



September 6, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: 1676-P
P.O. Box 8016
Baltimore, MD 21244-8013

File Code: 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 Healthcare Financial Management Association (HFMA) would like to thank the Centers for Medicare & Medicaid Services (CMS) for the opportunity to comment on the 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 (hereafter referred to as the Proposed Rule) published in the *Federal Register* on July 21, 2017.

HFMA is a professional organization of more than 38,000 individuals involved in various aspects of healthcare financial management. HFMA is committed to helping its members improve the management of and compliance with the numerous rules and regulations that govern the industry.

Introduction

HFMA would like to commend CMS for its thorough analysis and discussion of the myriad Medicare reimbursement decisions addressed in the 2018 Proposed Rule. Our members would like to comment on the proposals related to the following:

- Proposed Payment Rates under the Medicare Physician Fee Schedule (PFS) for Non-excepted Items and Services Furnished by Non-excepted Off-Campus Provider-Based Departments of a Hospital
- MACRA Patient Relationship Categories and Codes
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services

Please find HFMA members' comments below.

Proposed Payment Rates under the Medicare PFS for Non-exempted Items and Services Furnished by Non-exempted Off-Campus Provider-Based Departments of a Hospital

In the 2017 Outpatient Prospective Payment System (OPPS) interim final rule with comment period (IFC), CMS implemented Section 603 of the Bipartisan Budget Act by establishing the PFS as the “applicable payment system” for most items and services provided in non-exempt off-campus provider based departments (PBDs). For CY 2017, CMS set the payment rate for services provided in non-exempt PBDs at 50 percent of the OPPS rate, inclusive of packaging.

For CY 2018, the PFS rule proposes to reduce payments to non-exempt PBDs to 25 percent of the OPPS rate. CMS arrived at this by incorporating clinic visits paid under OPPS that are reported using HCPCS code G0462 into its prior analysis. CMS states it is waiting for CY 2017 claims before it re-runs the data to re-determine the “PFS Relativity Adjuster.” CMS acknowledges that the relativity adjuster is based on services that reflect “greater than 50 percent of services billed in off-campus PBDs.” Further, the proposed rule states that comparisons between the OPPS and PFS rates for other services vary greatly based on the service mix provided by a non-exempt site, packaging policies, and multiple procedure payment reductions. **HFMA members are deeply concerned that CMS has significantly reduced rates to non-exempt OPDs, and is proposing further reductions, based on limited analysis of the actual costs to provide services to Medicare beneficiaries in non-exempt OPDs.** HFMA members note that, unlike the relative value unit (RVU) system which the PFS is based on, OPPS payments to hospitals for most services are based on the actual cost to provide care. This is derived from hospital cost reports and submitted claims. Given concerns about the accuracy of the RVU system, HFMA strongly encourages CMS to use data based on actual costs to determine appropriate payment levels for services provided in non-exempt PBDs.

An American Hospital Association (AHA) analysis of the codes CMS used for rate setting in the 2017 IFC suggests that neither the current rate of 50 percent nor the proposed rate of 25 percent of the OPPS is adequate payment for services provided to Medicare beneficiaries in non-exempt PBDs.¹ As the AHA points out in its comment letter, CMS neglected to account for differences in packaging costs and failed to consider the indirect costs incurred by hospitals when it used the non-facility rate. As a result, the AHA analysis found that the appropriate payment rate for services provided in non-exempt PBDs was 64 percent of the OPPS rate. **HFMA members believe CMS must revisit its analysis and incorporate the impact of packaged services. Until CMS can re-run its analysis and determine an appropriate payment rate for services provided to Medicare beneficiaries in non-exempt PBDs, it should increase the PFS relativity adjuster to 64 percent of the OPPS payment rate.**

Further, in light of the payment variability across services acknowledged by CMS in the proposed rule, HFMA believes the final rule should establish the PFS rate as the floor for payments to non-exempt OPDs. Otherwise, even at 64 percent of the OPPS payment rate, HFMA is concerned that some services provided in non-exempt HPDs will be paid less than what they would have been paid under the PFS.

¹ <http://www.aha.org/advocacy-issues/letter/2016/161221-cl-opps-final-rule.pdf>

MACRA Patient Relationship Categories and Codes

CMS proposes that the newly created patient relationship HCPCS codes can be submitted on a voluntary basis for CY 2018. Reporting (or not reporting) the modifier will have no impact on claims payment during this time period. HFMA strongly supports this proposal as it is aligned with our prior comments on this issue. We concur with CMS's assertion in the proposed rule that it will need to provide clinicians and their administrative staff with a significant amount of education on the appropriate usage of these new modifiers.

To help physicians prepare, HFMA asks CMS to provide in the final rule, or through sub-regulatory guidance, a draft timeline that defines the glide-path to mandatory reporting. The timeline should include key activities related to educating clinicians, testing the modifier, and refining it based on feedback from early adopters. In addition, HFMA members ask CMS to work closely with stakeholders to determine when and how the patient relationship modifier will be incorporated into the cost categories in the Merit-based Incentive Payment System and attribution methods in CMS/CMMI's various portfolio of alternative payment model (APM) portfolio. **HFMA members believe that, given the administrative complexity of implementing the modifiers and incorporating them into CMS's payment systems and APMs, mandatory reporting should not occur sooner than Jan. 1, 2021.**

We advocate for 36 months for multiple reasons. HFMA agrees with the American Medical Association's CPT Editorial Panel that the verbiage describing the different modifiers needs to be better defined. Currently, the modifiers are defined using the words "continuous," "broad," "focused," and "episodic." Given that these are all relative terms, they lack the specificity necessary to base claims payment on.

Also, as discussed above, CMS needs to develop and execute a multipronged clinician education strategy. A key component of the education should include feedback to clinicians on appropriate use of the modifier based on actual submitted claims. Another focus area for educational programming must be on the documentation necessary to substantiate attaching a specific patient relationship modifier to one or more CPT/HCPCS codes billed. HFMA strongly encourages CMS to work with providers and other stakeholders to develop a reasonable documentation standard based on what is currently available in the medical record as a result of existing requirements.

Once the modifiers become mandatory, HFMA believes clinicians should have the opportunity to review, on an annual basis, the patients, episodes, and services attributed via the patient relationship modifier. A process to have cases removed from resource utilization measures that have been mis-attributed to a clinician must also be developed in consultation with stakeholders. Given that patients' relationships with their physicians can change over the course of the year, we believe that this is an important step toward ensuring the accuracy of the resource use determinations.

Our members encourage CMS to invest the time and resources necessary to educate physicians and refine the patient relationship categories and codes, as described above. Otherwise, HFMA is concerned that any methodology for resource use analysis that is developed without a comprehensive set of physician relationship codes that can be easily submitted by all physicians will result in inaccurate resource use assignment among physicians, which is ultimately contrary to Congress's intent.

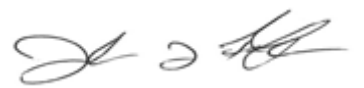
Appropriate Use Criteria for Advanced Diagnostic Imaging Services

In the CY 2018 OPPS rule CMS states that it expects to make voluntary reporting of AUC criteria available beginning in July 2018. Further, CMS believes the Jan. 1, 2019, proposed start date provides adequate time for it to develop the claims-based procedures and system changes necessary to process claims with the AUC information. It also believes this time frame will allow development of processes for the transfer of the AUC consultation information from the ordering to the furnishing professional and facility and development of billing systems to translate the AUC consultation information into Medicare claims in the form of G codes and HCPCS modifiers. However, CMS will continue to pay claims regardless of whether the claims correctly included the required information during this period. Despite this, it does not expect to continue the educational and operational testing period beyond the first year of the AUC program.

HFMA members appreciate CMS's flexibility in implementing the AUC criteria by making CY 2019 an "educational and operational" period. However, our members are deeply concerned that many hospitals may not be ready by CY 2020. Given the multiple competing IT requirements physicians and hospitals face as a result of recently proposed or finalized rules, we are concerned that hospitals, and the vendors that support them, will not be ready for Jan. 1, 2020, when the educational and operational testing period ends. Developing the software, creating the HL-7 transactions, and building the pathway from the hospital electronic health record to the billing system to ensure the proposed G-code(s) and related modifier(s) are included on claims for imaging services will require a significant amount of time. Further, it is not possible for hospitals and their vendors to begin work on this immediately, as the rule is not finalized and the G-codes and modifiers are not currently available. **Therefore, HFMA asks CMS to extend the educational and operational period for an additional year for the AUC program.**

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2018 Physician Fee Schedule. As an organization, we take pride in our long history of providing balanced, objective financial technical expertise to Congress, CMS, and advisory groups. We are at your service to help CMS gain a balanced perspective on these complex issues. If you have additional questions, you may reach me or Richard Gundling, Senior Vice President of HFMA's Washington, DC office, at (202) 296-2920. The Association and I look forward to working with you.

Sincerely,



Joseph J. Fifer, FHFMA, CPA
President and Chief Executive Officer
Healthcare Financial Management Association

About HFMA

HFMA is the nation's leading membership organization for more than 38,000 healthcare financial management professionals. Our members are widely diverse, employed by hospitals, integrated delivery systems, managed care organizations, ambulatory and long-term care facilities, physician practices, accounting and consulting firms, and insurance companies. Members' positions include chief executive officer, chief financial officer, controller, patient accounts manager, accountant, and consultant.



HFMA is a nonpartisan professional practice organization. As part of its education, information, and professional development services, HFMA develops and promotes ethical, high-quality healthcare finance practices. HFMA works with a broad cross-section of stakeholders to improve the healthcare industry by identifying and bridging gaps in knowledge, best practices, and standards.