MISSOURI HOSPITAL ASSOCIATION

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September 6, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1693-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019: Medicare Shard Savings Program Requirements: Quality Payment Program: and Medicaid Promoting Interoperability Program (CMS-1693-P)

Dear Ms. Verma:

On behalf of its 144 hospital members, the Missouri Hospital Association offers the following comments in response to CMS' proposed calendar year 2019 physician fee schedule payment and policy updates.

EVALUATION/MANAGEMENT CODING AND PAYMENT

The Centers for Medicare & Medicaid Services states that the "current set of 10 CPT codes for new and established office-based and outpatient E/M visits and their respective payment rates no longer appropriately reflect the complete range of services and resource costs associated with furnishing E/M services." The agency proposes E/M coding consolidation "to mitigate the burden associated with the outdated documentation guidelines for these services." As proposed, Medicare E/M documentation requirements would require physicians and other qualified practitioners to differentiate between two levels of service, rather than the current five levels, as follows.

New patient office visits	CY 2018 Non-facility payment rate	CY 2018 Non-facility total RVUs	Proposed CY 2019 Non-facility payment rate	Proposed CY 2019 Non-facility total RVUs
99201	$45	1.26	$44	1.20
99202	$76	2.12	$134	3.73
99203	$110	3.05		
99204	$167	4.65		
99205	$211	5.85		

Established patient office visits	CY 2018 Non-facility payment rate	CY 2018 Non-facility total RVUs	Proposed CY 2019 Non-facility payment rate	Proposed CY 2019 Non-facility total RVUs
99211	$22	0.61	$24	0.67
99212	$45	1.24	$92	2.55
99213	$74	2.06		
99214	$109	3.04		
99215	$148	4.10		

MHA applauds CMS' interest in reducing provider administrative burden. However, while the proposal might make E/M documentation simpler regarding Medicare beneficiaries, providers would find themselves dealing with a more complex and burdensome coding system overall. Documentation and coding for E/M services is based on the American Medical Association's Current Procedural Terminology codes. Each of these E/M codes has a corresponding charge that is the same for all payers. Since providers use the same CPT system for both Medicare and non-Medicare patients, those providers would be compelled by this proposal to comply with different documentation and coding requirements for the same E/M code, based on payer type. The CMS proposal may decrease the amount of time spent documenting E/M codes for Medicare patients, but it would increase overall administrative complexity and burden by requiring multiple documentation processes.

To enable the type of administrative simplification envisioned by the proposed rule, the AMA's CPT coding system would need to be revamped to supplant the current five-tiered system for E/M codes with a two-tiered system. CMS may wish to engage with provider stakeholders, other payers and the AMA's CPT coding system designers to assess the implications and feasibility of such a proposal.

MHA also is concerned that collapsing E/M charging into two tiers may impede Medicare beneficiaries' access to care. As proposed, physicians will have an incentive to treat patients with low intensity and low acuity needs. This may promote shifting patients with higher acuity needs to hospital emergency departments, even though they might be appropriately treated in a physician clinic. MHA appreciates CMS proposing to make available "add-on" payments that are designed to mitigate access issues. However, these add-on codes are insufficient to capture all of the potential visit complexities. If CMS considers expanding add-on payment opportunities, it should weigh whether added documentation requirements of a robust set of add-on payments would offset the administrative simplification benefits of moving from a five-tiered E/M coding system to a two-tiered system. CMS may wish to engage stakeholders to assess the implications and feasibility of implementing a two-tier system with expanded add-on payments.

In a more specific comment related to these add-on payments, MHA recommends that if the final rule creates an add-on payment of about $12 (0.33 RVUs) for office visits performed by certain specialties via a new code GCG0X, orthopedics should be included as an eligible specialty.

MODERNIZING PHYSICIAN PAYMENT THROUGH COMMUNICATION TECHNOLOGY-BASED SERVICES

Beginning January 1, 2019, CMS proposes to pay separately for the following newly-defined physician services furnished using communication technology for virtual care. This includes: (1) Brief non-face-to-face appointments, such as virtual check-ins, using HCPCS code GVCI1; and (2) Evaluation of patient-submitted images or video via "store and forward" technology using HCPCS code GRAS1. CMS also proposes to pay separately for new codes describing inter-professional web-based consultation and also expands on its policy to cover remote patient monitoring services. CMS previously recognized RPM services as a new modality of technology-based services and began providing separate payment under CPT code 99091. CMS proposes to add new codes to describe when a qualified health professional remotely monitors physiological parameters such as weight, blood pressure, pulse oximetry, and respiratory rate using CPT codes 990X0, 990X1 and 994X9.

MHA supports CMS' proposal to reimburse separately for the above services. The new payments will improve patient coordination of care

GLOBAL SURGERY DATA COLLECTION

The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 required CMS to implement a process to collect data on postoperative visits and to use the data to assess the accuracy of global surgical package valuation. CMS invites comments pertaining to increased reporting compliance and whether visits typically are being performed in the 10-day global period. Also, the agency is seeking comment on whether it should mandate the usage of modifiers -54 "for surgical care only" and -55 "postoperative management only," regardless of whether the transfer of care is formalized.

MHA encourages CMS to continue to maintain CPT code 99024 as it remains the best option to document post-operative visits. MHA recommends not mandating usage of modifiers -54 and -55. Doing so would add to the administrative burden associated with documentation and billing.

2019 MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) PROPOSALS

MIPS Score and Payment Adjustments

Eligible clinicians and group practices would continue to be scored 0-100 points in MIPS based on data in four performance categories: quality (45 points), cost (15 points), promoting interoperability (25 points) and improvement activities (15 points). CMS would maintain the bonus that adds up to five percentage points to the final MIPS score of eligible clinicians and groups that treat complex patients. MHA requests clarification on the criteria for determination of a "complex patient."

Weighting of MIPS Cost Category

CMS proposes to increase the weight of the cost category from 10 percent to 15 percent of an eligible clinician's or group's final MIPS score in 2019. The cost category originally was scheduled to increase to 30 percent in 2019.

CMS would continue to measure eligible clinicians and group practices on the Total Per Capita Cost and Medicare Spending Per Beneficiary measures. The agency would add eight episode-based measures listed below. The episode-based measures only include items and services that are related to the episode of care for a clinical condition or procedure, as opposed to including all services that are provided to a patient over a given period of time.

MHA does not support increasing the weight of the cost category to 15 percent based on concern that the cost measures are unreliable and not conducive for primary care. In addition, providers do not have adequate detailed cost data on attributed patients in the first two years of MIPS.

RFI ON PRICE TRANSPARENCY: IMPROVING BENEFICIARY ACCESS TO PROVIDER AND SUPPLIER CHARGE INFORMATION

CMS requests information about potential actions to address beneficiary out-of-network access to care, surprise medical bills, and patient health plan literacy regarding coverage and benefits. CMS is specifically interested in comments regarding whether Medicare-enrolled physicians and group practices should be required to inform patients how much their out-of-pocket costs for a service will be before those patients are furnished that service.

To avert unnecessary administrative costs and federal and state regulatory conflict, MHA recommends that if CMS pursues additional transparency standards, they not supersede existing state standards or community-based voluntary initiatives. Also, new federal transparency initiatives should be implemented using technology developed by CMS to allow patient access to web-based estimates using CMS data.

Thank you for your consideration of these comments.

Sincerely,

Daniel Landon
Senior Vice President of Governmental Relations

dl/djb