Illinois Health and Hospital Association

September 11, 2017

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue SW, Room 445-G
Washington, D.C. 20201

RE: 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; Proposed Rule (*Federal Register,* Vol. 82, No. 139, July 21, 2017)

Dear Ms. Verma:

On behalf of our more than 200 member hospitals and 50 health systems, the Illinois Health and Hospital Association (IHA) is taking this opportunity to formally comment on the proposed rule concerning revisions to payment policies under the Physician Fee Schedule and other revisions to Part B for CY2018. IHA commends the Centers for Medicare & Medicaid Services (CMS) for its thorough analysis in the development of this rule. However, IHA has strong concerns with certain provisions, and presents the following comments for your consideration:

REDUCTION IN PAYMENTS FOR NON-EXCEPTED SERVICES IN CERTAIN OFF-CAMPUS, HOSPITAL OUTPATIENT DEPARTMENTS: Although CMS does not propose to make any other changes to its site neutral policy in CY 2018 it is retaining its problematic policy that the relocation of an existing provider-based, hospital outpatient department does not qualify that facility for excepted status from that policy. Consequently, those facilities that have re-located, regardless of the reason, will be paid at the site-neutral payment rate versus the full Outpatient Prospective Payment System (OPPS) rates. **IHA continues to advocate against this policy and again strongly recommends that CMS allow those hospital-based outpatient facilities that have re-located to continue to be paid the Outpatient Prospective Payment System (OPPS) rates.**

In addition, CMS proposes to reduce payments made for non-excepted facility services from 50 percent of the OPPS rates to 25 percent. This is a significant payment reduction, and IHA is concerned that the availability of services to Medicare beneficiaries could be compromised as a result. **Therefore, IHA strongly recommends that CMS rescind this proposal in the final rule.**

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PROPOSED CHANGES TO EVALUATION/MANAGEMENT (E & M) CODING: In response to CMS' request for feedback regarding ways to reduce administrative burdens and improve Evaluation and Management (E/M) visit codes, IHA offers the following comments and suggestions:

CMS proposes the removal of the history and exam elements of an E/M service; consequently, only the care coordination effort (time elements) and medical decision-making factors elements would remain. This could result in an opportunity to enhance medical decision making by improving collection of care coordination data while simultaneously increasing the level of service based on the complexity of the coordination of care. For example, some patients require more than two consults from different providers, and the referring provider must review previous medical records. Under the current time statement requirement, vital data is not obtained unless the referring provider includes more documentation than the current guidelines require. **IHA recommends that CMS update its guidelines to require the referring provider to clearly state to whom the patient was referred and where his or her medical records originated. Consulting providers would also be more efficient by gathering this complexity of care coordination detail. All vital steps in care coordination should be clearly defined and time assigned to the respective actions performed by clinical team should be well documented in the medical record.**

Further, if CMS eliminates the history/exam requirements of a visit and shifts focus to the medical decision making during the patient visits, IHA recommends that the agency focus on the complexity of the patient's status and consider co-morbidities of the patient. For example, if the patient has Type II Diabetes with peripheral vascular disease, the physician would need to effectively document any complication as well as any co-morbidities resulting in interactions. When documenting medical decision making, CMS should also require the physician to document objective components stating the medical necessity of the visit and the appropriateness of the care setting. For instance, certain services are only medically necessary within certain settings such as ambulatory care, inpatient care or the emergency department. The documentation in the medical record should include the detail to support the medical necessity within the context of the setting in which it is provided.

Finally, IHA encourages CMS to clarify long-used terminology. For example "intensive monitoring" should have a specific definition with discrete criteria that is measurable and objective. Often times, the Medicare Administrative Contractors (MACs) do not clearly define CMS terminology, meaning that providers are required to interpret the guidance to the best of their ability; doing so puts the provider at risk that its interpretation will be considered incorrect by an auditor. By placing this requirement on all its contractors, CMS would move closer to its stated goal of reducing administrative burdens, as it is on record as stating it wishes to do so.

PROPOSED ADDITIONAL MEDICARE-COVERED, TELEHEALTH SERVICES: CMS proposes to add two additional services to the listing of Medicare covered telehealth services:

- Counseling visit to determine low-dose computed tomography (LDCT) eligibility; and
- Psychotherapy for Crisis.

IHA supports these additions to the list of Medicare-covered, telehealth services.

PROPOSED REDUCTIONS TO THE CY 2018 VALUE MODIFIER MAXIMUM PENALTY:
For CY 2018, CMS proposes to reduce the payment penalties associated with the Value-Based Modifier (VM) program for those eligible clinicians that fail to meet reporting requirements under the Physician Quality Reporting Program (PQRS). **IHA supports these reductions.**

Ms. Verma, thank you again for the opportunity to comment. If you or your staff has any questions on the comments, they should be addressed to Thomas Jendro at (630) 276-5516 or tjendro@team-iha.org.

Sincerely,

A.J. Wilhelmi
President & CEO