden while maintaining E/M coding integrity, CMS proposes that the respective G-codes would apply to primary care and unique specialty visits.

While we agree that the add-on code concept addresses increased complexity within a blended rate model, we additionally note the following:

- **Stand Alone:** While CMS implies that the G-code enhancements would apply to stand-alone E/M visits, primary care visits can be associated with procedures without diminishing the primary care independence of the E/M. For example, a pediatric primary care visit could be associated with non-indwelling bladder catheterization (CPT 51701; 0-day global) which may be necessary to
sterilely obtain urine in support of an independently performed E/M on a febrile infant. Whether performed by primary or specialty care, physicians should be allowed to report the supplemental G-code regardless whether the E/M is stand alone or accompanied by a procedure.

- **Primary Care vs Specialty RVU Weighting:** In recognition of the national compensation differential between primary and specialty care, and with sensitivity to the maldistribution of primary vs specialty care services in the United States, assuming such a stark difference in valuation (1.75 vs 8.25 minutes) accentuates the perception of lesser valuation for primary care services both literally and figuratively. While we recognize CMS efforts over the past few years to create primary care opportunities such as through care coordination and transitional care services, the primary/specialty discrepancy should be addressed further through a more balanced valuation of their respective G codes.

- **Recognition of Specialty Taxonomy within Primary Care:** Appropriate recognition by the payer of the specialist is essential for reliable acknowledgment of the specialty care G code. Payers differ in their use of provider enrollment specialty codes, and enrollment as a non-specialist may undervalue a specialist’s services which otherwise merit higher complexity and valuation. For example, pediatric specialists who otherwise experience high visit complexity may be enrolled as pediatric medicine and thus unable to utilize the higher valued G code. While higher specificity taxonomy codes exist in identifying this specialization, payers often do not utilize this taxonomy specificity in provider enrollment. Furthermore, even though CMS has restricted its specialty G-code assignment to a narrow scope of specialties, the nature of pediatric specialty care is such that all pediatric specialists confront increased complexity in the patients they manage, and the add-on complexity modifier should accommodate this unique pediatric perspective on specialty care.

- **Recognition of Visit Complexity within Primary Care:** Within pediatric primary care, physicians have a higher percentage of visit complexity based on their focus on patients with complex chronic disease such as diabetes, cystic fibrosis, oncology, congenital cardiac disease, and renal failure. The primary care G-code valuation may not appropriately value the services for these physicians dedicated to the care of these exceptionally complex diseases thus creating an unintended shift of care for these patients to fragmented specialty care. Thus, an opportunity may exist for creation of an alternative add-on code that solely addresses visit complexity even when performed by a physician who is otherwise designated as primary care.

- **Non-Medicare Payer Recognition of G Codes:** In acknowledging CMS queries regarding timing of blended rate implementation, and in recognition of the importance of the G-code add-on in supplementing payment, we caution that most non-Medicare payers do not recognize the G codes, and if this remains unchanged, this would disadvantage physicians who collaborate with payers based on Medicare-published RVUs but whose payers may not otherwise incorporate the full Medicare HCPCS code set (such as these new G codes). Collaborating with the AMA in creating CPT codes that have a higher probability of widespread adoption among multiple payers will assist in supporting not only RVU adoption but also incorporation of supplemental add-on services. We recognize that while CMS created E/M proposals that in their entirety are intended to create balance and maintain program integrity, few payers would be able to adopt all features of the program at the outset, although some payers may adopt features that would create disruptive imbalance. Such an occurrence is especially likely in pediatrics where patients are covered by a
combination of public and private payers as opposed to Medicare’s unifying platform in the senior population. The pervasiveness of the far-reaching CMS proposals has some parallels to the national ICD-10-CM initiation in October 2015 where all healthcare participants and systems were provided ample opportunity to prepare, and all payers were required to implement the new standard on the same universal date. Unless all payers were provided the opportunity to simultaneously incorporate these changes in E/M documentation, administrative burden would actually increase for those physicians (such as pediatricians) who must comply with multiple different payers. The widespread reliance of payers on Medicare’s RVU-based fee schedule and approach to E/M creates an opportunity for CMS to allow for preparation and alignment in advance of implementation.

- **Patient Relationship Categories to Differentiate Complexity:** We advise CMS to not use patient relationship category codes to differentiate E/M complexity. The patient’s relationship to the physician need not drive E/M complexity. Rather, the patient’s presenting problem and the nature of the physician’s work underlie visit valuation. For example, the episodic relationship categories provide no insight into the level of complexity of an isolated E/M visit and thus would not have any impact on individual E/M visit valuation.

- **Accommodation for Non-Medicare Payers:** While CMS’ proposal to blend rates addresses Medicare payment policy, blended rates will not necessarily be adopted by non-Medicare payers (such as Medicaid). Since the majority of non-Medicare payers utilize components of the Medicare PFS in establishing their own fee schedules, we urge CMS to continue to publish the RUC-recommended RVUs for codes 99201-99215. These values are important to archive to allow non-Medicare payers a reference point upon which they can develop their own payment policies—especially if they do not adopt a blended rate approach. Thus, such publication will support non-Medicare payer utilization and reference in setting their own fee schedules. In accommodating publication of these values, we recommend that CMS include a separate ‘Download’ file for codes 99201-99215 and their RUC-recommended values on the CMS.gov web page for the RBRVS rule.

We note that while CMS has been socializing its interest in modifying E/M documentation guidelines for several years now through its annual PFS publications, this 2019 proposed rule represents the initial formal announcement by CMS regarding office E/M rate blending. This places CMS in an ideal position to now implement many of its documentation revisions while providing opportunity for ongoing collaborative review of its proposed payment structure. As CMS participates in that rate structure review, we believe CMS will have the opportunity to consider the following:

- That the blending of level 2 through 5 rates will potentially create disincentive for physicians to confront patient complexity and thus encourage either parsing complex patient problems into multiple visits or to referring complex patients to other settings such as emergency departments.
- That the uniqueness of supplemental G codes to Medicare and their contribution to administrative claim complexity will not be sufficient to offset this gap in representing patient complexity.
- That opportunities exist to administratively simplify rates incrementally (and less dramatically) such as by considering a model similar to initial and subsequent inpatient E/M which addresses low, medium, and high complexity services through a 3-code structure which could be similarly achieved through integration of office-based levels 4 and 5 while distinctly retaining the level 3 category.
Impact of Blended Typical Time and the Prolonged Services G Code

The Academy welcomes CMS creation of a 30-minute direct contact prolonged services code and looks forward to similar CPT code development to enhance opportunity for non-Medicare payer adoption. We anticipate that like the CPT direct contact codes, passing the halfway point (reaching 16 minutes of prolonged service) would allow physicians to report this service. In a 5-code scenario dominated by counseling, direct contact prolonged services do not apply until the appropriate time has transpired beyond the highest level code. For example, in a 5 code level scenario without a blended code family, and if CMS adopts our recommendation to grant wide physician discretion in applying time as a controlling factor, direct prolonged service with the new GPRO1 code would not apply for an established office E/M until 56 minutes had been reached (99215 with GPRO1). In a blended rate scenario, and assuming the typical established and new patient office E/M times assigned by CMS (31 and 38 minutes, respectively), the physician would report the new prolonged service code at 47 minutes for the established patient and 54 minutes for the new patient. While 54 minutes may be reasonable for the new patient, the 47 minute established patient prolonged service threshold is too high if the intent is to capture higher level complexity that is otherwise currently represented with existing level 4 and 5 services.

CMS Approach to Same Day E/M with Global Period Procedure

Given that Medicare payment policies are frequently adopted by the Medicaid program and by private payers, CMS has an important obligation to children and their providers to consider the impact of every policy on children, their families, and their physicians.

The Academy encourages CMS to reconsider its proposal to reduce payment on the least costly service performed on a day when the physician or group performs both an E/M and global procedure. First, as we noted above, if two physicians in the same group perform same-day medically necessary E/M visits, CMS should not apply a payment reduction to either E/M. In addition, with regard to same day E/M with global procedure, the RUC has already valued these procedural services so as to avoid any overlap with same day E/M. We already provided the pediatric example of bladder catheterization performed on the same day as an E/M in evaluating fever in an infant, and performance of these services on the same day does not render either one less value from the standpoint of resource utilization or physician work. We encourage CMS to consider these points and at the very least, ensure that this policy does not impact same-day E/M or impact E/M performed with procedures for which a global concept does not apply (XXX procedures).

Communication Technology

The Academy congratulates CMS for its innovative leadership in recognizing the role that digital communication plays in support of patient care. We are pleased that CMS is now actively valuing physician-to-physician digital communication (such as through interprofessional consultation services) as well as patient-to-physician communication (such as through its newly proposed Virtual Check-in (GVCII)). We note that this newly proposed service is similar to CPT code 99444, online medical evaluation, and we are currently collaborating with the American Academy of Family Physicians and the American College of Physicians in developing new CPT time-based codes to address online digital evaluation and management. Similar to GVCII, our proposal addresses patient-initiated encounters for established patients and has similar E/M bundling recommendations as your GVCII. Since our proposal addresses cumulative communication that transpires over a maximum one-week period, we think one cumulative encounter per week is a reasonably applied frequency limit for these services. Typically, the initiation of these communications occurs via the EHR portal, but as the so-called eVisit transpires,
subsequent communication may occur not only via the portal but also via telephone and other digital communication. Our proposal is time-based in increments of 5-10, 11-20, and greater than 20 minutes, and we agree that these eVisits are most appropriate for established patients. We note that you are also proposing GRAS1 for remote evaluation of pre-recorded information. Patient-initiated communication using store-and-forward information is also included in our eVisit proposal with the appreciation that as an eVisit progresses over a possible maximum of one week, transmission of images and data may be necessary, but we appreciate that your GRAS1 proposal is exclusively focused solely on store-and-forward image and data transmission as opposed to a broader view of multiple modalities of digital communication. Thus, we can envision that your GRAS1 proposal would be suitable for both new as well as established patients since the focal point of the assessment is the transmitted image or data. We also recognize that either of these visit types could evolve into an E/M—either via face-to-face or via Medicare’s definition of telehealth. We hope to have the opportunity to collaborate with CMS in aligning these services with future CPT development as our eVisit proposal progresses through review.

Quality Payment Program
The Academy appreciates the opportunity to provide comments on the CY 2019 Updates to the Medicare Quality Payment Program. Much of the proposed changes, and the program itself, have no obvious relation to pediatrics. Nevertheless, pediatricians know Medicaid and private payers often adopt Medicare policies even though those structures were created to meet the needs of adult practice and are often inappropriate, inapplicable, or unworkable in pediatrics. Imposing adult structures on pediatrics may unnecessarily increase cost without the gain of a corresponding benefit. The Academy urges CMS to consider the unique needs of pediatric populations and identify payment models that reflect the unique emphasis on prevention and healthy growth and development that is the foundation of pediatric primary care. Only by designing a payment system with children in mind at the beginning will the health care system produce quality care, improved outcomes, and lower costs.

To achieve this, the AAP would appreciate the opportunity to have its leadership meet with CMS staff to discuss ways that we can partner to further our shared goals of improving the health and well-being of children and adolescents through innovative payment models that meet children’s unique needs. We would like to discuss ways to ensure that the patients that the health needs of our member’s patients are fully considered while CMS increasingly focuses on Medicare-driven reform.

The Academy appreciates the opportunity to provide comments on the July 27th proposed rule and looks forward to working with CMS to ensure that the physician fee schedule accurately reflects the work value of physician practice and pediatric care.

Sincerely,

Colleen A. Kraft, MD, MBA, FAAP
President

CAK/ljw