



A Passionate Voice for Compassionate Care

September 10, 2018

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Room 445-G Herbert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

REF: CMS-1693-P

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule (PFS) and Other Revisions to Part B for calendar year (CY) 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Ms. Verma:

The Catholic Health Association of the United States (CHA) is pleased to submit these comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule entitled *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* (83 Federal Register 35704-36368 July 27, 2018).

- **Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services**

In the CY 2019 proposed rule (83 FR 35722-35723), CMS distinguishes between services that are paid under the statutory telehealth benefit and those services that are routinely furnished via telecommunications technology. If a service is paid under the telehealth benefit, the patient must be located in a health care facility located in a rural area and only physicians and other practitioners may be paid for furnishing the service. Under the telehealth benefit, eligible services are those normally furnished face-to-face where a real time interactive telecommunications system substitutes for the in-person encounter.

For CY 2019, CMS aims to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology. These services would not be subject to the same restrictions that apply under the Medicare telehealth benefit.

1. *Brief Communication Technology- Based Service, e.g., Virtual Check-In (HCPCS Code GVCII)*

CMS proposes to pay for a “virtual check-in”—a brief, non-face-to-face check-in with a patient via communication technology--to assess whether the patient's condition necessitates an office visit. The service would not be separately paid if it resulted in a related evaluation and management service (E/M) being furnished within 7 days.

CHA supports CMS' proposal to pay for a “virtual check-in” visit that substitutes for what may otherwise be an in-person visit. We believe these kinds of brief interactions between a physician/qualified practitioner and a patient can result in improved efficiency and savings to the Medicare program through fewer in-person visits. One question we ask CMS to clarify is whether the brief virtual check-in may be furnished under the “incident to” benefit—that is, can a virtual check-in furnished by ancillary clinical staff working under the direct supervision of a physician/qualified practitioner be billed to Medicare?

The proposed rule requires the patient to initiate and consent to receiving the services as there would be associated coinsurance. CMS seeks comments on whether the patient consent should be noted in the medical record for each service. CHA urges CMS to establish the least burdensome policy for physician/practitioner community consistent with the “Patients over Paperwork” initiative, but also to consider that the patient should not be surprised by an unexpected bill for coinsurance from the physician. CHA recommends that CMS provide beneficiary education on cost-sharing for this and all telehealth services and consider waiving cost-sharing to encourage beneficiary utilization.

CMS further requests comment on whether the virtual check-in should have a frequency limit. CHA does not believe a frequency limit should be established and that Medicare should pay for all medically reasonable and necessary check-in visits. A frequency limit could result in a medically necessary check-in visit not being paid, resulting in an in-office visit that could have been avoided.

2. *Remote Evaluation of Pre-Recorded Patient Information (HCPCS Code GRAS1)*

CMS is proposing to allow payment for “store and forward” communication technology where a physician uses recorded video and/or images captured by a patient in order to evaluate a patient's condition. Under CMS' proposal, this service could be billed as a stand-alone service to the extent that there is no resulting E/M office visit and there is no related E/M office visit within the

previous 7 days of the remote service being furnished. CMS is seeking comment as to whether these services should be limited to established patients, or whether there are certain cases, like dermatological or ophthalmological services, where it might be appropriate for a new patient to receive these services. **CHA supports paying for remote evaluation of pre-recorded patient information.**

3. *Interprofessional Internet Consultation (CPT Codes 994X6, 994X0, 99446, 99447, 99448, and 99449)*

CMS proposes to make separate payment for interprofessional consultations undertaken for the benefit of treating a patient. However, CMS has concerns about how these services can be distinguished from activities undertaken for the benefit of the practitioner and requests comment on both this issue and how to best minimize potential program integrity concerns. CMS further proposes that consent be obtained from the beneficiary in advance of furnishing the service, including ensuring the patient is aware of any applicable cost sharing.

CHA supports CMS' proposal and recommends addressing program integrity concerns by requiring that the service only be billed when the requesting physician is asking a question specifically related to an individual patient's care.

4. *Medicare Telehealth Services*

CMS proposes to add the following codes to the Medicare telehealth services list:

G0514 – Prolonged preventive service(s) requiring direct patient contact beyond the usual service; first 30 minutes.

G0514 – Prolonged preventive service(s) requiring direct patient contact beyond the usual service; each additional 30 minutes.

CHA supports the addition of these two codes to the telehealth list.

5. *Expanding the Use of Telehealth Under the Bipartisan Budget Act (BBA) of 2018*

Monthly ESRD-Related Clinical Assessments. Consistent with the BBA 2018, CMS proposes to add a renal dialysis facility and the home of an individual as telehealth originating sites but only for the purposes of the monthly ESRD-related clinical assessments furnished through telehealth. In addition, also consistent with BBA 2018, CMS is proposing not to apply the rural geographic restriction to monthly ESRD-related clinical assessments where the originating site is a hospital-based or critical access hospital-based renal dialysis center, a renal dialysis facility, or the home of an individual. CMS will not pay the telehealth facility fee if the originating site is the home of an individual. **CHA supports these proposals.**

Stroke Services. BBA 2018 removes the rural geographic restriction on Medicare payment under the telehealth benefit for diagnosing, evaluating or treating symptoms of a stroke. However, the telehealth facility fee would only be paid when the site originating the stroke services is rural. CMS proposes to implement this provision by creating a modifier that would be used by practitioners and telehealth originating sites when furnishing acute stroke telehealth services. Consistent with the BBA 2018, CMS is also proposing to allow “mobile stroke units” to be originating site only for furnishing acute stroke services. **CHA supports these proposals.**

- **Evaluation & Management (E/M) Visits**

CMS makes a complex series of proposals related to Medicare payment for office/outpatient visits (CPT codes 99201-99205). The most significant of these proposals would change the 5-level payment structure for each set of these codes (one for new patients and a second one for established patients) to 2 levels. CMS proposes to retain the level 1 code and create a single payment rate for levels 2-5. For instance, CMS would create a single payment for a level 2-5 established patient office visit of about \$92 in 2019 regardless of whether the physician spent 10 minutes or 30 minutes face-to-face with the patient, compared to the current 5-level payment structure with payment rates that will vary from about \$45 to \$148. Add-on payments of about \$5 and \$14 could be billed for furnishing a primary care visit and “inherent visit complexity.” CMS would also allow for billing of a prolonged E/M service that exceeds the typical E/M time spent face-to-face with the patient by 30 minutes rather than the current 60 minutes.

CHA is very concerned that CMS’ proposal could be detrimental to patient quality of care and continuity of care, and result in underpayment of clinicians who provide comprehensive care to medically complex patients in a single visit. For example, the proposal would create unintended incentives for physicians to do many short visits with patients rather than providing comprehensive care in a single visit for patients with multiple problems. Ostensibly, CMS is proposing to collapse the payment levels from 5 to 2 to simplify documentation and reduce physician burden. However, CHA questions whether that goal will be achieved by CMS’ proposal. While CMS indicates that it will audit E/M billing only up to a level 2 office visit that triggers the single payment for a level 2-5 office visit, physicians would continue to be required to bill the level of office/outpatient E/M furnished. Physicians are given a choice of how to document the visit selected between: 1) the level of medical decision making; 2) the 1995 or 1997 documentation guidelines; or 3) face-to-face time (unlike current policy, counseling and coordination of care would not have to account for more than 50 percent of the total time). CHA believes that the combination of documentation choices together with retaining the current E/M code structure will not simplify the selection of an E/M code or how to document the code selected. Further, as private payers may retain the current 5 level payment structure, CMS’ proposal for a different system for the most consequential services billed under the PFS may complicate rather than simplify physician payment and coding.

We believe the add-on codes and billing for the prolonged services codes may create further confusion unless these services are better defined. It is unclear whether the prolonged services code can be billed in addition to any office/outpatient E/M service or can only be billed in addition to a level 5 office/outpatient E/M code. CHA further notes that the prolonged services add-on will not ameliorate the incentives to furnish shorter visits. The prolonged services code will pay approximately \$67 for spending 30 minutes beyond the typical time with a patient furnishing an office/outpatient E/M service. However, the physician can receive the full E/M payment of approximately \$92 for providing the minimum level to qualify to bill a level 2 office visit. CHA reiterates its concern that CMS' proposal will discourage treating patients that require longer visits with their physician and respectfully requests that CMS not finalize the proposal.

While CHA urges CMS not to finalize the proposal to collapse the visit codes from 5 payment levels to 2, there are other proposed changes that are independent of this proposal that CHA supports and recommends that CMS finalize:

- Proposal to remove the requirement for physicians to document why a home visit was furnished in place of an office/outpatient visit;
 - Proposal to eliminate prohibition on billing same-day visits by practitioners of the same group and specialty;
 - Allowing elements of patient history to be recorded by staff or the patient in the medical record and not have to be repeated by the physician, and allowing the physician to document only the information that has changed since the last visit and not the entire patient history for each E/M;
 - Proposals to change the teaching physician rules that will allow the physician, a resident or a nurse to document the presence of the teaching physician and the physician's participation in the review and direction of services.
- **Payment Rates Under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital**

Section 603 of the Bipartisan Budget Act amends section 1833(t) of the Act, which governs how Medicare makes payment under the hospital Outpatient Prospective Payment System (OPPS). Except for dedicated emergency departments and limited other exceptions, section 603 precludes off-campus hospital outpatient departments that opened after November 2, 2015 ("603 departments") from being paid under the OPPS. Section 603 departments are paid using another "applicable payment system" under Medicare Part B.

In the 2017 OPPS interim final rule with comment (81 FR 79720 through 79729), CMS adopted the physician fee schedule (PFS) as the "applicable payment system" for CY 2017 and set the payment rate at 50 percent of what would have been paid under the OPPS. The final rule for CY 2018 reduced the payment to 40 percent of the OPPS rate.

CMS proposes to continue its policy of using the “PN” modifier to identify services furnished in non-excepted off-campus provider-based departments (PBD) and apply a PFS relativity adjustment (CMS’ term for the OPSS payment reduction) of 40 percent. To determine the PFS relativity adjuster, CMS compares a “site neutral” PFS rate to the rate paid under the OPSS.

In past years, CMS did not have data from non-excepted off-campus departments for this comparison. For CY 2019, CMS has its first year of data billed using the “PN” modifier. As a result, CMS uses all codes billed with the “PN” modifier for comparing PFS and OPSS rates. Unlike past years, CMS does not provide the detail used to perform its calculations or its results other than saying that its analysis supports maintaining a PFS relativity adjuster of 40 percent.

It is difficult for public commenters to evaluate CMS’ proposal without more information. **CHA reiterates our comments that whatever methodology CMS uses to pay for services in non-excepted off-campus PBDs should be based on accurate data and must result in adequate payment.** The current proposal fails on both counts. A reimbursement rate that is only 40 percent of the OPSS rates for hospital outpatient services in new off-campus departments is insufficient to maintain access to the low-income and rural communities we serve.

We also reiterate our prior comment asking CMS to include provisions related to this policy in the OPSS rule. While CMS calls the payment system it uses to pay for services in non-excepted off-campus PBDs a “physician fee schedule,” it only affects payment to hospitals (non-excepted off-campus PBDs retain their status as hospitals) not to physicians. Further, it is a physician fee schedule in name only as the rates are determined based on 40 percent of the OPSS and it incorporates all OPSS packaging policies. CHA and other hospital stakeholders would find it more logical and easier for the hospital community to find this provision in the OPSS rule rather than the physician rule.

- **Part B Drugs: Add-On Percentage for Certain Wholesale Acquisition Cost (WAC)-Based Payments**

CMS proposes that, effective January 1, 2019, WAC-based payments for Part B drugs utilize a 3 percent add-on payment in place of the 6 percent add-on payment that is currently applied. CMS notes this proposal does not include WAC-based payments for single-source drugs under the provision of the statute that specifies that the payment is 106 percent of the lesser of ASP or WAC. **CHA opposes this proposal.** We are particularly concerned about the effect of this change on providers and specialists whose patients need access to innovative drugs. While CHA shares CMS’ concern about the rising cost of prescription drugs and appreciates the agency’s desire to address the problem, this approach simply cuts costs, in a way that could harm patients, without tackling the fundamental underlying systemic factors driving pharmaceutical costs.

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- **Merit-based Incentive Payment System: Promoting Interoperability Category**

CHA supports the goal of aligning requirements under the MIPS Promoting Interoperability category with those of the Medicare Promoting Interoperability Program for hospitals. This alleviates burdens, particularly where hospitals engage in MIPS reporting on behalf of employed physicians or community clinician partners. Even where the hospital is not reporting on behalf of clinicians for this category, aligning the objectives and measures ensures that clinicians and hospitals are working in the same way toward improving electronic exchange of health records.

However, CHA continues to be concerned about the potential for clinicians to be given zero points for this category in 2019 because they fail to meet the mandate to use only 2015 **certified electronic health record technology** CEHRT. While providers continue to move toward meeting this requirement, existing electronic health record systems need to be updated by vendors, and clinicians and staff need to be trained on the modifications. **If the final rule requires use of 2015 Edition CEHRT alone for the 2019 MIPS, we urge CMS to be flexible in scoring this category and to provide expedited hardship exceptions for providers acting in good faith who have not met this requirement.**

In closing, thank you for the opportunity to share these comments in regard to the proposed FY 2018 PFS rule. We look forward to working with you on these and other issues that continue to challenge and strengthen the nation's hospitals. If you have any questions about these comments or need more information, please do not hesitate to contact me or Kathy Curran, Senior Director Public Policy, at 202-721-6300.

Sincerely,

A handwritten signature in black ink that reads "Michael Rodgers". The signature is written in a cursive, flowing style.

Michael Rodgers
Senior Vice President
Public Policy and Advocacy