hfma
healthcare financial management association

September 10, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: 1693-P
P.O. Box 8016
Baltimore, MD 21244-8013

File Code: CMS–1693-P

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:

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 2019; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (hereafter referred to as the Proposed Rule) published in the *Federal Register* on July 27, 2018.

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 2019 Proposed Rule. Our members would like to comment on the proposals related to the following:

- Minimizing Documentation Requirements by Simplifying Payment Amounts
- MIPS Proposed Addition of Low-Volume Threshold Criterion Based on Number of Covered Professional Services; Low-Volume Threshold Opt-In
- MIPS Performance Category Measures and Activities
- MIPS Facility-Based Measurement
- Exclusion of MIPS Eligible Clinicians Participating in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) Demonstration
- Identification and Review of Potentially Misvalued Services
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services
- Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

Please find HFMA members' comments below.

Minimizing Documentation Requirements by Simplifying Payment Amounts
CMS proposal includes changes in documentation requirements for E/M visits with the proposal of a minimum documentation standard for an office or outpatient E/M visit. For the purposes of PFS payment for an office/outpatient E/M visit, CMS is proposing that practitioners would only need to meet documentation requirements currently associated with a level 2 visit for history, exam and/or MDM (except when using time to document the service). Practitioners may continue to choose and report the level of E/M visit they believe to be appropriate under the CPT coding structure **HFMA commends and supports these efforts toward administrative simplification and reduction in burden of documentation for practitioners.**

CMS is also proposing one payment rate for CPT codes 99202 through 99205 (new patient) and another payment rate for CPT codes 99212 through 99215 (established patient). As a result, visits that once were billed for the most medically complex patients (Levels 4 and 5) will see a significant reduction in reimbursement. HFMA has concerns regarding the impact of these changes for practitioners that frequently treat Medicare's most medically complex patients. This will penalize those physicians who care for these patients and may result in unintended consequences of limiting some practices ability to treat these patients.
As mentioned in the Medicare Payment Advisory Commission (MedPAC) report published June 2018, CMS lacks the updated data source to adequately price out current expenses and calculate proper RVU.

MedPAC also released a recommendation in June of this year to increase reimbursement for E/M services due to the time, complexity and intensity they require. It was reported in their recommendation that CMS is currently undervaluing E/M services compared to other services reimbursed to physicians.

> "Ambulatory evaluation and management (E&M) visits allow clinicians to manage patients' chronic conditions, develop care plans, coordinate care across providers and settings, and discuss patients' preferences. E&M services are critical for both primary care and specialty care. The Commission has long been concerned that, over time, E&M services have become undervalued in the Medicare physician fee schedule (the "fee schedule") relative to other services, such as procedures. This could limit beneficiary access to E&M services."

Additionally, singular payment rate could ultimately jeopardize the financial stability of many physician practices across the country that see the most complex Medicare beneficiaries. While we commend CMS for proposing an add-on for primary care visits, the $5 add-on is inadequate in covering the additional resources to deliver complete care to Medicare's complex patient population. While we agree that coding needs to be simplified, the collapsing of payment rates does not accomplish this goal. **HFMA recommends CMS postpone these payment rate changes to E/M codes until CMS can conduct a more detailed analysis of the impact of these changes to practices and specialties that treat a high volume of medically complex patients.**

MIPS Proposed Addition of Low-Volume Threshold Criterion Based on Number of Covered Professional Services; Low-Volume Threshold Opt-In
Currently, MIPS includes clinicians' billing more than $90,000 per year and those who furnish professional services to more than 200 beneficiaries. The proposed rule includes an additional threshold of those

providing more than 200 covered professional services. The proposal then allows for an opt-in policy for MIPS eligible clinicians who meet one or more of the threshold criteria to allow providers to opt in. **HFMA supports this proposal as it allows those providers who have been investing time and infrastructure to have the ability to participate in MIPS even if they do not meet all of the thresholds.** The Bipartisan Budget Act modified the calculation of the low volume threshold by excluding Medicare Part B medications and services billed separately from the Physician Fee Schedule. These adjustments will make it difficult for physicians and physician groups to predict whether they will be subject to MIPS or excluded in 2019 performance year. **HFMA recommends CMS provide timely notification, prior to or within the first 30 days of the 2019 performance year, regarding physician and group eligibility results based on the results of the first determination period.**

MIPS Performance Category Measures and Activities
Proposed changes to the cost performance category. The proposed rule increases the cost weight to 15% of the final score in 2019 (up from 10%). Consistent with previous years, cost is measured using the Medicare Spend Per Beneficiary (MSPB) and the Total Per Capita Cost measure. In addition, CMS is proposing to add 8 episode-base cost measures to the 2019 MIPS performance period. While we generally support episode-based cost measures as a bridge step to outcome-based payment models, **HFMA's members encourage CMS to use 2019 as a pilot year to better test these new episode measures with a broad cross-section of physicians before it attempts to integrate them into the cost category in the MIPS program.**

In addition, CMS has set a .40 reliability threshold for the cost measures and one measure, Simple Pneumonia with Hospitalization has a markedly lower reliability threshold than the other measures. **HFMA recommends eliminating the Simple Pneumonia episode until further testing can be done by CMS to ensure the appropriate case minimum for an accurate and reliable measure of cost for this episode of care.**

MIPS Facility-Based Measurement
Facility based measurement will automatically apply to those clinicians and groups who are eligible for facility-based measurement. For facility-based scoring, the measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period will be used for facility-based clinicians. The quality and cost performance score are reached by awarding a score associated with the same percentile performance in MIPS as the VBP score. **While HFMA understands and appreciates the intent of this proposal, we ask that an "opt-out" process be clearly published, so those providers who do not want to participate in facility based measurement can easily be removed. Also, we are concerned that this model could have patient access implications if providers migrate towards those facilities with high VBP scores in their respective market.**

Exclusion of MIPS Eligible Clinicians Participating in MAQI demonstration
The proposal allows for clinicians participating in the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) to be eligible for waivers that will exempt them from reporting under MIPS and payment adjustment if they participate to a sufficient degree in Qualifying Payment Arrangements with Medicare Advantage Organizations (MAOs).

The MAQI Demonstration project requires clinicians to reach a threshold of a certain percentage of payments or percent of patients tied to a combination of AAPMs and Qualifying Payment Arrangements

with MAOs. The proposed thresholds are 25 percent for payment and 20 percent for patient count. These are the same thresholds under the current rule for clinicians to become a Qualifying APM Participant. Thresholds currently for partial QPs is 20% for payment and 10% for patient count. **HFMA recommends lowering the exemption threshold to the current Partial QP threshold allowing those clinicians that achieve the 20 percent for payment and 10 percent for patient count exemption from MIPS. HFMA further requests that those clinicians who participate at either the 25 percent payment threshold or the 20 percent patient count threshold be eligible for a 5% bonus payment, consistent with how CMS applies the AAPM bonus.**

In addition, HFMA recommends that CMS calculate the risk and patient count threshold performance at the group practice level, not at the individual clinician level. We believe assessing risk at the individual clinician level is unworkable, the key reason is that risk contracts in the MA exist between the group and the plan and not between individual clinicians and the health plan.

Identification and Review of Potentially Misvalued Services
In the proposed rule, **C**MS sought comment on the best approach to 10-day global codes for which the preliminary data suggest that postoperative visits are rarely performed by the practitioner reporting the global code, and in particular, on whether it should consider changing the global period and reviewing the code valuation. **HFMA supports a review of the current global period and code valuation to determine whether a change is necessary.**

On a related issue, CMS also sought comments on whether it should consider requiring use of the modifiers in cases where the surgeon does not expect to perform the postoperative visits, regardless of whether or not the transfer of care is formalized. **HFMA does not believe that requiring use of modifiers in cases where the surgeon does not expect to perform the postoperative visit is worthwhile. This is based on the significant potential documentation by the physician, and extra work on the coding side leading to a delay in billing. Additionally, basing this on expectation is problematic as things change during the post encounter time window. We would not recommend CMS moving in this direction.**

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 2019. 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 2020 an "educational and operational" period. However, our members are deeply concerned that many hospitals may not be ready by CY 2020. Additionally, the lack of identification for "outlier ordering professionals" prior to the start date of this period makes following protocol extremely challenging.

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, the identification of outlier ordering professionals not being completed until after the start date makes it challenging for said professionals to validate the need to follow prior authorization processes. **Therefore, HFMA asks CMS to extend the educational and operational period for an additional year for the AUC program and clearly identify outlier ordering professionals prior to that date.**

Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

CMS posed the following questions to which we have responded below:

How should we define ''standard charges'' in various provider and supplier settings? Is there one definition for those settings that maintain chargemasters, and potentially a different definition for those settings that do not maintain chargemasters?

Should ''standard charges'' be defined to mean: Average or median rates for the items on a chargemaster or other price list or charge list; average or median rates for groups of items and/or services commonly billed together, as determined by the provider or supplier based on its billing patterns; or the average discount off the chargemaster, price list or charge list amount across all payers, either for each separately enumerated item or for groups of services commonly billed together? Should ''standard charges'' be defined and reported for both some measure of the average contracted rate and the chargemaster, price list or charge list? Or is the best measure of a provider's or supplier's standard charges its chargemaster, price list or charge list?

Information on charges or on average or "standard charges" is of limited value to consumers, as it will likely be significantly different from the amount they will be expected to pay. Chargemaster prices serve only as a starting point; adjustments to these prices are routinely made for contractual discounts that are negotiated with or set by third-party payers. Few patients actually pay the chargemaster price. Information on the average amount *paid* for services is somewhat more useful to consumers, but it still falls short. The price information that is most useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek as noted above.

What types of information would be most beneficial to patients, how can hospitals best enable patients to use charge and cost information in their decision-making, and how can CMS and providers help third parties create patient-friendly interfaces with these data?

HFMA believes that charges are not sufficiently helpful for the patient. The price information that is most beneficial and useful to consumers is an estimate of their individualized out-of-pocket responsibility for the specific service(s) they seek. For insured patients, this amount is contingent on their health plan benefit design, including coinsurance and copayments, and the amount of deductible

remaining to be met. Uninsured patients may seek information about the cash price when (a) they are uninsured (b) they are covered by high-deductible health plans (HDHPs), or (c) they are seeking care with an out-of-network provider.

Price transparency for the uninsured is subject to a substantial and growing number of laws at both the federal and state levels. It is the first responsibility of providers to ensure that policies and practices adhere to these legal requirements.

Insured patients may obtain an individualized price estimate from their health plan. Estimates are based on CPT codes, which must be obtained from a patient's physician or other care provider. Resources on the estimate-request process are available to consumers, including HFMA's *Understanding Healthcare Prices: A Consumer Guide*, which is available at no charge to any healthcare organization for posting online in the patient financial services section of their websites.

In addition, many hospitals and health systems post price information for common procedures online, and/or make this information available by phone.

Beyond that, HFMA's Patient Financial Communications Best Practices stipulate that providers should inform uninsured patients that they will review insurance eligibility with them to identify payment solutions or financial assistance options that may help them with their financial obligations for the care received. If appropriate, the patient should be referred to a financial counselor and/or offered information about the provider's financial counseling and assistance policies and programs. Financial assistance may take the form of free or discounted care, depending on an individual patient's circumstances, along with organizational policies.

For those patients who are not eligible or choose not to apply for financial assistance, and who are able to pay cash at the time of service, many organizations offer a discount. The cash discount may be posted on the organization's website or communicated by telephone or in person, upon request. In recent years, some hospitals offer uninsured patients or patients with high-deductible health plans (HDHP), an option to pay for common tests and procedures in full at the time of service in exchange for sharply discounted prices.

If a patient seeks care from an out-of-network provider (based, for example, on that provider's reputation) and contacts the health plan for assistance, the health plan should clearly explain what percentage (if any) of out-of-network provider charges the plan will cover, and describe any other significant out-of-network benefit plan issues (e.g., a "reasonable and customary rate of reimbursement" limit on what the health plan will pay). The health plan should also inform the patient that—if the patient intentionally seeks care from an out-of-network provider—it is the patient's responsibility to independently obtain price information from that provider. Provider policies vary on whether to offer a self-pay or cash discount to these patients.

Should health care providers be required to inform patients how much their out-of- pocket costs for a service will be before those patients are furnished that service? How can information on out-of-pocket costs be provided to better support patients' choice and decision-making? What changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs? How can CMS help beneficiaries to better understand how co-pays and coinsurance are applied to each service? What

can be done to better inform patients of their financial obligations? Should provider sand suppliers of healthcare services play any role in helping to inform patients of what their out-of-pocket obligations will be?

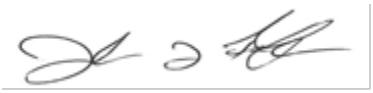
> HFMA believes that patients should receive information about their out-of-pocket costs for a service before the service is furnished, though as stated previously, we believe for insured patients, the health plan is best positioned to provide that information. For uninsured patients, the provider—i.e., the entity, organization, or individual that furnishes a healthcare service—should be the principal source of price information for uninsured patients or patients who are seeking care from the provider on an out- of-network basis.

Can we require providers and suppliers to provide patients with information on what Medicare pays for a particular service performed by that provider or supplier? If so, what changes would need to be made by providers and suppliers? What burden would be added as a result of such a requirement?

> Similar to "standard charges" the Medicare payment information for a particular purpose would not be useful for patients as Medicare payments vary from provider to provider depending on a multitude of factors. Additionally, those non-Medicare beneficiaries would not see this information as relevant for their purposes. So, providing this information would likely be more confusing than useful.

HFMA looks forward to any opportunity to provide assistance or comments to support CMS's efforts to refine and improve the 2019 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
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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.