Catholic Health Association of the United States

A Passionate Voice for Compassionate Care

September 11, 2017

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-1676-P

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention 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 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program*. Our comments are limited to the sections of the proposal that address payment to nonexcepted off-campus provider-based departments of a hospital and specific requests for comment on Medicare telehealth services.

We appreciate your staff's ongoing efforts to administer and improve Medicare's payment systems, especially considering the agency's many competing demands and limited resources. CHA offers the following comments on these sections of the proposed rule.

- **Payment for Off-Campus Provider-Based Departments**

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. CMS' original proposal had been to pay 603 departments nothing. CHA welcomed CMS' abandonment of its original proposal, and urged CMS in the future to pay 603 departments no less than 50 percent of the OPPS rates.

Proposed Payment Change from 50 percent to 25 percent of the OPPS

CHA strongly opposes CMS' proposal to cut reimbursement to 603 departments to 25 percent of the OPPS rates for CY 2018. As noted above, CMS adopted (with some exceptions) a set of payment rates for 2017 for 603 departments that were based on a 50-percent reduction to the OPPS payment rates (inclusive of packaging). CMS arrived at the 50-percent reduction by comparing the difference between the facility and the non-facility amount paid under the PFS for a given service to the OPPS payment for the same service for 22 of the most commonly furnished services in off-campus hospital outpatient departments. Weighted by volume, CMS determined the ratio between PFS and the OPPS payment was 45 percent. Acknowledging that the ratio did not account for OPPS packaging—the OPPS payment includes compensation for additional services paid separately under the PFS—CMS raised the ratio to 50 percent.

Importantly, CMS left visit services out of the weighted average calculation for 2017—far and away the most commonly provided services furnished in off-campus hospital outpatient departments according to CMS' data. For the 2018 PFS proposed rule, CMS proposes to do the inverse of what it did for 2017, use only visit services and not the remaining 22 services it used for the 2017 calculation. In last year's 2017 OPPS final rule with comment, CMS established the PFS payment equal to 50 percent of the OPPS rate for use in 603 departments as "a transitional policy until such time that we have more data to better identify and value nonexcepted items and services furnished by nonexcepted off-campus provider-based department (PBD) and billed by hospitals."

In the 2018 PFS proposed rule, CMS states "at present, we do not have more precise data than were available when we established the PFS Relative Adjuster in the CY 2017 interim final rule, and we do not anticipate having such data until after the end of CY 2017." Yet, despite this, CMS has proceeded to propose another methodology for calculating the payment rate and proposed another 50 percent reduction in payment for 603 departments, from the current 50 percent to 25 percent of the OPPS payment. As CHA said in prior comments, we are indifferent to the methodology that CMS uses to pay for services in 603 departments if the payment amounts are adequate and based on accurate data**. CHA strongly opposes the proposal to pay 603 departments at 25 percent of OPPS rates. For CY 2018, CMS should set the payment rate at no less than 50 percent. Until CMS has accurate and sufficient claims data to determine a payment rate, we recommend CMS maintain the 2017 payment methodology.**

CHA hospitals provide services to low income and rural communities. Payment rates under the existing provisions of section 603 are already affecting access to needed services by lessening the hospital's ability to move into these communities when physicians are leaving their practices. Reducing payment to hospitals further can only lessen access to needed services in these vulnerable communities.

Relocation Policy

Under current CMS policy, excepted off-campus provider departments lose their excepted status if they move or relocate from their current physical address (including a change in the unit number of the address). CHA continues to believe that this policy is inconsistent with the plain meaning of the statute and adversely impacts the ability of providers to improve access to care for communities that are medically underserved or have vulnerable population, as detailed in our September 6, 2017 comment letter on the CY 2017 OPPS proposal**.** There are legitimate reasons why relocating may be in the best interest of the communities served. For example, main providers may move which would require relocating the off-campus PBD, and it is certainly not unusual for a PBD to wish to move to another unit or office suite in the same medical office building. An off-campus PBD may also relocate to expand the scope of services to medically underserved or other vulnerable patient populations. We urge CMS to reconsider this policy in the future.

Inclusion of Changes to Hospital Outpatient Departments in the Physician Fee Schedule Rule

We urge CMS to propose future changes in 603 department reimbursement in the annual OPPS update. In 2017 CMS adopted the PFS as the "applicable payment system" required by Section 603. Other than this special payment mechanism being called "physician fee schedule," it neither affects Medicare payments to physicians nor has any nexus to the traditional PFS. OPPS packaging and other OPPS policies would continue to apply to 603 departments as they do to non-603 hospital outpatient departments. The only difference is that hospitals are paid at 50 percent of the OPPS. Section 603 does not change the status of 603 departments as hospital outpatient departments and the special PFS created for 603 only affects hospitals. For this reason, CHA has found it odd that CMS has chosen to use the PFS rule to propose changes affecting section 603 hospital outpatient departments.

The resulting need to submit two sets of comments—one specifically for PFS comments and a second one for the OPPS rule – seems contrary to the Administration's stated priority to reduce regulatory burden and make the Medicare program more efficient. Including future section 603 changes in the OPPS rule rather than the PFS rule would help in the effort to make regulatory process more efficient for those individuals and organizations interested in reading fewer regulations and making one set of public comments.

- **Medicare Telehealth Services: Remote Patient Monitoring**

CMS has requested comments related to Medicare telehealth services, including comments on whether to make separate payment for CPT codes that describe remote patient monitoring. It 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).

The wide array of connected health technologies available today – whether called "telehealth," "ehealth; "mHealth," "store and forward," "remote patient monitoring," or other similar terms – offer great promise to expand access to care, improve patient care, reduce hospitalizations, help avoid complications, and improve patient engagement, particularly for the chronically ill, regardless of where they live. It can also mitigate workforce shortages and eliminate the need for patients to travel long distances for their care. In some rural communities, it can mean the difference between getting no care at all and getting the right care at the right time.

Many of CHA's members are leaders in using telehealth to provide innovative solutions to their communities' care needs. However, significant barriers continue to stifle the promise of telehealth, including the need to update payment systems such as Medicare to provide adequate and appropriate reimbursement for telehealth services. CHA applauds CMS' initiative in exploring how Medicare can be improved to accommodate telehealth services.

The bundling of remote monitoring with other codes has minimized reimbursement for remote monitoring solutions, inhibiting the use of this valuable method for enhancing patient care and outcomes. Among the constraints faced by providers interesting in using these codes for evidence based remote monitoring of patients with multiple chronic conditions are:

- Prescriptive, inflexible, minimum clinical time requirements that do not reflect variation in clinical time needed as patient condition fluctuates
- Inadequate valuation of office expense to maintain remote monitoring kit(s) that are provided to each patient for the duration of their monitoring (and returned upon completion of the monitoring period)
- Inadequate valuation of 24/7 monitoring service associated with remote monitoring services
- No reimbursement for set up and patient training

CHA would endorse efforts to unbundle CPT code 99091. At the very least, the unbundled code should be available for use to treat patients with congestive heart failure, chronic obstructive pulmonary disease and multiple chronic conditions. CPT 99091 is not an ideal code for remote monitoring. It lacks proper valuation for the technology or patient education/training component of remote monitoring. In addition, the current code only allows billing in 20 or 60 minute segments. In practice, 30 minutes of clinician review time is required. It would be more efficient and effective to bill clinician time spent in review of remote monitoring in shorter time

'chunks.' Adding the option of billing time in 10 or 15 minute segments which could then be combined would allow for more realistic accounting of the clinician's actual time. To strengthen and enhance the use of telehealth, CMS should continue to evaluate and reduce the current administrative complexity challenging ehealth, take steps to value chronic care management properly, and propose the adoption of appropriate new codes as they are developed by the AMA.

In closing, thank you for the opportunity to share these comments on the proposed 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,

Michael Rodgers
Senior Vice President
Public Policy and Advocacy