September 10, 2018

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Ave., SW, Room 445-G
Washington, D.C. 20201

File Code: CMS-1693-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

Dear Administrator Verma:

On behalf of our more than 200 member hospitals and health systems, the Florida Hospital Association (FHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) physician fee schedule (PFS) proposed rule for calendar year (CY) 2019. While we appreciate the work CMS has undertaken to reduce regulatory burden for providers, we are focusing our comments on two issues that will instead add to that burden and increase confusion. We will address our concerns related to CMS's proposals to collapse the payment rates for evaluation & management (E/M) visit codes and the reporting of appropriate use criteria for advanced diagnostic imaging services by institutional providers.

Proposal to Collapse Evaluation & Management Payment

To code and bill E/M visits in office or other outpatient settings, providers select one of five levels of E/M visit codes, based upon the history of the patient's present illness, a physical examination and the provider's medical decision-making (MDM). Almost every specialty furnishes E/M visits, but they represent a greater share of total allowed services for providers who do not routinely furnish procedural interventions or diagnostic tests.

Current PFS payment rates for E/M visit codes increase with the level of visit billed in accordance with the increased resources necessary to care for more complex patients. CMS believes this structure no longer accurately reflects the services and resource costs associated with furnishing E/M visits and that its complexity contributes to the burden of documenting these visits. Thus, CMS proposes to pay blended rates for levels 2 through 5 E/M visits, with one rate for established patients and another for new patients.

We have serious concerns about CMS's proposals to collapse the payment rates for levels 2 through 5 E/M visits and to require only the documentation necessary for a level 2 visit and we urge CMS to not finalize these proposals at this time as they could have negative effects on

patient care as well as unintended consequences. In addition, the agency has provided very little policy justification for, or analysis of, its proposals. In short:

- CMS provided no transparency as to the modeling for its proposal to collapse E/M payment rates, and it underestimated the true impact on payments to providers.
- The proposal results in a significant disconnect between the resource use and intensity of physician services and their compensation, which could in turn threaten access to care for vulnerable populations.
- Neither CMS's 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.
- An implementation date of January 1, 2019 presents far too short a time frame for any provider to understand and implement this new policy.
- This proposal could cause massive disruption to large and small practices, depending on their mix of specialties and volume of Medicare patients.

The FHA is extremely concerned about the negative consequences for patient care that could result from CMS's payment proposal. By reducing payments for many providers, the proposal to collapse the payment rates for E/M visits devalues providers' time, increasing the already heavy pressure they face to maximize the number of patients they see each day. Providers also may have to reduce the time they spend with patients if the additional time needed to fully treat more complex patients no longer earns payment commensurate with that time. In the practices that would be unable to absorb payment cuts of the magnitude anticipated, providers could elect to stop seeing Medicare beneficiaries, cutting off access to care for vulnerable patients. These payment cuts also could potentially force entire practice groups to enter into large groups or institutional settings.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The Protecting Access to Medicare Act (PAMA) of 2014 required CMS to establish a program to promote the use of appropriate use criteria (AUC) for advanced diagnostic imaging that integrates AUC into the clinical workflow. The statute requires that payment may be made to the furnishing professional for an applicable advanced diagnostic imaging service only if the claim indicates that the ordering professional consulted with a qualified clinical decision support mechanism (CDSM) as to whether the ordered service adheres to applicable AUC. This policy applies only when applicable imaging services are provided in specific settings – a physician's office, hospital outpatient department (including an ED), an ambulatory surgical center, and any other provider-led outpatient setting as determined by CMS. In this rule, CMS proposes to add independent diagnosing testing facilities to the list of applicable settings to which AUC consultation and reporting requirements apply.

Section 1834(q)(4)(B) of the Social Security Act requires that payment for an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system may only be made if the claim for the service includes certain information about the AUC consultation. In the CY2018 PFS final rule, CMS specified that this requirement applied only to "furnishing professionals." However, CMS now proposes to revise its regulations to clarify that

AUC consultation information must be reported on all claims – from both furnishing professionals and facilities – paid under applicable payment systems. The FHA opposes this proposal because it does not appropriately target the AUC program to the ordering professionals to whom it is designed to apply. In direct contradiction to this Administration's goal of reducing regulatory burden, this proposal actually increases the regulatory burden for furnishing facilities, when it is the outlier ordering professionals that are the source of the problem.

The AUC requirements introduce new data-reporting variables to the flow of information needed for hospital billing. CMS's proposal would require hospitals to capture this information and enter it into their billing systems. This would be an extremely difficult task given that there are a variety of pathways through which hospitals receive data-reporting information. Capturing this information for reporting under the AUC requirements would involve major system changes at a variety of operational areas, resulting in steep costs for hospitals and health systems to maintain compliance with a program that governs ordering professionals who practice outside of their control. This work would add to the burden of institutional providers who are already required to demonstrate the medical necessity of the services they provide based on the orders of various professionals.

Even if hospitals and health systems devise a system by which to capture AUC information, they have no way to report it. The electronic claim standard for the institutional provider (837i) does not capture or have a placeholder for reporting the ordering physician's national provider identifier (NPI). Even if the 837i is modified, hospitals and health systems would still need to make sweeping and costly system changes to interface with a modified 837i. The time to change the 837i standard would be about four to five years.

These costly regulatory routines that CMS's proposal introduces inappropriately penalize hospitals and health systems, putting their payment at risk if AUC information does not appear on orders they receive from individual physicians. The AUC program was intended to evaluate physicians who order advanced diagnostic imaging services, not hospitals and health systems. By shifting the burden of compliance to furnishing providers, this proposal could force hospitals and health systems to take dollars away from patient care, driving up patient costs.

The FHA appreciates the opportunity to provide these comments for consideration in finalizing the CY2019 physician fee schedule proposed rule. If there are questions on these comments, please do not hesitate to contact me at kathyr@fha.org.

Sincerely,

Kathy Reep

Kathy Reep
Vice President/Financial Services