North Carolina Healthcare Association

Uniting hospitals, health systems and care providers for healthier communities

September 10, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue S.W., Room 445-G
Washington, DC 20201

Ref: CMS-1694-P: RIN 0938-AT31
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

Dear Ms. Verma:

On behalf of our 130-member hospitals and health systems in our state, the North Carolina Healthcare Association (NCHA) appreciates the opportunity to comment on 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; and Medicaid Promoting Interoperability Program published in the *Federal Register* on July 12, 2018.

NCHA is pleased that CMS is taking steps to reduce burdens on hospitals and health systems and recognize communication technology-based services as a covered service. We hope that CMS will work with the provider community to encourage Congress to amend the Social Security Act to expand the telehealth payment provisions. We remain disappointed that CMS is continuing its site-neutral payment policies. We are also concerned about CMS's proposed reduction in payments for certain drugs, and the removal of providers' ability to distinguish evaluation and management codes for different levels of resource use and intensity of services.

NCHA supports CMS's recognition of the use of communication technology for remote provider-patient check-ins (*brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit*) that would include 5-10 minutes of medical discussion. NCHA supports the use of audio-only technologies to fulfill this requirement, as many patients may lack video options. NCHA also believes the CMS should also ensure that other communication technologies be included as well. An example includes "MyChart," a secure online patient portal that provides access to the electronic medical record.

NCHA supports CMS's proposed use of these separate billing codes when provided to an established patient and by a physician or qualified health professional who can report evaluation and management services and not originating from a related E/M service provided within the previous seven (7) days nor leading to a service or procedure within the 24 hours following the contact or the "next available appointment."

NCHA does not support the application of a frequency limit to the use of this code at this time. We believe that physicians can use these codes, along with face-to-face or other E/M services, to provide effective and efficient care to their patients.

NCHA supports CMS's recognition of the use of communication technology for remote evaluation of Pre-recorded Patient Information ("store and forward" videos or images) for determining whether a patient's condition necessitates an office visit or other service. We agree that there may be appropriate exceptions to the "established patient" requirement for dermatological or ophthalmological cases, and request that CMS provide flexibility in the requirement for those situations.

NCHA supports CMS's recognition of the resources used for interprofessional telephone/Internet assessment and management services and appreciates its development of at least six current procedural terminology (CPT) codes to reimburse those services provided by a consulting physician.

NCHA does not support additional consent requirements for these services. The services are proposed for established patients, so consent agreements will already be in place. Hospital protocols will ensure that all patient services provided under these proposed new codes are compliant with patient consent requirements.

NCHA recommends that CMS allow the new Remote Physiologic Monitoring codes to be billed "incident to" under general supervision. Requiring providers to be in the same building/setting as the physician is not practical and would create barriers to access for these services.

NCHA supports CMS's proposal to provide coverage for these remote communication technologies and believes that their use can improve both the efficiency and the effectiveness of patient care when appropriately implemented. We also recommend that CMS base any proposed rate calculations on actual resources used to provide services, and that CMS include providers' input in the development of reimbursement levels for these codes.

CMS has indicated that other meaningful telehealth changes will require changes to the Social Security Act. NCHA supports expansion of the number of providers eligible to render these services.

NCHA also supports removal of the artificial geographic limitations that are now in place for Medicare patients. The potential for telehealth to improve access to care for Medicare patients, especially those with limited mobility, is immense, regardless of whether they live in urban or rural areas.

NCHA supports the proposed Evaluation and Management (E/M) documentation policy changes and opposes the proposal to collapse payment rates for eight office visit services for new and established patients down to two each. NCHA supports CMS's "Patient over Paperwork" initiative. CMS has included several proposals to modernize the documentation and coding requirements and reduce their complexity and administrative burden. This is certainly a positive response to concerns about the significant administrative burdens related to the documentation requirements for E/M services. Current E/M documentation requirements take significant time, time that should be spent on patient care, and make it more difficult to locate medical information in patient's records that is necessary to provide high quality care. **NCHA supports the following proposed changes:**

1. **Changing the required documentation of the patient's history to focus only on the interval history since the previous visit.**
2. **Removing the requirement for physicians to re-document information that has already been documented in the medical record by ancillary staff.**
3. **Eliminating the requirement that medical records must document the medical necessity of furnishing a home visit rather than an office visit.**
4. **Allowing providers the option to continue using the current 1995 or 1997 E/M documentation guidelines, or alternatively, to use MDM or time with the patient to determine the appropriate level of E/M visit.**

We also oppose a proposed policy that would cut payments for multiple services delivered in the same day.

CMS proposes to pay a single blended rate for the level 2 through 5 E/M visit for established patients and also for new patients. CMS's proposal requires providers to meet only those documentation requirements currently associated with a level 2 E/M visits (subject to some exceptions). CMS stated that providers may continue to choose and report the level of E/M visit they believe to be appropriate. **NCHA strongly opposes the proposal to collapse E/M payment rates. The proposal will result in inappropriate payment for the level of services rendered and hurt physicians and other health care professionals in specialties that treat the sickest patients and those who provide comprehensive primary care services. This proposal will result in some physicians being significantly overpaid for the services they render while other physicians, who are treating the sickest patients, will be grossly underpaid. Implementation of this proposal will ultimately jeopardize access to care for those Medicare beneficiaries with the greatest needs. Also, we do not believe that your assertion that this payment change will reduce the burden of documenting E/M visits will materialize because other payers will not adopt such an ill-conceived payment approach.**

For calendar year 2019, CMS proposes to make no changes to the site-neutral payment rate under the Physician Fee Schedule. Specifically, CMS would allow non-excepted provider-based departments to continue billing non-excepted services on the institutional claim using a PN modifier and would maintain payment for non-excepted services at 40 percent of the Outpatient Prospective System amount for calendar year 2019. The 40% reimbursement rate is an imprecise adjustment that is not based on appropriate data and disregards other relevant factors, such as the specific mix of services furnished by non-excepted provider-based departments, differences between the packaging policies under Outpatient Prospective System versus the physician fee schedule, and other payment adjustments that differ between the two payment systems. This could contribute to the differences in aggregate payment amounts for a broader range of services. **NCHA remains concerned that CMS's continued flawed site-neutral reimbursement policies will prevent North Carolina communities from having access to the most up-to-date services that they desperately need.**

These proposed site-neutral reimbursement cuts will result in the re-evaluation of developing and planned hospital-based OPPS site. These reimbursement cuts will undermine the ability of hospitals to develop and/or integrate lower-cost ambulatory facilities at locations that would better service the patient's needs and increase access to much needed care in these rural and underserved areas. The cost structures of hospitals and their hospital-based ambulatory care facilities are much different than for freestanding physician offices and freestanding ambulatory surgery centers. Hospitals have greater investment in information systems, equipment technology, facilities, quality and safety systems, and other human and technology resources. Without adequate and appropriate reimbursement from Medicare and other payers for off-campus hospital departments, hospitals will not have the financial resources to develop such sites in rural and underserved communities. These communities have not been adequately served by other health care stakeholders, such as freestanding physician offices and freestanding ambulatory surgery centers, because of their challenging economic profiles. Furthermore, such changes undermine our hospitals' efforts to integrate and coordinate care between ambulatory, acute, and post-acute care sites at the same time that CMS and others are promoting accountable care, Triple Aim, and population health management**.**

NCHA also opposes the proposal to reduce payment for new Part B drugs and biologicals form the rate of 106 percent of wholesale acquisition cost (WAC) to 103 percent of WAC.

Thank you for your consideration of our comments. If you have any questions, please contact me (slawler@ncha.org, 919–677-4229), Jeff Weegar, Vice President Financial Policy (jweegar@ncha.org, 919-677-4231) or Ronnie Cook, Finance and Managed Care Consultant (rcook@ncha.org, 919-677-4225).

Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association