AHPA
ADVENTIST HEALTH
POLICY ASSOCIATION

September 11, 2017

VIA ELECTRONIC MAIL
regulations.gov

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244-8013

Re: CMS-1676-P, Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018

Dear Ms. Verma:

On behalf of the Adventist Health Policy Association (AHPA), we appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) Calendar Year (CY) 2018 Physician Fee Schedule (PFS) proposed rule. Our organization is the policy voice for five Seventh-day Adventist health systems that include 82 hospitals and more than 300 other health facilities in 17 states and the District of Columbia.

AHPA represents a major segment of the U.S. hospital sector. Our member hospitals operate in a variety of settings, ranging from rural Appalachia to California. Therefore, we believe that we can provide an objective and sound policy voice in response to CMS' PFS proposed rule. Below please find AHPA's comments and recommendations to CMS' proposed policies. Specifically, we comment on the following five issue areas:

- Non-Excepted Off-Campus Hospital Outpatient Provider-Based Departments Payment Reductions
- Remote Patient Monitoring
- Evaluation and Management (E&M) Documentation Guidelines
- Physician Quality Reporting System (PQRS)
- Value-Based Payment Modifier and Physician Feedback Program

Non-Excepted Off-Campus Hospital Outpatient Provider-Based Departments Payment Reductions

For CY 2018, CMS proposes to implement a 50 percent cut in the PFS payment rate for non-excepted off-campus Hospital Outpatient Provider-Based Departments (HOPDs). As mandated by Section 603 of the *Bipartisan Budget Act of 2015* (BBA), certain items and services furnished by off-campus HOPDs are no longer paid under the Outpatient Prospective Payment System (OPPS). Instead, CMS selected the PFS as the applicable payment system for those items and services. CMS currently reimburses those services under the PFS at 50 percent of the OPPS payment rate. The Agency is proposing to reduce that rate to 25 percent of the OPPS rate for CY 2018. CMS states that this payment reduction is being done to eliminate the payment incentive for hospitals to purchase physician offices, convert them to off-campus HOPDs and bill under the higher OPPS payment rate.

AHPA strongly opposes the proposed payment reduction. We believe that such a significant payment reduction will limit access to care for Medicare beneficiaries. Hospitals already suffer negative payout margins when treating Medicare patients in HOPDs. According to the Medicare Payment Advisory Commission's (MedPAC) June 2015 data book, Medicare margins were negative 12.4 percent for outpatient services in 2013. MedPAC's March 2017 report notes that these average Medicare margins will continue to be negative. Therefore, additional cuts to HOPDs will threaten beneficiary access to these services. New HOPDs will not be able to operate with a 75 percent payment reduction (50 percent in 2017 and then 50 percent again in 2018). The locations may close and the services could be relocated (on campus, to an exempt off-campus location, or 250 yards of an inpatient unit) or relicensed.

While we understand that CMS is seeking to reduce costs, we urge the Agency to consider the potential implications of this policy on patients. Reimbursement cuts of this magnitude will likely hamper access to care and increase costs in the long term. For example, studies have shown that hospitalizations following surgery are more likely to occur for procedures that are performed in physician offices compared with HOPDs.[1]

Moreover, HOPDs are not physician offices and should not be treated as such. These facilities provide services to low-income and vulnerable populations generally not served by physician offices. For example, relative to patients seen in physician offices, patients seen in HOPDs are 2.5 times more likely to be Medicaid, self-pay or charity patients and 1.8 times more likely to be dually eligible for Medicare and Medicaid.[2] Numerous studies have also demonstrated that HOPD patients tend to have more severe chronic conditions than those treated in physician offices.[3] Therefore, HOPDs incur higher costs when providing procedures similar to those in physician offices. The proposed payment rate would not adequately capture the costs of treating these complex patients.

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[1] Ohsfeldt, Robert. Outcomes of Surgeries Performed in Physician Offices Compared With Ambulatory Surgery Centers and Hospital Outpatient Departments in Florida. (April 2017). Retrieved at: http://insights.sagepub.com/outcomes-of-surgeries-performed-in-physician-offices-compared-with-amb-article-a6307-discuss?article_id=6307&tab=discuss

[2] American Hospital Association (2014). "Hospital Outpatient Department Costs Higher Than Physician Offices Due to Additional Capabilities, Regulations." Retrieved at: http://www.aha.org/research/policy/infographics/pdf/info-hopd.pdf

[3] Comparing The Mix Of Patients In Various Outpatient Surgery Settings (November 2003). Retrieved at: http://content.healthaffairs.org/content/22/6/68.full

CMS' proposal would also fail to compensate HOPDs for those costs associated with Medicare compliance. As opposed to physician offices, HOPDs have greater requirements for adverse event reporting, risk management and quality improvement processes.[4] For example, unlike physician offices, HOPDs are required to construct or equip a surgical suite according to uniform minimum standards. These regulatory requirements increase the cost of providing services to Medicare beneficiaries regardless of whether the service performed is the same.

Based on the issues referenced above, we ask that CMS reconsider its proposal to further reduce payments for HOPDs. We believe that further analysis should be done to determine the payment rate of non-excepted HOPDs. These payments must capture the patient mix of the facilities, the higher regulatory costs incurred, and the intensity of resources provided to treat more complex patients.

Medicare Telehealth Services

CMS proposes to add seven services to the Medicare telehealth list. These codes are proposed because the Agency believes that the services are sufficiently similar to those currently on the telehealth services list. The services proposed for addition to the telehealth list are:

- **HCPCS Code G0296:** Counseling visit to discuss the need for Lung Cancer Screening Using Low Dose Computed Tomography (LDCT).
- **CPT Codes 90839 and 90840:** Psychotherapy for crisis; first 60 min.
    - As a condition for payment, the distant site practitioner must be able to mobilize resources at the originating site to diffuse the crisis and restore safety.
    - CMS states it believes "mobilizing resources" is the ability to communicate with and inform staff at the originating site to the extent necessary to restore safety.
- **CPT Code 90875:** Interactive complexity.
- **CPT Codes 96160 and 96161:** Administration of patient-focused health risk assessment instrument and Administration of caregiver-focused health risk assessment instrument.
- **HCPCS Code G0506:** Comprehensive assessment and/or care planning for patients requiring chronic care management services.

AHPA supports the addition of these codes to the list of telehealth services covered by Medicare. We commend the Agency for seeking to increase access to care by expanding coverage of telehealth services.

Remote Patient Monitoring

CMS requests comments on whether to make separate payment for CPT codes that describe remote patient monitoring. The Agency is particularly interested in comments regarding CPT code 99091: Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver. This code is currently considered a bundled code (Procedure status of B). CMS also seeks comments about when this code should not be bundled into another service.

AHPA believes that CPT code 99091 should be allowed to be billed separately as opposed to bundled. For example, when 99091 is billed with CPT code 99490 (Chronic Care Management Services), no additional payment is made for the collection and interpretation of digital physiologic data. As more

[4] Urman RD, Punwani N, Shapiro FE. Patient safety and office-based anesthesia. *Curr Opin Anaesthesiol*. 2012;25:648–653.

patient generated data and device data is sent to providers, more time is being spent on interpreting this data. We recommend allowing separate reimbursement for CPT code 99091 to compensate for this activity when it exceeds the scope or time required for that of CPT code 99490. CMS has acknowledged the value of the activity, collection and interpretation of this data, by creating the 99091 code. The next step would be to allow it to be billed separately.

Evaluation and Management (E&M) Documentation Guidelines

CMS seeks ideas on how to reduce the documentation burden associated with Evaluation and Management (E&M) documentation guidelines and how to better align them with the current practice of medicine.

AHPA commends the Agency for seeking to improve the E&M documentation guidelines. It is our belief that the current guidelines have fostered an environment where providers are performing and documenting a comprehensive history and exam on most patients regardless of the patient's presenting problems or comorbidities. The nuances between different levels of service and different E&M types are so confusing and numerous, that physicians are adopting comprehensive histories and exams for most cases just to avoid potentially missing a history or exam element. **We recommend that the Agency revise the guidelines so that documentation is focused on the severity of the patient's presenting problems and the work required to treat such problems.** Doing this would allow physicians to document the medically necessary history and exam elements for a specific patient and efficiently treat the presenting problem. Similar to inpatient payment methodologies or risk-based payments, medical decision-making levels best support the overall severity and complexity of the encounter. Moreover, we believe that a comprehensive reform of E/M documentation guidelines would require a collaborative effort among stakeholders.

Physician Quality Reporting System (PQRS)

CMS proposes to reduce the number of required measures in the Physician Quality Reporting System (PQRS) from nine measures across three National Quality Strategy (NQS) domains to six measures with no domain requirement. For individual Eligible Professionals (EPs), this requirement would apply to the claims, qualified registry (except for measures groups), Quality Clinical Data Registry (QCDR), direct Electronic Health Record (EHR) product, and EHR data submissions vendor project. For group practices, this would apply to the qualified registry, QCDR, direct EHR product and EHR data submissions vendor project.

AHPA supports the proposal to decrease the number of required measures under the PQRS. We believe that reducing the number of required measures from nine to six would provide greater continuity between the final year of the PQRS and the beginning of the Merit-Based Incentive Payment System (MIPS). Six measures with no domain limitation is consistent with the MIPS criteria.
CMS also proposes to eliminate the following requirements under the PQRS:

- The requirement that individual EPs and group practices reporting via QCDR report an outcome or "high priority" measure.
- The requirement that individual EPs and group practices reporting via a claims or qualified registry report a cross-cutting measure.
- The requirement that group practices of 100 or more EPs that register to participate in the Group Practice Reporting Option (GPRO) must administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS patient survey.

AHPA supports the elimination of these requirements. Since there are so few outcome and cross-cutting measures, eliminating the requirement that individual EPs and group practices report via QCDR would provide more flexibility to report high performing measures. We also believe that CAHPS participation is costly, administratively burdensome, and often duplicative of other patient experience surveying occurring in health care systems. Therefore, we agree with these outlined proposals and recommend their adoption.

Value-Based Payment Modifier and Physician Feedback Program

CMS proposes to modify the Value-Based Modifier (VM) policies for the 2018 payment adjustment so that there are fewer EPs and groups receiving a negative VM adjustment. According to the rule, adjustments for groups and solo practitioners would be reduced from:

- -4 percent to -2 percent for groups with 10 or more EPs and at least one physician.
- -2 percent to -1 percent for groups with between two and nine EPs, physician solo practitioners, and for groups and solo practitioners consisting only of non-physician EPs.

AHPA supports this proposed payment adjustment. We believe that it would particularly help small practices who may already find it difficult to participate in the PQRS.

Conclusion

AHPA welcomes the opportunity to further discuss any of the recommendations provided above. If you have any questions or would like further information, please do not hesitate to contact Julie Zaiback-Aldinger, Director of AHPA, at Julie.Zaiback@ahss.org.

Sincerely,

Jeff Bromme
President
Adventist Health Policy Association