Texas Health Resources

Healing Hands. Caring Hearts.℠

August 29, 2014

Ms. Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

Re: CMS-1612-P, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for CY 2015; Proposed Rule (Vol. 79, No. 133), July 11, 2014.

Dear Ms. Tavenner,

On behalf of the Texas Health Resources (THR) health care system, including Texas Health Presbyterian Hospitals, Texas Health Arlington Memorial Hospital, and Texas Health Harris Methodist Hospitals, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed changes to the Medicare Physician Fee Schedule for Calendar Year (CY) 2015. We comment on CMS' proposals related to: clinical lab local coverage determination policies; proposed changes to the clinical lab fee schedule; and, the electronic health record incentive program; and, the elimination of the Sunshine Act exclusion for continuing medical education (CME).

THR supports CMS' proposal to add seven new codes to its list of approved Medicare telehealth services and encourages the agency to consider adding other services in future rulemaking.

Secondly, THR is pleased that CMS recognizes the need to pay for services related to chronic care management (CCM), but we suggest that CMS re-examine whether the rate of $41.92 for care management services provided to patients with two or more chronic conditions adequately reimburses providers for the full scope of services. We are concerned about CMS' proposal to expand the scope of services to include a new requirement that physicians billing CCM services must utilize electronic health record technology certified to the most recent version of certification criteria and ask for a reasonable delay in this requirement.

We appreciate CMS' interest in learning more about the relatively recent trend in hospital acquisition of physician practices, but we are concerned that the proposed methodology of creating a Healthcare Common Procedure Coding System (HCPCS) modifier to track services furnished in off-campus, provider-based hospital outpatient departments has not been considered thoroughly. As a result, we urge the agency to reconsider a data collection methodology that is less burdensome, test it among providers, make adjustments as needed and then provide ample time for hospitals to implement the change.

THR agrees that monitoring and evaluation of innovative payment and service delivery models being tested by the Center for Medicare and Medicaid Innovation (CMMI) is necessary. However, the proposal to require CMMI participants to provide large amounts of individually

identifiable health information raises significant privacy concerns and would impose a large administrative burden on hospitals participating in such models.

In addition, while we share CMS' goal of promoting physician quality improvement, THR strongly urges the agency to adopt the following changes to its physician quality measurement proposals:

- CMS should not increase the maximum payment penalty of the Physician Value-Based Payment Modifier (VM) from 2.0 to 4.0 percent until it can adequately address the program's significant data reporting, risk adjustment and measure testing issues.
- Instead of requiring the VM apply to participants in the Medicare Shared Savings Program (MSSP) and CMMI initiatives, CMS should create a "VM Innovation Pathway" in which individual, eligible professionals and groups participating in MSSP and CMMI initiatives are automatically given a zero percent adjustment in the VM. Such an approach could avoid potentially inappropriate comparisons of performance, strengthen the incentive for physicians to participate in innovative care delivery models and minimize the risk of sending "mixed signals" to physicians about their quality performance.
- CMS should not mandate the reporting of the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS) for the Physician Quality Reporting System (PQRS) until CY 2016 (affecting CY 2018 PFS payment) at the very earliest. While we strongly agree with the value of patient experience, physicians may need more time to plan for the significant costs of implementing CG CAHPS.

Furthermore, while THR is concerned about the proposed changes to the MSSP's measure set, we appreciate that the agency has proposed two changes that are responsive to the concerns raised by hospitals participating in the MSSP. Specifically, we applaud CMS for proposing to adopt a predictable schedule for updating performance benchmarks, and to award bonus points to accountable care organizations demonstrating year-to-year performance improvement.

Current law relating to the Open Payments (Physician Payment Sunshine Act) program requires applicable drug and device manufacturers and group purchasing organizations (GPOs) to disclose any ownership or investment interests in such entities held by physicians or their immediate family members, as well as information on certain payments or transfers of value made to physicians and teaching hospitals. It also excludes the reporting of payments associated with certain continuing medical education (CME) events (those meeting the accreditation or certification requirements and standards of certain listed organizations). In general, THR is supportive of sound and reasonable policies aimed at making financial relationships between pharmaceutical and medical device companies and physicians more transparent.

CMS, in the new proposed regulations, seeks to eliminate the current exclusion for certain CME events because it believes this may have the unintended consequence of appearing to endorse or support the continuing education events of some accrediting organizations but not others. CMS, however, also provides for reporting exclusion in cases where a sponsoring manufacturer is unaware of the identity of the speakers for 18 months, which together could be impracticable since most of the CME program agendas and speakers are publicly noticed prior to and during the events. CMS also proposes two alternatives to current requirements, to expand the current list of accreditation organizations or to establish exclusion qualifying

accreditation or certification standards, which CMS itself notes may not address the concerns of endorsement or how and who would enforce the accreditation/certification standards.

CME and Continuing Education (CE) are vital components of THR's healthcare system and this education allows our healthcare workforce to remain up-to-date on the latest in medical science. Accredited CME and CE is the gold standard with strict standards to guarantee independence from commercial influence.

In the February 2013 Final Rule on Sunshine Act implementation, CMS created a bright line "CME exemption" that made it clear to physician participants that they could present at, and attend, accredited continuing medical education programs without concern that this would result in their being listed in the Open Payments system. This in turn resulted in physicians avoiding the potential intimation that they had been improperly influenced by commercial interests.

THR understands that the proposed revision to the rule would mean that exempt third-party transfers to CME and CE, only when an industry donor is unaware of physician participation (as speakers, faculty, or attendees) in a continuing education activity either before or after the activity takes place. This raises serious concerns for THR because this type of information is readily available through brochures, program books, and through other communication methods. As such, it would be difficult for funders to claim that they are not "willfully ignorant" about this information during or after the program. Indeed, this information is often freely available in advance of a CME or CE activity takes place through marketing materials for the activity.

In order to support CMS' intention to expand the field for the exemption, while at the same time avoiding the unintended consequence of making funders "willfully ignorant" of the names of speakers/faculty/attendees, THR recommends that CMS modify the language in the proposed rule to clarify that the exemption applies under section 403.904(g)(1)(i) when an applicable commercial supporter provides funding or in-kind support to a CME/CE provider but does not select or pay the covered recipient speaker/faculty/attendee directly, or provide the CME/CE provider with a list in any format of individuals to be considered as faculty/speakers/attendees for the activity. This could be addressed by the agency providing guidance that the above mentioned is achieved if the commercial supporter is unaware of the speakers/faculty/specific attendee names before signing an agreement to commit to providing the commercial support for a specific activity. Furthermore, this guidance should clarify that if commercial supporters become aware of the names of speaker/faculty/attendees, after the commitment to support the activity is made, the activity will remain exempt.

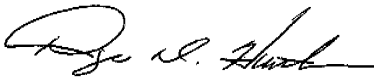
THR urges CMS to ensure that indirect commercial support for CME programs and services, where the accredited provider exercises complete control over the content and speakers/faculty, remains exempt from reporting under the Open Payments system. Overall, CME is an important element of THR's healthcare system because it improves physician knowledge and competency; enhances patient outcomes; and, reduces costs, increases efficiency, and fosters collaboration. It is easily conceivable that the consequence of the proposed changes could result in fewer participants, fewer faculty, fewer supporters and a reduction in the number of CME offerings provided by our healthcare system. It is vital to the health and well-being of our patients that THR's healthcare workforce remain well educated and informed on the latest medical science in their respective fields. Thus, we urge CMS to

build upon current accreditation standards and provide clear and realistic timeframe regarding sponsor notice as it considers proposals to eliminate the current CME exclusion.

THR is also deeply concerned that physician payments will decline by an estimated 21 percent on April 1, 2015 due to the flawed sustainable growth rate formula. Cuts of this magnitude are unsustainable. We urge CMS to work with Congress to fix the flawed physician payment formula permanently, and to do so in a manner that does not result in reduced payments to hospitals and other providers.

In closing, Texas Health Resources appreciates the opportunity to share our comments on the proposed rule. If we can provide you or your staff with additional information, please do not hesitate to contact Joel Ballew, Vice President, Government and Community Affairs, Texas Health Resources at JoelBallew@texashealth.org, or by phone at 682-236-6794.

Sincerely,



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