



Commenting on CMS CY 2019 Medicare Physician Fee Schedule/ Quality Payment Program Proposed Rule

Comments due September 10, 2018

Many AAHPM members and stakeholder partners are concerned about the Centers for Medicare & Medicaid Services (CMS) proposed rule providing revisions to payment policies under the Physician Fee Schedule and Part B for CY 2019 and updates to the Quality Payment Program. To aid in submission of comments, the Academy has prepared suggested talking points on those proposals with the greatest potential impact on patients with serious illness and the hospice and palliative care practitioners that care for them. Users may adopt any/all of the talking points, focusing on the items of most importance to them.

For background on the proposed rule:

- CY 2019 Medicare Physician Fee Schedule/Quality Payment Program [Proposed Rule](#)
- MPFS proposed rule [Fact Sheet](#) ; CMS [slide presentation](#) re: E/M & virtual care proposals
- QPP proposed rule [Fact Sheet](#) and CMS [slide presentation](#)

How to submit comments:

Electronically – due by 11:59 pm ET on 9/10/18

- Submit comments online at <https://www.regulations.gov/comment?D=CMS-2018-0076-0621>
- You can insert your feedback directly in a comment box, or prepare a letter (reference CMS-1693-P) and upload your file to the site.

By express or overnight mail – due by 5:00 pm ET on 9/10/18

You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1693-P,
Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Address letters to:

Seema Verma, MPH
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services

Suggested talking points:

Talking points are provided on the pages that follow. Feel free to adapt/paraphrase those points that focus on proposals most important to you. You need not comment on all the items addressed, or you may wish to weigh in on proposals in the rule which are not covered here. These talking points are meant only as a guide.

- Access Regulations.Gov “[Tips for Submitting Effective Comments](#)”

Questions? E-mail advocacy@aahpm.org

Sample Points to Include in PFS/QPP Comment Letter

- Thank you for the opportunity to comment on the CY 2019 Physician Fee Schedule and Quality Payment Program proposed rule.
 - Briefly discuss your practice/focus/setting
(Include any/all of the following that apply)
 - I'm writing to share my perspectives on CMS's proposals regarding documentation and payment for office/outpatient evaluation and management (E/M) services.
 - I also offer feedback on select other proposals for payment under the Physician Fee Schedule
 - Finally, I have provided comments on CMS's approach to preventing and addressing opioid use disorder (OUD) through the Merit-Based Incentive Payment System (MIPS).
- To begin, I would like to express my thanks to CMS for prioritizing burden reduction under the PFS proposals. I recognize that CMS has taken bold steps to address burden associated with E/M visits in this year's rule, specifically with respect to E/M documentation requirements, and I believe that many of the proposed documentation changes go a long way towards reducing burden that many clinicians like myself experience.
 - Specifically, I request that CMS finalize the following proposals, which I believe can be implemented independent of any of CMS's corresponding proposed payment changes for E/M services, and would enhance my ability to care for seriously ill Medicare beneficiaries:
 - Allowing physicians to document visits based solely on the level of medical decision making (MDM) or the face-to-face time of the visit as an alternative to the current guidelines;
 - Limiting required documentation of the patient's history to the interval history gathered since the previous visit (for established patients);
 - Eliminating the requirement for physicians to re-document information that has already been documented in the patient's record by practice staff or by the patient;
 - Removing the need to justify providing a home visit instead of an office visit;
 - Eliminating the prohibition for same-day E/M visits by practitioners of the same group and specialty; and
 - Eliminating the requirement that teaching physicians have to enter a separate note in the medial record.
- However, I have deep concerns with CMS's proposals to modify payment for office/outpatient evaluation and management (E/M) services – specifically to collapse payment for level 2 through 5 visits and to establish new add-on codes that are both problematic in their construction, and pay insufficiently to offset the loss created by the code collapse.
 - As a Hospice and Palliative Medicine (HPM) specialist, I care for the most seriously ill Medicare beneficiaries – individuals who typically suffer from complex medical conditions and functional limitations, many of whom are near the end of life.
 - Because of their complexity, I typically –and almost exclusively – bill level 4 and level 5 visits in the outpatient setting.
 - Providing payment based on weighted average billing of office/outpatient E/M visits across all specialties – many of whom routinely bill level 2 and level 3 visits – would result in payment rates that are insufficient to support the level 4 and 5 services that my patients require.
 - Indeed, analysis conducted by the American Medical Association shows that Hospice and Palliative Medicine physicians would, on average, receive an alarming 20 percent reduction in E/M payment for office visits under CMS's proposals.
 - Such payment reductions would be devastating for clinicians in my field.
 - If CMS were to finalize its policies as proposed, I anticipate that many palliative care practices, like my own, would close.

- I also disagree that CMS's proposed add-on payments would be sufficient to offset the payment reductions that would occur as a result of the code collapse, particularly for palliative care clinicians and practices.
- Further, I have concerns that CMS's proposed policies seek to tie payment to a practitioner's specialty instead of patients' complexity and need for services.
- I am also concerned that CMS did not recognize the intensive resources required for Hospice and Palliative Medicine specialists to provide care to our patients, as clearly demonstrated by CMS' decision not to include Hospice and Palliative Care in the list of specialties covered by the complexity add-on codes.
- **The end result of CMS's package of E/M payment proposals – in addition to the significant payment cuts for Hospice and Palliative Medicine specialists noted above – is that patients with serious illness will likely experience reduced access to care.**
 - This is because many clinicians, as well as hospitals and health systems, will likely face strong incentives to avoid caring for the most complex patients, limit the length of visits, and/or bring patients in for multiple visits.
 - Frequent, shorter visits would be particularly burdensome for patients with serious illness given their limited mobility, symptom burden (including pain, fatigue, nausea and shortness of breath), and strained family caregivers.
- For all of the above reasons, **I urge CMS not to finalize the its proposed E/M payment proposals, either for CY2019 or for any future year.** Instead, I call on CMS to work with the medical community to develop new proposals that better address the underlying challenges that exist with the E/M codes.
- With regard to other payment proposals included under the Physician Fee Schedule:
 - I support CMS's proposal to pay for new communication technology-based services under the Medicare program, including the Brief Technology-based Service, Remote Evaluation of Pre-Recorded Patient Information, and Interprofessional Internet Consultation codes.
 - These high-value services proposed for payment are delivered routinely by hospice and palliative care professionals to Medicare beneficiaries in their homes and communities. This improves patient and caregiver experience of care and can help avoid unnecessary and expensive emergency department visits and hospitalizations.
 - Such payment will help to improve access to Physician Fee Schedule services, particularly for underserved patients and those in rural areas.
 - I also support new payment for chronic care management services provided personally by a physician or advance practice professional.
 - This code recognizes the type of care that palliative care practices provide, in addition to face-to-face visits, to support and coordinate their patients' treatment plan and care preferences.
 - It is also an important addition to existing chronic care management codes that pay for clinical staff time, to support fully interdisciplinary care management and coordination.
 - However, I'd ask that that CMS accept all RVUs and direct PE inputs as recommended by the RVS Update Committee (RUC).
 - As CMS continues to assess whether a bundled payment is appropriate for management and counseling treatment for substance use disorders (SUD):
 - I urge CMS to ensure that payments are sufficient to cover the cost of care for patients with complex care needs, such as concurrent serious illness management, and that the bundle doesn't limit access to other services and providers, so that access to appropriate care is not reduced for these patients.

- With respect to CMS’s request for comments regarding non-opioid alternatives for pain treatment, including barriers to access:
 - I support this focus in so far as it promotes comprehensive integrative pain management.
 - I urge Medicare coverage of multi-modal and non-pharmacological pain treatments that have shown to be effective; otherwise, prescribers will necessarily default to currently reimbursed treatments, like opioids, in order to ensure their patients’ pain is managed.

- Separately, in its updates to the Quality Payment Program, CMS offers several potential policies that it could pursue to leverage the Merit-based Incentive Payment System (MIPS) program in the Administration’s efforts to prevent opioid use disorder (OUD) and address the surge in opioid-related overdose deaths that is currently impacting patients, families and communities across the nation.
 - For example, CMS proposes to revise the definition of high-priority measures to include opioid-related quality measures.
 - CMS also proposes to add several new measures and activities to the MIPS program specifically focused on opioid use.

- While I recognize that opioid abuse, misuse, and diversion are taking a huge toll on the country, and agree that OUD should be a high priority for the Administration, I’m concerned that several of CMS’s proposals could result in unintended consequences that would harm the seriously ill patients I care for every day.
 - Specifically, if CMS’s policies are finalized, they would create incentives to reduce opioid prescriptions – even for patients with debilitating pain resulting from advanced disease progression who would respond to opioid treatment with more potential benefit than risk.
 - Therefore, as CMS considers finalizing its policies, I urge the agency to:
 - Consider the unintended consequences that could befall seriously ill patients who would experience barriers to receiving appropriate pain management;
 - Consider protections that could be incorporated into opioid-focused measures, such as exceptions for patients receiving hospice and palliative care and other patients with advanced stage serious illness;
 - Rely on clinical evidence regarding the reliability and validity of measures or activities to address public health and safety concerns with opioids;
 - Not finalize actions that are unsupported by evidence, but driven instead by a sense of urgency and may ultimately cause more harm than good.

- Thank you for your consideration of these comments.