hivma
hiv medicine association

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September 10, 2018

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

Re: 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 (CMS–1693–P)

Dear Administrator Verma:

The HIV Medicine Association (HIVMA) appreciates the opportunity to comment on the Proposed Rule for the 2019 Physician Fee Schedule. HIVMA represents more than 5,000 clinicians caring for people with HIV in communities across the U.S.

In October of 2017, CMS announced a new initiative called "Patients Over Paperwork" to "reduce unnecessary burden, to increase efficiencies, and to improve the beneficiary experience."[1] While we support reducing administrative burden and health care costs, we have serious concerns with CMS' proposal to do so at the cost of patient care. In the case of persons living with HIV, this could have disastrous consequences, including reducing the number of medical providers with HIV expertise willing to see patients covered by Medicare. **HIVMA joins with other physician organizations to strongly urge the agency to postpone implementation of the proposal to consolidate the evaluation and management (E&M) codes and cut reimbursement for these services, and instead work with the physician community to refine the simplification of relevant E&M codes and address other aspects of the proposal that threaten the sustainability of patient care for Medicare beneficiaries**.

The proposed rule would collapse the number of codes used to describe encounters for new and existing patients from five to two codes. While CMS proposes to reduce the documentation required with the use of the revised codes, reimbursement for these codes and services also would be cut. CMS also proposes three new add-on codes (for primary care, specialty complexity, and prolonged services) in an attempt to allow for adjustments by physicians to account for cases of higher patient complexity. Far from reducing burden, requiring additional coding actually increases the burden on physicians.

Furthermore, CMS has proposed the application of the Multiple Procedure Payment Reduction policy to E&M visits conducted on the same day as another procedure, resulting in a 50% payment reduction in the less costly physician service provided. Finally, CMS has also proposed creating an outpatient E&M-specific, standard practice expense hourly rate (PE/HR) which creates distortions in the Indirect Practice Cost Indices, causing significant additional reduction in payment rates for certain specialties.

We appreciate that CMS understands the administrative burden endured by providers under the current documentation that applies to all E&M service codes, and we agree with CMS that it is important to address these issues. We support the proposal to allow use of medical staff (MAs, RNs etc.) to document the patient's history and chief complaint with attestation by the physician that this information was reviewed during the encounter. We also recognize CMS for initiating what we hope will be a meaningful effort to correct longstanding deficiencies in both the descriptions and the valuations for office visits. However, HIVMA has significant concerns about aspects of the proposed rule that link documentation changes to payment reductions as well as the use of the proposed add-on codes, and the creation of a new PE/HR rate for the proposed E&M codes.

HIVMA members are committed to providing high quality care to patients with HIV. While advances in HIV treatment have transformed the disease to a chronic condition, a significant number of people living with HIV have serious co-occurring conditions, including hepatitis C, cardiovascular disease, serious mental illness and substance use disorder. The Medicare Programs covers an estimated 20 percent of patients with HIV, and a majority of Medicare beneficiaries with HIV are dually eligible for Medicaid coverage. While patients with HIV generally have a higher level of complexity than the general population, our Medicare patients with HIV are among our most complex, due to the length of time they have been living with HIV, their multiple co-morbid conditions as well as challenging socio-demographic factors. Infectious Diseases Specialists are the largest specialty represented among HIV physicians and according to CMS, the specialty of infectious diseases is ranked 2nd out of 67 specialties when assessing average Hierarchical Condition Category (HCC) risk score and 7th when assessing Medicare-Medicaid Dual Eligible Patient Ratios.[1]

We request a delay in implementing the proposed rule for the following reasons:

1. In analysis conducted by the Infectious Diseases Society of America (IDSA) of the financial impact of the proposed changes on practicing Infectious Diseases physicians, the proposal would result in significant financial losses to ID/HIV physicians who, because of the complexity of cases they see on a daily basis, typically code level 4 and level 5 E&M codes. Whereas CMS suggests in the proposed rule that the impact of the proposed changes would result in a modest increase in overall payments to the specialty of infectious diseases, **the IDSA analysis of the data indicates the impact to be -5.1% of total payments for ID physicians who see patients in the office setting**.[2] In a **separate analysis conducted by the American Medical Association, the**

[1] Medicare Program; CY 2018 Updates to the Quality Payment Program, Proposed Rule. Federal Register / Vol. 82, No. 125, p.30137. Available at https://www.federalregister.gov/documents/2017/06/30/2017-13010/medicare-program-cy-2018-updates-to-the-quality-payment-program

[2] The Moran Company. Infectious Disease Specialists - Impact Summary. Data analysis of 2016 Medicare Physician and Other Supplier Public Use File (PUF), 2018 RVU File (Q4), 2019 Proposed PFS Addendum B. August 2018.

estimated financial impact on ID of the CMS proposed E&M changes and including the impact of the MPPR proposal is -9%.[3]

2. The proposed rule assumes that a reasonable proxy for complexity of a patient is the measure of the time the physician spends with the patient. This assumption fails to recognize that over time a more experienced physician takes less time than a junior physician to perform complex care management and that productivity expectations are often set by practice administrators.
3. The proposed rule and the proposed timeline for implementation of a radical change to outpatient billing without formal and meaningful input from the physician community would set a dangerous precedent for future physician services valuation conducted by CMS.
4. The proposed timeline for implementations would place serious administrative burden on physicians and group practices and could result in disruptions in patient care as practices attempt to adjust their billing systems and budgets that are already in place for the 2019 fiscal year.

Below we provide further detail and rationale for our request of the agency to delay implementation of the proposal related to outpatient E&M codes and the use of add-on codes.

Simplifying the Outpatient E&M Code Set

We support the agency's efforts to simplify coding but believe that two codes will not provide enough granularity to capture the complexity of most of the patients that HIV physicians treat. We would prefer to explore the suitability a three-code structure to allow for differentiation of encounters that involve truly complex patient care. We also take this opportunity to state our belief that non-face-to-face work such as record review often times constitutes a significant level of effort for effective management of complex patients. We hope that CMS will collaborate with IDSA, HIVMA and other medical societies to correct longstanding deficiencies in both the descriptions and the valuations for office visits that recognizes all the work involved in providing high quality care to patients with HIV and other complex conditions.

Improving Documentation Requirements

Documentation requirements, particularly in subsequent care visits, should focus on capturing diagnostic and medical complexity and uncertainty, risk and impact of the care, data management and care coordination. Elements in the record that we think can be used to effectively document complexity and communicate care include the following:

a. Complexity of pertinent patient history and comorbidities (ICD-10)
b. Record review
c. Radiology review, (may involve review with radiology colleagues)
d. Laboratory review and interpretation (may involve communication with lab)
e. Testing request and interpretation

[3] AMA. Estimated Impact of CY2019 Evaluation and Management Proposed Policy by Medicare Specialty. Analysis uses Estimated CY2017 Medicare Utilization and CY2019 Medicare CF for both "Current Method" and "Proposed Method"; E/M MPPR Estimate based on 2016 Medicare Carrier 5% Standard Analytic File. August 2018.

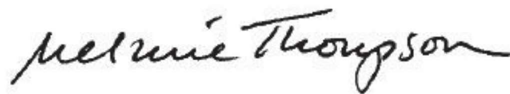
f. Interventions/treatment arranged – drainage, surgery, timing, potential risks and side effects, etc.
g. Follow-up assessments and comparison to prior status via exam, radiology, etc.
h. Care coordination with other providers and arranging care transitions

Assigning Complexity at the Patient-level, not by Specialty

HIVMA supports the work of IDSA, through its involvement with the Cognitive Care Alliance that has advocated for an improved methodology to be adopted in order to appropriately value cognitive care delivered in E/M services. Over the past two years, the CCA has engaged CMS in discussions around funding research to explore better inputs that adequately capture patient complexity. Given the window of opportunity that CMS has presented, we would propose that CMS work with IDSA, HIVMA, the CCA, and other medical societies to explore the application of CMS Hierarchical Condition Categories (CMS-HCC, which are derived from ICD-10 coding) and the related Risk Adjustment Factors to assess medical complexity at the patient level. We are hopeful that these available measures of complexity, currently used by CMS in the Quality Payment Program as well as in the Medicare Advantage Program, might prove useful as a means of capturing patient complexity in association with a simplified E&M code set. Should a three-code set be established then HCC Risk Adjustment Factor ranges could be assigned to each code, with reimbursement reflecting the higher payment for treating patients of higher complexity.

HIVMA appreciates the opportunity to provide input on the proposed rule. We hope you will consider the impact of the rule on the care of Medicare beneficiaries with HIV and other complex conditions and delay implementation of the proposed changes and cuts to E&M services. We welcome the opportunity to work with CMS to reduce administrative burden and healthcare costs while also improving patient care. Please contact the HIVMA executive director Andrea Weddle at aweddle@hivma.org with questions regarding our comments.

Sincerely,



Melanie Thompson, MD
Chair, HIVMA Board of Directors