TMA Tennessee Medical Association — Physicians Caring for Tennesseans

September 2, 2014

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS–1612–P
P.O. Box 8013
Baltimore, MD 21244–8013

RE: 2015 Physician Fee Schedule Proposed Rule Comments

To Whom It May Concern:

Please accept these comments to the proposed Revisions to Payment Policies Under the Physician Fee Schedule published starting on page 40318 of the Federal Register Vol. 79, No. 133 on Friday, July 11, 2014 submitted on behalf of the Tennessee Medical Association (TMA). TMA is the oldest and largest volunteer medical society in Tennessee representing all medical specialties and all geographic areas of the state. We have nearly 8000 physician and medical student members. The vast majority of our members are participating providers in the Medicare program. The rules proposed therefore directly impact most of our members.

Surgical Global Period

We are deeply concerned with CMS' proposal that would transition all 10-day and 90-day global surgical codes to 0-day global codes. CMS' proposal stems from concerns raised by the Department of Health and Human Services Office of Inspector General (OIG), the Government Accountability Office (GAO), and the Medicare Payment Advisory Commission (MedPAC) about various aspects of the global surgical package, including the number and level of post-operative visits actually furnished compared to the number and level factored into the bundled payment amount. We appreciate CMS' intent to better understand the value of each discrete service independent of the services with which they are packaged, but despite this, we still have concerns about the impact this proposed change will have on patients, how we anticipate CMS will implement this policy, and how other payers will respond to a new payment structure for services that were once "bundled."

The TMA is not convinced that CMS and other federal agency partners have fully considered the impact of eliminating the global surgical package on beneficiaries. Anticipated consequences include disruptions in beneficiary care, poor quality outcomes, and increased financial burden. Additionally, the administrative burden on practices will increase as claims will have to be submitted, tracked and reconciled for each follow up visit. Currently, only one claim is required for the entire episode of care.

Beneficiaries, many of whom are on fixed incomes, may be less likely to receive the post-operative care they need if those visits will have a separate co-payment. Even if the total out-of-pocket outlay would be the same (or less), patients may discontinue their follow-up care too soon in order to avoid the additional copayments. This disruption in care could lead to a poor quality outcome, or worse, a failed treatment. This is particularly true for beneficiaries undergoing forms of surgery as the beneficiary may believe that important, medically necessary post-operative follow-up is not required if they "feel fine".

Many Medicare beneficiaries elect to participate in a Medicare Advantage plan, in which they have a substantial co-payment for each visit. Often this co-payment may be $40 or even $50 dollars. In these cases, the beneficiary absorbs a considerable cost of the follow up visits. This financial burden will induce some patients to forgo follow up visits, compromising the final outcome of the procedure.

In addition, beneficiaries who see a physician who practices in a hospital-owned provider-based clinic, could be subject to additional cost-sharing and co-payments given the addition of a facility fee on top of the physician fee. This would also result in higher spending in an already financially strained Medicare program fund.

Since some patients will require more post-operative visits than the "typical patient" scenario used to value the current global RVUs, the net co-payments for patients in some instances will be greater than currently paid under the global payment policy. Not only could this provide a disincentive for follow-up care, but if implemented, CMS will be burdening patients with an additional financial strains.

The TMA is also concerned with the mechanism by which CMS would unbundle and revalue each discrete service. Simply "backing out" the post-operative visits and other discrete services would be inappropriate and could lead to a payment amount that does not reflect the true cost of providing the service, as the values established through the AMA, RUC and CMS are based on the "typical patient." The time and effort it would take to revalue each discrete service does not outweigh the benefit to unbundling the global surgical package.

Finally, we are very concerned with how other private insurers would respond to CMS' action if finalized. It is not clear whether health plans would follow-suit, and if they did not, the administrative burden to practices and the confusion by patients would be overwhelming.

For these reasons, we vehemently urge CMS to reconsider any move to unbundle global surgical codes.

G-Code Monthly Payment

This portion of the proposed rules establishes an actual G-code amount per beneficiary, apparently in the range of $41-$45 on average, to monitor patients with multiple chronicity. TMA believes that this is a step in the right direction, recognizing the value of these services. It will be critically important to obtain feedback from primary care physicians regarding the cost of providing these services.

Medicare patients are some of the most challenging patients to monitor and treat because of multiple co-morbidities. We believe that data shows that 60% have four or more chronic conditions. If this proposed rule is adopted, primary care physicians for the first time could be paid for taking care of Medicare beneficiaries with two or more chronic conditions without providing a face-to-face patient encounter. That could mean coordinating care provided by specialists; managing lab and imaging reports, medications and care plans; and talking with patients and family members on the telephone. These are services primary care physicians and patient-centered medical homes commonly provide, but for which they are not specifically paid.

We have an additional concern. The G-code will be difficult to bill for without clarification from CMS. The proposed rule requires physicians to have electronic health record systems that are certified under 2014 meaningful use standards and to have care plan and structured data capabilities that capture claims information. However, the 2014 meaningful use standards do include that requirement.

Physicians must not be burdened with more administrative requirements than are needed to justify billing with G-codes.

Cuts in Payment for Colonoscopies

CMS's proposed fee changes contain significant cuts in payments for certain common codes used for colonoscopy and upper endoscopy procedures even though these procedures are screening in nature and designed to ultimately save costs through early detection. Last year, in the proposed 2014 rule, CMS had very few reduced payment changes, but in the final rule, several common procedures were cut as much as 30%. We do not wish to see the same result in the final 2015 rules.

CMS is proposing to do away with the current ability of anesthesiologists to bill CMS separately for sedation services during colonoscopies, and instead cover the entire service as a bundle. That way, patients will not be billed twice for separate Part B co-payments, one for the gastroenterologist and another for the anesthesiologist. The TMA is all for simplification as long as it does not result in more cuts in payment to physicians. Simplify the billing structure but do not reduce the reimbursement level as a result.

Increase in PQRS Reporting Requirements

Quality reporting requirements will be increased with the advent of penalties. CMS will impose a 2 percent payment penalty for physicians who fail to meet the 2015 Physician Quality Reporting System (PQRS) requirements and is proposing additional requirements physicians will need to fulfill. At the same time, the rules propose to cut the period physicians have to request an informal review of a PQRS penalty from 90 days to just 30 days. Thirty days is not enough time for medical practices to assimilate this information and perfect an appeal. CMS is shooting itself in the foot by shortening the appeal provision. Physicians failing to meet the requirements will merely file an appeal just for the purpose of perfecting it in time and then review the data. By leaving the appeals provision at 90 days, fewer appeals will be filed and CMS will not endure as much of a backlog in dealing with them.

Public Reporting of PQRS Data

PQRS data will be publicly reported. The rule proposes making all 2015 measure data from group practices available in 2016. CMS plans to publish individual measures for all physicians on the Physician Compare website later in 2016. We urge that data not be published until the well documented problems with the website are cleared up. Otherwise, physicians will continue to have problems and the website will publish flawed data. The federal government does not need any more embarrassment regarding flawed websites.

Timeline for Changing Physician Codes

The proposed rules provide for a new timeline for changing physician codes and service values, effective in 2016. The proposed revised timeline will mean physicians can submit recommendations no later than January 15 for the following year – 11 and ½ months before the change would be in effect. The change not only will severely limit recommendations from the Relative Value Scale Update Committee (RUC) and CPT® Editorial Panel but also, according to the AMA, it would increase the time for a new or revised code to be included in the Medicare fee schedule from 10-20 months to 20-27 months. The TMA support AMA's proposed revisions that would provide greater transparency and better alignment between relative value unit recommendations and the regulatory process.

Local Coverage Determination Process for Clinical Lab Testing

CMS has proposed to alter the local coverage determination process for clinical laboratory testing. One proposed change is the elimination of the requirement to present a draft Local Coverage Determination (LCD) to a Contractor Advisory Committee (CAC). We have found the CAC meetings to be productive in Tennessee and a useful exchange of ideas between physicians and the Medicare carrier, Cahaba GBA. As such, we would not like to see a change in how LCDs are promulgated. Physician practices have little time to monitor websites for changes and submission of written comments are not as productive as physician to physician dialog with the Medicare carrier.

Sunshine/Open Payment

CMS proposes to eliminate the so-called CME exclusion from the requirement for reporting financial relationships between providers and the pharmaceutical industry. The exclusion did not require reporting of payments that were targeted at Continuing Medical Education. That made sense. Physician speakers at CME events are not chosen by the industry. Many times physician speakers do not even know that a pharmaceutical company is sponsoring a CME program. This mutual unawareness of the identity of speaker/sponsor places CME events at a very low risk of abuse so as to have to come under the Sunshine Act reporting requirement. Payments made for most CME should still not required to be reported because they are indirect payments in which the provider is unaware of the source of the funding and the manufacturer does not suggest, select or directly pay for covered speakers.

Osseointegrated Hearing Devices

Since 2005, Bone Anchored Hearing Devices (BAHD) have been classified as prosthetics; not hearing aids. As such, the costs for these devices and the surgeries associated with their implantation and on-going therapy have been covered by Medicare. As a result, many Medicare patients have been able to recover a significant portion of hearing they had lost due to damaged, diseased, or dysfunctional ear function.

Hearing aids are removable sound amplification devices. BAHDs are distinguishable from hearing aids in that 1) they are implanted and 2) they act as a replacement for the ear system “organ” as opposed to enhancing the existing organ. This replacement of the organ function acts in much the same way as an eye lens implant used in cataract surgery enables a patient to see or a hip replacement hardware allows a patient to walk without assistance.

In these examples, CMS has, until this point, classified the procedures, devices, and requisite surgeries and therapies as prosthetic in nature and covered by Medicare. In 2013, CMS paid out $9 million for all related BAHD procedures, an extremely small amount of the net Medicare expenditures of $492 billion during the same time period.

CMS is not seeking to revise the definition of BAHD utilization because the prostheses are unproven or experimental in nature. To the contrary, this therapy results in upwards of a 90% success rate, and the technology has, and will continue, to improve rapidly.

Additionally, the external BAHD device is easy to use with minimal encumbrance for almost any daily activity, and performs properly without medical intervention as long as basic personal hygiene and device maintenance instructions are followed. The TMA urges CMS not to adopt the portion of the rules that would reclassify BAHD as hearing aids instead of prosthetics.

Absence of SGR Repeal

The TMA concedes that the proposed rules cannot be used to address an SGR repeal. However, adoption of these rules will result in a 20.9% cut in physician reimbursement due to the flawed formula.

TMA Tennessee Medical Association — Physicians Caring for Tennesseans

For the 12th consecutive year, the proposed fee schedule reflects an SGR-mandated payment cut to physicians. While this will likely lead to another last minute patch, temporary fixes are not the answer to sustain access to quality care for our elderly population. Physicians seek stable payment sources in order to keep their doors open, especially in rural areas. Post-ACA enactment, we are seeing health plans increasing the number of high deductible products and narrowing networks resulting in a threat to the stability of physician reimbursements. Decisions on participation cannot wait until the proverbial "eleventh hour" and the inevitability of a fix is never a given in the mind of physicians. We understand Congress ultimately must take action to repeal the SGR but to propose cuts in these rules in addition to the projected -20.9% is disingenuous. Tennessee physicians are fed up with this charade.

Finally, the Tennessee Medical Association would like to draw your attention to the comments submitted on August 29 by the American Medical Association and hope that its suggestions are incorporated in the final rule. TMA and its 8000 members appreciate the opportunity to furnish these comments on the proposed 2015 Physician Fee Schedule rules.

Sincerely,

Yarnell Beatty
Vice President of Advocacy
Tennessee Medical Association

2301 21st Avenue South □ P.O. Box 120909 □ Nashville, TN 37212 T 615.385.2100 □ TF 800.659.1862 □ F 615.383.5918 www.tnmed.org