The Hospital + Healthsystem Association of Pennsylvania

Leading for Better Health

September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

SUBJECT: CMS-1693-P. Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and other revisions to Part B for Calendar Year 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program; Proposed Rule, July 27, 2018

Dear Administrator Verma:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member institutions, we appreciate the opportunity to comment about the Centers for Medicare & Medicaid Services' (CMS) Medicare Physician Fee Schedule proposed rule for calendar year (CY) 2019.

While HAP supports many of the payment and policy proposals, especially efforts to reduce paperwork and administrative provider burden contained within the proposed rule, we have significant concerns about the proposal to consolidate evaluation and management (E/M) services as well as continuing cuts to non-excepted off-campus hospital provider-based departments and the potential harm they will have for providing needed access to care for Medicare beneficiaries.

Additional key areas included in the attached comments are:

- Overhaul of documentation and payment for E/M visits
- Expansion of payment policies for telehealth services
- Changes to the Merit-based Incentive Payment System (MIPS)

Thank you for your consideration of HAP's comments regarding this proposed rule. If you have any questions, contact Kate Slatt, senior director, health care finance policy, at (717) 561-5317.

Sincerely,

Jeffrey Bechtel
Senior Vice President, Health Economics and Policy

Attachment

HAP
Leading for Better Health

HAP Comments—Physician Fee Schedule
Proposed Rule for Calendar Year 2019

EVALUATION AND MANAGEMENT VISITS

The 2019 Medicare Physician Fee Schedule proposed rule proposes significant changes to the documentation and payment of outpatient and office visits. Currently, providers bill one of five levels of evaluation and management (E/M) codes depending on the level of complexity of the visit. Reimbursement increases with the level of E/M code (and corresponding complexity) billed.

The rule proposes collapsing payment to a single payment rate for E/M visits levels 2 through 5 for new patients (99201–99205) and a separate single payment rate for level 2 through 5 visits for established patients (99212–99215). To supplement payment, the Centers for Medicare & Medicaid Services (CMS) proposed three add-on codes that would recognize resource-intensive visits specific to inherent complexity, primary care, and prolonged visits. As the physician fee schedule must be budget neutral, CMS proposes to fund these add-on payments using the multiple procedure payment reduction (MPPR), reducing payment by 50 percent for the least expensive procedure or visit when a procedure is performed during the same day as an office visit.

As part of CMS' effort to reduce administrative burden, the rule proposes changing E/M documentation requirements by allowing providers to choose one of three different methods of documentation including:

- Current framework of evaluation guidelines from 1995 or 1997
- Medical decision making
- Time

Also intended to reduce burden, the rule proposes requiring only the documentation necessary for a level 2 visit. It proposes eliminating the requirement of re-documenting information already included in the patient's medical record. Providers would be expected to only document new information that has occurred since the last visit.

Teaching Physician Documentation requirements for E/M services under the PFS, Medicare Part B pays for teaching physician services subject to certain conditions, including that the patient's medical record must reflect the teaching physician's review and direction of services performed by residents in teaching settings. According to stakeholder feedback, the documentation requirements for E/M services furnished by teaching physicians are burdensome and duplicative of information that may have previously been entered into the medical record by residents or others. To address this feedback, CMS proposes to require only that medical records document the teaching physician's presence during the time the service was furnished, not that the information must be documented by the teaching physician him or herself.

HAP appreciates efforts undertaken by CMS to reduce administrative burden as part of its "Patients Over Paperwork" initiative. Efforts included in this rule to reduce unnecessary duplication of information already included in a patient's medical record as well as providing flexibility in the methods of documentation will allow providers to refocus upon the patient, where their time and skills have the most value.

While supportive of efforts to reduce paperwork for providers, HAP has significant concerns related to the payment proposal included above. Collapsing payment to a single rate would have substantial impact on clinicians who care for a higher acuity and complex patient. It is not clear, due to the lack of transparency in the CMS modeling, what the true impact of this change could mean for payment to providers. The disconnect between the resource use and intensity of physician services and the compensation that the proposal creates, and the potential resultant significant negative impacts on patient care, is concerning. A change this significant requires additional time and analysis to avoid unintended consequences that could result with a hasty implementation. Also, HAP believes that neither CMS' proposed add-on codes, nor its proposal to allow providers to default to level 2 E/M visit documentation requirements, would offset the proposed payment decrease.

HAP urges CMS to refrain from finalizing the proposals to consolidate payment for levels 2 through 5 E/M codes, implement the MPPR, and add-on codes until further analysis can be completed and significant consultation with stakeholders is conducted.

HAP urges CMS to decouple efforts to minimize documentation burden from the payment policy and to move forward with finalizing proposals to:

- **Allow physicians either to document visits based on the level of medical decision making or time required, or use the 1995 or 1997 E/M guidelines**
- **Eliminate the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or the patient**
- **Limit required documentation of the patient's history to the interval since the previous visit**
- **Remove the need to justify a home visit instead of an office visit**
- **Allow the presence of a teaching physician for E/M services to be demonstrated by the notes in the medical record made by a physician, resident, or nurse**

HAP encourages CMS to engage stakeholders in efforts to redesign payment for outpatient and office visits that ensure accurate payments reflecting the resources used to provide services.

PAYMENT REDUCTIONS FOR NON-EXCEPTED PROVIDER-BASED HOSPITAL OUTPATIENT DEPARTMENTS

Section 603 of the Bipartisan Budget Act (P.L. 114-74), enacted November 2, 2015, imposed site-neutral payment provisions for off-campus provider-based departments (PBD). The site-neutral policy mandated that items and services furnished at an off-campus PBD can no longer be billed under the outpatient Medicare reimbursement system. Subsequent rulemaking provided that the impacted off-campus departments would be paid under the Medicare PSF. A "grandfather clause" preserved payments for excepted off-campus PBDs that were billing for Medicare outpatient services before a certain date, and the 21st Century Cures Act included provisions to address situations where hospitals were in a "mid-build" situation when the act was passed.

The payment rule for calendar year (CY) 2017 set "site neutral" Medicare reimbursement rates at 50 percent of the outpatient payment rate. The CY 2018 rule reduced payment to 40 percent of the outpatient rate.

Historically, Medicare recognized that off–campus PBDs were different from traditional physician offices and warranted a different payment method/rate. Reasons for this include:

- Types of patients that off-campus PBDs serve—higher severity patients and a large portion of low-income, underserved patients
- Services provided—comprehensive services for complex patients for whom the hospital is the appropriate setting
- Regulatory burden—compliance with hospital conditions of participation and 24/7 emergency standby capacity

The CY 2019 proposed rule continues the policy to pay for non-excepted services in off-campus PBDs at 40 percent of the Outpatient Prospective Payment System (OPPS) amount.

HAP strongly opposes continuing the reduced rate of payment for off-campus PBDs during CY 2019 and urges CMS to improve the accuracy of its methodology. CMS should revise the proposed applicable payment rates to appropriately reimburse for services provided by off-campus PBDs. Specifically, CMS should accurately account for indirect and direct practice expense and differences in packaging across the OPPS and the PFS for non-excepted PBDs. Analyses completed by the American Hospital Association and the Association of American Medical Colleges indicate a more accurate PFS Relatively Adjuster is 65 percent.

VIRTUAL HEALTH

Technology-based communication

Separate and distinct from Medicare's payment for telehealth services, defined in section 1834(m) of the Social Security Act, the rule proposed two new billable codes that will reimburse communication technology-based service:

- Brief communication technology-based services: GVCI1 would be billable when a provider uses communication technology to conduct a brief, non-face-to-face check-in with an established patient to determine if an office visit or other service is warranted
- Remote evaluation of pre-recorded patient information: GRAS1 would be billable for the remote professional evaluation of patient-transmitted information conducted via pre-recorded store and forward video or image technology. The purpose of the evaluation would be to determine whether a patient's condition warranted an office visit or other service

CMS also is proposing establishing reimbursement for six current procedural terminology (CPT) codes that would allow payment for interprofessional consultation using telephone/internet. CMS believes that specialists are incentivized to schedule visits with a patient when a primary care physician could have informally consulted with the specialist to provide appropriate care to the patient. Providing payment for this service is intended to reduce the number of specialist visits when a phone call or Internet-based interaction between providers would have sufficed.

The rule also proposes a new code, CPT 994X9, that allows clinical staff, including registered nurses and medical assistants, to be reimbursed for remote patient monitoring services under the PFS.

HAP supports efforts to leverage technology in ways that would allow proactive treatment of Medicare beneficiaries. HAP urges CMS to finalize separate payment for communication technology-based services that would allow providers to evaluate patients in a cost-effective way while determining the best site and plan of care for future treatment, if warranted. Finalizing the proposal to allow all remote patient monitoring (RPM) services to be performed by clinical staff will be an important advancement forward as providers continue efforts to focus on population health.

Telehealth

The rule proposes the addition of two codes for prolonged preventive services that extend beyond the typical service time of the primary procedure and require direct patient contact. CMS is adding these codes as it believes these services are sufficiently similar to services currently on the telehealth service list.

CMS also proposes expanding the use of telehealth pursuant to the Bipartisan Budget Act of 2018, specifically:

- Expanding access to home dialysis therapy—removes the geographic requirements for telehealth services for purposes of the monthly end-stage renal disease-related clinical assessments
- Expanding the use of telehealth for individuals with stroke—removes restrictions on geographic locations and the types of originating sites where acute stroke telehealth services can be furnished and further specifies that these services can be furnished in any hospital, critical access hospital, mobile stroke units, or any other site determined appropriate by the Secretary of Health and Human Services, in addition to the current eligible telehealth originating sites

Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. However, coverage and payment for telehealth services remain major obstacles for providers seeking to improve patient care. Medicare, in particular, lags far behind other payors due to its restrictive statutes and regulations.

Specifically, Medicare currently pays for telehealth services when the patient being treated is in a health professional shortage area or in a county that is outside any metropolitan statistical area, as defined by the Health Resources and Services Administration and the U.S. Census Bureau, respectively. The telehealth site must be a medical facility, such as a physician's office, hospital, or rural health clinic, and not the patient's home.

As CMS noted in the proposed rule, statute specifies both the types of entities that can serve as originating sites and the geographic qualifications for originating sites. This restriction limits the delivery of medically necessary and potentially life-saving services to patient beneficiaries. Expansion of telehealth services would improve care to patient beneficiaries and ultimately reduce total health care expenditures. By way of illustration, consider a patient in the intensive care unit of a community hospital. Telehealth would facilitate physician–driven clinical management and communication after hours, improving clinical outcomes for the patient. In addition, expansion of telehealth services would improve patient access to specialists.

In light of these severe geographic constraints and other requirements, most Medicare beneficiaries are not eligible to use this service.

HAP appreciates CMS' continued efforts to increase the number of services covered by CMS and the targeted removal of geographic limitations for a small number of services. HAP urges Congress and the Administration to continue to expand Medicare coverage of telehealth, such as by a presumption that Medicare-covered services also are covered when delivered via telehealth unless CMS determines on a case-by-case basis that such coverage is inappropriate.

CHANGES TO MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

There are several changes proposed to the MIPS in the rule including:

- Adding eligible clinician types—the inclusion of clinical psychologist, physical therapist, occupational therapist, and clinical social workers as eligible clinician types
- Adding a new low-volume threshold determination criterion—adding the number of services to the dollar amount and number of beneficiaries as criteria to determine low-volume providers. Currently, the low-volume threshold is set at eligible clinicians billing more than $90,000 per year and furnishing covered professional services to more than 200 Medicare beneficiaries. The rule proposes adding that eligible clinicians must provide more than 200 covered professional services under the PFS. To be included, a clinician must exceed all three criterion
- Including an "opt-in" policy—allows providers who are excluded from MIPS based on the low-volume threshold determination to opt-in to the program if they exceed at least one of the low-volume threshold criteria
- Removing 34 measures from the MIPS measures set as part of its "Meaningful Measures" framework
- Increasing the weight of the cost performance category— increasing the cost performance category weight from 10 percent to 15 percent
- Adding eight new episode-based cost measures—measures include elective outpatient percutaneous coronary intervention, knee arthroplasty, revascularization for lower extremity chronic critical limb ischemia, routine cataract removal with intraocular lens implantation, screening/surveillance colonoscopy, intracranial hemorrhage or cerebral infarction, simple pneumonia with hospitalization, and ST-elevation myocardial infarction with percutaneous coronary intervention

HAP supports most of the proposals related to MIPS included in the rule and applauds CMS' efforts to allow more clinicians to participate in the MIPS facility-based measure option as well as streamlining and focusing the measures in its quality programs. However, it has significant concerns with proposals related to the cost performance category including increasing the weight of the category and adding new episode-based cost measures.

At the top of HAP's list of concerns are that the newly proposed episode-based measures are not endorsed by the National Quality Forum (NQF). We also have concern related to the reliability and accuracy of the methodology behind these measures, including the concern related to the complexity of the attribution methodology proposed.

HAP urges CMS to refrain from adding new episodic cost measures until they are evaluated and endorsed by NQF. HAP also urges CMS to refrain from increasing the weight of the cost category until existing concerns with methodology related to current cost measures are fully addressed.